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COMMUNITY HEALTH CENTERS: SAVING LIVES, SAVING MONEY

HEARING

OF THE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

UNITED STATES SENATE

ONE HUNDRED EIGHTEENTH CONGRESS

FIRST SESSION

ON

EXAMINING THE COMMUNITY HEALTH CENTERS

MARCH 2, 2023

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C O N T E N T S

STATEMENTS

THURSDAY, MARCH 02, 2023

COMMUNITY HEALTH CENTERS: SAVING LIVES, SAVING MONEY

Thursday, March 2, 2023

U.S. SENATE,
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,
Washington, DC.

The Committee met, pursuant to notice, at 10:02 a.m., in room 430, Dirksen Senate Office Building, Hon. Bernard Sanders, Chairman of the Committee, presiding.

Present: Senators Sanders [presiding], Murray, Baldwin, Kaine, Hassan, Smith, Hickenlooper, Markey, Cassidy, Collins, Murkowski, Braun, Marshall, Romney, Mullin, and Budd.

OPENING STATEMENT OF SENATOR SANDERS

The CHAIRMAN. The Committee on Health, Education, Labor, and Pensions will come to order. Today, we are going to be taking a hard look at a major crisis in America, and that is that millions of our people do not have access to the health care that they need.

The point that I, and I think some of our panelists will be making over and over again, is not only is this unfair to working class, to lower income Americans who cannot access a medical home when they need it, and we are losing over 60,000 people a year because they don't get to a doctor on time, but in addition to that, from a financial and cost effective perspective what we have now is basically insane.

We have a situation where when people get sick, they don't go to the doctor. And you know what happens when you don't go to the doctor and you are sick, you get sicker and maybe you end up in an emergency room where the cost of primary care is 10 times or 8 times more than it is if you walked into a community health center.

If you can't afford prescription drugs, you get sicker and you may end up in the hospital at a cost of $100,000. So, what we are talking today about is two things. My own personal view, not shared by everybody on this dais, is that health care is a human right and that we should emulate what goes on around the rest of the world and guarantee health care to all people.

I don't have the votes to do that. But I do hope, and by the way I think we are making progress, in a bipartisan way at least saying, whether you are in rural Indiana or rural Vermont or Louisiana, or you may be in New Hampshire, that you do have the

right to get into a doctor's office and save the health care system substantial sums of money.

It is a funny thing. We had a hearing a couple of weeks ago on the crisis in the health care workforce, and it turns out that there was strong bipartisan support. Nobody denied the fact that we need more doctors, and nurses, and dentists, and mental health practitioners, and pharmacists.

We all understood that. And ironically enough, I mean, to talk about nonpartisanship, the witness that Senator Casey brought was, I thought, brilliant, talking about what was going on in Louisiana, doing extraordinary work——

Senator CASSIDY. Cassidy not Casey——

The CHAIRMAN. Oh, I am sorry.

[Laughter.]

The CHAIRMAN. Casey was good, too.

[Laughter.]

The CHAIRMAN. But you were better.

Senator CASSIDY. Yes.

Senator KAINE: All the Irish guys look alike.

The CHAIRMAN. There you go.

[Laughter.]

The CHAIRMAN. But the witness that Senator Cassidy brought from Louisiana was, I thought he was great. Could have been our witness. We brought Dr. James Herbert from New England University. It turns out I first met Dr. Herbert through Susan Collins. That was our witness.

Two years ago, it was her witness. All right, why is that? Because I think we all understand we have got a crisis. We have got to work together. So, our challenge right now is to do the right thing for the American people and say that when you get sick, there will be a medical home for you to go to.

Our other job right now is to say that in a health care system which spends $13,000 per person, that is an insane amount of money. That is double what any other major country does. That we understand when we invest in primary health care, we are going to save the system money.

That is the struggle we have. And I am determined to do everything I can in a bipartisan way to make sure that we put together the kind of primary health care system the American people want us to do. So, with that, let me introduce Senator—what is the last name? Cassidy?

Senator CASSIDY. Collins. Collins.

[Laughter.]

OPENING STATEMENT OF SENATOR CASSIDY

Senator CASSIDY. Today we are discussing an important piece of health care infrastructure, community health centers. I am a doc. I worked on Louisiana Safety Net or Charity Hospital System for over 25 years.

I know how community health centers provide primary care to low income and uninsured patients, and also provide behavioral health, dental services, and other care essential to those folks, our fellow Americans. And this is a topic we can agree upon. Now, I hate to be a fly in the ointment of what should be a good hearing, but I am a little bit upset that the majority chose not to work with Republicans in developing the hearing.

There is no reason we could not have gone through the basic bipartisan Senate procedure to hold a bipartisan hearing. Republicans support this issue. Now, calling partisan hearings is a prerogative of the Chairman, but for issues like this there is no reason our staff should not be working together from square one.

I raised this because last week the Chairman made a wonderful comment. He said that hearings should not be by themselves a hearing. They should be a gateway to bipartisan legislation. But it is difficult to have a bipartisan legislative agenda if the hearings that serve as a prelude are partisan. We can have fruitful hearings, produce meaningful legislation when the minority is engaged and able to contribute.

But in this case, the minority must be included in the planning of the hearing. That said, we look forward to hearing—listening to our witnesses and learning more about what we can do to address the needs of patients who depend upon community health centers. In Louisiana, there is over 350 health center sites serving over 400,000 patients per year.

Over a third are in rural areas, and rural communities tend to be older and at times to have a greater disease burden with fewer physicians and other health care personnel available. These factors make community health centers work all the more important.

Now, this Committee must reauthorize the Community Health Center Fund before September 30th. As Ranking Member, getting this and other reauthorizations done on time and in a fiscally responsible way is my priority. To do this effectively, we need an understanding of the full picture.

The landscape of community health centers has changed significantly since the Affordable Care Act was passed, and the mandatory Community Health Center Fund was created. Ms. Farb from the Government Accountability Office will give us color on this from their most recent work from 2019. And here is my chart.

GAO's report shows that health centers revenue more than doubled from 2010 through 2017. Further the GA—so here is where we are now, this is where we were. Further GAO's review raises the question, in fact points out, that community health centers have become less dependent upon grants as revenue from Medicare, Medicaid, and private payers has increased. And so here is Medicaid back then, here is Medicaid now.

Much, much greater growth. Grants have grown too, but you can see that Medicare has gone up, private has gone up, other, and it is unclear to me if other includes 340B because—and Ms. Farb is kind of shaking your head no. And 340B is an incredible source of revenue that I don't even think we know how much there is there.

This is not to say that increased funding for health centers is not needed. That is what we will discuss today. But to underscore the fiscal climate we are in, Americans expect and deserve a full and thorough review of how their tax dollars are spent.

As Ms. Farb is aware, this week I requested the GAO update its work on sources of funding for community health centers, and I ask unanimous consent to insert that request into the record.

The CHAIRMAN. Without objection.

[The following information can be found on page 109 in Additional Material:]

Senator CASSIDY. Thank you, sir. As policymakers, this information is critical to making informed decisions, especially when speaking about mandatory spending. So, Ms. Farb, I thank you in advance for taking this project on.

Last, the Community Health Center Fund reauthorization needs to be paid for and high protections maintained. We agree. As a physician, I will say an ounce of prevention is worth a pound of cure. If we improve health on the front end, we avoid costly care on the back end. The Chairman and I, we are together on that.

However, we know that the Congressional Budget Office must operate within scorekeeping rules. More spending, from their perspective, is more spending. There are a lot of figures that will be used today about health center savings for the overall health care system. I have seen $24 billion, $25 billion.

Some of these statistics are based upon data from 2006. Now, it is interesting to think about how CBO could account for savings based on prevention, but they haven't in the past, and I don't think any of us think that data from 2006 is a basis for picking amounts.

Now, health centers do great work, but as we know in competing priorities, mandatory funding for health centers still needs to be paid for. In closing, I thank our witness panel. I look forward to hearing how health centers are using investment from the Federal Government to provide essential care.

Particularly as we sit down and understand this year's reauthorization of the community health centers, we need your information. With that, I yield.

The CHAIRMAN. Okay. Thank you very much, Senator Cassidy. I just wanted to briefly respond to Senator Cassidy's opening thoughts about this being a quote unquote, bi—part of this being a partisan hearing. I don't see it that way.

I think we you and I have a disagreement is I think the minority has a right to invite any witness that you want. And I think the majority has a right to invite any witness we want. I don't want you to have to clear your witnesses with me. We are not going to clear all witnesses with you.

I think so far, we have had wonderful witnesses on both sides. And I think that is the way we should proceed in a democratic society. All right, with that, let us hear from our panelists. And I thank you all very, very much for being here. I have read your testimony. It is, I think, very strong.

Let's begin with Amanda Pears Kelly, who is the CEO of Advocates for Community Health, whose members include some leading—some 30 leading health centers around the country.

Amanda is also the Executive Director of the Association of Clinicians for the Underserved. She has many years of experience working to expand access to high quality primary care to those who need it most. Thank you so much for being with us.

STATEMENT OF AMANDA PEARS KELLY, CHIEF EXECUTIVE OFFICER, ADVOCATES FOR COMMUNITY HEALTH, EXECUTIVE DIRECTOR, ASSOCIATION OF CLINICIANS FOR THE UNDERSERVED, WASHINGTON, DC

Ms. PEARS KELLY. Thank you so much, Chairman Sanders, Ranking Member Cassidy, and distinguished Members of the Committee. My name is Amanda Pearce Kelly. I am the Chief Executive Officer of Advocates for Community Health, ACH.

ACH, as you heard, is a membership organization of community health centers focused on advocacy to grow integrated primary care and cutting-edge innovation in our field. I have worked with community health centers in some capacity my entire career. Growing up in Maine, there were times where a federally qualified health center was actually my primary source of care.

I am honored to testify today on behalf of the 30 million patients that health centers serve, and on behalf of our incredible members, to shed more light on how community health centers save lives and save money.

As other witnesses will testify, there has been consistent data over time that community health centers perform exceptionally well and do so at a lower cost than other providers in other primary care settings.

As noted in the testimony of Dr. Robert Nocon at the Kaiser Permanente School of Medicine, community health centers were estimated to save a total of $25.3 billion for the Medicaid and Medicare programs in 2021.

Community health centers have a five-decade history of success. But in the past few years, they have overperformed in five key areas that I detailed in my written testimony. Today, I want to highlight two.

First, rural health care. Community health centers are responding to the growing health care access crisis in rural areas. Between 2010 and 2021, 136 rural hospitals closed. Research has shown that in areas previously served by a rural hospital, there is a higher probability of new community health center delivery sites post closure.

Over time, most rural areas are seeing an increase and access to community health centers. And community health centers are not only part of the solution to preserving access to care in rural communities that might otherwise go entirely without. They are also an economic driver contributing to long term financial stability.

Every community health center's workforce and governing board is built from the community that it serves, and these facilities are often among the largest employers in the surrounding area.

Second, building and retaining the health care workforce. The foundation of community health center quality care is their integrated, interdisciplinary workforce, and community health centers proudly serve as the training ground for a country's primary care workforce.

To recruit, train, and retain workers, community health centers leverage HRSA's health care workforce scholarships and education loan programs, which help train a diverse workforce, including the National Health Service Corps and the Teaching Health Center Graduate Medical Education Program.

A critical factor I would like to call out is that community health centers' extraordinary growth has dramatically outpaced funding. From Fiscal Year 2015 to 2021, total community health center funding increased by 11 percent, while the number of patients served increased by 24 percent, from 24.1 million to more than 30 million today.

Similarly, the number of health center visits reached a record 124 million in 2021. Unfortunately, community health centers are facing an unprecedented set of financial challenges, and immediate and long-term funding is more vital than ever before.

Medicaid unwinding will lead to an estimated $2.5 billion loss in funding for health centers. Expiration of ARP funding eliminates up to 7 percent of health center bottom lines and a vital source of workforce funding.

92 percent of community health centers surveyed said that they would have experienced additional turnover without funding or other benefits from the American Rescue Plan. Contract pharmacy limitations, PBM discrimination, and state claw backs has also led to significant decline in 340B revenue for health centers.

Indeed, the stakes are very high, but I am here today to make a bold ask. HHS's vision for community health center funding, $30 billion by 2030, isn't rooted in dollars and cents. It is rooted in a vision of what we can achieve for our patients, our communities, and all those in need, and also savings across our health care system.

We have seen what we can do with flat funding, but we want to push ourselves even further. Specifically, by 2030, we aim to serve 40 million patients, train 25,000 additional providers, increase the percentage of community health centers reaching national clinical benchmarks by 25 percent, increase the percentage of community health centers participating in value-based care by 20 percent, develop and bring to scale at least 15 innovative interventions to address social determinants of health.

We are requesting a 5-year extension of the Community Health Centers Trust Fund beginning at $6.2 billion in Fiscal Year 2024 and scaling up to $10 billion in Fiscal Year 2028. We realize these are large amounts of funding in a difficult fiscal time for our Country, but I want to call out a few saving stats from my written testimony and in general.

For every dollar invested in primary care, $13 is saved in downstream cost. We know that health centers specifically save $24 billion to the system a year. We also know that for every $1 invested

in health centers, $3 are returned. Investing in health centers doesn't just save lives, it saves money.

I hope my testimony today made the case that community health centers are the best place to invest scarce Federal resources. Not only do community health centers have a proven track record of savings, accountability, and positive economic impact, they are the breeding ground for an invaluable innovation to drive further savings and better health outcomes, all while responding to localized needs of their community.

Congress has the opportunity to set this vital health care system on the right path for the future. Whether measured in lives or dollars, there is no better health care investment than the health center program.

We look forward to working with the Committee and your colleagues on a bipartisan basis, and I thank you so much for the opportunity to testify, and welcome questions.

[The prepared statement of Ms. Pears Kelly follows:]

PREPARED STATEMENT OF AMANDA PEARS KELLY

Thank you, Chairman Sanders, Ranking Member Cassidy, and distinguished Members of the Committee. My name is Amanda Pears Kelly, and I am the Chief Executive Officer (CEO) of Advocates for Community Health (ACH). ACH is a membership organization of community health centers focused on visionary and innovative policy and advocacy initiatives to affect positive change for community health centers, the patients they serve, and the Nation's health care system as a whole. Rooted in community health, our members are forward-thinking community health centers that lead the way in comprehensive, integrated primary care and cutting-edge innovation to help shape a rapidly evolving health care landscape.

I have been working with community health centers in some capacity my entire career. Growing up in Maine, there were times when a federally qualified health center was my primary source of health care. I'm honored to testify today on behalf of the 30 million patients served by community health centers and our fantastic members, to shed more light on how community health centers save lives and save money.

In my testimony, I will make the case that increasing investment in community health centers is the best investment you can make in health care—delivering cost savings, patient health, and community well-being. I will outline the extraordinary surge in services provided by community health centers since the last time Congress considered the Community Health Center Trust Fund, how it dovetails with a perfect storm of financial challenges community health centers currently face, and how Congress can make an investment that can truly transform our Nation's primary care system.

I. Introduction

As other witnesses will testify, there has been consistent data over time that community health centers perform exceptionally well and do so at a lower cost than other providers and other primary care settings. Across the board, being connected to primary care services leads to better outcomes and lower costs. Recent research has shown that, for every $1 invested in primary care, $13 is saved in downstream costs.[1] Of the 4.3 trillion dollars in health spending in the U.S. every year, the Nation only spends 5 percent on primary care. However, research has shown that if the U.S. spent closer to 12 percent,[2] it would cut per-patient costs and lead to a decrease in overall health care expenditures. And the most effective way to achieve a return on investment from primary care is to invest in community health centers,

[1] Sherril Gelmon et al., "Implementation of Oregon's PCPCH Program: Exemplary Practice and Program Finding" (Oregon Health Authority, September 2016), *https://www.oregon.gov/oha/HPA/dsi-pcpch/Documents/PCPCH-Program-Implementation-Report-Final-Sept-2016.pdf*.

[2] Robert L. Phillips and Andrew W. Bazemore, "Primary Care And Why It Matters For U.S. Health System Reform," *Health Affairs* 29, no. 5 (May 2010): 806–10, *https://doi.org/10.1377/hlthaff.2010.0020*.

which are the gold standard of primary care—comprehensive, patient-centered, patient-governed, accountable, competitively funded, and tailored to the needs of local communities. As my colleagues at the National Association of Community Health Centers (NACHC) found in a recent survey, **without community health centers, 15 million more patients would be at risk for not having a usual source of primary care**.[3]

Community health centers innovate in various ways. These innovations range from data infrastructure to school-based health centers. They include providing an emergency room, integrating transition of care for incarcerated patients, advancing maternal and child health, offering dental procedures and optometry care, integrating behavioral health and substance use treatment, using mobile units to reach patients where they live and work, and providing Programs of All-Inclusive Care for the Elderly for frail dual eligible beneficiaries to allow those patients to stay within their community.

Community health centers continue to be a cost-effective option for both patients and the health care system alike. After controlling for health status, health insurance coverage, income, age, and other factors, patients who received a majority of their ambulatory care at community health centers had significantly lower annual overall medical expenditures (24 percent) and ambulatory expenditures (25 percent) than those who did not.[4] This also held true for Medicaid patients, where health centers save 24 percent per patient compared to other providers,[5] and Medicare patients, where costs for health centers are 10 percent lower than physician office patients and 30 percent lower than outpatient clinics.[6] As noted in the testimony of Dr. Robert Nocon at the Kaiser Permanente School of Medicine, **community health centers were estimated to save a total of $25.3 billion for the Medicaid and Medicare programs in 2021**.[7]

Furthermore, not only do community health centers save the health care system and patients money, but they also serve as economic engines for under-resourced neighborhoods. In 2019, community health centers generated $63.4 billion in total economic activity, of which $32 billion were indirect economic impacts generated from supporting local businesses.[8] A national and local study by Capital Link has shown that, for every dollar of Federal funding invested in community health centers, $11 is generated in total economic activity through increased spending on related health service expenses, food services, transportation, construction, and more.[9]

II. Community Health Center Expansion of Services

Community health centers have a five-decade history of success, but in the past few years, these hyper-local health care hubs have been met with new and challenging circumstances. In response to these unprecedented challenges, they have once again stepped up and demonstrated their full potential. I will highlight five areas of particular contribution: confronting the COVID–19 pandemic, caring for rural communities in the wake of decreasing access, providing critical behavioral health services, addressing the social determinants of health (SDOH), and serving as major employers and economic drivers even in times of economic downturn.

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[3] "Closing the Primary Care Gap: How Community Health Centers Can Address the Nation's Primary Care Crisis", (National Association of Community Health Centers, February 2023), *https://www.hcadvocacy.org/wp-content/uploads/2023/02/Closing-the-Primary-Care-Gap—Full-Report—2023—digital-final*.

[4] Patrick Richard et al., "Cost Savings Associated With the Use of Community Health Centers," *The Journal of Ambulatory Care Management* 35, no. 1 (March 2012): 50, *https://doi.org/10.1097/JAC.0b013e31823d27b6*.

[5] Robert S. Nocon et al., "Health Care Use and Spending for Medicaid Enrollees in federally Qualified Health Centers Versus Other Primary Care Settings," *American Journal of Public Health* 106, no. 11 (November 2016): 1981–89, *https://doi.org/10.2105/AJPH.2016.303341*.

[6] Dana B. Mukamel et al., "Comparing the Cost of Caring for Medicare Beneficiaries in federally Funded Health Centers to Other Care Settings," Health Services Research 51, no. 2 (April 2016): 625–44, *https://doi.org/10.1111/1475-6773.12339*.

[7] Robert Nocon (Kaiser Permanente Bernard J. Tyson School of Medicine). "Testimony on Community Health Centers: Saving Lives, Saving Money before the U.S. Senate Committee on Health, Education, Labor and Pensions Committee." (March 02, 2023).

[8] "Community Health Centers Are Economic Engines" (National Association of Community Health Centers, October 2020), *https://www.nachc.org/wp-content/uploads/2020/12/Economic-Impact-Infographic-2.pdf*.

[9] "Health Centers Provide Cost Effective Care" (National Association of Community Health Centers, July 2015), *http://nachc.org/wp-content/uploads/2015/06/Cost-Effectiveness-FS-2015.pdf*.

It is important to note that these accomplishments exemplify the unique ability of community health centers to respond quickly to local community needs. Even in the face of nationwide trends, each community health center can address the particular impact on its local community based on the input of their consumer majority boards, which are run by community health center patients as required by statute.

1. Confronting the COVID–19 Pandemic

Community health centers saved money and lives throughout the COVID–19 pandemic, serving as the single largest source of comprehensive primary health care for medically underserved urban and rural communities.

According to the Health Resources and Services Administration (HRSA), community health centers provided more than 23 million vaccinations, nearly 70 percent of which were given to racial and ethnic minority patients. Additionally, community health centers served as trusted partners in the communities with early and consistent education on vaccination. They also provided 22.56 million COVID tests, which led to the identification of over 3 million COVID-positive patients. 62 percent of community health centers offered monoclonal antibody therapy, and 25 percent of community health centers distributed COVID–19 oral antiviral medication throughout the pandemic. [10]

To keep patients safe while maintaining access to care, community health centers quickly expanded access to telehealth services. In 2021, 99 percent of community health centers offered primary care services via telehealth—and 21 percent of the 124.2 million patient visits occurred virtually. [11] As community health centers have demonstrated time and time again, they were able to adjust immediately, with many organizations setting up full-blown telehealth operations in a matter of days and weeks to address the needs of their community and ensure continued access to care even in the most dire of scenarios.

Every dollar of the funding provided by Congress through the American Rescue Plan went toward providing care to underserved patients—from retaining and recruiting the community health center workforce, to conducting outreach services to ensure the most vulnerable populations remained connected to care. In addition, as community health centers serve so many patients who are frontline workers in essential industries, health centers were responsible for keeping these frontline workers healthy with a consistent source of care, which enabled them to continue working and permitted our country to continue to function.

2. Caring for Communities in the Wake of Rural Hospital Closures

Community health centers have also responded to the growing health care access crisis in rural areas. Between 2010 and 2021, 136 rural hospitals closed. [12] Nineteen of these closures occurred in 2020, the year the COVID pandemic hit the United States. Based on the most recent data, community health centers serve one in five rural residents, but those numbers are rising. Research has shown that in areas previously served by a rural hospital, there is a higher probability of new community health centers service delivery sites post-closure. [13] Over time, most rural areas are seeing an increase in access to community health centers. [14]

- An analysis of the economic impact of a single community health center in Kansas offers insights into how these impacts are felt within a community. In 2018, Mercy Hospital, the sole hospital in rural Fort Scott, Kan-

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[10] All COVID related data retrieved from Health Resources and Services Administration, Health Center Data Dashboard. Available online: *data.hrsa.gov*.

[11] "2021 Health Center Program Highlights Uniform Data System Trends," Bureau of Primary Healthcare, Health Resources and Services Administration, August 9, 2022, *https://bphc.hrsa.gov/sites/default/files/bphc/data-reporting/uds-2021-data-trends-speakers.pdf*.

[12] "Rural Hospital Closures Threaten Access: Solutions to Preserve Care in Local Communities" (American Hospital Association, September 2022), *https://www.aha.org/system/files/media/file/2022/09/rural-hospital-closures-threaten-access-report.pdf*.

[13] Katherine E. M. Miller et al., "Access to Outpatient Services in Rural Communities Changes after Hospital Closure," *Health Services Research* 56, no. 5 (October 2021): 788–801, *https://doi.org/10.1111/1475-6773.13694*.

[14] Nathaniel Bell et al., "Changes in Access to Community Health Services among Rural Areas Affected and Unaffected by Hospital Closures between 2006 and 2018: A Comparative Interrupted Time Series Study," *The Journal of Rural Health: Official Journal of the American Rural Health Association and the National Rural Health Care Association* 39, no. 1 (January 2023): 291–301, *https://doi.org/10.1111/jrh.12691*.

sas, closed its doors. In the wake of its closure, a nearby community health center, Community Health Center of Southeast Kansas, stepped in to expand health services in Fort Scott, taking over the hospital building and many of its clinics. Not only did the community health center's expansion preserve health care access for the residents of that rural town, but the transformation also allowed the community health center to increase its patient caseload from 47,000 in 2018 to 65,000 by 2021 and to contribute $12.4 million in economic growth to the community, adding 109 jobs in health care and 40 other community jobs. [15]

Community health centers are not only part of the solution to preserving access to care in rural communities that might otherwise go entirely without, but they also are an economic driver contributing to long-term financial stability. Every community health center's workforce and governing board is built from the community it serves, and these facilities are often among the largest employers in the surrounding area.

- Columbia Basin Health Association [16] serves a rural area of Washington state. In 2020, even at the height of the COVID–19 pandemic, the organization was still able to provide $136,000 in community support, including migrant worker outreach, Thanksgiving food baskets, and COVID testing events. The health center also held 50 community events, volunteered 2700+ hours for community events, and offered $8,000 in scholarships through their Healthy Future program.

3. Providing Behavioral Health Care

Community health centers are one of the most important access points for quality behavioral health care in the United States, and they were called to this mission even more so during the pandemic.

First, community health centers actively integrate behavioral health and primary care to improve health outcomes among low socioeconomic status and underserved communities by addressing the social needs of patients. Community health centers are significantly more likely than other safety net practices and non-safety net practices to offer early, late, or weekend appointments, provide medication-assisted treatment for opioid use disorders, offer behavioral health services, and screen patients for SDOH. [17]

Second, community health centers' integrated staffing models drive behavioral health integration. Many centers use paraprofessionals for behavioral care management, which helps reduce staffing shortages and promotes patient-centered care, as Commonwealth Fund's Reggie Williams testified at a March 2022 U.S. Senate Finance Committee Hearing on "Behavioral Health Care When Americans Need It: Ensuring Parity and Care Integration." [18] Additionally, a recent report demonstrated that National Health Service Corps (NHSC) behavioral health staff at community health centers improves care and reduces costs. On average, **each additional Full-Time Equivalent NHSC behavioral health staff was associated with a savings of $3.55 per visit in Community Health Centers; in rural areas, there were greater savings of $7.95 per visit**. [19]

Third, community health centers have leveraged telehealth to reach more patients in need. A 5-year Patient-Centered Outcomes Research Institute study highlighted how several rural community health centers successfully use telehealth for mental health services. The study looked at two models of care: linking patients to specialists via telehealth or integrating telehealth into primary care services. Both groups

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[15] Leighton Ku et al., "The Value Proposition: Evidence of the Health and Economic Contributions of Community Health Centers" (Geiger Gibson/RCHN Community Health Foundation Research Collaborative, August 2022).

[16] "CBHA 2020 Annual Report" (Columbia Basin Health Association, 2020), *https://www.cbha.org/documents/Annual-Reports/CBHA-Annual-Report-2020.pdf*.

[17] Valerie A. Lewis et al., "FQHC Designation and Safety Net Patient Revenue Associated with Primary Care Practice Capabilities for Access and Quality," *Journal of General Internal Medicine* 36, no. 10 (October 1, 2021): 2922–28, *https://doi.org/10.1007/s11606-021-06746-0*.

[18] Reginald D. Williams II, "Testimony: Ensuring Access to Behavioral Health Care—Making Integrated Care a Reality," Commonwealth Fund, March 30, 2022, *https://doi.org/10.26099/h4n0-p508*.

[19] Xinxin Han, Patricia Pittman, and Leighton Ku, "The Effect of National Health Service Corps Clinician Staffing on Medical and Behavioral Health Care Costs in Community Health Centers," *Medical Care* 59 (October 2021): S428, *https://doi.org/10.1097/MLR.0000000000001610*.

"reported substantially and statistically significant improvements in perceived access to care, decreases in their mental health symptoms and medication side effects, and improvements in their quality of life." [20]

- "Since the onset of the pandemic, we have seen an increase in mental health related issues impacting our students," said the Director of Behavioral Health at Camarena Health in rural Central Valley, California. "We are hopeful (that) with ... funds we will continue to provide the much-needed mental health services to our students, specifically to the students and families in our rural communities where mental health (services) is difficult to access." [21]

From this foundation, community health centers across the country were able to leverage those models to meet the unprecedented need during the pandemic. Mental health and substance use disorder services exceeded pre-pandemic levels in 2021. Overall, the number of visits for mental health issues rose by 19 percent from 2019 to 2021. There was a particularly notable increase in the number of patients experiencing anxiety disorders; in 2021, three million patients, or 10 percent of all community health center patients, had an anxiety disorder diagnosis, an increase of 17 percent from 2019. The number of patients receiving medication-assisted treatment (MAT) for opioid use disorder also increased substantially; in 2021, more than 180,000 patients received MAT representing an increase of 29 percent from pre-pandemic levels.

In addition to growing demand during the pandemic, these increases also reflect growth in community health centers' capacity to provide mental health and SUD services. For example, a survey of community health centers in late 2021 found that roughly two-thirds (64 percent) of community health centers added a new mental health or SUD service, including services that community health centers were newly able to provide via telehealth. In 2021, community health centers served 2.7 million patients for mental health needs and provided substance use disorder services to 286,000 patients. Community health centers had an increase of 138,000 patients seeking mental health and substance use disorder services between 2020 and 2021. [22]

Unfortunately, the current need is far greater than the existing capacity to provide these services. Given our Nation's current mental health and substance use disorder challenges, more must be done to care for those in need. Community health centers have demonstrated not only effectiveness in providing this type of care and responding directly to the needs of their community, but they have also done so in a highly cost-effective manner—one that ultimately saves lives and our health care system money.

4. Addressing the Social Determinants of Health

Community health centers are uniquely positioned to address SDOH and improve population health outcomes. According to Healthy People 2030, SDOH are "the conditions in the environments where people are born, live, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks." [23] 6 in 10 of adults have one chronic disease and 4 in 10 adults have multiple chronic diseases. [24] Evidence shows that social and behavioral factors are significantly associated with the development of chronic diseases such as hypertension and diabetes, and often these SDOH are manageable or treatable. [25] Even worse, dis-

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[20] John C. Fortney et al., "Comparison of Teleintegrated Care and Telereferral Care for Treating Complex Psychiatric Disorders in Primary Care: A Pragmatic Randomized Comparative Effectiveness Trial," *JAMA Psychiatry* 78, no. 11 (November 1, 2021): 1189–99, *https://doi.org/10.1001/jamapsychiatry.2021.2318*.

[21] "Camarena Health 2021 Annual Report" (Camarena Health, 2021), *https://www.camarenahealth.org/wp-content/uploads/2022/09/CAM-2021AnnualReport-Web-AZ.pdf*.

[22] Jessica Sharac et al., "Changes in Community Health Center Patients and Services During the COVID–19 Pandemic," *KFF* (blog), December 21, 2022, *https://www.kff.org/Medicaid/issue-brief/changes-in-community-health-center-patients-and-services-during-the-covid-19-pandemic/*.

[23] "Social Determinants of Health—Health People 2030," Office of the Assistant Secretary of Health, n.d., *https://health.gov/healthypeople/priority-areas/social-determinants-health*.

[24] "Chronic Diseases in America," Centers for Disease Control and Prevention, December 13, 2022, https://*www.cdc.gov/chronicdisease/resources/infographic/chronic-diseases.htm*.

[25] Vishal Vennu et al., "Associations between Social Determinants and the Presence of Chronic Diseases: Data from the Osteoarthritis Initiative," *BMC Public Health* 20, no. 1 (August 31, 2020): 1323, *https://doi.org/10.1186/s12889-020-09451-5*.

parities in SDOH exacerbate chronic diseases, especially in certain communities, and limit ways for people to live a healthy, fulfilled life.[26] The COVID-19 pandemic exacerbated SDOH challenges; compared to before the pandemic, over half of the community health centers said they saw an increase in the number of patients seeking housing services (69%), food and nutrition services (63%), and transportation services (53%).[27]

As of 2021, 74 percent of community health centers collected social risk data to help design and execute critical interventions.[28] Of the 26 percent of community health centers that don't currently collect social risk data, 80.7 percent of these community health centers (or 21 percent overall) plan on collecting social risk data in the future.[29] In response to the needs they are seeing, community health centers have implemented a variety of solutions to address the wide range of SDOHs that their patients experience. The following examples highlight ways community health centers have tackled food insecurity, housing instability, and linguistic diversity—all services that are above and beyond what is required by community health centers under the 330 statute.

Food Insecurity:

In 2021, 32.1 percent of households with incomes below the Federal poverty line were food insecure,[30] meaning the issue presents itself at our country's community health centers every single day. Each center tailors its programs to the needs of its local community.

- East Boston Neighborhood Health Center in Massachusetts takes a four-pronged approach to addressing food insecurity: (1) Food Access programs increase access to healthy foods at Farmers' Markets; (2) the center's Community Resource and Wellness Center serves over 700 families each week with groceries and necessities; (3) an onsite kitchen makes more than 2,000 prepared meals each week for elderly enrolled in its home-delivered meals program through the Senior Care Options or Program of All-Inclusive Care of the Elderly programs; and (4) an onsite WIC program supports thousands of families each year.
- Peninsula Community Health Services (PCHS) in Bremerton, Washington, screens all patients for SDOH, including food security. In 2022 they screened 40,007 patients across 88,701 visits and identified 303 patients who needed referrals for food as an immediate need. As a part of their process, PCHS provides emergency food boxes inside their clinic—a service they offer without any designated funding. Those patients were then also sent to work with PCHS Community Health Workers for 434 "touches," during which the community health center works to coordinate more stable food resources, another non-billable service the community health center shouldered to ensure their patients' needs are met.

Housing Instability:

Without stable housing, it is near impossible for a patient to care for basic health and human needs. A person without stable housing lives, on average, 27.3 fewer years than the average housed person.[31] With nearly 1.3 million patients at commu-

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[26] Paula Braveman and Laura Gottlieb, "The Social Determinants of Health: It's Time to Consider the Causes of the Causes," *Public Health Reports* 129, no. 1—suppl2 (January 1, 2014): 19–31, *https://doi.org/10.1177/00333549141291S206*.

[27] Jessica Sharac et al., "How Community Health Centers Are Serving Low-Income Communities During the COVID–19 Pandemic Amid New and Continuing Challenges," *KFF* (blog), June 3, 2022, *https://www.kff.org/Medicaid/issue-brief/how-community-health-centers-are-serving-low-income-communities-during-the-covid-19-pandemic-amid-new-and-continuing-challenges/*.

[28] "2021 Health Center Program Highlights Uniform Data System Trends," Bureau of Primary Healthcare, Health Resources and Services Administration, August 9, 2022, *https://bphc.hrsa.gov/sites/default/files/bphc/data-reporting/uds-2021-data-trends-speakers.pdf*.

[29] "2021 Health Center Program Highlights Uniform Data System Trends," Bureau of Primary Healthcare, Health Resources and Services Administration, August 9, 2022, *https://bphc.hrsa.gov/sites/default/files/bphc/data-reporting/uds2021-data-trends-speakers.pdf*.

[30] "Food Security and Nutrition Assistance," United States Department of Agriculture, October 18, 2022, *https://www.ers.usda.gov/data-products/ag-and-food-statistics-charting-the-essentials/food-security-and-nutrition-assistance/*.

[31] Travis P. Baggett et al., "Mortality Among Homeless Adults in Boston: Shifts in Causes of Death Over a 15-Year Period," *JAMA Internal Medicine* 173, no. 3 (February 11, 2013): 189–95, *https://doi.org/10.1001/jamainternmed.2013.1604*.

nity health centers nationwide experiencing homelessness, housing instability and homelessness are key issues that community health centers must tackle. [32]

- At Jordan Valley Health Care in Missouri, all patients are screened for whether or not they have a regular place to live or are at risk of losing their housing. Based on the screening findings, specialists onsite work to identify housing assistance and patient options as soon as possible.
- Lifelong Medical Care in California serves transitional housing residents in single-resident occupancy housing—often the final stepping stone from homeless to stable housing—working to stabilize more than 500 patients annually onsite.

Data shows a return on investment through securing stable housing, including fewer emergency room visits, lower health costs, and improved health outcomes and quality of life. [33] Community health centers play an integral role in ensuring stable housing, ongoing access to care, and bridging gaps in other SDOH, all leading to healthier, more stabilized patients.

Linguistic Access

Patients with limited English proficiency are among the most vulnerable populations. A 2001 Robert Wood Johnson Foundation report found that 94 percent of providers cite communication as the most important priority for delivering care. However, more than 70 percent of providers reported that language barriers compromise patients' understanding of care and treatment, leading many to skip care altogether. [34] Part of providing comprehensive care at community health centers includes providing culturally sensitive and linguistically competent care. About 1 in 4 patients served by community health centers in 2021 are best served in a language other than English. [35]

This problem is especially challenging in the Asian American community. In 2019, about 3 in 10 (30.8 percent) Asian American adults and 1 in 8 (12.1 percent) Native Hawaiian/Pacific Islander (NHPI) nonelderly adults had low English proficiency (LEP), compared with 32.9 percent of Hispanic adults, 3.1 percent of Black adults, and 1.4 percent of white adults. An estimated 14.9 percent of Asian American adults lived in a household where all members aged 14 and older reported having LEP. AANHPI adults with LEP were more likely than those proficient in English to have economic disadvantages such as lower incomes, lower levels of education, and higher uninsurance rates. [36]

- North East Medical Services (NEMS) in San Francisco, California provides many languages and dialects as a standard part of their culturally competent care, including English, Cantonese, Mandarin, Toishan, Vietnamese, Burmese, Korean, Spanish, and Hindi. [37] The NEMS health center also helps improve health literacy by providing health education resources in other languages. [38] Resources are available for asthma, high blood pressure, childhood immunization schedules, diabetes, mental health, and nutrition.

Community health centers of all sizes provide language services, and centers use different modalities to fit the needs of their patients. Centers often have bilingual health providers and nonclinical staff, provide interpreters, and/or use video services

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[32] "2021 Health Center Program Highlights Uniform Data System Trends," Bureau of Primary Healthcare, Health Resources and Services Administration, August 9, 2022, *https://bphc.hrsa.gov/sites/default/files/bphc/data-reporting/uds-2021-data-trends-speakers.pdf*.

[33] Mekdes Tsega et al., "ROI Calculator for Partnerships to Address the Social Determinants of Health: Review of Evidence for Health-Related Social Needs Interventions" (The Commonwealth Fund, n.d.), *https://www.commonwealthfund.org/sites/default/files/2019-07/ROI-EVIDENCE-REVIEW-FINAL-VERSION.pdf*.

[34] Robert Wood Johnson Foundation. 2001. New survey shows language barriers causing many Spanish-speaking Latinos to skip care. [Online]. Available: *www.rwjf.org/news*.

[35] "2021 Health Center Program Highlights Uniform Data System Trends," Bureau of Primary Healthcare, Health Resources and Services Administration, August 9, 2022, *https://bphc.hrsa.gov/sites/default/files/bphc/data-reporting/uds-2021-data-trends-speakers.pdf*.

[36] Jennifer M. Haley et al., "Many Asian American and Native Hawaiian/Pacific Islander Adults May Face Health Care Access Challenges Related to Limited English Proficiency," Urban Institute, December 12, 2022, *https://www.urban.org/research/publication/many-asian-american-and-native-hawaiianpacific-islander-adults-may-face-health*.

[37] "About Us," North East Medical Services, n.d., *https://nems.org/about-us/*.

[38] "Health Education Resources," North East Medical Services, n.d., *https://nems.org/resources/health-education-resources/*.

to assist in providing care.[39] During the pandemic, language often was a barrier for telemedicine. However, a recent qualitative study showed that audio-only visits with bilingual staff improved patient experience and access to care at community health centers.[40] The audio-only visits also removed barriers to broadband and connectivity issues.

Providing culturally and linguistically competent care is a cornerstone of the community health center model, and is a fundamental part of continued access to care for the 30 million patients served by community health centers. It's important to note that true access to care must consider and incorporate patient needs to yield positive health outcomes, which ultimately yield savings and demonstrable returns on investments across the health care system as a whole.

5. Building and Retaining the Health Care Workforce

The foundation of community health center quality care is their integrated, interdisciplinary workforce, and community health centers proudly serve as the training ground for our country's primary care workforce. Community health centers naturally embrace the **National Academy of Sciences, Engineering, and Medicine's recommendation for Implementing High-Quality Primary Care: Train primary care teams where people live and work**.[41] Between 2020 and 2021, community health centers increased their full-time employees by 7 percent, especially to improve maternal health outcomes.[42]

To recruit, train and retain workers, community health centers leverage HRSA's health care workforce scholarships and education loan programs which help train a diverse workforce, including dentists, dental hygienists, mental health professionals, community health workers, nurses, midwives, primary care professionals, and faculty.[43] These programs provide care in community-based settings to the most vulnerable patients, and help retain a workforce who are most likely to serve those communities after training. These vital programs include:

- National Health Service Corps
- Health Careers Opportunity Program
- Scholarships for Disadvantaged Students
- Teaching Health Center Graduate Medical Education Program.

In total, in 2021–2022, there were over half a million participants nationwide and over 368,000 graduates across these programs.[44] Among these, over 42,000 participants reported being from an underrepresented minority, disadvantaged, or rural background. Over 25,000 participants focused on the Department of Health and Human Services (HHS) priority of health equity and SDOH. 69 percent of recent graduates now practice in a medically underserved community, primary care setting, or rural area. NHSC providers represent a diverse group of clinicians. 33 percent of the Nation's total population identifies as Black or Hispanic/Latino. This same population only represents 11 percent of physicians in the U.S. However, roughly 25 percent of physicians serving through the NHSC identify as Black or Hispanic/Latino, a key indication that the NHSC is successfully driving clinician diversity.[45]

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[39] "Serving Patients with Limited English Proficiency: Results of a Community Health Center Survey" (National Health Law Program, June 16, 2008), *http://nachc.org/wp-content/uploads/2015/06/LEPReport.pdf*.

[40] Denise D. Paỳn et al., "Telemedicine Implementation and Use in Community Health Centers during COVID–19: Clinic Personnel and Patient Perspectives," *SSM—Qualitative Research in Health* 2 (December 1, 2022): 100054, *https://doi.org/10.1016/j.ssmqr.2022.100054*.

[41] "Implementing High-Quality Primary Care: Rebuilding the Foundation of Healthcare," National Academy of Sciences, Engineering, and Medicine, n.d., *https://www.nationalacademies.org/our-work/implementing-high-quality-primary-care*.

[42] "2021 Health Center Program Highlights Uniform Data System Trends," Bureau of Primary Healthcare, Health Resources and Services Administration, August 9, 2022, *https://bphc.hrsa.gov/sites/default/files/bphc/data-reporting/uds-2021-data-trends-speakers.pdf*.

[43] "Bureau of Health Workforce Field Strength and Students and Trainees Dashboards," Health Resources and Services Administration, n.d., *https://data.hrsa.gov/topics/health-workforce/field-strength*.

[44] "Health Professions Training Programs," Health Resources and Services Administration, n.d., *https://data.hrsa.gov/topics/health-workforce/training-programs*.

[45] Association of Clinicians for the Underserved. "2023 Fact Sheet: National Health Service Corps Program." [online]. *https://clinicians.org/wp-content/uploads/2023/02/NHSC-2023-Fact-Sheet.pdf*.

In addition, many community health centers run paraprofessional education training programs, which employ many minorities and women and contribute to the 1.5–2.5x return on investment to their community. Two community health centers in Massachusetts exemplify this well:

- East Boston Neighborhood Health Center (EBNHC) in Massachusetts has its own Education and Training Institute that establishes career ladders for the community health center's existing and future professionals, managers, and leaders and provides the education and skill training needed for individual growth and advancement. By bringing education and training opportunities to the community, community health centers address both sides of a vital employment issue. The community health center provides employees and community members with the education and skills needed to obtain well-paying jobs in health care, which in turn creates a source of qualified employees to meet EBNHC's staffing requirements. From entry-level skills to professional development, the community health center is developing a range of training and advancement courses and seminars in such a way as to recognize the complex lives and needs of community members and entry-level EBNHC employees.
- Lowell Community Health Center in Massachusetts works with the city to give patients a voice in how Federal funding is allocated. The community health center leads most discussions because it is the trusted voice within the community, ensuring that any economic impact is distributed equitably.

Community health centers in Massachusetts are more likely to employ people from the area, and the state's community health centers added more than 21,500 jobs in 2021. In Massachusetts alone, community health centers saved $1.1 billion for Medicaid and $1.9 billion for the U.S. health system. [46]

Much like the consumer majority board, which ensures the community health center is driven by and responsive to the community's needs, much of the community health center workforce is also built of the community they call home. Often among the largest employers in the communities they serve, community health centers have been deliberate in designing career pathways and training opportunities to respond to and support the needs of their patients and their workforce. Data has also shown that care provided by caregivers with a shared experience leads to better health outcomes, a factor community health centers take into account as they seek to develop their own homegrown workforce and cultivate true community transformation.

- Camarena Health, in rural Central Valley California, illustrates this with one of their Behavioral Health Navigators. One of their employees started as a behavioral health case manager and climbed into the navigator position. He is a Madera native, and his lived experiences help him understand and serve his community at the health center. [47]
- Nieves Gomez, the CEO of Columbia Basin Health in rural Washington state, grew up in a family of migrant workers. He experienced the community health center first as a patient, then professionally, and now leverages his experience and knowledge in his current leadership role.

We would be pleased to share with the Committee examples of similar stories and pathways within the community health center network. These testimonials demonstrate the unique opportunities and commitment community health centers have made to support the health and professional development of not just patients, but their workforce who hail from within the community as well.

III. Community Health Center Performance: Expanding Patient Care, Increasing Quality

Community health centers provide these services and more while caring for a growing patient population from a wide range of backgrounds. Community health

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[46] Internal report from Capital Link. Data available upon request.

[47] "Camarena Health 2021 Annual Report" (Camarena Health, 2021), *https://www.camarenahealth.org/wp-content/uploads/2022/09/CAM-2021AnnualReport-Web-AZ.pdf*.

centers are required to integrate their patient voice into their governance.[48] At least 51 percent of community health center board members must be patients served by the community health center, ensuring local buy-in, collaboration, and direct knowledge of community needs. Additionally, community health centers must complete needs assessments every 3 years to ensure an ongoing understanding of the unmet needs of their community and improve the delivery of care. While these needs assessments often try to understand causes of morbidity and mortality, these reports often assess SDOH, such as housing, the physical environment, and cultural/ethnic factors.

In 2021, HRSA-funded community health centers provided comprehensive primary care to a record 30.2 million patients, a 43 percent increase over the past 10 years.[49]

- *Rural/Urban*: 20.7 million patients were served by urban community health centers, and 9.5 million patients were served by rural community health centers.
- *Racial/Ethnic*: 63 percent of patients identified as a member of a racial/ethnic minority group.
- *Socioeconomic*: 90 percent of patients had incomes at or below 200 percent of Federal Poverty Guidelines.
- *Veterans*: Almost 390,000 veterans served, a 3.3 percent increase from 2020 to 2021.
- *Insurance Status*: 48 percent Medicaid, 11 percent Medicare, and 20 percent uninsured.
- *Language*: 24 percent of patients were best served in a language other than English.
- *Age*: 8.6 million patients aged 0–17 (29 percent), 18.3 million patients aged 18–64 (60 percent), and 3.3 million patients aged 65+ (11 percent).

As Vermont Community Health Center CEOs Josh Dufresne and Jeff McKee state, "**Health centers cannot keep doing more with less**."[50] The present trajectory is unsustainable, and the Federal funding for health centers is not keeping pace with rising medical costs and patient population growth.[51] Community health centers' extraordinary growth has dramatically outpaced funding. From Fiscal Year 2015 to Fiscal Year 2021, total community health center funding increased by 11 percent ($5.1B to $5.7B) while the number of patients served increased by 24 percent (24.1 million to 30 million).[52] Similarly, the number of health center visits reached a record 124 million in 2021.[53]

Also notable, the quality of care provided by community health centers has not altered or been sacrificed in the face of growth. 1,058 community health centers (77 percent) have achieved Patient-Centered Medical Home (PCMH) recognition, and community health centers have an eight times greater odds of attaining PCMH certification compared to other types of health care practices.[54] The PCMH model of care enables community health centers to have strong patient outcomes at lower costs despite treating patients who are often sicker, with more complex health care needs, and those who come from a poorer population than in other health care settings. 79 percent of community health centers met or exceeded one or more national

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[48] "Health Center Program Compliance Manual" (Bureau of Primary Health Care, Health Resources and Services Administration, August 20, 2018), *https://bphc.hrsa.gov/sites/default/files/bphc/compliance/hc-compliance-manual.pdf*.

[49] "2021 Health Center Program Highlights Uniform Data System Trends," Bureau of Primary Healthcare, Health Resources and Services Administration, August 9, 2022, *https://bphc.hrsa.gov/sites/default/files/bphc/data-reporting/uds-2021-data-trends-speakers.pdf*.

[50] Josh Dufresne and Jeff McKee, "Dufresne & McKee: Health Centers Cannot Keep Doing More with Less," VTDigger, January 18, 2023, *https://vtdigger.org/2023/01/18/dufresne-mckee-health-centers-cannot-keep-doing-more-with-less/*.

[51] Matrix Global Advisors. The Overlooked Decline in Community Health Center Funding. 2022. *https://acrobat.adobe.com/link/review?uri=urn:aaid:scds:US:58b05b79-f372-30b3-aa7c-874ee1517dec*.

[52] Julia Paradise et al., "Community Health Centers: Recent Growth and the Role of the ACA," *KFF* (blog), January 18, 2017, *https://www.kff.org/medicaid/issue-brief/community-health-centers-recent-growth-and-the-role-of-the-aca/*.

[53] Jessica Sharac et al., "Changes in Community Health Center Patients and Services During the COVID-19 Pandemic," *KFF* (blog), December 21, 2022, *https://www.kff.org/medicaid/issue-brief/changes-in-community-health-center-patients-and-services-during-the-covid-19-pandemic/*.

[54] "Community Health Center Chartbook 2022" (The National Association of Community Health Centers (NACHC), 2022), *https://www.nachc.org/wp-content/uploads/2022/03/Chartbook-Final-2022-Version-2.pdf*.

clinical benchmarks in 2020, with more than half (55 percent) reporting improvements in 5 or more clinical quality measures (CQMs) and 1 in 6 community health centers nationwide (16 percent) reporting clinical quality measures (CQMs) and 1 in 6 community health centers nationwide (16 percent) reporting improvements in 8 or more CQMs. [55]

- Chief of Information Services Dave Perkins at Yakima Valley Farm Workers Clinic in western Washington, describes community health centers' commitment to quality: "Tearing down barriers between patients and their care has been a cornerstone of our organization from its inception. We hope to continue that trend by ensuring their health information is always at our patients' fingertips." [56] Yakima is working with CMS on advancing health equity metrics for all community health centers. Additionally, as highlighted in the Washington Health Alliance's 2022 Community Checkup Report, the clinic had the fourth-best composite percentage in Washington state, representing an overall score that represents four areas: prevention and screening, chronic disease care, coordinated and cost-effective care, and appropriate and cost-effective care. [57]

IV. Community Health Center Financial Crisis

Unfortunately, even as community health centers continue to leverage successes and look to expand to meet the increasing needs of patients in new and existing communities, they are facing an unprecedented set of financial challenges.

Medicaid Unwinding

States have begun the process of redetermining eligibility for every beneficiary covered under Medicaid, a process that was on hold during the Public Health Emergency. While the number of Medicaid enrollees who may be disenrolled during the "unwinding" period is highly uncertain, it is estimated that millions will lose access to Medicaid coverage. The Kaiser Family Foundation estimates that between 5.3 million and 14.2 million people will lose Medicaid coverage once the continuous enrollment provision ends. [58]

Community health centers expect that the end of the Public Health Emergency and continuous Medicaid coverage will pose a significant risk to community health centers, as Medicaid provides health care coverage to over 48 percent of community health center patients [59]—or about 15 million patients—and made up 41 percent of community health center revenue in 2021. [60] A new report from the Geiger Gibson/RCHN Community Health Foundation Research Collaborative at the George Washington University Milken Institute School of Public Health puts the facts into a stark reality: **up to 2.5 million community health center patients could lose their Medicaid coverage once continuous enrollment ceases**. [61] HHS estimates that 56 percent of those losing coverage will be due to loss of eligibility and will need to transition to another source of coverage. 44 percent will lose Medicaid coverage despite still being eligible ("administrative churning"), although HHS is taking steps to reduce this outcome. Community health centers will continue to care

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[55] "Health Center Program: Impact and Growth," Bureau of Primary Health Care, Health Resources and Services Administration, August 2022, *https://bphc.hrsa.gov/about-health-centers/health-center-program-impact-growth*.

[56] "Report to Our Communities 2021" (Yakima Valley Farm Workers Clinic, 2021), *https://www.yvfwc.com/wp-content/uploads/2022/07/119-220711-RTOC-Web-Single-8.5x11-Pages.pdf*.

[57] "2022 Community Checkup Report" (Washington Health Alliance, 2022), *https://wahealthalliance.org/wp-content/uploads/2022/03/2022-community-checkup-report-Improving-Care-in-WA-state.pdf*.

[58] Jennifer Tolbert and Meghana Ammula, "10 Things to Know About the Unwinding of the Medicaid Continuous Enrollment Provision," *KFF* (blog), February 22, 2023, *https://www.kff.org/Medicaid/issue-brief/10-things-to-know-about-the-unwinding-of-the-Medicaid-continuous-enrollment-provision/*.

[59] "National Health Center Program Uniform Data System (UDS) Awardee Data," Health Resources and Services Administration, 2021, *https://data.hrsa.gov/tools/data-reporting/program-data/national*.

[60] *KFF*. "Community Health Center Revenues by Payer Source," December 5, 2022. *https://www.kff.org/other/state-indicator/community-health-center-revenues-by-payer-source/*.

[61] Leighton Ku et al., "The Potential Effect of Medicaid Unwinding on Community Health Centers," Geiger Gibson Program in Community Health, GW Milken Institute School of Public Health, January 19, 2023, *https://geigergibson.publichealth.gwu.edu/potential-effect-Medicaid-unwinding-community-health-centers*.

for these patients regardless of their status. **But without additional resources, they will face enormous financial challenges to sustain everything from workforce recruitment and retention, to continued programming to address SDOH, to community outreach to keep patients healthy**.

This widespread coverage loss could trigger a deficit of $1.5 billion to $2.5 billion in patient revenue for community health centers, which amounts to between 4 percent and 7 percent of total community health center revenue nationally. By law, community health centers must "provide comprehensive, high-quality primary care and preventive services regardless of patients' ability to pay." However, a revenue impact of this size means that community health centers, the Nation's largest primary care system for medically underserved rural and urban communities, could be faced with increasing challenges to serve between 1.2 million and 2.1 million patients; and with this sharp reduction in resources, community health centers also could lose the ability to employ or retain 10,700 to 18,500 of their staff. The study is based on estimates of the unwinding's impact prepared by the Urban Institute and data on community health centers from the 2021 Uniform Data System data.[62] The study's authors report that these estimates likely are low, since they are based on 2021 community health center data and the number of patients served by community health centers likely increased over the 2022–2023 period.

Even in a normal year, community health centers confront the natural churn of Medicaid patients, which can result in access barriers as well as additional administrative costs. When individuals who remain eligible for coverage are disenrolled, they may experience gaps in coverage that could limit access to care and lead to delays in getting needed care. Research indicates that enrollees who experience fluctuations in coverage are more likely to report difficulties getting medical care and are more likely to end up in the hospital with a preventable condition.[63] In addition, there are administrative costs associated with disenrolling an enrollee and then subsequently processing a new application.[64] Community health centers are ready to serve additional patients, but centers are burdened with additional administrative barriers to help patients keep or transition to the proper health insurance coverage.

As the Commonwealth Fund points out, community health centers and safety-net providers will play a critical role after the unwinding.[65] Community health centers not only serve patients, but also serve as navigating partners to help patients maintain or find insurance coverage and connect patients to community-based organizations and agencies. This includes connecting members to Supplemental Nutrition Assistance Program, Special Supplemental Nutrition Program for Women, Infants, and Children, assistance for victims of interpersonal and family violence, and other clinically and health-related social needs network services. 37 percent of community health centers expanded enrollment assistance staff, and 42 percent were scheduling advanced appointments for high-risk patients.[66] To re-engage patients, regardless of insurance status, community health centers must conduct linguistically and culturally appropriate outreach in some of the most hard-to-reach communities.

- At Cumberland Family Medical Center (CFMC) in Kentucky, one patient eloquently captures the expertise and understanding community health center staff provide. "I am a widow and am on a fixed income. I cannot afford insurance if it was not for the ACA. I tried signing myself up, but was unable to get the application completed, but with the help of CFMC's KyNectors, I now have insurance and can afford to go to the doctor when

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[62] Leighton Ku et al., "The Potential Effect of Medicaid Unwinding on Community Health Centers," Geiger Gibson Program in Community Health, GW Milken Institute School of Public Health, January 19, 2023, *https://geigergibson.publichealth.gwu.edu/potential-effect-Medicaid-unwinding-community-health-centers*.

[63] U.S Government Accountability Office. "Medicaid: States Made Multiple Program Changes, and Beneficiaries Generally Reported Access Comparable to Private Insurance," November 15, 2012. *https://www.gao.gov/products/gao-13-55*.

[64] Katherine Swartz et al., "Evaluating State Options for Reducing Medicaid Churning," *Health Affairs* 34, no. 7 (July 2015): 1180–87, *https://doi.org/10.1377/hlthaff.2014.1204*.

[65] Sara Rosenbaum, Caitlin Murphy, and Rebecca Morris, "When Medicaid's COVID–19 Pandemic Continuous Enrollment Guarantee Unwinds, Safety-Net Providers Will Play a Critical Role," Commonwealth Fund, July 7, 2022, *https://doi.org/10.26099/f09x-dp94*.

[66] Jessica Sharac et al., "How Community Health Centers Are Serving Low-Income Communities During the COVID–19 Pandemic Amid New and Continuing Challenges," *KFF* (blog), June 3, 2022, *https://www.kff.org/Medicaid/issue-brief/how-community-health-centers-are-serving-low-income-communities-during-the-covid-19-pandemic-amid-new-and-continuing-challenges/*.

> I need to. The KyNectors were so helpful and any time I have a question I still call her. She even called after I was enrolled to make sure I had received my insurance card. Thank you CFMC for caring about your patients and going above and beyond to make sure they have the best care possible."received my insurance card. Thank you CFMC for caring about your patients and going above and beyond to make sure they have the best care possible."received my insurance card. Thank you CFMC for caring about your patients and going above and beyond to make sure they have the best care possible."[67]

Without additional resources to support community health centers to continue to provide care to those in need and help patients navigate coverage gaps, access and health outcomes could suffer as a result.

Expiration of Supplemental COVID Funding

The expiration of supplemental COVID funding will be an additional challenge, as it made up 7 percent of community health center revenues in 2021.[68] While much of the COVID funding was used for non-recurring expenses specific to the COVID pandemic, in a survey of our members, we found that community health centers were forced to use this funding to fill critical gaps, especially in the area of the workforce.[69] Due to the years of flat funding in the community health center program, our centers have been unable to make additional investments in workers at all levels. With this supplemental funding, community health centers were able to prioritize recruitment and retention. As it goes away, they are once again faced with flat budgets against dramatically increasing needs and market rates. Simply put, community health centers do not have the resources to compete with some privately held practices, hospital systems, or corporate-owned or financially backed practices, causing severe challenges for both recruiting and retaining staff. **To put this issue into greater context, if community health centers lack the funding and resources necessary to retain and recruit staff at all levels, access to care will suffer**.

Erosion of the 340B Program

Making an already dire situation worse, the 340B program, a vital revenue stream for federally qualified community health centers, is slowly being eroded by the actions of state policymakers, pharmaceutical companies, and pharmacy benefit managers. In national studies of the 340B program, 92 percent of community health centers utilize 340B savings to increase access for low-income and/or rural patients by maintaining or expanding services in underserved communities.[70] A study of a regional network of community health centers found that the number of community health center patients who are 65 and older is twice as high in rural communities as in urban communities, who more often have complex medication regimens and higher costs.[71] The 340B program enables community health centers to manage more clinical complexity for these patients.

Unfortunately, the revenue they have to make these investments is shrinking. States across the country, including California, have taken back community health centers' 340B revenue—taking it for general state funds, without the reinvestment guardrails by which community health centers must abide. Pharmaceutical companies refuse to honor discounts at contract pharmacies, which decreases 340B savings and cuts off access to medications. And finally, both Pharmacy Benefit Managers and insurers discriminate against 340B entities by targeting them with lower reimbursement. Taken together, these actions place a consistent source of revenue for community health centers at risk.

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[67] "Outreach Stories & Patient Testimonials," Cumberland Family Medical Centers, n.d., *https://www.cumberlandfamilymedical.com/media/outreach-stories-patient-testimonials.aspx*.

[68] Jessica Sharac et al., "Changes in Community Health Center Patients and Services During the COVID–19 Pandemic," *KFF* (blog), December 21, 2022, *https://www.kff.org/Medicaid/issue-brief/changes-in-community-health-center-patients-and-services-during-the-covid-19-pandemic/*.

[69] Internal ACH survey data available upon request.

[70] "Summary of NACHC's Report on 340B: A Critical Program for Health Centers" (National Association of Community Health Centers, June 2022), *https://www.nachc.org/wp-content/uploads/2022/06/NACHC-340B-Report-Summary-June-2022.pdf*.

[71] OCHIN. "How Affordable Prescription Medication Program Supports Care for Low-Income Patients," July 5, 2022. *https://ochin.org/blog/affordable-prescription-medication-program-supports-care-low-income-patients.*

Workforce Shortages

In a recent NACHC survey, 92 percent of community health centers surveyed say they would have experienced additional turnover without funding and other benefits from the American Rescue Plan. Rates of estimated additional turnover are highest among rural community health centers. 97 percent of community health centers surveyed believe that additional Federal funding would help employee retention and recruitment. [72] As mentioned above, community health centers are at a significant disadvantage when it comes to retaining and recruiting the health care workforce. While anecdotally, hospitals and larger systems report losing between $100,000—$200,000 annually per primary care physician, they can make that money back through specialty referrals and other high-cost services. Community health centers have no ability, nor is their model such, that they can recoup revenue via specialty referrals or other services—a critical difference in understanding the financial structures under which Community Health Centers function. It's important to note that community health centers' quality of care—measured through vaccinations, cancer screenings, and control of diabetes—decreases health care costs while limiting the centers' ability to recoup costs. Therefore, programs like the National Health Service Corps and others offer community health centers tools to recruit and retain providers, and ensure that primary care growth continues in medically underserved areas.

At a time when the health care workforce is already severely strained, and recruitment and retention strategies like loan repayment programs, competitive salaries, training, education and career pathways are vital, community health centers cannot afford to take a step backward and further batter an already weary workforce. Burnout comes with a cost. Turnover in the primary care physician workforce costs the United States $979 million; $260 million of that (27 percent) is attributable to burnout. [73] Community health centers are poised to serve millions of additional patients, but this is dependent on critical investments and expansion of community health center funding to both stabilize and grow the community health center workforce.

V. Conclusion: The Case for Investment

Community health centers work tirelessly to meet the evolving needs of their patients. With the right investment, community health centers can fulfill their mission as hyper-local health care hubs—treating the full range of patients' needs, supporting community transformation, and achieving true health equity. ACH's vision for community health center funding—$30 billion by 2030—isn't rooted in dollars and cents. It's rooted in a vision of what can be achieved for our patients, our communities, and all those in need. We seek to push ourselves further, achieving better outcomes for patients and eliminating health care disparities, including between rural and urban communities. Specifically, by 2030, we aim to:

- Serve 40 million patients
- Train 25,000 additional providers
- Increase the percentage of community health centers reaching national clinical benchmarks by 25 percent
- Increase the percentage of community health centers participating in value-based care by 20 percent
- Develop and bring to scale at least 15 innovative interventions to address the SDOH

We urge Congress to scale investment in community health center funding, including infrastructure, workforce, and innovation. We request a 5-year extension of the Community Health Center Trust Fund, with the following annual funding amounts: fiscal year 2024: $6.2 billion; fiscal year 2025: $6.98 billion; fiscal year 2026: $7.87 billion; fiscal year 2027: $8.87 billion; and fiscal year 2028, $10 billion.

We realize these are large amounts of funding in a difficult fiscal time for our country. But I hope my testimony today made the case that community health cen-

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[72] "Current State of the Health Center Workforce: Pandemic Challenges and Policy Solutions to Strengthen the Workforce of the Future", (National Association of Community Health Centers, March 2022), *https://www.nachc.org/wp-content/uploads/2022/03/NACHC-2022-Workforce-Survey-Full-Report-1.pdf.*

[73] Christine A. Sinsky et al., "Health Care Expenditures Attributable to Primary Care Physician Overall and Burnout-Related Turnover: A Cross-Sectional Analysis," *Mayo Clinic Proceedings* 97, no. 4 (April 1, 2022): 693–702, *https://doi.org/10.1016/j.mayocp.2021.09.013.*

ters are the best place to invest scarce Federal resources. As has been documented over and over again, the savings yielded by the community health resources. As has been documented over and over again, the savings yielded by the community health center program are immense.

Not only do community health centers have a proven track record of savings, accountability, and positive economic impact, they are the breeding ground for invaluable innovation to drive further savings and better health outcomes, all while responding to the localized needs of their community. The Health Center Program is a shining example of a vital Federal investment with localized control and impact, and massive system-wide returns in the form of savings, employment, and economic stimulation in otherwise underserved communities.

Community health centers are required to serve every patient who walks through their doors, regardless of their insurance status or ability to pay. But to do so, we need an investment from the Federal Government that matches our communities' needs. This comprehensive, culturally, and linguistically competent care also requires a strong community health center workforce. Rather than disinvest in community health centers and force them to pull back, we need to reinvest to allow them to expand and offer more people their high-quality, low-cost services. Investing in community health centers allows us to accomplish the following:

- Focus on providing access and care without worrying about piecemealing funding
- Fully provide patient-centered, holistic models of care that incorporates social needs
- Allow agility in providing emergency/pandemic care
- Reinvest in providing care and medication to our uninsured population
- Provide robust outreach to underserved patients

As we have established in this testimony, community health centers have significantly increased services and expanded the number of patients served—all while facing damaging financial headwinds. Yes, we have proven we can do a great deal with limited resources; but we could do even more with meaningful investment. Community health centers are poised to care for our Nation's underserved, innovate and drive new models of care, produce healthier patients and communities, and save our health care system scarce resources.

I'm fortunate to have conversations daily with community health center leaders who can easily tell me about the long list of programs, services, expansions, and new models they'd like to bring to fruition if only they had the resources to do so. Congress has the opportunity to set this vital health care system on the right course for the future. Whether measured in lives or dollars, there is no better health care investment than the Health Center Program.

[SUMMARY STATEMENT OF AMANDA PEARS KELLY]

Increasing investment in community health centers (CHCs) is the best investment Congress can make in health care—delivering cost savings, patient health, and community well-being. Access to primary care at health centers leads to better outcomes and lower costs—up to $30 billion annually in Medicare and Medicaid combined. Health centers are the gold standard of primary care—comprehensive, patient-centered, patient-governed, accountable, competitively funded, and tailored to the needs of local communities. Since Congress last considered the Community Health Center Trust Fund, community health centers have demonstrated particular capacity in the following areas:

- **COVID–19**: CHCs provided tens of millions of vaccinations and COVID tests and access to monoclonal antibody therapy and antiviral medication. They quickly expanded access to telehealth services and conducted important outreach services, provided employment, and kept frontline workers connected to health care.
- **Rural Health Care**: Health centers serve one in five rural residents, and those numbers are rising. In areas previously served by a rural hospital, there is a higher probability of new CHC service-delivery sites post closure. Over time, most rural areas are seeing an increase in access to CHCs. Health centers are an economic driver contributing to long term financial stability in rural areas.

- **Behavioral Health**: CHCs actively integrate behavioral health and primary care to improve health outcomes, and leverage staffing strategies and telehealth services to improve care. There has been unprecedented need for mental health and substance abuse disorder services during and after the pandemic; the current need is far greater than existing capacity to provide these services.
- **Social Determinants of Health**: The majority of CHCs collect social risk data to help design and execute critical interventions, and many have successfully implemented solutions to address patient needs.
- **Workforce**: CHCs are the training ground for our country's integrated, interdisciplinary primary care workforce. CHCs have workforce programs and policies to help train and retain providers who are most likely to serve those communities after training. They also provide career ladders for staff and students interested in healthcare. Much of the health center workforce comes from the communities they serve.

In 2021, HRSA-funded health centers provided comprehensive primary care to a record 30.2 million patients, a 43 percent increase over the past 10 years. Health centers' extraordinary growth has dramatically outpaced funding. As the need continues to increase, CHCs face an unprecedented set of financial challenges, including the ongoing Medicaid unwinding, the expiration of supplemental COVID funding, continued erosion of 340B program revenue, and dire workforce shortages.

The Case for Investment: ACH's vision for health center funding—$30 billion per year (including discretionary and mandatory funding) by 2030—is rooted in a vision for what we can achieve for our patients, for our communities and for all those in need. We seek to push ourselves further, achieving better outcomes for patients and eliminating health care disparities, including between rural and urban communities. We urge Congress to scale investment in health center funding, including infrastructure, workforce, and innovation. We request a 5-year extension of the Community Health Center Trust Fund, with the following annual funding amounts: fiscal year 2024: $6.2 billion; fiscal year 2025: $6.98 billion; fiscal year 2026: $7.87 billion; fiscal year 2027: $8.87 billion; and fiscal year 2028, $10 billion.

Not only do health centers have a proven track record of savings, accountability, and positive economic impact, they are the breeding ground for invaluable innovation to drive further savings and better health outcomes, all while responding to the localized needs of their community. Whether measured in lives or dollars, there is no better health care investment than the Health Center Program.

The CHAIRMAN. Thank you very much, Ms. Pears Kelly. Our next witness will be Ben Harvey. Mr. Harvey is the CEO of the Indiana Primary Health Care Association. He will be introduced by Senator Braun of Indiana.

Senator BRAUN. Thank you, Chairman Sanders, and Ranking Member Cassidy. A pleasure to introduce Ben Harvey, fellow Hoosier, graduate of Taylor University back in Indiana. Heads our Indiana Primary Health Care Association. Great job at doing it.

Previously served in a senior role with the Missouri Department of Health and Senior Services. His work has helped increase the number of community health centers throughout Indiana and modernized the state's telehealth laws, which is going to become increasingly important, I think, down the road in health care, resulting in greater access to quality care for many Hoosiers.

Greatly appreciate your willingness to come and share your Hoosier practicality with all of us here and look forward to hearing what you have to say.

STATEMENT OF BEN HARVEY, M.A., CHIEF EXECUTIVE OFFICER, INDIANA PRIMARY HEALTH CARE ASSOCIATION, INDIANAPOLIS, IN

Mr. HARVEY. Well, thank you, Senator Braun, for the introduction. It is an honor to be here. It is an honor to be in this room. Honored to be introduced by a distinguished Hoosier like yourself, so thank you for that.

Chairman Sanders, Ranking Member Cassidy, Members of the Committee, thank you for the invitation to be here to discuss community health centers. I would like to specifically thank you, Mr. Chairman, for your work to expand the National Service Core, Community Health Centers, Teaching Health Center Program.

Your leadership is appreciated by health centers in my state, across the country, so thank you for that. I would also like to thank Senator Braun, Senator Young, the Senators from Indiana, for their longstanding support of Indiana's community health centers.

Before I begin, I just want to note that I have a very personal connection to health centers and the work that they do. I grew up in a rural, medically underserved part of Indiana, Grant County, and I have seen firsthand the impacts of a lack of medical services on individual lives. So, the concept deaths of despair, that idea that young adult Americans are dying earlier, that is a very real thing to me.

I have seen friends and family die of substance use disorders, suicide, chronic diseases. These are very real. So, I stand as a witness not only to the impact that health centers have on the health care system, but also on the impact they have on individual Americans and the people that they serve.

Health centers, like Amanda mentioned, are nonprofit, patient governed organizations that provide high quality, comprehensive primary health care to people living in medically underserved areas. In 2021, health centers nationally reached the historic milestone of serving 30 million Americans in a single year.

In Indiana, we have 350 clinical delivery sites that serve a little over 600,000 Hoosiers, 90 percent of whom are below 200 percent of the Federal poverty level, and 65 percent of whom are below the poverty level. Health centers in Indiana have established themselves as the safety net for Indiana's communities.

A recent example of this is the response to health centers, Southern Indiana Community Health Centers and Indiana Health Centers, had to a closure over a hospital in Bedford. Both SICHC and IHC stepped into that situation, which you are all aware of, when a rural hospital closes. It can have pretty detrimental impacts to health.

It can also have a detrimental impact to the economy. Both of those health centers stepped into that void to provide continuity of services, to work with the other existing critical access hospital, and to support the local community.

In addition to that, we know CHCs positively impact the economies of the communities in which they operate, which are oftentimes economically distressed, in addition to being medically underserved. In Indiana, the total economic impact is over $1 billion an-

nually, and that number is certainly much larger at a national level.

Health centers additionally impact their local economies by providing employment and workforce development opportunities in areas that are impacted by higher rates of unemployment.

For example, Eskenazi Health Center on Central Indiana has created their own medical assistant training program, which allows the training of existing non-clinical staff. It also allows Eskenazi Health Center, it gives them the ability to work with local community groups, like the Goodwill of Central and Southern Indiana, to identify potential candidates from the community for job training.

It is well established and well noted that integrated team based primary care services improve health care quality and cost outcomes. Decades of research like, those done by Dr. Nocon, have consistently shown health centers create cost savings despite serving populations who are at higher risk of poor overall health and chronic conditions.

Health centers save at least $24 billion a year. It is a well-established number. Health center patients have lower rates of multiday hospitalizations, hospital admissions, lower rates of ED utilization, lower rates of specialty care visits, and lower numbers of inpatient bed days. And research again has shown that health center patients have about 24 percent lower overall costs than patients receiving primary care in other settings.

Access to primary care, like those found at health centers, can be improved and sustained through strategic investments. We know that the portion of Americans with identified source of primary care is decreasing.

In Indiana, HRSA and the CDC, two Federal agencies, estimate there are more than 2 million Hoosiers in health professional shortage areas and roughly 800,000 Hoosiers who report lacking a usual place to go for medical care.

Additional Federal investments in health centers would extend their reach into the underserved communities in Indiana and deepen their existing service lines, creating greater access to maternal and newborn health, mental and behavioral health care, and oral health care.

Federal funding, Senator Cassidy just showed an image on this, which is generally less than 20 percent of health centers' overall budget, provides critical funding to stabilize operations and provide startup funding for new services or new service sites in underserved areas.

Again, in conclusion, the Community Health Center Program is a cornerstone of the U.S. health care system and Indiana's health care system. Health centers are a cost effective, high quality, highly efficient form of primary care, which save billions of dollars every year and improve the lives and health of millions of Americans, many of whom I know.

Health centers need continued sustained funding and are primed to meet the ongoing and expanded needs of the patients in the communities they serve. And again, thank you for the invitation to testify, and I look forward to your questions.

[The prepared statement of Mr. Harvey follows:]

PREPARED STATEMENT OF BEN HARVEY

Chairman Sanders, Ranking Member Cassidy, and distinguished Members of the Committee, thank you for the invitation to discuss the impact of Community Health Centers (CHCs) on the health of people across America, in addition to CHCs economic impact, ability to lower health care costs, and the opportunity for further investment in CHCs.

I would like to specifically thank Chairman Sanders for his dedicated efforts to significantly expand the National Health Service Corps, Community Health Centers, and Teaching Health Centers. Your leadership is much appreciated by CHCs across the country. I would also like to thank the Senators from Indiana, Sen. Braun, who sits on this prestigiuous Committee, and Sen. Young, for their long-standing support of Indiana's CHCs.

Before I begin I would like to note the very personal connection I have with CHCs. Born and raised in a medically undeserved part of rural Indiana, I have seen firsthand the costs of limited access to care and poor health. "Deaths of despair" the expression describing the decreasing life expectancy of young-adult Americans, is very real to me, having seen too many friends succumb to substance use disorders, suicide, and chronic disease. I stand as a witness not only to the impact CHCs have on the overall health care system, but also as a witness to the impact they can and do have on the individual Americans they serve.

CHCs are nonprofit, patient-governed organizations that provide high-quality, comprehensive primary health care to people living in medically underserved areas. Serving 1 in 11 people nationwide, CHCs are committed to providing care to all patients, regardless of income or insurance status. In 2021, CHCs marked the historic milestone of serving 30 million Americans in a single year.

Established in 1982, the Indiana Primary Health Care Association (IPHCA) is the membership body for Indiana's CHCs and CHC Look-A-Likes. IPHCA supports a membership that includes Indiana's 27 CHCs and 12 Look-A-Likes who collectively have over 350 clinic sites across Indiana that provide primary medical, dental, and behavioral health care to over 600,000 Hoosiers, 90 percent of whom are below 200 percent of the Federal Poverty Level (FPL), and 65 percent of whom are below the FPL.

CHCs in Indiana range from large, urban-centered CHCs who serve more than 50,000 patients annually, to small rural CHCs who serve less than 5,000 patients annually. Collectively, more than 50 percent of patients at Indiana's CHCs identify as a racial and/or ethnic minority, with 16 percent of patients being best served in a language other than English.

The Direct Economic Impact of CHCs

Within the US health care system, the main role of CHCs is to provide high-quality primary health care with a particular focus on serving vulnerable populations. CHCs, in particular, provide care to low-income patients and those who are uninsured or under insured. In this role as a health care safety-net provider, CHCs offer a comprehensive array of health care services which include primary care, behavioral health, chronic disease management, preventive care, as well as other specialty, enabling, and ancillary services such as radiology, laboratory, dental, transportation, translation, and social services.

CHCs are a specifically defined type of health care organization. CHCs must offer services to anyone, regardless of their ability to pay; have a sliding fee system; be a nonprofit or public organization; be community-based with a board of directors composed primarily of patients; provide services in areas that are medically underserved or to an underserved population; offer comprehensive primary care services; and have an ongoing quality assurance program.

CHCs positively impact the economies of communities in which they operate, which are often times economically distressed in addition to being medically vulnerable. In late 2020, the Center for Health Policy at the Indiana University, Richard M. Fairbanks School of Public Health conducted a once in a decade study of the economic impact of CHCs in Indiana. The total economic impact of CHCs in Indiana was nearly $1 billion annually. This is an increase of $800 million, up from a $195 million annual impact in 2009. Every dollar spent on CHC operations, supplies, and personnel generates an additional $.81 for the overall state economy, up from $.54 in 2009.

Investments in CHCs generate not only direct economic benefits for the local economies in which they operate (e.g., hiring of staff, materials, physical plant), but also two types of economic spin-off benefits: (1) indirect economic benefits to the businesses that support the operation of the CHCs (e.g., the suppliers of materials, construction firms), and (2) induced economic benefits to the local economy from the increased spending by persons who have received either direct or indirect benefits from the operation of CHCs. The size of these "ripple effects" can sometimes exceed the original direct benefit, particularly when the local economy is depressed or when unemployment is high, which is often the case in communities in which CHCs are located.

CHCs in Indiana provided 2,910 direct jobs to employees who support the operation of CHCs and another 3,082 jobs to workers in the larger economy who provide the goods and services purchased by CHCs and through income generated directly or indirectly by the CHCs. The impact on jobs has increased substantially since 2009 by contributing an additional 2,049 direct jobs and another 2,496 indirect jobs to Indiana's economy.

CHCs additionally impact their local economies by providing workforce development opportunities in areas that are impacted by higher rates of unemployment and poverty. By partnering with local schools of higher education, community partners, public schools, or even developing their own training programs, CHCs create the opportunity to improve local labor conditions and create a newly skilled workforce.

In 2021, Indiana University's Bowen Center for Health Workforce Research and Policy, conducted an analysis of health professional education and training efforts being undertaken by Indiana's CHCs. The analysis recognized CHC's response to workforce challenges, and alignment with organizational missions to serve their community, to train the next generation of the health workforce and engage in health professional education and training as a part of their engagement, many CHCs serve as training sites for health professions students of all types, with a particular emphasis on occupations that are in high-demand. These high-demand occupations, many of which would not exist in the community except for CHCs, consist of wide range of specialties and offer unique services pertinent to serving underserved communities.

A CHC in Northwest Indiana, HealthLinc, offers a grow-your-own Medical Assistant (MA) program, operated in partnership with the National Institute of Medical Assistant Advancement, which hosts MA students enrolled in local training programs. Supported by the Indiana Department of Workforce Development's *Next Level Jobs Workforce Ready Grants*, HealthLinc has focused on "upskilling" existing non-clinical employees by enabling them to participate in on-the-job training. Due to the success of the MA trainings, and their commitment to improving their community through the creation of employment opportunities, HealthLinc plans to expand their program to include training Dental Assistants.

HealthLinc's work is not an outlier. Eskenazi Health Center in Central Indiana, has created their own MA training program, which allows the training of existing non-clinical staff. The program also gives Eskenazi Health Center the ability to work with local community groups, such as Goodwill of Central & Southern Indiana, to identify potential candidates from the community for job training. This training extends both the capacities of Eskenazi Health Center, related to their own workforce needs, and the individual community member or employee, who has now developed a highly sought-after and marketable skill set they may not otherwise have the opportunity to develop.

CHCs have also established themselves as the safety-net for Indiana's communities. One very recent example in Indiana is the response of Southern Indiana Community Health Center (SICHC) and Indiana Health Centers (IHC), to the closure of Ascension St. Vincent Dunn Hospital in Bedford, IN, in December 2022. A hospital closure in a community can lead to devastating gaps in access to care, and have ripple effects, include short and long-term negative economic effects, across the community. This was particularly true in Bedford, as Dunn Hospital was the only hospital with a labor and delivery unit.

Recognizing the needs of the Bedford community, SICHC and IHC both boldly stepped forward to fill the void for primary care services, particularly OB services, created by the hospital closure. Both CHCs worked with the community to create continuity of care, fill access gaps created by the closure, and to create new partnerships, such as a collaboration with a local Critical Access Hospital, to support the newly vulnerable community.

Health Care Cost Savings Generated by CHCs

High-quality primary care services are a critical component of the U.S. health care system. It is well established that integrated, team-based primary care services improve health care quality and cost outcomes. CHCs in particular are a cost-effective, high-quality, and highly efficient form of primary care, in part due to the comprehensive and integrated nature of the services CHCs provide.

Research shows CHCs provide comparable and oftentimes higher quality care compared to other health entities, particularly for the most vulnerable Americans. A 2013 brief from The Kaiser Commission on Medicaid and the Uninsured found that when comparing data collected from CHCs to HEDIS data, CHCs often outperformed MCOs in key chronic care metrics, including A1c control for diabetics and blood pressure control for hypertensive patients. Indiana data tells a similar story; CHC patients are more likely to have chronic diseases like hypertension and diabetes under control compared to the general population of Medicaid recipients in the state.

CHCs provision of community-based, relationship oriented care for basic health needs, chronic disease management, substance use disorders, and many other services in an integrated, enabling and collaborative fashion across the health care system creates substantial reductions in overall cost. Decades of research have consistently shown CHCs create cost savings, despite serving populations who are a higher risk of poor overall health and chronic conditions. CHCs save at least $24 billion in costs annually for the health care system. It is estimated that it is between $500-$2,300 less expensive for a Medicaid patient to receive primary health care at a CHC than at another provider.

CHCs help lower the cost of medical care by providing the types of primary and preventive services that reduce the need for costlier medical care such as preventable emergency room visits and in-patient hospital care. CHC patients have lower rates of multi-day hospital admissions, lower rates of ED utilization, lower rates of specialty care visits and lower numbers of inpatient bed days. Research has shown that health center patients have 24 percent lower overall costs than patients receiving primary care in other settings.

A recent study conducted on the impact of funding for CHCs on utilization and emergency department visits in Massachussetes provides a clear demonstration of the effect of CHCs on health care cost drivers. The study found that areas in Massachusetts which had greater funding increases provided to CHCs resulted in increased growth in patient visits, and reductions in the number of people with visits to the emergency department, especially for conditions that do not require immediate emergency care. This reduction in visits to the emergency department was unique to areas with increases in health center funding, and provides evidence for the impact CHCs have on patients by providing a usual option for primary care.

As one CHC leader was quoted as saying in the report conducted by the previously mentioned analysis conducted by the Indiana University, Fairbanks School of Public Health:

> "***We really feel like our niche is safety net care. So, we really look for those opportunities in the community to pickup the vulnerable and marginalized populations. We've got a couple of different programs that we feel like really get at the heart of that. One of those programs is an emergency department follow-up program. If folks are seen in the emergency department and they don't have somewhere to follow-up, we will see them. An example would be if I had a primary care provider and I got stitches in the emergency department today [and] my primary care provider couldn't get me in, I could come to [the CHC] for follow-up***."

Opportunities and Need for Further Investment in CHCs

Access to primary care can be improved through sustained and strategic investments in CHCs. The health center model ensures access to primary care for all individuals, that is patient-center, community-based, and high-quality.

The reach and impact of the health center program has grown substantially, and has demonstrated the ability for continued growth. Since 2015, the number of federally funded CHCs has remained relatively constant, with no Federal grant adjustments to keep pace with inflation or other costs. Yet, the number of clinic sites operated by CHCs across the Nation has increased from 10,000 in 2015 to over 14,000 in 2021. The number of patients served by CHCs has also increased, growing by 6

million, or 24 percent during the same time period. In Indiana, this expansion has resulted in an increase from 100 clinic sites in 2015, to over 350 at the time of this Hearing. The number of Hoosiers served by CHCs also increased by over 150,000 from 2015 to today.

Despite the successful expansion of CHCs, we know that the portion of Americans with an identified source of primary care is decreasing, a trend further investment in CHCs can help reverse. This is partially related to the ongoing, chronic shortage of primary care access. In Indiana, according the Health Resources and Services Administration (HRSA), there are currently more than 2 million Hoosiers in primary care Health Professional Shortage Areas. It is not surprising then that based on national estimates, roughly 800,000 Hoosiers report lacking a usual place to go for medical care.

Specifically focusing on a population CHCs serve extensively, the medically uninsured, paints a similar picture of an opportunity to address unmet need. Among the non-elderly population in Indiana in 2021, there were nearly 600,000 uninsured Hoosiers, who we know traditionally face limited access to health care services. In 2021, nearly half (46.7 percent) of nonelderly uninsured adults reported not seeing a doctor or health care professional in the past 12 months compared to 18.2 percent with private insurance and 13.1 percent with public coverage. Of the nearly 600,000 uninsured Hoosiers, 150,000 are served by Indiana's CHCs which, with additional Federal funding serving as a catalyst, is a number that would certainly increase and help to address the issue of access to care for uninsured Hoosiers.

Additional Federal investments in CHCs would extend their reach into underserved communities across Indiana, and deepen their existing service lines, creating greater access to maternal/newborn health care, mental and behavioral health care, and oral health care. The last time a competition for CHC New Access Points was held by HRSA in 2019, approximately 500 applications were submitted nation-wide. However, due to limited funding, only 77 organizations were funded.

According to the National Association of Community Health Centers, a commitment by Congress to allocate an additional $500 million over 5 years will enable over 750 new CHCs to reach approximately 4 million new patients. Federal funding, which is generally less than 20 percent of a CHCs overall budget, provides critical funding to stabilize operations and provide start-up funding for new services or service sites.

Conclusion

The health center program is a cornerstone of the U.S. health care system and Indiana's health care system. CHCs are a cost-effective, high-quality, and highly efficient form of primary care, which save billions of dollars every year and improve the health of millions of Americans. CHCs need continued, sustained funding, and are primed to meet the ongoing and expanded needs of the patients and communities they serve.

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[SUMMARY STATEMENT OF BEN HARVEY]

Community Health Centers (CHCs) are nonprofit, patient-governed organizations that provide high-quality, comprehensive primary health care to people living in medically underserved areas. In 2021, CHCs marked the historic milestone of serving 30 million Americans in a single year, 600,000 of whom were Hoosiers.

CHCs are a specifically defined type of health care organization. CHCs must offer services to anyone, regardless of their ability to pay; have a sliding fee system; be a nonprofit or public organization; be community-based with a board of directors composed primarily of patients; provide services in areas that are medically underserved or to an underserved population; offer comprehensive primary care services; and have an ongoing quality assurance program.

In Indiana, CHCs have a direct economic impact of nearly $1 billion. CHCs also impact their local economies by providing workforce development opportunities in areas that are typically impacted by higher rates of unemployment and poverty.

Research has consistently shown health center patients covered by Medicaid and Medicare routinely have lower annual costs than patients seen by other providers. CHC patients have lower rates of multi-day hospital admissions, lower rates of ED utilization, lower rates of specialty care visits and lower numbers of inpatient bed days. CHCs save at least $24 billion in costs annually for the health care system.

Access to primary care can be improved through sustained and strategic investments in CHCs. The health center model ensures access to primary care for all individuals, that is patient-center, community-based, and high-quality.

CHCs are a cost-effective, high-quality, and highly efficient form of primary care, which save billions of dollars every year and improve the health of millions of Americans. CHCs need continued, sustained funding, and are primed and ready to continue, and expand, to meet the needs of the patients and communities they serve.

The CHAIRMAN. Mr. Harvey, thank you very much for your testimony. Our next witness is Dr. Robert Nocon, who is an Assistant Professor at Kaiser Permanente School of Medicine, who prior to

that was a researcher at the University of Chicago. Dr. Nocon, thanks a lot for being with us.

STATEMENT OF ROBERT S. NOCON, M.H.S, PH.D., ASSISTANT PROFESSOR, KAISER PERMANENTE BERNARD J. TYSON SCHOOL OF MEDICINE, LOS ANGELES, CA

Dr. NOCON. Chairman Sanders, Ranking Member Cassidy, and distinguished Members of the Committee, thank you for the opportunity to testify on the topic of community health centers today.

As was mentioned, I work as an Assistant Professor at the Kaiser Permanente Bernard J. Tyson School of Medicine, and I am a health services researcher who studies the financing and organization of care in the safety net.

I state for the record that my views today are my own as a researcher and do not necessarily represent the views of Kaiser Permanente or the KP School of Medicine. As others have noted, community health centers have long played a critical role in providing access to comprehensive, high quality primary care across the United States.

There is also a long history of academic research on community health centers and the care they provide. I will be focusing my comments on research that assesses the cost and utilization of care for community health center patients, and I will specifically highlight an ongoing series of studies that I conduct along with my collaborators at the University of Chicago.

In these studies, our group uses national Medicaid and Medicare administrative claims data, drawing from data from 2012 to 2016. We use the claims data to identify patients who receive most of their primary care in community health centers, and comparison patients who mainly get their primary care in other settings.

We conduct separate studies for general populations of adults, children, and individuals duly eligible for Medicaid and Medicare, as well as more focused studies on individuals with opioid use disorder and those with diabetes.

By using these national claims data sets, we are able to study a range of different types of health care utilization and cost, not only the types of services that community health centers provide, but also the services that occur downstream of primary care, such as emergency department use and hospitalization.

Across these studies, we find that health center patients have greater use and cost for primary care services, but generally less use and cost of other services. When we add up those costs across all services, we find that health center use is associated with lower total costs of care, on average, 15 percent lower for adults and 22 percent lower for children.

In terms of quality of care, while specific results vary by disease area, we mostly find that health centers have similar or better levels of performance on quality measures, such as prevention of unnecessary hospitalizations, and completion of recommended well-child visits.

Applying our estimates of cost savings to the national population of health center patients in 2021, we estimate that health centers

resulted in a cost savings of over $25 billion, from reduced payments from Medicaid and Medicare, over a 1-year period. Beyond our own research group studies, our findings are consistent with multiple studies over time that have found community health centers to be associated with lower total costs.

Dr. Leighton Ku of George Washington University shared his own estimates in assessment of the literature, which I appended to my testimony. Notably, much of Dr. Ku's work has used a completely different dataset, national surveys of patients, and observed similar levels of cost savings associated with health centers.

Across different populations, data sets, years, and research groups, several studies have described this pattern of health center care being associated with lower total costs, and comparable or better quality.

Overall, these studies provide a large body of evidence that support the case for health center value. Given the Committee's consideration of future Federal health center grant funding, I will close by highlighting one additional theme from our work, which is the particular importance of this grant funding to health center operations.

Recently published studies from our group have shown that health center staffing and service volume are particularly sensitive to changes in Federal health center grant levels, and these grants are associated with stronger overall financial health as an organization.

Other witnesses today have and will continue to speak eloquently about the supportive services and advance care model that health centers provide. Our research suggests that this model of care contributes to value through lower Medicaid and Medicare costs for other types of utilization, and the community health center grant funding under consideration by this Committee is particularly important to maintaining this program and the benefits it provides to our most medically underserved communities.

Thank you for the opportunity to testify today, and I look forward to your questions.

[The prepared statement of Dr. Nocon follows:]

PREPARED STATEMENT OF ROBERT NOCON

Chairman Sanders, Ranking Member Cassidy, and distinguished members of the Committee, thank you for the opportunity to testify on the topic of community health centers.

My name is Robert Sayoc Nocon. I am an Assistant Professor of Health Systems Science at the Kaiser Permanente Bernard J. Tyson School of Medicine in Pasadena, California.[1] My research focuses on the financing and organization of care in the health care safety net. I have extensive experience studying the cost and utilization of care among patients receiving primary care at community health centers supported by the Health Resources and Services Administration (HRSA). Along with collaborators at the University of Chicago, we have conducted a series of studies that compare costs of care for patients who obtain most of their primary care in community health centers against costs for patients who attend other settings. Our studies use national data to analyze this topic among diverse populations and we consistently find that care for patients in community health centers is associated with lower total health care costs. Our studies contribute to a large body of research that dates back over 30 years and repeatedly reaches similar conclusions across different datasets, time periods, and research teams.[2]

The Critical Role of Health Centers

HRSA-supported community health centers (called "health centers" or abbreviated as "HCs" hereafter) have played a critical role caring for the nation's most marginalized patients since their inception in the 1960s. In 2021, health centers served roughly one-in-11 people in the US, including 1-in-5 individuals with Medicaid insurance or no insurance and 1-in-3 people in poverty.[3] To support their role in providing comprehensive primary and preventive care in underserved communities, health centers are eligible to apply for benefits such as enhanced Medicaid reimbursement rates, discounted drug pricing, and assistance in recruitment and retention of primary care providers.[4] The vast majority of health centers receive federal grant funding through Section 330 of the Public Health Service Act from the Bureau of Primary Health Care (BPHC) at HRSA. Through American Recovery and Reinvestment Act (ARRA) and Affordable Care Act (ACA) funding, both the second Bush and the Obama administrations prioritized expansion of this program to meet the needs of uninsured and underinsured Americans as well as those who rely on Medicaid and Children's Health Insurance Program (CHIP) for health insurance. In FY22, the proposed Health Center Program budget was $5.6 billion.[5]

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[1] My role in this hearing is to represent my views as a researcher and expert on health center costs of care. My statement does not represent Kaiser Permanente or the Kaiser Permanente Bernard J. Tyson School of Medicine.
[2] https://publichealth.gwu.edu/sites/default/files/The%20Value%20Proposition%20GG%20IB%20%2368_Final_0.pdf
[3] https://www.nachc.org/research-and-data/research-fact-sheets-and-infographics/2021-community-health-center-chartbook/
[4] https://bphc.hrsa.gov/funding/funding-opportunities/health-center-program-look-alikes
[5] https://www.hrsa.gov/sites/default/files/hrsa/about/budget/budget-justification-fy20220.pdf

Research has Documented Cost Savings Associated with Health Centers

Given the critical role of health centers, a large body of research has assessed the impact of these providers on utilization and cost of care. As Leighton Ku and colleagues have observed, studies comparing total costs of care for health center and non-health center patients have frequently found care in health centers to be associated with lower total costs, with estimates of savings ranging from 8 to 33%.[6] Our team's previous analysis of Medicaid claims from 13 states using 2009 claims data showed that health center patients with fee-for-service Medicaid insurance had lower use and spending than did non–health center patients across all services, with 22% fewer visits and 33% lower spending on specialty care, and 25% fewer admissions and 27% lower spending on inpatient care.[7] Total spending was 24% lower for health center patients. In a study of the Medicare population in 14 states in 2009, total median annual costs for Medicare patients seen in health centers were 10% lower compared to patients in private physician offices and 30% lower compared to patients in outpatient clinics.[8] These findings suggest that investments in comprehensive primary care services offered by health centers reduce the tertiary care burden among publicly insured patients.

More Recent Studies Have Reinforced these Findings with National Data

In an ongoing series of studies, we sought to expand our previous multi-state studies with national claims data that examined specific patient sub-populations in greater detail, including Adults (age 18-64), Children (<18), and "Duals" (individuals dually eligible for Medicaid and Medicare).[9] We also separately conducted focused analyses of patients with opioid use disorder[10] and diabetes.[11] We used national claims data for all analyses. Most analyses used 2012 data, but we leveraged more recent 2014 and 2016 claims for selected analyses.[12] Our studies classify patients into health center or non-health center groups based on whether they

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[6] https://publichealth.gwu.edu/sites/default/files/The%20Value%20Proposition%20GG%20IB%20%2368_Final_0.pdf

[7] Nocon RS, Lee SM, Sharma R, et al. Health Care Use and Spending for Medicaid Enrollees in Federally Qualified Health Centers Versus Other Primary Care Settings. Am. J. Public Health. Nov 2016;106(11):1981-1989.

[8] Mukamel DB, White LM, Nocon RS, et al. Comparing the Cost of Caring for Medicare Beneficiaries in Federally Funded Health Centers to Other Care Settings. Health Serv. Res. Apr 2016;51(2):625-644.

[9] Adult, Child, and Duals studies have been completed and are in various stages of the peer review process.

[10] Peterson L, Murugesan M, Nocon R, Hoang H, Bolton J, Laiteerapong N, Pollack H, Marsh J. Health care use and spending for Medicaid patients diagnosed with opioid use disorder receiving primary care in Federally Qualified Health Centers and other primary care settings. PLoS One. 2022 Oct 18;17(10):e0276066.

[11] Knitter AC, Murugesan M, Saulsberry L, Wan W, Nocon RS, Huang ES, Bolton J, Chin MH, Laiteerapong N. Quality of Care for US Adults With Medicaid Insurance and Type 2 Diabetes in Federally Qualified Health Centers Compared With Other Primary Care Settings. Med Care. 2022 Nov 1;60(11):813-820. doi: 10.1097/MLR.0000000000001766.

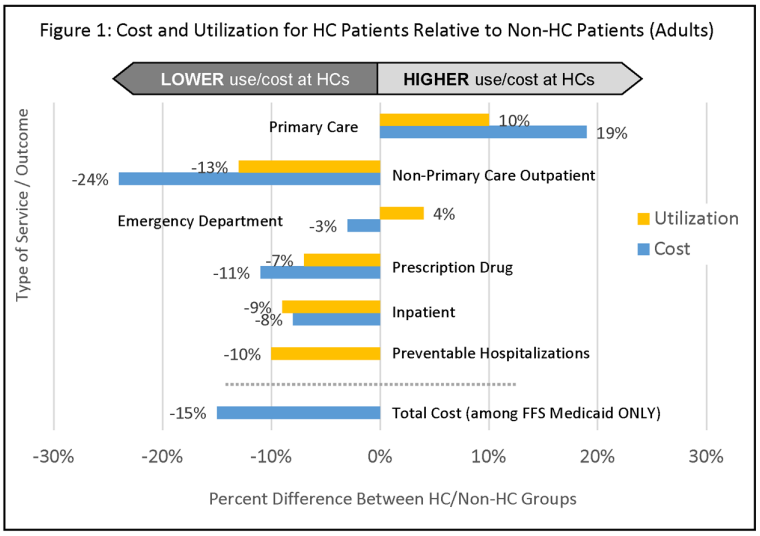
[12] 2012 data was the most recent available for all states at the time we began the work. We were able to incorporate 2016 claims for the analysis of Duals and 2014 claims for a subset of 17 states for some analyses in the Adult study.

receive the majority of their primary care at a health center and we use statistical methods to ensure that we compare similar groups of patients.[13]

In our studies of general populations of adults and children, we consistently find that **health center patients have lower total costs and similar or better levels of quality of care**.

Among adults (Figure 1, below), we find higher cost and utilization for primary care, but lower cost and utilization in other downstream services (e.g., inpatient care). Emergency department care for adults shows a mixed pattern with health center patients having higher emergency department care utilization, but lower costs. We measure total cost across all types of services for Medicaid Fee-for-Service beneficiaries and find that health center patients have 15% lower total cost than comparable non-health center patients. We use a measure of preventable hospitalizations as in indicator of access to quality ambulatory care and find that health center patients have 10% less preventable hospitalizations (i.e. higher quality).

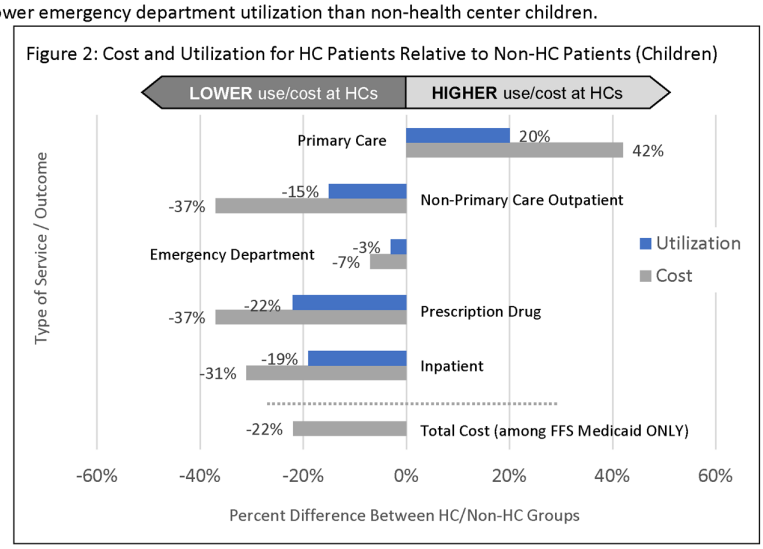
Figure 1: Cost and Utilization for HC Patients Relative to Non-HC Patients (Adults)



[13] We use a statistical method called propensity score overlap weighting to construct similar health center and non-health center groups. Our studies control for characteristics such as patient demographics (age, race/ethnicity, gender), disease burden/illness, insurance characteristics (Medicaid eligibility category, total number of eligible months, Temporary Aid for Needy Families program indicator), patient location, and distance to the nearest health center.

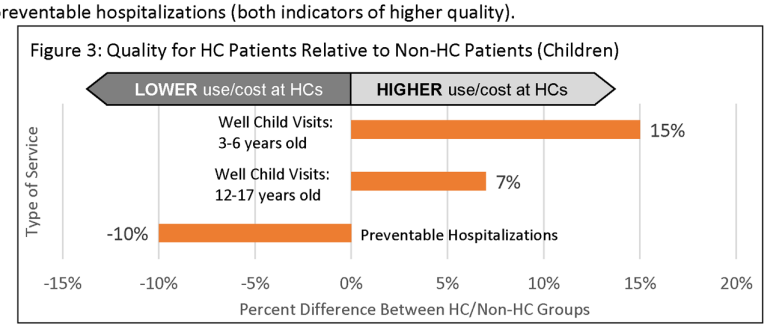
Among children (Figures 2 and 3, below), we find a similar pattern of higher primary care use and cost, lower use and cost of other downstream services, and 22% lower total cost overall for health center patients. In contrast to the adult findings, children in the health center group had lower emergency department utilization than non-health center children.

Figure 2: Cost and Utilization for HC Patients Relative to Non-HC Patients (Children)



Our quality analyses for children included two types of measures – preventable hospitalizations and rate of completion of recommended well-child visits. We find that children receiving most of their primary care from health centers have higher rates of well-child visits and fewer preventable hospitalizations (both indicators of higher quality).

Figure 3: Quality for HC Patients Relative to Non-HC Patients (Children)



In addition to general populations of adults and children, we have conducted in-depth studies of specific subpopulations of interest to HRSA and the health center community: Duals, Medicaid beneficiaries with opioid use disorder, and Medicaid beneficiaries with diabetes.

- *Dually Eligible*. Health center patients had higher primary care costs and lower non-primary care costs, resulting in lower total costs. This pattern was observed in both younger (<65) disabled duals and aged (>=65) duals.
- *Medicaid Beneficiaries with Opioid Use Disorder*.[14] FQHC patients had higher primary care utilization and fee-for-service cost, and similar or lower utilization and cost for other services. No difference in total cost. Quality findings were mixed, with health center patients faring better on measures related to use of behavioral health therapy and potentially inappropriate prescribing of benzodiazepines and opioids, but worse on timely receipt of medication for opioid use disorder and retention in treatment.
- *Medicaid Beneficiaries with Diabetes*.[15] Health center patients had fewer hospitalizations, but more ED visits than comparable non-health center patients. Health center patients had lower rates for several process-based quality measures, with both groups showing low performance overall.

Estimating the Cost Savings to Medicare and Medicaid from Community Health Centers

To provide insight into how these cost differences between health center and non-health center patients may have resulted in cost savings for Medicare and Medicaid, we apply the cost differences observed in our studies to the national population of health center patients in 2021 (Table 1, below). We use the results shown above for the adult, child, and dual-eligible population. Since our most recent national studies do not examine Medicare-only patients, we use the 2016 study of Medicare patients in 14 states by Mukamel et. al. to estimate savings for this population.

We estimate that in 2021, the health center program saved over $25 billion to Medicaid and Medicare over a 1-year period, which reflects higher use and spending on primary care for health center patients, but much lower spending on non-primary care services. Notably, these cost savings estimates are on par with work from Ku and colleagues that used different methods and datasets to reach an estimate of $24 billion in savings across all payers in 2009 dollars[16] and in an updated 2023 memo on costs and savings associated with community health centers.[17]

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[14] Peterson (2022)
[15] Knitter (2022)
[16] https://hsrc.himmelfarb.gwu.edu/cgi/viewcontent.cgi?article=1024&context=sphhs_policy_ggrchn
[17] Leighton Ku. "Preliminary Thoughts on Cost and Savings Associated with Community Health Centers." February 2023. (Provided by the author and attached as an Appendix)

Table 1. Estimated Cost Savings to Medicare and Medicaid

Patient Population	Average Annual Cost Savings Per Patient	Number of Health Center Patients	Total Estimated 2021 Savings
Adults with Medicaid (18-64)	$1,786	8.4 million	$14,954 million
Children with Medicaid (0-17)	$937	6.6 million	$6,183 million
Dual Medicare-Medicaid Eligible	$1,559	1.3 million	$1, 965 million
Adults with Medicare only	$670	3.3 million	$2,234 million
		Estimated Total	$25.3 billion[18]

Conclusion: Our Research – and the Broader Health Center Literature – Shows Strong Evidence for Health Center Value

Across general adult, pediatric, and dual eligible populations, care for health center patients shows consistent patterns of greater primary care use and cost, lower use and cost of most services downstream of primary care, all resulting in lower total cost for health center patients. While quality of care findings show more mixed results depending on the specific patient sub-population, we generally find that patients receiving most of their primary care in a health center tend to receive comparable or better quality of care than patients in other settings. This combination of lower cost and comparable quality provides strong evidence for health center value.

One explanation for this pattern of utilization is that health centers may provide a more comprehensive model of primary care that reduces the use of more acute medical care services. This interpretation is consistent with the design and intent of the Health Center Program, which is constructed by statute to align with medically and socially complex needs. For example, health centers must be governed by a board of directors with a majority of representatives from their patient populations and maintain "enabling" services (e.g., translation, transportation) designed to increase access to care for safety-net populations.

[18] We use adjusted differences between health center and non-health patient total costs among fee-for-service Medicaid and Medicare beneficiaries (as described above in this statement) and adjust for medical care inflation to estimate 2021 savings. We note that in sensitivity analyses that we conduct in our adult and child Medicaid studies, utilization results are generally similar between fee-for-service and managed care populations, which provides evidence for the generalizability of cost findings from fee-for-service to managed care. Adult and child populations reflect non-dually eligible. Counts of health center patients were obtained from HRSA Uniform Data System and include both Awardee and Look-a-Like health centers.

A key strength of our analyses is that we are able to examine these patterns of care and lower total cost across national populations in Medicaid and Medicare, using detailed administrative claims databases from every state and the District of Columbia for most analyses. We acknowledge that the 2012-2016 data used in our studies does not reflect major shifts in the national health care landscape such as later stage effects of the Affordable Care Act or the dramatic national impact of the COVID-19 pandemic. However, the consistency of similar findings across different studies over several decades (which cover previous major shifts in the national and healthcare landscape) lead us to believe that we will continue to see similar patterns of care for health center patients with more recent data. Our team is currently analyzing 2018 claims to provide updates to these analyses.

Strong and stable funding of health centers is essential for these organizations to continue to serve as the backbone of the US primary care safety net. Prior research by our team has shown that community health center grant funding is associated with better overall financial performance among health centers, which is particularly important given that one-quarter of health centers operated at a negative or near-zero margin from 2012 to 2017.[19] Our work has also shown the critical importance of health center grant funding in maintaining community health center staffing and services, with a recent policy forecasting model created by our team showing the outsized impact that Section 330 funds have on health centers staffing and services.[20] Health centers serve communities with some of the greatest medical needs and complex social risks, such as unstable housing and limited financial resources. These communities are also among those that have been hit hardest by the pandemic, creating a challenging operating environment for any healthcare organization.[21] As we attempt to move forward from the pandemic and support our most vulnerable communities in their recovery, ensuring adequate financing for health centers is a strong investment in the US healthcare system and one that research shows provides high value.

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[19] Jung D, Huang ES, Mayeda E, Tobey R, Turer E, Maxwell J, Coleman A, Saber J, Petrie S, Bolton J, Duplantier D, Hoang H, Sripipatana A, Nocon RS. Factors associated with federally qualified health center financial performance. Health Services Research. 2022 March 9. Online ahead of print.

[20] Shiyin Jiao S, Konetzka RT, Pollack HA. Huang ES. Estimating the Impact of Medicaid Expansion and Federal Funding Cuts on FQHC Staffing and Patient Capacity. Milbank Q. April 12, 2022.

[21] https://www.kff.org/medicaid/issue-brief/how-community-health-centers-are-serving-low-income-communities-during-the-covid-19-pandemic-amid-new-and-continuing-challenges/

Appendix: Memo shared by Leighton Ku: “Preliminary Thoughts on Costs and Savings Associated with Community Health Centers” (5 pages)

TO: David Reynolds, Senate HELP Committee
Sophie Kasimow, Senate HELP Committee
Michaela Brown, Senate HELP Committee

FROM: Leighton Ku, PhD, MPH
Professor of Health Policy and Management
Director, Center for Health Policy Research
George Washington University

DATE: Feb. 24, 2023 - revised

SUBJECT: Preliminary Thoughts on Costs and Savings Associated with Community Health Centers

You requested my input about evidence concerning the costs and savings associated with the use of community health centers, as authorized under Section 330.

My colleagues and I at the Milken Institute School of Public Health at George Washington University recently released two reports that are relevant to this topic. An August 2022 report summarizes research and evidence about the contributions of community health centers, particularly cost savings that may occur when patients receive care at community health centers, compared to similar patients getting care at other places (mostly private physician offices).[1] It highlights nine studies from a number of researchers (including me and my GW colleagues and researchers from the University of Chicago, Johns Hopkins University, Michigan State University and others) using different data and research designs:

Study	CHC Patient Population	Cost-Savings
Duggar et al, 1993	California Medicaid Patients	33%
Duggar et al, 1994	New York Medicaid Patients	26%
McRae & Stampfly, 2006	Michigan Medicaid Patients	10%
Richard et al, 2012	National Population	24%
Mundt & Yuan, 2014	Michigan Medicaid Patients	8%
Mukamel et al, 2016	14 States Medicare Patients	10%
Nocon et al, 2016	13 States Medicaid Population	24%
Bruen & Ku, 2019	National Population Children	35%
Huang, Nocon, et al, 20222	Adult Medicaid Patients	15%

[1] Ku L, Sharac J, Morris R, Jacobs F, Shin P, Brantley R, Rosenbaum S. The Value Proposition: Evidence of the Health and Economic Contributions of Community Health Centers. Geiger Gibson/RCHN Community Health Foundation Research Collaborative Policy Brief #68. August 2022. https://publichealth.gwu.edu/sites/default/files/The%20Value%20Proposition%20GG%20IB%20%2368_Final.pdf

[2] In the August report this study is cited as Nocon (not yet published). It is still not published in a peer reviewed journal, but the Univ. of Chicago team shared a more complete unpublished summary of a series of papers: Huang E, Nocon R, Jankins R, Asfour N, Chin M. Health Centers and the Changing Policy

These studies, done over a span of roughly 30 years, consistently show that, health centers increase use for primary and preventive care for disadvantaged populations, which has the result of lowering the use of and costs for other, more expensive forms of care like inpatient or emergency care. These results are backed up by numerous other studies (cited in the August report) that show how community health centers provide high quality primary care for patients, compared to care that may be received in other settings. For the sake of simplicity, I can summarize the findings as estimating that CHC patients have significantly lower total medical expenditures, compared to similar patients who did not receive care at CHCs (or less care from CHCs):

- For Medicaid patients, savings equivalent to 8% to 33% of total Medicaid costs across six studies, **with a conservative midpoint savings of about 20%.**
- For Medicare patients, Mukamel, et al. found that care for CHC patients cost 10% less than care for patients at regular physician offices and 30% less than care at hospital outpatient departments**. A conservative estimate is 10% savings.**
- We conducted national studies, not using Medicaid or Medicare claims data and one study estimated 24% average savings and another estimated 35% savings for children.
- While the studies vary somewhat in the methods and findings, they are surprisingly harmonious in their conclusions: investments in quality primary and preventive care in community health centers helps spare the use of more expensive forms of care and lowers overall medical expenditures.

These savings are all the more remarkable given that community health centers receive enhanced payments in Medicaid and Medicare under the prospective payment system (or alternative payment models), so they generate savings despite the higher primary care payment rates. The enhanced payments coupled with federal health center funding help health centers provide additional health services, including mental health, dental and substance use services, and non-reimbursable social and other support services, such as transportation, needed by low-income patients in underserved areas, which are not available in most doctors' offices. In fact, even though health centers serve a patient population at higher risk for complex health issues than those served in "regular" private physician offices, data show that health centers run very lean operations and use efficient primary care teams, including greater use of nurse practitioners, physician assistants, nurses and medical aides and others to deliver high quality care to provide primary care in medically underserved areas. This is why community health centers are an effective and efficient way to expand primary care services.

Unfortunately, none of these studies reflect more recent changes brought on by the COVID-19 pandemic. Regrettably, it will take several years before it is possible to conduct such an assessment because COVID – and now the Medicaid unwinding – are still affecting care and because it takes years to accumulate and analyze the data.

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and Payment Environment, Sept. 12, 2022. The Medicaid savings estimates are based on fee-for-service Medicaid claims data from 2012. There also appear to be results related to child and dual eligible Medicaid populations, but the details are not available.

But we know that health centers were surprisingly resilient through their ability to pivot to telehealth in 2020 and then to reopen their doors more recently. During this public health crisis, health centers provided critical COVID testing to approximately 19 million low-income patients, the majority of whom are racial/ethnic minorities, extensive vaccination support and substantial mental health care in underserved communities.[3]

I used the CBO Medicaid and Medicare baselines (from May 2022) to estimate the effect of 20% Medicaid and 10% Medicare savings per Medicaid or Medicare patient enrolled at CHCs:

MEDICAID (20% savings)	**FY 2022**	**FY 2023**	**FY 2024**	**FY 2025**	**FY 2026**	**FY 2027**	**FY 2028**
Federal Savings per person per year"							
Child	$354	$376	$334	$360	$372	$394	$436
Traditional Adult	$964	$1,030	$1,030	$1,100	$1,168	$1,230	$1,280
Expansion Adult	$1,334	$1,418	$1,542	$1,654	$1,756	$1,860	$1,982
*Blended Avg**	*$792*	*$843*	*$857*	*$914*	*$971*	*$1,026*	*$1,082*
Total (Fed & State) Savings per person per year:							
Child	$545	$578	$514	$538	$572	$606	$640
Traditional Adult	$1,482	$1,576	$1,713	$1,838	$1,951	$2,067	$2,191
Expansion Adult	$1,482	$1,576	$1,713	$1,838	$1,951	$2,067	$2,191
*Blended Avg**	*$1.070*	*$1,137*	*$1,186*	*$1,266*	*$1,344*	*$1,424*	*$1,504*

* The blended average assumes the average composition of non-elderly Medicaid patients in health centers is 44% children, 30% traditional adults and 26% expansion adults. The actual proportions vary across sites; remember that 12 states have not yet expanded Medicaid.

MEDICARE (10% savings)	**FY 2022**	**FY 2023**	**FY 2024**	**FY 2025**	**FY 2026**	**FY 2027**	**FY 2028**
Federal Savings per person per year*	$1,302	$1,413	$1,376	$1,535	$1,636	$1,708	$1,924

* Based on the net Medicare federal benefit outlays per Part B beneficiary

The estimate is that, in years FY 2024 to 2028, for every additional Medicaid patient served at a community health center, the federal savings will roughly average $857 to $1,082 per year, while combined federal and state savings will average about $1,186 to $1,504 per Medicaid enrollee per year. (This is conservative because the 20% savings estimate is conservative and because I am only basing this on adult and child expenditures, not more costly aged or disabled Medicaid patients at health centers.)

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[3] Sharac J, Jacobs F, Shin P, Rosenbaum S. Community Health Centers' Response to the COVID-19 Pandemic: Two-Year Findings from HRSA's Health Center COVID-19 Survey (April 2020—April 2022). May 2022. https://www.rchnfoundation.org/wp-content/uploads/2022/05/Two-Year-Findings-from-HRSA%E2%80%99s-Health-Center-COVID-19-Survey.pdf

The estimate of Medicare savings in FY 2024-28 is that, for every additional Medicare patient served at a health center, federal Medicare outlays will be reduced by about $1,376 to $1,924 per person per year (The 10% savings estimate is conservative and I am excluding non-federal Medicare costs, e.g., the amounts paid by patient premiums and cost-sharing). Although the estimated percent savings per person are smaller for Medicare (10%) than for Medicaid (20%), the dollar savings per person are larger because total federal expenditures per beneficiary are so much larger for Medicare's aged and disabled populations.

Of course, it is important to remember that about half (47%, 14.3 million persons in 2021) of health center patients are on Medicaid and 10.6% are on Medicare. The proportion of Medicaid patients almost certainly rose in 2022 and 2023 and the proportion of Medicare patients is rising and will continue to rise as baby boomers age. Thus, for every additional 1 million total patients that health centers can serve, we could roughly estimate there will be about 500,000 more Medicaid patients and 11,000 Medicare patients, which could yield savings per person comparable to those stated above. (About one-fifth of health center patients are uninsured and one-fifth have private insurance (including Health Insurance Marketplaces.)

These numbers are changing, however. Because of the Medicaid continuous enrollment requirement, the number on Medicaid has certainly grown, but after March 2023 enrollment will fall as the "Medicaid unwinding" takes its toll. In a January 2023 report, we estimated that by the time unwinding is done, health centers could lose about 2.5 million Medicaid patients. [4] We have also seen draft data from a survey that the National Association of Community Health Centers has fielded; a majority of health center respondents anticipate serious financial and staffing problems will arise from unwinding and the loss of Medicaid revenue. Unless Congress responds by bolstering health center grant funding, this will lead to substantial revenue losses for health centers and could result in them losing the capacity to serve between 1.2 and 2.1 million patients (compared to 30 million total patients in 2021).

We know from prior analyses that the number of patients who can be served by health centers has been primarily influenced by the level of HRSA grants as well as by Medicaid expansions.[5] [6] Section 330 funding forms the core of financial support and "primes the pump" so that centers can earn more revenue by serving Medicaid, Medicare and other insured patients, as well as supporting costs to care for the uninsured. In addition to their core Section 330 grants and insurance revenue, health centers rely on other federal, state and local grants as well as patient cost-sharing.

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[4] Ku L, Sharac J, Shin P, Rosenbaum S, Jacobs F. The Potential Effect of Medicaid Unwinding on Community Health Centers. Jan 2023. Geiger Gibson Program in Community Health. Data Note. https://geigergibson.publichealth.gwu.edu/potential-effect-medicaid-unwinding-community-health-centers

[5] Han X, Luo Q, Ku L. Medicaid Expansions and Increases in Grant Funding Increased the Capacity of Community Health Centers, Health Affairs, 2017 Jan.; 36 (1):49-56.

[6] Jiao S. et al. Estimating the Impact of Medicaid Expansion and Federal Funding Cuts on FQHC Staffing and Patient Capacity. Milbank Quarterly, 2022; 100(2):1-21.

If federal community health center grants are level-funded in 2024 (i.e., total funding around $5.8 billion), then health centers will be forced to shrink, due to both underlying medical inflation and the loss of Medicaid revenue due to the unwinding. This will lower the level of primary care services in communities across the county and would stifle the ability of health centers to serve their current patients, much less serve new areas or expand the range of services offered.

Increases in community health center grant funding could, depending on the level of increase, permit health centers to cover some of Medicaid revenue losses to stem the loss of patient capacity due to Medicaid unwinding and keep pace with rising medical costs. Larger grant increases could enable health centers to expand into other underserved communities across the nation, to increase the number of Medicaid and Medicare patients receiving quality primary care at health centers, which would lead to further reductions in federal Medicaid or Medicare expenditures. It could also help health centers expand the range of services available, such as mental health, substance use and dental care services available in underserved communities.

As you know, a challenge is whether CBO's interpretation of scorekeeping rules would permit it to offset increases in health center funding with Medicaid or Medicare savings. Usually, funds spent through discretionary appropriations are not scored as providing budgetary savings in mandatory programs.[7] It may be possible to score offsetting Medicaid or Medicare savings if increases for health center funding are provided as mandatory funds rather than as discretionary appropriations, but that may be subject to the interpretation of scorekeeping rules.

[7] Congressional Budget Office. CBO Explains Budgetary Scorekeeping Guidelines. Jan. 2021. https://www.cbo.gov/system/files/2021-01/56507-Scorekeeping.pdf

[SUMMARY STATEMENT OF ROBERT NOCON]

- My statement describes research on cost and utilization of care for patients of community health centers.
- Community health centers serve a critical role in providing access to comprehensive, high quality primary care in areas of high health care need across the United States.
- A large body of research, dating back over 30 years, has studied how care for patients who use health centers differs from patients who use other types of primary care providers.
- Research conducted along with my collaborators at the University of Chicago has used national administrative claims data from Medicaid and Medicare to analyze this topic. We find that health center patients have greater use and cost for primary care services, but generally less use and cost of other services "downstream" of primary care, such as inpatient hospitalization.
- Accounting for all types of medical care utilization, we find that health center use is associated with lower total costs of care. Health center patient total cost is 15 percent lower for adults and 22 percent lower for children, compared to similar patients who go to other settings for their primary care.
- In terms of quality of care, while specific results vary by disease area, we mostly find that health centers have similar or better levels of performance on quality measures such as prevention of unnecessary hospitalizations or completion of recommended well-child visits.
- Applying our estimates of cost savings to the national population of health center patients in 2021, we estimate that health center care resulted in a cost savings of over $25 billion to Medicaid and Medicare over a 1-year period.
- Our research findings are consistent with numerous studies over time that have found community health centers to be a cost-efficient way of strengthening the health care safety net.

The CHAIRMAN. Thank you, Dr. Nocon, for your testimony. Our next witness is Sue Veer, President and CEO of Carolina Health Centers in South Carolina, where she has served since 2006. Ms. Veer has over 35 years of experience supporting the development and leadership of health centers and primary care associations.

She also serves on the Board of Directors of the National Association of Community Health Centers. Ms. Veer, thank you so much for being with us.

STATEMENT OF SUE VEER, M.B.A., C.M.P.E., PRESIDENT AND CHIEF EXECUTIVE OFFICER, CAROLINA HEALTH CENTERS, GREENWOOD, SC

Ms. VEER. Thank you, Chairman Sanders. Chairman Sanders, Ranking Member Cassidy, and Members of the Committee, I want to thank you for this opportunity to testify about the important work of community health centers.

As the Senator said, my name is Sue Veer. I am the President and CEO of Carolina Health Centers, which is a federally qualified health center that serves as the primary care medical home for over 25,000 patients in rural South Carolina.

My career has spanned 35 years in several different settings of care, but one constant has been a commitment to ensure that everyone, regardless of demographic or socioeconomic barriers and circumstances, has access to appropriate and effective health care that is delivered with respect, dignity, and compassion, and there

is no better fit for that commitment than community health centers.

Health centers manage their patients across not just the continuum of care, but oftentimes the entire spectrum of their lives. We provide access to comprehensive primary and preventive care, but also address social determinants of health by tackling really difficult challenges like homelessness, joblessness, domestic violence, parenting skills, food insecurity, transportation, the list goes on.

Access to these programs and services drives more appropriate and effective use of health care services and improved health outcomes, resulting in cost savings across the entire health care delivery system. And while cost prevention may not count in the scoring of Congressional funding, it matters in real life. It matters in reality.

Health centers also have a significant financial impact or economic impact, and you are going to hear a lot of that and you have had a lot of that in writing. A study with Carolina Health Centers that was completed by Capital Link in 2020 indicated $24 million in savings to the overall health care system, and 456 jobs generated, and $53 million in direct and indirect spending in our communities.

Our primary service area, as I said, covers 3,708 square miles and 7 rural counties. We were established in 1977, and we now operate 12 medical practice sites, 3 of which are pediatric, 2 community pharmacies, and we provide agricultural farmworker services during the growing season.

Behavioral health and substance use disorder services are particularly important and they are provided through integrated, inhouse behavioral health services and collaboration with the local mental health and substance use agencies. It is a particular challenge, however, due to the lack of third-party reimbursement or any other source of funding.

In a Medicaid non expansion state, few adults have coverage, and consequently we estimate that 80 percent of those needing services have no source of third-party reimbursement. This challenge extends to our ability to provide substance use disorder because behavioral health is an incredibly important component of medication assisted treatment.

Our pharmacy includes two entity owned pharmacies which are both open retail and 340B, and we also provide prescriptions through several contract pharmacy arrangements necessary due to both geographic barriers and limited payer networks.

Our clinical pharmacists are also part of the treatment team, and oral health is provided through a contract—a network of contract dentists, and we subsidize that care for our low income, uninsured, and underinsured patients.

In the time I have remaining, I really want to introduce three initiatives that contribute to our ability to effectively manage the care of our patients. The first is those integrated models of care. But here I want to focus on early childhood services as it is a bit unique to Carolina Health Centers.

We operate an early childhood service department that includes four evidence-based programs, three of which are home visitation programs. They also provide a range of care coordination to make sure the needs of all families are met. They—you have an outline of the criteria for all those programs, but what is important is the impact for families, as well as across the health care delivery system.

On more than one occasion, home visiting nurses have identified pre-term labor, preventing possible death of either mother or baby, or preventing premature delivery, which would have resulted in a costly NICU visit. We have seen countless stories of parents who have ended abusive relationships, finished high school, gone back to college.

Also, our pediatricians attest to the fact that these parents are often the most adherent to treatment protocols well-child checks, and not using the emergency room for ambulatory sensitive conditions.

These success stories really speak to the impact on health and well-being of our families, but behind the scenes, it is really about the resources they have saved, not to mention the fact that these families can now make meaningful contributions in their communities. I have very little time left.

I do want to mention, and you have in writing, an outline of our Quality and Population Management Department, which really works to close gaps in care, making sure people use care effectively, and second, manage the medical loss ratio, which is a measure of how much of the MCO managed care company's capitated rate is spent on direct patient care.

We operate right around an 80 percent range, which is extremely cost effective. We are also a member of the OCHIN Health Center Controlled Network and Collaborative, which is 200 health centers that are a learning collaborative that optimizes the use of technology to manage care.

The last thing and in closing that I will mention is we have one site that is quite unique because it is located within the walls of a hospital contiguous to an emergency room. And over the how many ever years, it has been open I think now 12 years, and it has shown a dramatic reduction of use in the E.R.

Thank you very much. I look forward to your questions and the continuing discussion.

[The prepared statement of Ms. Veer follows:]

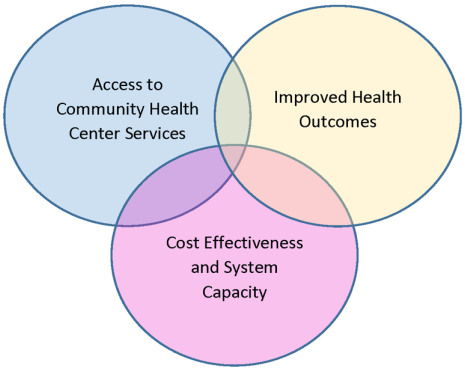
PREPARED STATEMENT OF SUE VEER

Introduction:

Good morning, Chairman Sanders, Ranking Member Cassidy, and Members of the Committee, and thank you for the opportunity to testify about the important work of Community Health Centers and the incredible value they deliver to this nation. My name is Sue Veer, and I am the President and CEO of Carolina Health Centers, Inc. (CHC), a Federally Qualified Health Center (FQHC) that serves as the primary care medical home for 25,770 patients in the rural area of South Carolina known as the Lakelands. I also have the privilege of serving on the Executive Committee of the National Association of Community Health Centers (NACHC) and the Board of Directors for the South Carolina Primary Health Care Association.

My career in health care spans 35 years and includes working in community hospitals, a major academic medical center, private practices, and now, the community health center world. Though my work environment has varied, the one constant has been my strong commitment to advocating on behalf of patients and their families – a commitment to ensure that everyone, regardless of demographic or socio-economic circumstances, has access to appropriate and effective health care that is delivered with dignity and compassion. When I discovered Community Health Centers in 2001, I found my career home and the perfect fit for my commitment to patient and family-centered care and my training in business and organizational development.

When I joined the health center movement, I discovered unlike other health care settings in which I had worked, the approach to patient care is not episodic or limited to what can be addressed within the walls of a traditional medical practice. Our health centers care for and manage their patients across not just the continuum of care, but often, the full spectrum of their lives. We provide comprehensive primary and preventive care, and address social determinants of health by tackling difficult challenges like homelessness, joblessness, domestic violence, parenting skills, food insecurity, transportation, and so much more. Community Health Centers embody the concept of whole-person care, producing immeasurable value in those patients' lives and across the health care delivery system. Let me illustrate:



As the Venn diagram illustrates, access to the programs and services at a community health center drives more appropriate and effective use of health care services and results in improved health outcomes. This, in turn, results in cost-effectiveness and increased capacity within the health care system. Where access, quality, and cost-effectiveness intersect lies the value proposition for Community Health Centers. As acknowledged in the announcement of this hearing, Community Health Centers save (and improve) lives[1] and save money, and those savings accrue not just to the health centers but across the entire delivery system.

I would be remiss if I did not include comments about the overall economic impact health centers have on their communities. The following data are from a study on Value and Impact prepared by Capital Link, and highlight the Carolina Health Centers, Inc. 2020 economic impact:

Savings to the Health Care System:	**Economic Stimulus:**	**Vulnerable Populations**
24% lower costs for health center Medicaid patients	456 total jobs - 256 health center jobs - 201 other jobs in the community	24,843 total patients served - 95.2% of patients are low income - 57.2% identify as an ethnic or racial minority - 10,133 are children and adolescents - 1.2% are veterans - 1.3% are agricultural farmworkers
$22 million in savings to Medicaid	$53 million in total economic impact from current operations - $34.5 million in direct health center spending - $28.6 million in community spending	
$42 million in savings to the overall health system	$7.9 million in annual tax revenues	

[1] Saving lives is listed first intentionally. Though we are committed to and work diligently to ensure cost effective care, our primary mission is the health and well-being of the patients and communities we serve.

	- $1.4 million in state and local tax revenue - $6.5 million in federal tax revenues	

The National Association of Community Health Centers (NACHC) can provide national as well as state-by-state economic impact data.

Overview of Carolina Health Centers, Inc.

Carolina Health Centers, Inc. (CHC is a Federally Qualified Health Center (FQHC) that serves as the primary care medical home for 25,770 patients in the rural area of South Carolina known as the Lakelands.

CHC's primary service area covers 3,708 square miles and includes the 7 rural counties of Abbeville, Edgefield, Greenwood, Laurens, McCormick, Newberry, and Saluda. Established in 1977, CHC now operates 12 medical practice sites, two community pharmacies, and provides agricultural farmworker health services during the growing season.

CHC's 12 medical practices include nine family medicine practices, two pediatric centers, and one practice site that includes both a family medicine and a pediatric practice. One of the family medicine practices operates as a faith-based practice and is aligned with a wide variety of community ministries to facilitate referrals. Agricultural farmworker services are provided during the growing season at our family practice location in the rural community of Ridge Spring in Saluda County.

CHC has served as something of a pioneer in demonstrating the impact of integrating comprehensive early childhood services into the pediatric medical home. For over 25 years, we have included child development professionals and evidence-based home visitation programs as part of our model of care. I plan to discuss these programs' contributions to value delivered later in my comments.

Behavioral Health and Substance Use Disorder (SUD) services are provided through a combination of in-house behavioral health specialists and collaboration with the Beckman Center for Mental Health Services, the local office of the SC Department of Mental Health. CHC directly employs six integrated behavioral health professionals, and a Beckman Center counselor is located at one of our practice sites. We also coordinate with the Beckman Center for psychiatric services. In addition, we are in the early stages of implementing an agreement to serve as a Designated Collaborating Organization for the Beckman Centers' Certified Community Behavioral Health Center (CCBHC) and will be assigning an Advance Practice Registered Nurse to provide primary care services at four of their locations throughout the service area.

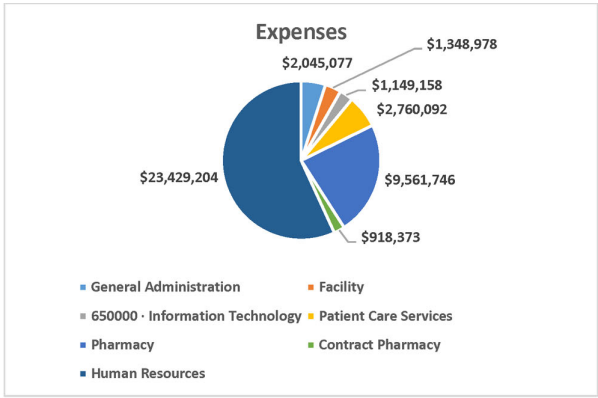
Meeting the escalating need for Behavioral Health and SUD is a particular challenge due to the lack of 3rd party reimbursement or any other source of funding. While the South Carolina Department of Health and Human Services recently adopted new reimbursement guidelines for FQHCs to expand the types of billable providers, in a non-expansion state, few adults have Medicaid coverage; consequently, these enhanced rules only benefit the pediatric population. We estimate that as high as 80% of our adult behavioral health visits have no source of 3rd party reimbursement. This challenge extends to the need for expanded SUD services. CHC has at least five medical providers interested – in fact anxious to provide Medication Assisted Treatment (MAT); however, our ability to add the behavioral health resources necessary to support MAT is limited by the lack of funding or 3rd party reimbursement.

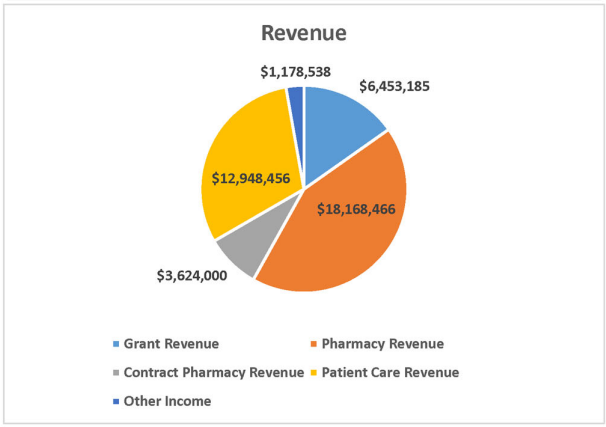
CHC Department of Pharmacy includes two entity-owned community pharmacies, both of which are open to the general public as well as CHC patients. We are a 340B covered entity and 340B purchased inventory is used for only established patients of CHC and only for those prescriptions that emanate from CHC's medical practices and HRSA Scope of Project. The 340B program enables us to offer deeply discounted prescription medication to our patients living at or below 200% of the federal poverty level. To ensure access for our patients given our large and very rural service area, the pharmacy operates a daily courier service that delivers prescriptions for established CHC patients to our outlying medical practice sites. We also provide mail-order medications and implemented home delivery within a limited range during COVID. We also provide prescriptions through several contract pharmacy arrangements, which are necessary due to both geographic barriers and limited payer networks, especially related to specialty drugs. In addition to operating a dispensing pharmacy, clinical pharmacists serve as part of the patient care team, assisting with patient and staff education and medication adherence.

Oral health care is provided through a network of contacted dentists with CHC providing a subsidy for low income uninsured and underinsured patients.

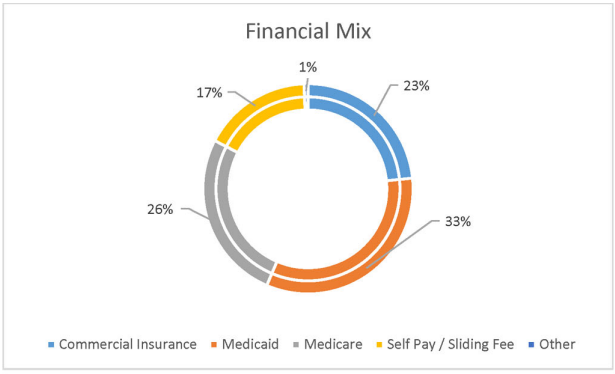
Like most health centers, CHC provides an array of enabling services to promote patient access and the effective use of the health centers services. Those include outreach, community education, transportation support, translation, and referrals to community resources. We have a comprehensive Quality and Population Health Department focused on optimizing the health of the patients we serve through care coordination and case management. The work of this department will be discussed later in my comments.

For the current fiscal year (June 1, 2022 - May 31, 2023), CHC has a total operating budget of $41,212,627, and projected revenue of $42,372,645, for a year end operating margin of 2.7%

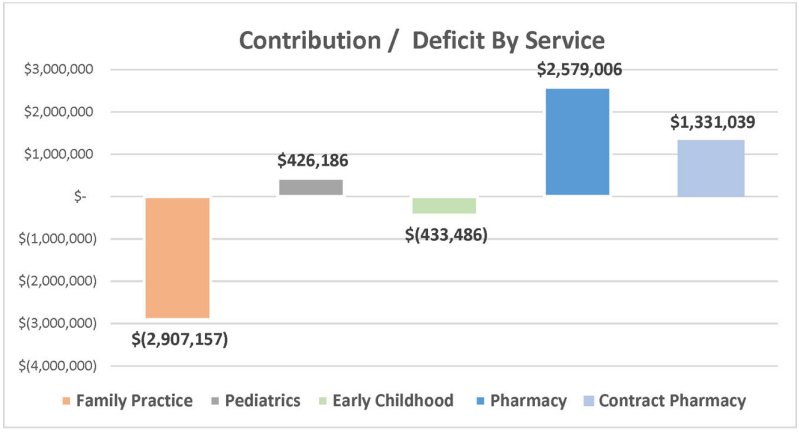




The 12-month Revenue Analysis below reflects a healthy payor mix with 33% of the patients covered by Medicaid and 26% by Medicare; however, it is important to point out that this does not reflect all health centers nor represent the total picture for CHC. It is important to point out that represents the aggregate of all patients across all CHC practice locations. First, that includes pediatric patients which make up over 30% of CHC's total patient population, and 95% of which are covered by Medicaid or private insurance. Measuring in the aggregate also does not account for the variation across practice sites, with many of our smaller rural sites having a significantly higher self-pay patient population – with two practice sites as high as 43%.



The previously mentioned lack of 3rd party coverage for adult family medicine is clearly reflected in the analysis below of contribution versus deficit to the operating margin:



CHC employs a total of 319 employees; however, that number does not reflect the vacancies resulting from current workforce challenges.

Having provided a substantial overview of Carolina Health Centers, Inc., I would like to focus the remainder of my comments on three specific initiatives that make a significant contribution to CHC's ability to effectively manage the care of our patients and deliver on our commitment to value.

Integrated Models of Care:

The primary care medical home model at Carolina Health Centers, Inc. (CHC) is built on a belief that, in order to improve the health of individuals and build healthy communities, the care we provide must extend well beyond the traditional medical practice and include integrated programs and services that address the social determinants of health. Three areas of integrated care that I mentioned earlier are Behavioral Health and SUD, Pharmacy Services, and Early Childhood Services. While all of these contribute significantly to providing quality and cost-effective care, I would like to focus here on Early Childhood Services, as it is a bit unique to CHC and a focus of growing interest among the Community Health Centers.

CHC's largest pediatric practice, The Children's Center, was born out of the vision of a group of pediatricians at the Greenwood Genetics Center. They believed that, in order to positively impact the health and well-being of future generations, the work of pediatrics must extend beyond the walls of the traditional pediatric model. These pediatricians formed a community-based non-profit organization focused on Early Childhood Development and helped leverage state funding for CHC to open The Children's Center over 25 years ago. For many years these two organizations were co-located and worked collaboratively to meet the needs of our shared patients and families. Then in 2009, the boards agreed to merge the organizations, creating a Department of Early Childhood Services within CHC.

Today, the Department of Early Childhood Services (ECS) operates four evidence-based models, three of which include a home visitation component. They also provide a range of care coordination to ensure that families with need but not meeting any specific program eligibility can access assistance. All of these programs are voluntary.

The four evidence-based programs and their goals are described below:

Nurse Family Partnership (NFP) – is a home visitation program staffed by bachelors prepared registered nurses, that serves low income, first time mothers starting early in pregnancy and continuing until the child's second birthday. The goals of NFP include:

- Improve pregnancy outcomes by teaching/encouraging mothers to engage in good preventive health practices including thorough prenatal care;
- Improving diet;
- Eliminating the use of habit-forming substances;
- Improving child health and development; and

- Improving the economic self-sufficiency of the family by supporting parents in the planning of future pregnancies, continuing their education, and finding employment.

Healthy Families America is a home visitation program of Prevent Child Abuse America. Families in need of services are identified through a risk assessment given at the 2-week well child check-up. Risk factors include low income, single parent, first child, 18 years-old or younger, Spanish speaking only, high/school or less educational level, late/no prenatal care, expressed concern about parenting lack of a support system, past history of child abuse/neglect, or a history of mental illness, domestic violence, and/or substance abuse. The goals of Healthy Families America include:

- Prevent the abuse and neglect of children in communities;
- Strengthen parent-child relationships;
- Promote healthy child development; and
- Enhance family well-being.

Parents as Teachers is a program that helps parents embrace and develop their role as the child's most influential teacher. Similar to the Healthy Families America program, families in need are identified through a risk assessment at the 2-week well child check-up. The goals of Parents as Teachers include:

- Supporting the parent's role in school readiness;
- Promote optimal early development; and
- Enhance the learning and health of children.

Healthy Steps is an evidence-based interdisciplinary pediatric primary care program that integrates child develop specialists into the pediatric care team to promote healthy development. Healthy Steps has an emphasis on low income and otherwise vulnerable families and the goals of the program include:

- Providing support for common and complex concerns including behavior, sleep, feeding, attachment, parental depression, social determinants of health, and adapting to life with a baby;
- Identifying when children are (and aren't) meeting developmental milestones;
- Connecting families to additional services as needed; and
- Fostering patient centered care and the appropriate and effective use of health care services.

Care Coordination is an essential role in ECS as it ensures that no family is left without resources to assist them with special needs or in navigating the health care system. The pediatric care team often refers families who are known to use emergency services for episodic care, or require referrals to specialists or other services within the community.

Early Childhood Services (ECS) have immeasurable impact for the families served, as well as across the health care delivery system. On more than one occasion, Nurse Family Partnership home visiting nurses have identified preterm labor, preventing the possible death of mother or baby, or preventing a premature delivery resulting in a long and costly stay in a neonatal intensive care unit (NICU). The Healthy Families America and Parents as Teachers staff share countless stories of parents who have ended abusive relationships, eliminated toxic substances from their lives, gone back and finished high school, and even completed college degrees. CHC's pediatric providers often share stories about the work of the Health Steps child development specialists positively impacts their patients, noting that these families are the most adherent to both well-child care protocols as well as treatment when needed for episodic and chronic illnesses. These families are also less likely to use an emergency department or urgent care for ambulatory sensitive conditions that are more appropriately treated in a less costly setting of care.

These success stories speak to the impact on the health and well-being of these families, but behind the scenes is the story of the resources that have been saved, not to mention the contribution these families are now making in the community.

Three of the four evidence based programs provided by CHC's Early Childhood services Department are funded (in part) by the Maternal Infant and Early Childhood Home Visitation program; however, a portion of the cost for these programs must be covered by CHC's operating margin.

Recently, the Health Resources and Services Administration (HRSA) released a Notice of Funding Opportunity that will enable more Community Health Centers to incorporate Early Childhood Development into their medical home model. I appreciate and applaud HRSA for helping to move the needle on this important work that can impact so many lives, build healthier communities, and drive the appropriate use of our health care resources.

Quality and Population Health/ Value-based Reimbursement

The Quality and Population Health Department at Carolina Health Centers, Inc. (CHC) has developed over the past ten years to now include eight professionals whose roles focus on managing how CHC patient access and utilize the health care system in order to optimize the benefit to the patient and ensure appropriate and effective use of healthcare resources.

The responsibilities of this cadre of case managers care coordinators, and quality and population health specialists include closing gaps in care, which means working directly with patients to ensure that they are receiving recommended primary and preventive care and screenings. Often for low income, uninsured, and underinsured patients, this includes working with other providers and community organizations to arrange for free or low cost screening services. Closing gaps in care is closely related to meeting Healthy Effectiveness Data and Information Set (HEDIS) measures that have been established by the National Committee for Quality Assurance (NCQA). Through the work of CHC's Quality and Population Health Team does to close gaps, we have saved lives through early detection and intervention for a myriad of potentially life threatening and definitely life changing conditions. Early detection and intervention results in far more cost effective care saving money across the entire continuum of care.

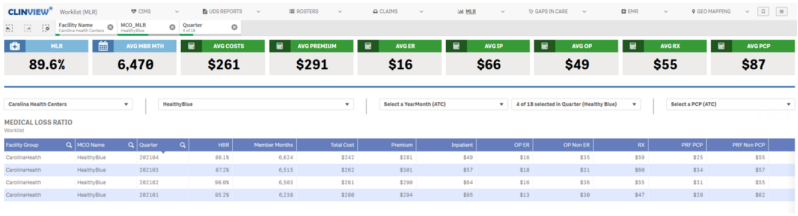
Another focus for CHC's Quality and Population team is evaluating patterns of high utilization of emergency departments, urgent care, and specialty care. Staff are able to identify these patterns of high utilization using reports provided by the managed care companies whose beneficiaries are assigned to a primary care provider (PCP) at CHC. Through outreach, education, and care coordination services, we are often able to alter a life long and even multi-generational pattern of inappropriate use of health care services, resulting in significant and long-term savings to the health care delivery system. Often times, this also results in better care management and improved health outcomes.

Care coordinators and case managers also work with complex patients to connect them to needed specialty care and social services and follow up with those patients assigned to a PCP at CHC, but who have never established care as a new patients. This is important for the patient, but also because the managed care companies attribute responsibility for care of those patients to the assigned PCP.

The results of this work are documented and measurable, and for Carolina Health Centers, Inc. and thirteen other health centers in South Carolina, have the potential to return benefit in terms of value-based reimbursement by the Medicaid Managed Care Organizations (MCOs). In January of 2008, fourteen of South Carolina's community health centers formed an Independent Practice Association (IPA) called Community Integrated Management Association (CIMS). The partners in CIMS are clinically and financially integrated in order to develop collaborative clinical protocols that support improved health outcomes, and to develop value-based reimbursement agreements with the MMCOs. As of this date, the CIMS heath centers have value-based agreements with four of the MMCOs and are working to develop similar agreements with Medicare plans as well as Market-based plans.

Basically, the value-based agreement measure performance in two ways. The first is based on the % of beneficiaries assigned to the practice that meet all of the plans selected quality measures, which may be HEDIS measures or other measures assigned by the Medicaid agency. The second is how the health center performs in terms of the Medical Loss Ratio (MLR) in the aggregate for all beneficiaries assigned to a PCP at that health center. MLR is a measurement of the amount of the MCOs capitation that is directed to health care services. MLR is reported in total as well as broken into composite parts representing different categories of care such as primary care, pharmaceutical costs, inpatient, and emergency care. In evaluating MLR through the lens of both quality and cost effectiveness, a MLR that is too low – i.e. below 80% - may indicate that the beneficiary is not receiving adequate care; while a MLR that is too high – i.e. 90% and above may indicate that the beneficiaries assigned to that PCP are not using health care resources in a cost effective manner. Because it encompasses all direct health care expenses, MLR is an excellent measure of the impact Community Health Centers are having on both quality and cost effectiveness.

Because CIMS is clinically and financially integrated, value-based reimbursement (or shared savings) paid by the MMCOs are based on the aggregate performance of all partner health centers; however, CIMS distributes those value based payments to the partnering centers based on their individual performance. Carolina Health Centers, Inc. (CHC) is in the top three performing partner centers, largely due to the investment that has been made in developing our Quality and Population Health team. The image below is an example of a report that is generated for CHC in the CIMS Quality Dashboard.



It is an excellent demonstration of the impact CHC has across all segments of the health care delivery system. Through Quality and Population Health management we are savings lives and saving money.

<u>Laurens County Community Care Center (LC4)</u>

is an excellent example of how Community Health Centers are able to partner with other provider organizations to increase access to primary care in a community and save money. LC4 was established in 2009 when Laurens County Community Hospital (now the Laurens County

campus of Prisma Health) was building a new emergency department. In their needs assessment they determined that over 60% of the ED utilization was related to non-emergency care that could be treated in a less costly health care setting. Through a dynamic partnership, the space vacated when the new ED was completed became a family medicine practice site of CHC. LC4 is located within the walls of the hospital, immediately contiguous to the new ED. Though patients are still treated in the ED for episodic, non-emergent conditions, those without an established source of primary and preventive care are referred next door to LC4 where the majority become established patients. Previous studies indicate a significant reduction in ED utilization for nearly 70% of the patients that establish a medical home with CHC. Reduced use of emergency services for ambulatory sensitive care has been recognized as one of the top strategies for reducing cost in our health care system and that savings has become a reality at LC4. Of note, 43% of the established patients at LC4 are self-pay, which suggests that these patients added to the financial burden in the ED. We are also saving and improving lives as we reduce the use of episodic care in favor of a comprehensive and integrated primary care medical home.

Closing:

Chairman Sanders, Ranking Member Cassidy, and members of the committee, I would like to close by thanking you, as well as all Members of Congress for your recognition that Community Health Centers essential to the health and well-being of communities across this nation, and for you long standing, bipartisan support that has enabled us to grow and stand in the during the past three difficult years.

I recognize that Congress is facing significant challenges in terms of fiscal policy and deeply appreciate the attention that is being paid to the needs of Community Health Centers, our patients, and the communities we serve.

I will leave you with my thoughts about what is important to me as health center leader.

I have alluded to significant challenges in terms of workforce development, lack of funding for behavioral health and SUD, and the inflationary pressure we have all experiences. There is unmet need across CHC's service area that clamors to be addressed. Community Health Centers are deteriorating and could benefit from capital funding. However, what is critical to me as a health center leader is funding that is sustainable, predictable, and fully supported now and into the future. Support for long-term, sustainable, and predictable funding enables me to confidently lead my health center into the future and empower the amazing team at CHC to continue the work of saving lives and saving money.

Thank you.

[SUMMARY STATEMENT OF SUE VEER]

My name is Sue Veer, and I am the President and CEO of Carolina Health Centers, Inc. My career in health care spans 35 years and includes working in community hospitals, a major academic medical center, private practices, and now, the community health center world. Though my work environment has varied, the one constant has been my strong commitment to advocating on behalf of patients and their families—a commitment to ensure that everyone, regardless of demographic or socio-economic circumstances, has access to appropriate and effective health care that is delivered with dignity and compassion.

In my testimony I plan to share an overview of my health center and examples that outline how access to the programs and services at a community health center drives more appropriate and effective use of health care services and results in improved health outcomes. This, in turn, results in cost-effectiveness and increased capacity within the health care system. As acknowledged in the announcement of this hearing, Community Health Centers save (and improve) lives and save money, and those savings accrue not just to the health centers but across the entire delivery system.

Carolina Health Centers, Inc. (CHC is a federally Qualified Health Center (FQHC) that serves as the primary care medical home for 25,770 patients in the rural area of South Carolina known as the Lakelands. CHC's primary service area covers 3,708 square miles and includes the seven rural counties of Abbeville, Edgefield, Greenwood, Laurens, McCormick, Newberry, and Saluda. Established in 1977, CHC now operates 12 medical practice sites, two community pharmacies, and provides agricultural farmworker health services during the growing season.

In addition to providing an overview of the programs and services at CHC, I plan to focus on three specific initiatives that make a significant contribution to CHC's ability to effectively manage the care of our patients and deliver on our commitment to value: Integrated care Models, Quality and Population Health Management, and Laurens County Community Care center (LC4), a health center site located in a hospital contiguous to the Emergency Department.

My comments are intended to support what is most critical to me as a health center leader, which is funding that is sustainable, predictable, and fully supported now and into the future. Support for long-term, sustainable, and predictable funding enables health center leaders like me to confidently lead our health centers into the future and empower our teams to continue the work of saving lives and saving money.

The CHAIRMAN. Ms. Veer, thank you very much. Our final witness will be Jessica Farb. She is the Managing Director of the health care team at the U.S. Government Accountability Office, the GAO.

Ms. Farb is responsible for leading the team that conducts audit work on the full spectrum of the health care sector. Ms. Farb, thanks so much for being with us.

STATEMENT OF JESSICA FARB, M.S., MANAGING DIRECTOR, GOVERNMENT ACCOUNTABILITY OFFICE, WASHINGTON, DC

Ms. FARB. Thank you. Chairman Sanders, Ranking Member Cassidy, and Members of the Committee, thank you for the opportunity to be here today to discuss GAO's work on the health center program.

For over 50 years, health centers have been helping low-income individuals across the U.S. access care in medically underserved areas, as was previously noted, and primary and preventative health care is provided to over 30 million people by 1,400 health centers today, regardless of their ability to pay.

In order to provide this care, health centers rely on revenue from a variety of public and private sources. There are four types of health centers under the health center program, which is adminis-

tered by the Health Services—Health Resources and Services Administration, or HRSA.

Over three-quarters of them are community health centers that serve the general population. The remainder health centers that serve specified populations, including health centers for the homeless, residents of public housing, and migrant workers.

The scope of health care provided by health centers is broad, as my colleagues have said today, and must include primary care, such as internal medicine and pediatric care, preventative care such as immunizations and prenatal care, emergency care, which may be provided through arrangements with providers beyond the health center and enabling services to facilitate access to care such as translation and transportation services.

Health centers are not required to provide behavioral health services, but according to HRSA, many do so to meet the needs of the populations they serve. In addition to the services they provide, health centers are also required to document the unmet health needs of residents in their service area and to periodically review their service area to determine whether the services provided are available and accessible to area residents promptly and as appropriate.

Health centers also must have a sliding scale based on a patient's ability to pay and generally must be governed by a community board where at least 51 percent of the members are patients of the health center. HRSA determines whether health center grantees meet these and other health center program requirements when making award determinations.

Over the past two decades, in response to program changes and funding increases, GAO has periodically been asked to examine various aspects of the Community Health Center Program.

For example, in 2008, we looked at the number of health center sites in medically underserved areas, as well as the types of services the health centers provided. In 2011, we described strategies used by health centers to reduce unnecessary emergency department utilization.

In 2012, we examined HRSA's oversight process and the extent to which the process identified and addressed noncompliance with key program requirements. Our most recent report on health centers published in 2019, described the amounts of health center revenue from 2010 through 2017.

During this timeframe, health centers revenue more than doubled, from $12.7 billion in 2010 to $26.3 billion in 2017, as Senator Cassidy pointed out. This increase occurred at the same time that the number of centers grew going from 1,124 centers to 1,373.

The number of patients served also grew by 7.7 million individuals. Our 2019 report also described trends in the sources of health care revenue. According to our analysis, about 60 percent of health centers' 2017 revenue came from Medicaid, Medicare, and private insurance payments for the care that was provided.

30 percent of health center revenue in 2017 came from Federal and state grants. Comparing those proportions to those in 2010, we found that revenue from public and private insurance had grown

over time, and accordingly, the proportion from Federal and state grants had decreased.

These Federal grants include those funded by the Community Health Center Fund, or CHCF. As we reported from Fiscal Year 2011 through 2017, health centers received approximately $15.8 billion from this fund. Of this amount, the vast majority, $12.6 billion, was awarded to maintain operations at existing health centers.

We were told by HRSA officials in the course of our prior work that these grants to the CHCF were used to fill the gap between what it costs to operate a center and the amount of revenue a center received. As such, these grants help centers cover care that would otherwise have been uncompensated.

The remaining portion of the $15.8 billion and CHCF grants from 2011 through 2017 were made to increase the amount of services provided in existing health centers, to increase the number of health centers, and to support special initiatives such as health information technology.

While our most recent reporting predates the pandemic, health center revenue since 2020 has included funding made available through COVID–19 supplemental appropriations. According to HRSA, health centers have led efforts to ensure access to COVID–19 tests, vaccines and treatments, providing essential primary care and preventive health care to patients and their communities.

As Senator Cassidy mentioned, in the coming months we will be starting an examination of trends in health center funding since our last review, including an assessment of how the supplemental funding provided in response to COVID–19 has been used. In addition, we anticipate analyzing the characteristics of the patients health centers served, among other issues.

Chairman Sanders, Ranking Member Cassidy, and Members of the Committee, this completes my prepared statement. I will be happy to answer any questions you may have.

[The prepared statement of Ms. Farb follows:]

PREPARED STATEMENT OF JESSICA FARB

United States Government Accountability Office

Testimony

Before the Committee on Health, Education, Labor and Pensions, U.S. Senate

For Release on Delivery
Expected at 10:00 a.m. ET
Thursday, March 2, 2023

HEALTH CENTERS

Trends in Revenue and Grants Supported by the Community Health Center Fund

Statement of Jessica Farb,
Managing Director, Health Care

GAO-23-106664

GAO Highlights

Highlights of GAO-23-106664, a testimony before the Committee on Health, Education, Labor and Pensions, U.S. Senate

Why GAO Did This Study

Across the U.S., nearly 1,400 health centers provided care to more than 30 million people in 2021, regardless of their ability to pay. Health centers were established to increase the availability of primary and preventive health services for low-income people living in medically underserved areas.

In order to provide these services, health centers rely on revenue from a variety of public and private sources. This revenue includes grants awarded by HRSA through its Health Center Program, including funding available through the CHCF. HRSA began awarding grants funded by the CHCF in fiscal year 2011. In more recent years, health center revenue also included funding made available through COVID-19 supplemental appropriations.

This testimony describes the Health Center Program, trends in health centers' revenues from 2010 through 2017, and the purposes for which CHCF grants were awarded. This testimony is based on GAO-19-496 and selected updates. For the 2019 report, GAO analyzed revenue data reported annually by health centers to HRSA from 2010 through 2017. In addition, GAO reviewed some HRSA data from 2021 to provide selected updates to the data we previously reported.

View GAO-23-106664. For more information, contact Jessica Farb at (202) 512-7114 or farbj@gao.gov.

March 2, 2023

HEALTH CENTERS

Trends in Revenue and Grants Supported by the Community Health Center Fund

What GAO Found

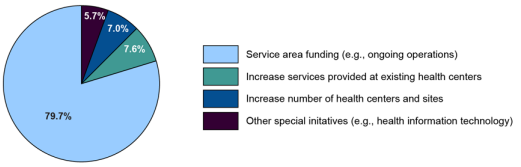
The federal Health Center Program was established in the mid-1960s in an effort to help low-income individuals gain access to health care services. It is administered by the Health Resources and Services Administration (HRSA). Through this program, HRSA makes grants to four types of health centers that primarily serve low-income populations: those that serve the general population in a certain service area, and those that serve the homeless, public housing residents, and migrant workers, respectively.

Health centers' revenue more than doubled from calendar years 2010 through 2017, from about $12.7 billion to $26.3 billion. Over the same time period, the number of health centers increased from 1,124 centers in 2010 to 1,373 centers in 2017. Health centers' revenue comes from a variety of sources, including reimbursements from Medicaid, Medicare, private insurance, and federal and state grants, which includes grants funded by HRSA's Community Health Center Fund (CHCF). While total health center revenue increased from 2010 through 2017, the share of revenue from each source changed in different ways. In particular, revenue from federal and state grants decreased from 38.0 percent of total revenue in 2010 to about 30.2 percent of total revenue in 2017 while reimbursements from Medicaid, Medicare, and private insurance increased.

GAO's analysis of HRSA data showed that from fiscal years 2011 through 2017, health centers received approximately $15.8 billion in federal grants funded by CHCF. Of the federal grants funded by CHCF from 2011 through 2017, 79.7 percent—or $12.6 billion—was awarded for the purpose of maintaining operations at existing health centers (see figure). According to HRSA officials, these CHCF grants were used to fill the gap between what it costs to operate a health center and the amount of revenue a health center received. As such, officials explained, the awards were a primary means through which health centers provided health care services that may be uncompensated, including services for uninsured patients or services not typically reimbursed by other payers, such as adult dental care. The remaining $3.2 billion in CHCF grants were made to increase the amount of services provided at existing health centers; increase the number of health centers and sites; and support other special initiatives, such as implementing health information technology.

Total Grant Funding from the Community Health Center Fund, Fiscal Years 2011-2017

Total amount: $15.8 billion



Source: GAO review of Health Resources and Services Administration award information. | GAO-23-106664

Chairman Sanders, Ranking Member Cassidy, and Members of the Committee:

I appreciate the opportunity to be here today to discuss the Health Center Program. As you know, health centers were established to increase the availability of primary and preventive health care services for low-income people living in medically underserved areas. These outpatient facilities receive federal funding and serve as an important safety net provider as the majority of their patients are uninsured or enrolled in Medicaid.

The majority of health centers serve the general population within a designated area, while other types of health centers provide care to more specific populations, including the homeless, residents of public housing, and migrant and seasonal farmworkers. Regardless of type, health centers are required to provide health care to individuals who are members of the health center's target population or to all individuals located in the health center's service area, regardless of their ability to pay. In some communities, these centers may be the only primary care providers available to certain vulnerable populations. In 2021 nearly 1,400 health centers operated more than 11,000 sites that provided care to more than 30 million people in the United States, including one in five rural residents and one in three living in poverty.

Health centers rely on revenue from a variety of public and private sources, including federal, state, and local governments; and payments for services from Medicaid, Medicare, private insurance, and patients. This revenue includes grants awarded by the Health Resources and Services Administration (HRSA) through its Health Center Program. In 2010, the Patient Protection and Affordable Care Act (PPACA) established an additional source of funding for the Health Center

Program's grants: the Community Health Center Fund (CHCF).[1] The CHCF supports a variety of grants to health centers for health care services for low-income populations.

My statement today describes the Health Center Program, trends in health centers' revenues from 2010 through 2017, and the purposes for which CHCF grants were awarded during our period of analysis. This statement is based on our most recent report on the Health Center Program, which was issued in May 2019, and selected updates.[2]

For our May 2019 report, we analyzed HRSA data collected from health centers and compiled in its Uniform Data System to identify the sources and amounts of revenue health centers received from calendar years 2010 through 2017, the most recent data at the time of our analysis.[3] We also reviewed HRSA grant documentation for grants funded by the CHCF for fiscal years 2011-2017—the most recent data at the time of our analysis—including information on the award amount and purpose of the grant, and reviewed some published studies that described the purposes for which CHCF grants have been made. Additionally, we interviewed HRSA officials, authors of the published studies, and an association representing health centers. Our May 2019 report includes a full description of our scope and methodology. In addition, we reviewed some HRSA data from 2021 to provide selected updates to the data we

[1]Pub. L. No. 111-148, § 10503, 124 Stat. 119, 1004 (2010), as amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, § 2303, 124 Stat. 1029, 1083 (2010); Medicare Access and CHIP Reauthorization Act of 2015, Pub. L. No. 114-10, § 221, 129 Stat. 87, 154 (2015); Bipartisan Budget Act of 2018, Pub. L. No. 115-123, § 50901, 132 Stat. 64, 282 (2018); Continuing Appropriations Act, 2020, and Health Extenders Act of 2019, Pub. L. No. 116-59, § 1101, 133 Stat. 1093, 1102; Further Continuing Appropriations Act, 2020, and Further Health Extenders Act of 2019, Pub. L. No. 116-69, § 1101, 133 Stat. 1134, 1136; Further Consolidated Appropriations Act, 2020, Pub. L. No. 116-94, Div. N, Title I, § 401, 133 Stat. 2534, 3113; CARES Act, Pub. L. No. 116-136, § 3831, 134 Stat. 281, 433; Continuing Appropriations Act, 2021 and Other Extensions Act, Pub. L. No. 116-159, § 2101, 134 Stat. 709, 728; Further Continuing Appropriations Act, 2021, and Other Extensions Act, Pub. L. No. 116-215, § 1201, 134 Stat. 1041, 1044; Consolidated Appropriations Act, 2021, Pub. L. No. 116-260, § 301, 134 Stat. 1182, 2922) (codified at 42 U.S.C. § 254b-2).

[2]GAO, *Health Centers: Trends in Revenue and Grants Supported by the Community Health Center Fund*, GAO-19-496 (Washington, D.C.: May 30, 2019).

[3]These data include data reported annually by health centers on their patient-related revenue, such as payments from Medicaid and Medicare, as well as other revenue provided from HRSA grants, other federal grants, and non-federal grants or contracts.

previously reported, such as amount of revenue health centers received and the number of health centers serving patients.

We conducted the work on which this statement is based in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Health Center Program

The federal Health Center Program was established in the mid-1960s in an effort to help low-income individuals gain access to health care services. The Health Center Program, authorized in Section 330 of the Public Health Service Act, is administered by HRSA's Bureau of Primary Health Care and makes grants—known as Section 330 grants—to four types of health centers that primarily serve low-income populations:

1. *Community health centers.* These health centers serve the general population with limited access to health care. They are required to provide primary health services to all residents who reside in the center's service area. More than three-quarters of health centers are community health centers.
2. *Health centers for the homeless.* These health centers provide primary care services to individuals who lack permanent housing or live in temporary facilities or transitional housing. These centers are required to provide substance abuse services and supportive services targeted to the homeless population.
3. *Health centers for residents of public housing.* These health centers provide primary health care services to residents of public housing and individuals living in areas immediately accessible to public housing.
4. *Migrant health centers.* These health centers provide primary care to migratory agricultural workers (individuals whose principal employment is in agriculture and who establish temporary residences for work purposes) and seasonal agricultural workers (individuals whose principal employment is in agriculture on a seasonal basis but do not migrate for the work).

HRSA's Section 330 grants are funded by a combination of discretionary appropriations provided through the annual appropriations process and

mandatory appropriations provided from the CHCF.[4] From fiscal years 2010 through 2021, funding appropriated for Section 330 grants—which includes funding from discretionary appropriations and the CHCF—increased from about $2.1 billion to $5.6 billion. In addition, some COVID-19 relief acts appropriated supplemental funding for Section 330 grants.[5]

Health centers are required to provide comprehensive primary health services, including preventive, diagnostic, treatment, and emergency health services. (See table 1.) All services that health centers provide must be available to patients at the center regardless of patient payment source or ability to pay and must be available (either directly or under a referral arrangement) to patients at all health center service sites. Services are provided by clinical staff—including physicians, nurses, dentists, and mental health and substance abuse professionals—or through contracts or cooperative arrangements with other providers.

Table 1: Selected Primary Health and Supplemental Services Provided at Health Centers

Category	Examples of services provided
Primary health services	Primary health services include basic health services including those related to family medicine, internal medicine, pediatrics, obstetrics, or gynecology.
Preventive health services	Required preventive services include • Well-child care • Prenatal and perinatal care • Immunizations • Voluntary family planning • Preventive dental care
Emergency medical services	Required services that are provided through defined arrangements with outside providers for medical emergencies during and after centers' regularly scheduled hours.
Enabling services	Required services include, but are not limited to • Translation services • Health education • Transportation for individuals residing in a center's service area who have difficulty accessing the center

[4]Discretionary appropriations are generally made through the annual appropriations process. Mandatory appropriations are generally created and funded in the same law in a multiyear or permanent basis and not through the annual appropriations process. Although created in 2010 under PPACA, the first year of CHCF funding was fiscal year 2011.

[5]For example, the American Rescue Plan Act of 2021 appropriated an additional $7.6 billion for Section 330 grants. Pub. L. No. 117-2, § 2601, 135 Stat. 4, 43.

Category	Examples of services provided
Supplemental services	Additional services that are not primary health services but are appropriate to meet the health needs of the service population, such as behavioral health and environmental health services.[a] Health centers are not required to provide these services.

Source: Public Health Services Act. | GAO-23-106664

[a]Behavioral health services include the services of psychiatrists, psychologists, and other appropriate mental health professionals. Environmental services can include the detection and alleviation of unhealthful conditions associated with water supply and lead exposure, among other things.

In addition to the services they provide, health centers are also required to document the unmet health needs of the residents in their service area and to periodically review their service areas to determine whether the services provided are available and accessible to area residents promptly and as appropriate. Health centers also must have a sliding fee scale based on a patient's ability to pay and generally must be governed by a community board of which at least 51 percent of the members are patients of the health center. HRSA determines whether health center grantees meet these and other health center program requirements when making award determinations.[6]

Trends in Health Centers' Revenue

Our analysis of HRSA data showed that health centers' revenue more than doubled from calendar years 2010 through 2017, from about $12.7 billion to $26.3 billion.[7] HRSA data also showed over the same time period, the number of health centers increased from 1,124 centers in 2010 to 1,373 centers in 2017. In addition, the number of patients served over the same time period increased by 7.7 million patients, from 19.5 million to 27.2 million. In 2021, there were nearly 1,400 health centers serving more than 30 million patients.

Health centers' revenue comes from a variety of sources, including reimbursements from Medicaid, Medicare, private insurance, and federal and state grants. While total health center revenue increased from 2010 through 2017, the share of revenue from each source changed in different

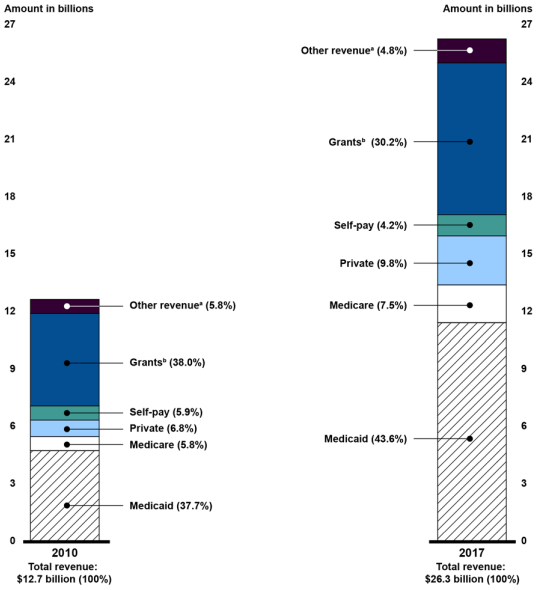
[6]In 2017 HRSA issued the Health Center Program Compliance Manual, which outlines 18 program requirements. The Health Center Program Compliance Manual is the consolidated resource to assist in understanding and demonstrating compliance with the Health Center Program requirements found in the Health Center Program's authorizing legislation and implementing regulations, as well as certain applicable grants regulations. For information on the Health Center Program Compliance Manual see https://bphc.hrsa.gov/compliance/compliance-manual.

[7]In real terms, the growth in revenue is less. Specifically, the inflation-adjusted increase was about 85 percent instead of 107 percent.

ways. In particular, revenue from federal and state grants decreased from 38.0 percent of total revenue in 2010 to about 30.2 percent of total revenue in 2017 while reimbursements from Medicaid, Medicare, and private insurance increased (see fig.1).[8]

[8]In 2021, revenue from federal and state grants represented about 31.2 percent of total revenue. Reimbursements from Medicaid, Medicare, and private insurance represented about 60.4 percent of total revenue. The remaining 8.4 percent includes revenue from self-pay, other public insurance, and non-patient related revenue not reported elsewhere, such as rent from tenants.

Figure 1: Health Center Revenue 2010 and 2017



Source: GAO analysis of Health Resources and Services Administration (HRSA) Uniform Data System data. | GAO-23-106664

Notes: Revenue in the Uniform Data System is defined as the gross receipts on a cash basis for each year collected by health centers, regardless of the period in which the paid for services were rendered. Dollars are nominal. Percentages may not add to 100 due to rounding.

[a]Other revenue includes two categories in the Uniform Data System: (1) other public insurance and (2) non-patient related revenue not reported elsewhere, such as revenue from fund-raising, rent from tenants, medical record fees, and vending machines.

[b]Grants in HRSA's Uniform Data System include three categories of revenue: (1) Section 330 grants, such as Health Center Program grants; (2) other federal grants, such as Medicare and Medicaid Electronic Health Record Incentive grants; and (3) non-federal grants or contracts, such as amounts from contracts that are not tied to the delivery of services and amounts received from state and local indigent care programs.

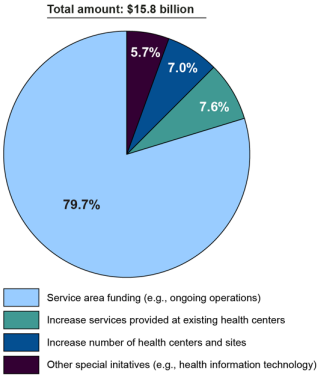
In response to earlier increases in program funding, GAO was previously asked to examine HRSA's oversight of the Community Health Center Program. In our May 2012 report, we made six recommendations for improving oversight such as strengthening HRSA's ability to consistently identify and cite grantee noncompliance and periodically assessing whether HRSA's new process for addressing grantee noncompliance was working as intended.[9] HRSA implemented all six of our recommendations.

Purposes of Community Health Center Fund Grants

GAO's analysis of HRSA data showed that from fiscal years 2011 through 2017, health centers received approximately $15.8 billion in Section 330 grants funded by the CHCF. Of this total amount, 79.7 percent—or $12.6 billion—was awarded for the purpose of maintaining operations at existing health centers (see fig. 2). According to HRSA officials, these CHCF grants were used to fill the gap between what it cost to operate a health center and the amount of revenue a health center received. As such, officials explained, the awards were a primary means through which health centers provided health care services that may be uncompensated, including services for uninsured patients or services not typically reimbursed by other payers, such as adult dental care. The remaining $3.2 billion in CHCF grants were made to increase the amount of services provided at existing health centers; increase the number of health centers and sites; and support other special initiatives, such as implementing health information technology.

[9]GAO, *Health Center Program: Improved Oversight Needed to Ensure Grantee Compliance with Requirements*, GAO-12-546 (Washington, D.C.: May 29, 2012).

Figure 2: Total Health Resources and Services Administration (HRSA) Section 330 Grants Funded by the Community Health Center Fund (CHCF), Fiscal Years 2011–2017



Source: GAO review of Health Resources and Services Administration award information. | GAO-23-106664

Notes: Section 330 grants funded by the CHCF are a subset of all Section 330 grants. Percentages may not add to 100 due to rounding. Dollars across fiscal years are nominal.

In the coming months, we will be starting an examination of trends in health center funding since our last review, including an assessment of how additional funding provided in response to the COVID-19 pandemic has been used. In addition, we anticipate analyzing the characteristics of the patients health centers serve, among other issues.

Chairman Sanders, Ranking Member Cassidy, and Members of the Committee, this concludes my statement. I would be pleased to respond to any questions you may have.

GAO Contact and Staff Acknowledgments

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The CHAIRMAN. Thank you very much. Now, we will begin with questioning. I will start and Senator Cassidy will follow, and then we will go around the table.

Panelists, let me read a quote which I think speaks to the bipartisan support the community centers have always had. This is what George W. Bush, President Bush said in 2004, and I quote, "I think it is a wise use of taxpayer money to expand and increase the number of community health centers all across America.

As a matter of fact, the goal I have set is every poor county in America has a community health center. It is much better if folks who need help get help at the community health center than in an emergency room or a local hospital. Not only do taxpayers save money, it is a more compassionate way to help people."

That is George W. Bush, 2004. Bush talked about expanding health centers to every low-income community in America. Today, we have medical deserts for almost 100 million Americans.

Was Bush right in his desire to expand community health centers all across this country? Amanda, do you want to take a shot at that?

Ms. PEARS KELLY. Certainly. I appreciate you calling out the long history of bipartisan support for health centers. And I think he is right. I think health centers are poised to step up and do everything that they can to care for as many people as are in need.

Our proposal focuses on reaching 40 million patients, but certainly I think health centers are up to the task. And I think to be honest, Senator and Members of the Committee, it really will come down to the investment that is made, enabling them to do so.

If we are talking about caring for 100 million Americans, which I think health centers could certainly scale to do with the appropriate investment, we would need to scale our proposal. It would be considerably more over year to year.

But there has never been a time where I have seen health centers not meet the task. And I think where we are today, it has everything to do with the investment that is made to enable them.

The CHAIRMAN. Thanks very much. Let me ask Ms. Veer, in your testimony, you talked about keeping people out of the expensive emergency room care and getting them to a community health center. We are doing a little bit of that in Vermont as well. Is it your understanding that all across this country, people who do not have a medical home end up in emergency rooms and much more expensive care than would otherwise be provided through a community health center? Say a word about saving money in that regard.

Ms. VEER. Absolutely, Senator. I believe the lack of a primary care medical home has that impact. And I think it is a multigenerational behavior that we see. Over generations, that is what people have done.

As a result of that, not only are the hospitals saddled with incredible bad debt of the—I mentioned that one of our health center sites is located next to an emergency room, and we originally hoped that we would get direct referrals from that emergency department.

What happened was really people got referred to us after the emergency room visit, but once they established care with us, 76 percent of them ceased using the emergency room within the next——

The CHAIRMAN. At great savings to the system.

Ms. VEER. At great savings to the system, because 43 percent of them are uninsured.

The CHAIRMAN. Okay. Mr. Harvey, you talked about diseases of despair, something that I have studied for quite a while. Tell us a little bit about what happens in rural America when people have no hope, no access to health care they need.

Mr. HARVEY. Yes, that is a great question. I mean, deaths of despair is kind of what it describes. You see the worse chronic diseases, substance use disorders creeping in, particularly in the county I grew up in as manufacturing jobs left.

Without access to care, mental health care, substance use disorder treatment, those things get worse and they get worse quickly. I think you see that too with suicide, increased rates of depression, increased rates of hopelessness, and rural America is really in, and this is maybe too broad of a statement, but it is in dire straits.

You see hospital closures—and health centers can be, in fact they are, they are that rate limiter. They have stepped into a lot of those areas and certainly in Indiana, and especially from substance use disorder, chronic disease treatment, provide that opportunity to even, one, hold back the tide, and two, reverse that.

The CHAIRMAN. Let me ask anybody on the panel. We are the richest country in the history of the world. We now spend twice as much per capita on health care as any other people. In your judgment is it in fact too much to ask that every American at least have access to quality primary health care? And as Senator Cassidy mentioned, that includes dental care, mental health counseling, lower cost prescription drugs. Is that too much to ask in the United States?

Ms. VEER. As I said in my testimony, that has been my life's commitment, is to ensure that we remove those barriers that prevent everyone from having access to that kind of care that also drives healthy behaviors that keep chronic disease controlled.

The CHAIRMAN. Anybody else want to—is this utopian, out of the reach of the United States of America?

Mr. HARVEY. No. I don't think so. I think you are right. I mean, I think access to care, taking maybe the policy piece out of this, obviously has policy implications, but access to care is a core piece of the foundation to a healthy life. I have a son that has down syndrome.

Without access to care life looks different for him. Life looks different for Hoosiers that don't have routine sources of primary care, that don't have routine sources of treatment. That really does matter.

The CHAIRMAN. Okay. Thank you all very much.

Senator Cassidy.

Senator CASSIDY. Thank you all. I, too, have devoted my professional life to making sure that those who do not have care have care, and I thank you for that commonality of interest. What our hearing here today is, how do we make sure that you have the adequate funding?

Is it otherwise adequate or is more needed? Ms. Farb when I was speaking about 340B, looking—by the way, looking at this, it clearly is important 340B because both Ms. Pears Kelly and Ms. Veer both speak about the importance of it. I think as much as $18 million out of your total $44 million budget seems to come from 30—in terms of revenue, seems to come from 340B.

Ms. VEER. It comes from our pharmacy services, a portion of which is 340B.

Senator CASSIDY. What portion of that would be 340B?

Ms. VEER. I apologize, Senator, I didn't have time to actually——

Senator CASSIDY. That is Okay.

Ms. VEER. [continuing]. Carve out those numbers.

Senator CASSIDY. But looking at your patient population, it is going to be a substantial portion.

Ms. VEER. It is going to be at least 60 percent.

Senator CASSIDY. Ms. Farb, what—when I was mentioning and asking, is 340B revenue included here, and you were kind of nodding your head no, do you have any comment on that?

Ms. FARB. Yes, Senator. So, the 340B program, given the way it works, so the entities are able to get discount of drugs and then they are able to submit claims for those drugs at the price that payer would pay.

The funding shows up in Medicare, Medicaid, and private insurance. That is where those revenues will show up. And I looked to my colleagues to confirm that is where they would be reported. They would not be reported as part of other revenue, according to HRSA.

Senator CASSIDY. Let me ask you this, because it is my understanding that when it comes to Medicare and Medicaid, that the Federal—that community health centers get an extra rate relative to the guy who is just practicing next door.

Ms. FARB. Right. They have an enhanced PBS.

Senator CASSIDY. What is the degree of that enhancement?

Ms. FARB. Off the top of my head, I can't answer that question, but I will look to my colleagues because they might actually know. Yes, I think they would.

Senator CASSIDY. Ms. Pears Kelly.

Ms. PEARS KELLY. I wouldn't—I can't give you the specifics on what it looks like to be enhanced, but I can tell you that it is—it doesn't actually cover the total cost. And Sue may be able to speak to this.

Senator CASSIDY. I accept that. I am just trying to figure out, as we put together a business plan, if somebody had told me that it is the lesser of 80 percent of what you charge and you can kind of

pick the charge or the PPS number, the lesser of those two. Mr. Harvey, you look at you are reading from——

Mr. HARVEY. Yes, I think it is a bit of a complicated picture, right. And PPS rates vary by state. So, Medicare has a set PPS rate with a geographic adjustment factor, but it varies by state Medicaid programs. And like Amanda mentioned, sometimes in certain places it will cover the total costs. But because of the global nature of what health centers provide, you are asked to do more——

Senator CASSIDY. I get that.

Mr. HARVEY [continuing]. Than a primary care.

Senator CASSIDY. Again, we are just talking about a business model. And how much subsidy is needed relative to that which you are receiving from other sources.

Mr. HARVEY. Yes.

Senator CASSIDY. Mr. Nocon, I noted that there is actually a bunch of lookalike community health centers. Lookalikes being they don't get the grant money that we are speaking of today, but nonetheless, they have grown. They have doubled since 2017. There is over 100 now.

Dr. NOCON. Yes.

Senator CASSIDY. When you did your study, did you compare the lookalikes, those not getting grants, versus those receiving grants in terms of the array of services provided, the stability of the organization, the effectiveness of the organization, etcetera?

Dr. NOCON. We have not done that. But the lookalikes are mixed into the sample for our studies.

Senator CASSIDY. Okay, Okay. And Ms. Farb, did you look at any of that, compare the difference between the two? Because clearly there is a business model out there that is working without the grant—without the grant dollars, and that is what I am interested in understanding this for. Ms. Farb.

Ms. FARB. No, we did not look at that, Senator.

Senator CASSIDY. Mr. Harvey.

Mr. HARVEY. Yes, specifically Indiana has the second most lookalikes, I believe, of any state in the country, which is hard to believe in comparison to California, New York, other large states. But qualitatively, the lookalike leaders that I have, because again, of the unique nature of what health centers are required to provide, they don't receive that grant funding. They don't receive coverage under the FTCA.

That is an economic strain. That is an economic pressure that they face because they don't have that sustained funding. Again, I could—we have a dozen lookalikes in the State of Indiana, and to an organization they would say that.

Senator CASSIDY. Well but that is not my question of whether or not there is a strain, is whether or not they have the ability to provide the services effectively.

Mr. HARVEY. Limited capacity compared to those that receive grant resources.

Senator CASSIDY. Gotcha. By the way, let me compliment Ms. Veer. It sounds like you are all using the 340B program the way the 340B program is supposed to be used. There are a lot of abuses of that program, but it does seem as if you are using it correctly.

Tell me, if you want to elaborate on that, and are you open to reforms to the program to make sure that patients at your facility get them and they are not going to build a chandelier in a hospital, which, etcetera, etcetera, etcetera. And please be brief, because I don't have time.

Ms. VEER. I will be as brief as I can. I think it is a complex problem, but and I do think there are abuses, but unfortunately the abuses get highlighted much more than the many, many thousands of organizations that do this right and that is patient centered. Certainly, we operate both a retail and 340B pharmacy.

340B is used only for patients of this health center and only for prescriptions that emanate from our health center sites. That revenue is managed very carefully to ensure that it is allocated to our operating margin. And I use operating margin specifically because it is not a profit margin.

It is a margin that allows us to operate much needed services. And that is—and it is a simple allocation of services that operate at a deficit are made whole by the contribution of our pharmacy margin. In terms of the——

Senator CASSIDY. Let me stop you there because I am already a minute over and I got to be gracious to my colleagues.

Ms. VEER. Okay. Certainly.

The CHAIRMAN. Thank you very much, Senator Cassidy.

Senator Hassan.

Senator HASSAN. Well, thank you very much, Mr. Chairman and Ranking Member Cassidy for this hearing. And thanks to the witnesses not only for being here but for the work that you do. Mr. Harvey, I want to start with a question to you.

Community health centers play a vital role in addressing the ongoing opioid crisis by serving as major providers of medication assisted treatment, which is widely accepted as the gold standard of care for individuals with opioid use disorder. However, many centers are facing difficulties in meeting the increased demand for treatment.

To help address these challenges, I worked with Senator Murkowski to pass into law the Mainstreaming Addiction Treatment Act, which eliminated an unnecessary hurdle to providing treatment. Mr. Harvey, what else can Congress do to make sure that community health centers can provide care for those with substance use disorders?

Mr. HARVEY. Yes. Thank you for the question. I appreciate that very much, and maybe give kind of a Hoosier response to this. But yes, a couple of things around opioid use disorder. One is the dearth of the mental health workforce. Finding a psychiatrist in particular in rural Indiana is, I would say, nearly impossible, but it is very difficult.

Senator HASSAN. I just want to focus a little bit on medication assisted treatment, because the purpose of this is to allow primary care physicians to prescribe buprenorphine. We know that along with counseling, very successful.

Mr. HARVEY. Correct. Yes, and that is exactly it. So, extending the opportunity outside of the psychiatrist office. Extending the capacity of the mental health workforce, that is really a critical aspect of this.

Workforce in general would be a big piece. Any administrative burdens as well. MAT over time, the administrative hurdles have gone down significantly, and that has really boosted access to treatment for——

Senator HASSAN. But you are also telling me, and I am sorry to cut you off, that more mental health workforce, more psychotherapy would be another critical thing we could do moving forward.

Mr. HARVEY. Yes, yes.

Senator HASSAN. Okay. Thank you. Let me follow-up, another question to you, Mr. Harvey, about our mental health crisis. In New Hampshire, patients seeking psychiatric care are being forced to wait in emergency rooms for days or weeks, hoping that an inpatient psychiatric bed will open up.

According to the state's latest reports, 26 Granite Staters, including three children, are being boarded in emergency departments, and this boarding can last for weeks. Last week, a Federal court ordered the state to devise a plan to address this emergency room boarding crisis.

How can community health centers help provide regular mental health care to patients and address mental health concerns before inpatient psychiatric care is needed?

Mr. HARVEY. Yes. That is a great question. I think you see that in Indiana. A number of the FQHCs will work with either the local court system or a number of local community providers to create a network of support for patients with mental illness, so you don't end up in that situation where someone ends up in the emergency room with nowhere else to go, right, and you just have a hold and it ends up in a spiral.

Certainly, supporting them with funding, with resources, with workforce to provide that continuity of care would be a big piece for health centers to go to address that really unfortunate situation. And that is, like you said, occurring in your state, but also occurring nationwide. And so, from a capacity standpoint, we really have a ways to go to address that.

Senator HASSAN. Well, thank you. Ms. Veer, I want to turn to you for a moment. New Hampshire community health centers are grappling with an unprecedented workforce shortage, something I know we have already talked about this morning.

To overcome this challenge, we have to prioritize the training and development of more doctors, nurses, and other community health care professionals. What role do community health centers play in training the health care workforce, and how can we support those efforts?

Ms. VEER. Thank you very much, and it truly is a challenge. I think certainly we serve as rotation sites, often many of us serve as rotationsites for both medical professionals, as well as we train nursing staff. And one of the things that we have recently done is begun to provide stipends, living stipends and second year residency, with a commitment for a 4-year service agreement.

In addition to loan repayment, that helps us. Now, that is an otherwise unfunded program, but it has enabled us to recruit and really get people into the health center model early. We are doing the same thing with our technical colleges.

Senator HASSAN. Well, and I know that in rural areas of the country, sometimes if we can get trainees into the rural areas too, they learn that they like not only the community health center model, but living in some really beautiful, wonderful rural areas in our Country, but we have to get them there so that they can experience it.

Ms. VEER. Yes, until you experience it, it may not be where you think you want to go.

Senator HASSAN. I will yield the rest of my time, Mr. Chairman. Thank you very much. And thanks again to all the witnesses.

The CHAIRMAN. Thank you, Senator Hassan.

Senator Collins.

Senator COLLINS. Thank you, Mr. Chairman. As Ms. Pears Kelly mentioned, having grown up in Maine, our community health centers in Maine play an absolutely indispensable role. Each year, the 20 community health centers provide critical health care services to nearly 210,000 patients.

That is about 16 percent of the population of the State of Maine, and more than 60 percent of the patients are low income, and about 20 percent are over the age of 70. But what I am hearing now from our Maine health centers is that they fear that a perfect storm is brewing.

They are experiencing unprecedented turnover and staff shortages. They feel they are facing threats to the critical 340B drug pricing program. And they are having difficulty in recovering from the pandemic because patients are being slow to return.

My question for Mr. Harvey and Ms. Pears is, given the current workforce crisis and the issues that I have mentioned, are our community health care services centers able to meet the workforce needs if we were to dramatically expand funding for them and scale that up rapidly? Are we going to end up with clinics that have more money but simply don't have the staff to serve? Mr. Harvey, we will start with you, and then Ms. Veer.

Mr. HARVEY. Yes, it is a fair question. I appreciate that question. Health centers, like you said, they are facing an array of difficulties coming up. Medicaid unwinding certainly in the states that have expanded Medicaid like Indiana.

You are going to lose hundreds of thousands of patients from Medicaid, that coverage, trying to transfer them. Do health centers have the capacity? I would say I have spoken to all 39 of our health centers, and individually, each one of them has expressed the de-

sire to go further, to do more, and to look for resources to do more, and that continued Federal funding.

I think we have got a long history here of saying if Federal funding is increased, you will see concomitant increases in the work that health centers do, in the patients that they see, and the service sites that they have, and the services they offer.

No, I don't think the funding would be lost. I think it is a really, like I said in my testimony, very wise investment on behalf of the Federal Government to continue to support and expand the support that health centers receive.

Senator COLLINS. Ms. Veer.

Ms. VEER. Yes, thank you very much for the question. And we definitely are facing those challenges. And I think two things come to mind. I hear of many health centers that are in fact in the process of reducing services because of the loss of contribution from the 340B program with the impact of the challenges that we have had there. And yes, you asked about being open to reform, Senator Cassidy.

I think we are there. We really need to look at that. However, I agree that if we have the adequate funding to continue expanding the services that we provide, we have always stepped up to the plate, stood in the gap.

We have always done it. I have a real commitment from the schools in the educational systems in my area. Now it is a pipeline, and so if people enter the pipeline now, it may be months, if not years, before we have them in place, but as we develop, we will get there.

Senator COLLINS. I want to associate myself with the remarks of Senator Hassan about training opportunities at community health centers. I think that is absolutely essential, as we heard from the President of the University of New England.

The more we can do those connections, the more likely the health care professional is to stay in a rural area and practice there. So, I think that is something we need to consider expanding and encouraging and incentivizing. Mr. Harvey, just a very quick final question for you.

My largest community health center at the Penobscot Community Health Center has seen a real drop-off in patients coming back after the pandemic. Is that unique to my state, or have you experience that?

Mr. HARVEY. No, I don't think so. I think people's patterns of engagement with the health care system changed because of COVID.

I think we have seen with health centers in Indiana some recovery from that, but it has to be really intentional intensive work and you have to develop new service lines, things like telemedicine, to reach patients from home to provide more—the right care in more convenient ways.

No, I don't think it's unique, but I do think that there is—that is an additional burden on health centers now to try to continue to reach those patients who may have changed—just changed behaviors because of the impacts of the pandemic.

Senator COLLINS. Thank you. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Collins.

Senator Smith.

Senator SMITH. Thank you, Mr. Chairman. And thanks to all of our panelists. I really appreciate this conversation. I want to just pick up on what Senator Collins and Senator Hassan were talking about. Creating opportunities for people to get training in rural communities is so important.

I am reminded of the University of Minnesota Duluth Preceptor Program, which puts folks in medical school in communities with rural doctors so they can understand what that means and how to do that kind of practice, because it is different when you don't have a whole huge hospital around you or a whole big network around you.

I think that is really something that I bet we could find good bipartisan agreement on. I am so blessed in Minnesota we have a strong network of community health centers. I have had an opportunity to visit many of them, and I have been so impressed by the work that they do, both in rural and—I mean in suburban and urban areas, but especially in rural communities where there is such a challenge getting access to health care.

Here is one example in Cook, Minnesota, which is in the Northern part of Minnesota, up by Lake Vermillion, nearly 100 miles away from the nearest big city, which is Duluth. The Scenic River's health service is the only primary care provider around for miles and hours.

I want to just ask, and I think I am going to ask this question of Mr. Harvey and maybe Ms. Veer first. If we were going to think of one or two things that we have to do in order to support those rural community health centers, we have talked about training, and I fully appreciate that.

What would be the one or two things that you want us to have foremost in our mind as we think about those rural centers?

Mr. HARVEY. Now you are speaking in my heart, rural health care. A couple different things. Rural health care is difficult. You talked about the workforce. Grow your own, that is a big piece of that.

Sustained, predictable funding for health centers is really a critical piece of that. Workforce funding, we have talked about 340B. Those, doing those things will go a long way to supporting rural health centers, and in particular leaning into programs like you have mentioned, training programs that help rural health centers grow their own.

Like you say, where you live, predicts where you are going to work. Oftentimes where you train, predicts where you are going to work. So that, doing all of those things will go a long way to supporting rural health care.

Senator SMITH. This question of sustained funding, I just want to follow-up on, because, Mr. Chairman, I remember so well visiting health clinics, some of these community centers in years past where they were faced with this fiscal cliff.

They are trying to figure out how to plan, how to economically provide health care to their communities, and yet the funding streams are uncertain. And so, they are like, on the one hand, trying to figure out how to lay off people because they are not sure if that funding is going to be in place, at the same time that they are trying to figure out how to meet growing demand on the other hand.

I think it just reminds me of what an important responsibility we have through the work that we are doing to reauthorize this legislation, to not put clinics in the position of wasting time and energy and resources trying to plan for a fiscal cliff that hopefully they won't have to face.

I just, I appreciate you bringing that up. Let me also ask a question related to sort of the, I don't know, we use this term wraparound services, which I don't know if most people outside of Washington even know what that means. But what I am trying to get at is how in Minnesota you often have additional services, additional needs that people have when they come to community health centers.

If you can't meet those needs, then the health care that you are trying to provide to them is not going to work. A great example of that is an FQHC center in Minnesota, which has been around for 50 years. And many of the folks that they are serving are folks that don't speak English.

They are immigrant workers, they are migrant workers that make our farm economy work, and it is our—to me, it is essential that they have access to health care. So that means we need interpretive services.

But interpretive services aren't paid for. They have got to figure out how to raise the money for that. Would anybody like to comment on the value, the importance of having those kinds of additional services in order to make the whole thing work?

Ms. VEER. I would say that they are absolutely essential. Our Spanish speaking population in three of our centers has increased probably tenfold over the last 5 years. And without translation services, we can't deliver appropriate care.

We really can't use the family member that is standing there that doesn't have the medical training. So, there is a real investment that needs to be made in that. And keeping in mind, I love the fact that you used the word sustainable and predictable, because flat funding in these days is not flat funding because of inflationary pressures that have really increased our costs.

Senator SMITH. Yes, I think—I appreciate that. And I suspect that almost everybody on this Committee would agree that while we may—we certainly have, I think, a moral obligation to make sure that people can get the health care that they need, if we are not able to provide health care to those folks, then they are going to—that doesn't mean that they are not going to get sick.

It just means that they are not going to get the health care that they need at the time that they need it, and that is why this is so important. Mr. Chairman, I have another question which I will submit for the record around the importance of integrated care,

mental health care and behavioral health care and dental care, which we do a good job of providing in community health centers, and we need to do a better job of. Thank you.

The CHAIRMAN. Thank you, Senator Smith.

Senator Braun.

Senator BRAUN. Thank you, Mr. Chairman. I am going to start off with this simple statement. No one should go broke in this country because they get sick or have a bad accident.

Everyone in a country like ours should have access to health care on the entire spectrum. Here is where it gets complicated. How do you do it? When I mentioned going broke, what is really broke in a different way is our health care system in general.

I think you are a manifestation of when it is not working where it should be, I don't even like to call it the private sector, it is not a market delivery, something is going to happen and you are the manifestation of it.

Eventually I will get to a question and see how you are doing such a good job of being the cost leader in it. We are in a place here where we borrow about 30 percent of what we spend. It would be a tricky long term business partner hooking up with the Federal Government as we now operate it. The other side is even worse.

You have got a system that has evolved over time, wrestling with it like I did as a small business owner. You can't imagine how frustrating it was to hear how lucky I was to only have my health insurance going up 5 to 10 percent each year. It didn't feel very lucky. 15 years ago, took it on at the grassroots level.

It would be for another time and conversation. You may want to come work for my company when you hear this, that I no longer run. We made it consumer driven, gave every tool to avoid the broken system by putting every wellness tool out there. Created a health care consumer. Cut costs by 50 percent then.

Have not had a premium increase in 15 years. Somehow, we ought to be talking about the entrepreneurialism that needs to go along with the entrepreneurialism you are doing being financed by the Federal Government. Your long-term business partner, I don't think is healthy. The system is broken.

We need to find out how working together we deliver a better product to the American public. What intrigued me is that you are doing primary health care. First of all, insurance was never probably intended for that, but then it would beg the question how do people that can't afford any health care, let alone insurance, how do they get proper health care?

Here you go. You are there. I think primary health care needs to be where it starts. If it is not through what you are doing, and maybe you are going to have individuals dealing on a direct pay basis with providers that can afford it, something other than we got.

Until that system gets fully transparent, competitive, and is run like a real market, we shouldn't be defending it here because it is broken. Let's start with you, Mr. Harvey, out of deference to being a Hoosier, and then we will go to Ms. Kelly.

What are you doing that takes the entry point in health care and where you are doing it at a better value than the other way that you get primary health care? What is the secret sauce?

Mr. HARVEY. Yes, it is a great question. I appreciate the question. I think there are three things that I was thinking of as you were making that—health centers provide integrated whole person care, that is community based, and we can't overlook that.

The community really runs and owns these organizations on the board. They are patient driven health centers, and they also provide those enabling services They have the ability to provide those comprehensive services to support, I think that was brought up earlier, things like translational services, things like transportation services.

They are really systems of primary care that are good, that are going deeper with individuals to produce those cost savings. So again, yes, I would agree with you. I think too what you mentioned, Senator Braun, and a long part of this is the administrative burden that health centers face.

We are not outside of that. Health centers aren't outside of that. We do that in the face of that, when you are dealing with very complex billing arrangements, you are dealing with all of the prior authorization pieces, all of the credentialing pieces that you have to deal with from an insurance perspective. There is this huge beast of administrative costs that goes into all of this.

Senator BRAUN. Are you transparent and do you post the prices of things you do?

Mr. HARVEY. Yes, that is right.

Senator BRAUN. Hallelujah.

Mr. HARVEY. Yes, health centers are required——

Senator BRAUN. The other side—the other side of provision doesn't do it. And now even practitioners, doctors and nurses, are getting tired of now having to be employed by huge corporations where it is not like it was before and they don't embrace transparency at all. So, before we run out of time, Ms. Kelly.

Ms. PEARS KELLY. Thank you. It is a great question, and I think Ben hit on several of the things that I would call out. But you mentioned a couple of things, the consumer component. The beauty of health centers has been said is that it is a 51 percent consumer majority board.

The services are actually driven by the people living in the community. They see what is needed. They are able to address that immediately. The other thing is that it is competitive.

All of the health centers have to go through a competitive grant process to make sure that they are actually in a position to address those needs and the community concerns. So, the savings is there.

The model has proven itself, the integration of care, all of it. I think you know the stats. I am happy to repeat them, but we have the stats around the savings for sure.

Senator BRAUN. Alert to the people that provide our health care, from hospitals now that I think control a bigger share of it than anyone. Used to be more evenly balanced with practitioners.

Health insurance, we got to get to where people accept their own responsibility for their own well-being and give them the tools to do it. They need to take a note from what you are doing because they ask for so many benefits from Government.

The way you pay for health care, whether it is the Government or on the private side, the delivery of it has got to get more competitive, more transparent, and more operate like markets and do what you are doing. Kudos. Keep doing it. Thank you.

The CHAIRMAN. Senator Hickenlooper.

Senator HICKENLOOPER. Thank you, Mr. Chairman and Ranking Member. I am proud to have a long history of supporting community health centers. I don't want to date myself, but 50 years ago I helped a very agitated, very focused young man named Mark Masselli start a Community Health Center, Inc. in Middletown, Connecticut back when I was a college student.

Community Health Center, Inc. is one of the Nation's largest and most innovative, I would argue, most innovative primary care centers for the poor, the underserved, just as you have all been saying, making sure that we help provide—they have been making sure that we help provide safety net providers in all 50 states with workforce training, research, and education.

They branched out even beyond Connecticut. But I do have that experience where, and I first saw telemedicine back and he was starting it in 1998, 1999 with certain applications, and clearly it blossomed during COVID in a way that we didn't really understand.

Dr. Nocon, you probably have some more data on how possible deleterious effects, negative effects of too much telemedicine, although I haven't seen any, but certainly the cost savings that I have seen have been dramatic.

Dr. NOCON. Yes, thank you for that question. We have not specifically looked at that question in terms of telemedicine use in the context of FQHCs, but certainly we have seen it, Kaiser Permanente, significant increases in use of telemedicine and certainly the fundamental sort of underlying costs of that you would expect to be a more efficient model of patient interaction.

Senator HICKENLOOPER. I will look forward to some measurements. I think that is the next step. As an industry, to begin to look at telemedicine and make sure that we are being careful to maintain quality but look at those things.

I mentioned that the community health center in Connecticut now has over 200 locations. And I thought, Ms. Kelly, I would ask you, since you are a parallel in a parallel universe, what are some of the ways you look to mobilize getting health care into every community?

Ms. PEARS KELLY. I think a couple of things. And I hate to bring this back to it, but it has to do with investment and funding. That is one of the most key factors that enables that expansion and that growth.

But I think because all of these health centers are community governed, they look at where there is increasing need, they do mar-

ket assessments. They look at where do they need to go to meet people where they are.

There are health centers that are extremely creative in trying to find ways, and leverage funding, and pull together what they can. But at the end of the day, that expansion does in a lot of ways depend on the Federal investment in order to have that stability.

That has come up earlier today that it is very difficult to stand something up without the continuity, without the guarantee of continuity. Though I think CHC, Inc. is a fantastic example of what can happen and what can be when there is an investment in health centers appropriately.

Senator HICKENLOOPER. Okay. Well, there—it is interesting if you go back and he has a book that has come out now on the first 50 years, as he humorously refers to his health center career. And it recounts in that first decade how many forces were aligned against them getting that funding and the continuity of funding.

All kinds of competitive health services saw this as an imminent threat to their future growth and well-being. And even I remember vividly back in the late 70's, some of the transportation funding they thought was getting waylaid by the community health center movement, which was just beginning to take up speed.

I agree with you completely that being able to move and expand so that we get into the smaller towns, the smaller communities, get that health service provided closer to where people live, depends on getting the funding there to get to get started. We have a wonderful community health center in Colorado called Tepeyac, all bilingual, and I know—watched you guys discussing that before.

But I do think the language barriers writ large are still a challenge. And there is software now that we can get that actually really helps us dramatically deal with the divisions caused by different languages. Have any of you guys used that as a solution?

Ms. VEER. Yes, we use technology across all 12 of our centers around translation. So, it is not always the perfect solution. Oftentimes, particularly in rural areas where we may have connectivity problems. So that can be difficult.

Senator HICKENLOOPER. Another problem we are going to address. A different committee.

Ms. VEER. Yes, different committee. But yes, it is very useful when you can't find the translation staff to be doing it in person.

Senator HICKENLOOPER. Great. Thank you very much. And I do have another question on workforce, but I won't ask about—I will submit it, but I know that you guys are all involved in how do we get more workforce training into the process. I know we discussed it a little bit as I watched in my office.

The CHAIRMAN. Thank you, Senator Hickenlooper.

Senator Marshall.

Senator MARSHALL. Well, thank you, Mr. Chairman. I am a huge fan of community health centers. I volunteered in them before. Practicing in rural Kansas as an obstetrician, I had significant interaction with our community health centers. I have tried to visit most of the 32 community health centers that we have across our

great state. Another program I think has been successful is the 340B program.

They are certainly profit centers for rural hospitals, any hospital that is using them as well as community health centers. My first question will be for Ms. Veer, and I am asking you to explain how the pharmacy benefit managers steal money from the 340B program from the community health centers.

As I understand it, and this is based upon community health centers and pharmacists, community pharmacists tell me that the PBMs have found a way to make money off the 340B program by requiring contract pharmacies to disclose which 340B drugs they dispense.

By requiring this disclosure, pharmacy benefit managers shave off a portion of those savings, savings which Congress intended to go to the safety net providers who support vulnerable patient populations.

Ms. VEER. That is very true. And I can give you some specific examples without naming specific PBMs.

Senator MARSHALL. Please do.

Ms. VEER. There are two major assaults on the 340B program. The first is manufacturers refusing to submit to a contract—or 340B pricing at contract pharmacies without submitting data.

When we submit data that becomes transparent to the PBMs, who then in turn, in order to recoup the rebates, they have lost, reimburse for less than what they would for a retail pharmacy. I will use one example. Because we operate both retail and 340B, it gives me a lens into both.

For the retail pharmacy that the reimbursement rate might be AWP –4 percent. You turn it over to 340B and it is AWP –32.5 percent. It is a dramatic reduction in reimbursement that oftentimes when you add IR fees on top of that, it is below cost.

Senator MARSHALL. Yes. Mr. Chairman, I just hope staff is taking note of this conversation. And this is an issue for a separate hearing. And Ranking Member, I certainly think we need to dive deeper into that one.

Next question for Ms. Farb. I am trying to put my numbers together here. As far as the payer mix, we saw the dollars and cents, but from a patient volume, most these clinics probably 60 percent Medicaid, 20, 25 percent Medicare. Does that sound about right to you?

Ms. FARB. I think that is correct, Senator, based on our analysis and based on currently what we see in terms of the patients who are covered, even going up to current numbers, I think. It is probably a little bit less, closer to 50 percent Medicaid and about 11 percent Medicare.

Senator MARSHALL. Okay. And then there is a certain number that would have private insurance.

Ms. FARB. Right. About 20 percent.

Senator MARSHALL. How many are just literally self-pay? Don't have insurance, don't have Medicaid, don't have Medicare.

Ms. FARB. Sure. Uninsured is about 20 percent or—and self-paid is included in that, too.

Senator MARSHALL. I know. So, you got to break those apart for us if you can.

Ms. FARB. I do not have those numbers broken out by uninsured versus self-payers, so.

Senator MARSHALL. Okay. Anybody have a quick guess who runs the clinics. Of that 20 percent that are self-pay, how many of those actually have private insurance? Half of them?

Mr. HARVEY. How many have private insurance? Are you talking about commercial insurance so that——

Senator MARSHALL. Of the number of patients that you see in your clinics, what percentage of them might have private insurance as opposed to Medicaid or Medicaid?

Mr. HARVEY. Generally, it is less than 10 percent in the State of Indiana.

Senator MARSHALL. Of all the patients you are seeing, it sounds like maybe 5 percent don't have either Medicare or Medicaid or insurance. I wanted to make that point to you as well. Ms. Veer, do you deny any access to your clinic because of a patient's inability to pay?

Ms. VEER. We do not.

Senator MARSHALL. Mr. Harvey, do you?

Mr. HARVEY. No.

Senator MARSHALL. Dr. O'Connor, are you aware of any clinics that don't allow access because of their ability to pay?

Dr. NOCON. No. That part is built into the statute around health centers.

Senator MARSHALL. This is what I am trying to communicate with the Chairman is that financial is not the problem with access to care. If their ability to pay is not the access to care, who is this group of people that aren't getting care then? So, you mentioned the desert. We have 32 clinics in Kansas.

I would guess that 95 percent of the patients that don't get health care live within 30 minutes of them. So, it is—why do patients not get health care that they need and they show up in my emergency room instead. Ms. Veer, why? What are we missing here? It is more than just throwing money at it.

Ms. VEER. It is more than throwing money at it, but the investment is really important. For example, I have one family medicine practice that is very in high demand and it is a 3-month wait to see a provider there.

Another thing that we are seeing, I think largely as a result of the pandemic that we are coming out of is more need for walk-ins, same day services, particularly for community members who may not already be established with us.

But as we see COVID continue to be part of our lives, they need testing, they need vaccines, they need treatment. And so, they are looking to us to provide that, but many of us can't—don't have the resources to do a same day walk-in clinic.

Senator MARSHALL. Great. I would love to have more answers, but I am past time. Thank you so much, Chairman.

The CHAIRMAN. Thank you, Senator Marshall.

Senator Markey.

Senator MARKEY. Thank you, Mr. Chairman, very much. Massachusetts is the birthplace of the community health center movement in the United States. From North Adams to Provincetown, our community health centers proudly bring health care to every corner of the state.

Our community health centers are leading the way in providing health care to trans people, treating substance use disorder, and battling health impacts of food insecurity. They are at the forefront and frontlines of responding to intensifying storms and stronger heat waves.

They care for people before they need to go to overcrowded emergency rooms and provide a welcoming environment to communities too often ignored or maltreated by our health care system. Health justice is not just about affording health care. Health justice means people can get the health care when and where they need it.

Community health centers provide the accessible, holistic, and compassionate care that empower the people who they serve. There is no question, we need community health centers that serve every single city and town in our Country.

Community health centers proved how vital they were in the early stages of the COVID pandemic. They provided gold standard care when treating people and getting people vaccinated. But COVID isn't the only crisis that we are facing. Climate change is bringing intensifying floods, fires, and pandemics.

With it, people are experiencing worsening health impacts. Ms. Pears Kelly, what would deep investments in community health centers mean for the ability for our health care system to adequately respond to the ever-increasing threat from climate change to our Country?

Ms. PEARS KELLY. Thank you very much. It is a very important question. So, this is a matter of public health, and further investment would enable health centers to be able to develop plan and operations to be responsive to natural disaster emergency, you name it.

But climate change is very much a high priority in this space, and we have had many health centers, whether it was in areas where there have been severe flooding, wildfires, hurricanes, and health centers are on the front line of that.

This continued investment enables them to be responsive to those needs, and frankly, to continue to play the role that they often do, which is to coordinate the response in these communities that are already underserved, which frankly can't afford to be battered any further.

Senator MARKEY. Yes, thank you. Mr. Harvey, thank you for your attention to substance use disorder and the opioid epidemic. As my colleague, Senator Hassan, mentioned, medication treatment is a key resource for people with opioid use disorder.

That includes methadone medication, which is locked behind outdated restrictions and regulations. Treatment barriers can have deadly consequences. How are community health centers helping patients overcome these structural barriers in our Country?

Mr. HARVEY. Yes, it is a great question. I appreciate you bringing that back up. A big piece of this is enabling the patients to get the treatment that they need by being accessible, by supporting their payment methodology, which we just talked about. And then as well, trying to navigate the system.

We spend a lot of time navigating the system. And also, to, I would say health centers are really good about integrating services, right, recognizing when someone has a substance use disorder, and trying to get them into available treatment, and as well building their treatment options around the existing constraints.

But it has been a long—there has been a long evolution of policy around mental health. Mental health is looked at now differently than it was when it was being legislated 15, 20 years ago, and that is a really good thing.

Health centers have been engaged in that evolution and are certainly seeing more and more patients coming to them with mental health needs and then seeking to address those.

Senator MARKEY. Okay. In follow-up——

Mr. HARVEY. Yes——

Senator MARKEY [continuing]. Talk about what can be done to ensure that there is better coordination between community health centers and hospitals, so that there is some form of continuum care for these people. Too many of them, as we know, are Black, Brown, immigrant, poor. So, their understanding of the system is very low. What can be done?

Mr. HARVEY. Sure. Yes, I mean, I think at the local level, the relationships matter a lot. Sometimes those can be one sided, but oftentimes they are a two-way street. I think the requirements that health centers have certainly assist them in the way they oriented the system in trying to develop those relationships.

Oftentimes, hospitals are very good at the dynamics of the hospital system right now. The players that are in the hospital system sometimes can be limiting factors for community health centers.

Like you said, payment mechanisms really can be limiting factors for patients getting in there. But by requiring that integration, requiring those two sides talk to each other, that goes a long way into creating services.

Senator MARKEY. Thank you.

The CHAIRMAN. Thank you, Senator Markey.

Senator Budd.

Senator BUDD. I thank the Chairman, I thank the Ranking Member, and the panelists for being here today. Just a few moments ago, I was in an agricultural meeting just one floor below in a couple of offices away, and while we were talking agricultural policy, the No. 1 question came up was about rural access to health care and not even related to this Committee.

Again, I appreciate you being here, but I hear all over North Carolina, I was last year or so in all 100 counties and I constantly hear about the access concerns for patients in rural North Carolina, and that community health centers really help close that gap serving over in our state.

It is a half million people, so I appreciate what you do. And it is an important safety net, and it is important that providers have the flexibility and tools that they need to treat patients, including in rural and underserved areas.

Community health centers also provide critical resources to expectant mothers in at risk families while making sure that taxpayer dollars don't fund abortions. The Community Health Center Fund is one of several funding sources for these centers, of course, as you know. But before considering its reauthorization, we need to understand how program funds have been used to make sure that we are staying accountable to the taxpayers.

Ms. Veer, again, thank you for being here. The funding for community health centers comes with—it is a mix of Federal, state, and private sources, as you know. But in your role as CEO of Carolina Health Centers, can you provide specific examples within the Federal funding programs where Congress could give health centers more flexibility to innovate and meet the needs of their patients?

Ms. VEER. That is an excellent question. And the first thing I think about when you say more flexibility to innovate is, it goes to workforce, and the ability to use resources to create those incentives for people to come on board with us. Innovation, certainly, I feel like we were really innovative with our early childhood services program.

We are something of a unique model within the community health centers, but I applaud HRSA because just recently they released a notice of funding opportunity for health centers to compete for funding to place an integrated early childhood services program in pediatric medical homes.

That is critical. I mean, we have saved lives. We have sent people back to college. So, looking beyond the walls of a traditional medical practice and what can we invest in that affects people's lives as it relates to their health.

One of the first grants—in fact, the first grant through the Office of Economic Opportunity back in 1965, had a quote that said, the need is not for passive recipients, but for the active involvement of the community in ways that will change their knowledge, their attitude, and their behavior as it relates to their health care.

We need to be able to be flexible in using our resources to go out into the community and affect people where they live.

Senator BUDD. Thank you for that. Further, can you go into more detail on how managed care and value-based arrangements improve health care outcomes for underserved areas while also generating savings for the health care system?

Ms. VEER. Absolutely. That I did put in my written testimony, some examples of this. Our health center is part of—we, 14 health centers in South Carolina are partners in what is called an inde-

pendent practice association, IPA for short, and our IPA is financially and clinically integrated to enable us to develop shared protocols about how we manage care, and to then work with our managed care, our Medicaid managed care organizations to develop value-based arrangements.

I can tell you that to date, those value-based arrangements have resulted in millions of dollars over the last 10 years for the 14 partnering health centers. We are provided are those incentives based on our collective performance, but then the IPA distributes them based on individual performance.

For example, my health center for the last few years has been in the top three performing of those partnering health centers.

Senator BUDD. Great. Thank you. And in the time, I have remaining, I can't leave out a fellow graduate of Appalachian state. So, Ms. Farb, thanks again for being here. As this Committee considers reauthorizing the Community Health Center Fund, are you aware if the GAO studied duplication or overlap in the funding sources to CHC?

Ms. FARB. We have not studied duplication or overlap, but as many of you know, we have a pretty robust process for looking for duplication and overlap throughout Federal programs.

The only area that we have looked at in the past that is related to overlap is whether or not the community-based health clinics that provide care through the Medicaid program, if there is duplication paid through Medicaid, and looked at how CMS oversees that. But we have not looked at the CHC Fund in particular.

Senator BUDD. Thank you again. And again, thank the panelists. I yield back.

The CHAIRMAN. Thank you, Senator Budd.

Senator Kaine.

Senator KAINE. Thank you, Mr. Chairman, Ranking Member. What a great panel. I have really learned a lot from sitting and listening to you. There are 30 community health centers that serve Virginia.

Two are in West Virginia, right on the border with Virginia and serve Appalachia, Virginia. 28 are based in Virginia, 26 are FQHCs, 1 is a rural health clinic, 1 is a lookalike. They serve about 370,000 Virginians. The FTEs in our Virginia health centers is about 2,800 FTEs. The work that they do, and I see it every day, is truly tremendous.

I want to ask Mr. Harvey, I am going to start with you on a workforce question, because I was intrigued in your testimony you talked about Indiana FQHCs that are doing their own grow your own programs to train medical assistants.

Medical assistants work in a variety of health care settings, performing both clinical and administrative tasks. They are critical members of the medical team. They support the delivery of high-quality care. From 2011 to 2021, the number of medical assistants employed in the U.S. grew from nearly 540,000 to over 725,000, reflecting the growth of this occupation as part of primary care teams.

Like other frontline workers, medical assistants reported a lot of burnout and stress during COVID. About 29 percent of them intend to leave their jobs within the next 2 years, by their own reporting. And when a provider leaves, an organization usually incurs a turnover cost of about 40 percent of that individual's salary to sort of figure out how to backfill and make it up, as well as intangible costs, lower levels of productivity, staff morale, patient satisfaction.

It is clear that medical assistants are very vital to primary care clinics. One way we can bring more medical assistants in is by reducing training costs, giving people more incentives. I recently reintroduced with Senator Braun of Indiana the JOBS Act, with my fellow—with many of my fellow HELP colleagues.

The bill would make high-quality, short-term education and workforce training programs eligible for Pell Grants. We don't allow Pell Grants to be used for high quality career and technical education. But we need to do more.

I would just like to ask Mr. Harvey, how would something like the JOBS Act, which would allow Pell Grants to be used for high quality CTE, help us bring people into entry level health care professions? And what other strategies do you all have to suggest to us around retention?

Mr. HARVEY. Yes, I think it would be a big catalyst, quite honestly. We have a program in Indiana that is similar that a number of health centers have used, that is funded by the Indiana Department of Workforce Development. Though it has its own limitations in terms of funding, it is next level jobs, the Governor's next level jobs program, and it provides opportunities for credits toward training in those high priority positions.

High demand occupations and medical assistants are part of that. A number of the health centers have relied on that because it is a critical source of funding to both support the cost of the training. Growing your own is a really great model, but it requires resources.

Then also for MAs, people that are in the community that are interested in being medical assistants oftentimes they are not good—oftentimes don't have college educations. They will need to support themselves, to be able to bear the cost of whatever that educational opportunity is.

But it is a huge catalyst because when you are growing your own in the community, and if you have resources to enable people who otherwise couldn't get that training, you get someone that is brought in more to the health center, bought in more, retained more. And then health centers oftentimes will double down by creating career ladders for MAs.

It's not unusual, and I think the Ranking Member made this point in the last hearing about a nurse that he knows, where you can go up from MA, LPN, RN, BSN, and really scale up in your career, and you can do that in a health center with some other supports around that.

I think that is a really, really important idea to support people in those areas.

Senator KAINE. I hope it is an idea whose time has come. It is interesting, the Pell Grant program is known for its flexibility, so we have Pell for full time college students. We have Pell for part time college students.

We recently restored something that had been part of Pell originally, which is Pell can be used by incarcerated folks to get skills so that when they finish their time, they are going to be able to get productive jobs. But we have never allowed Pell to be used for high quality, current technical education.

A family that is income qualified for Pell, if they got one child wants to go to college, Okay, great, we want you to go to college. You have got another child that wants to get CTE, it is like we don't really care about that. And in an economy where there are so many credential programs, you want to make sure that they are high quality that can be offered for entry level medical positions or other.

We are doing an infrastructure bill, who is going to build everything? I just hope we can take our tradition of using Pell and flexible—and finally, say, high quality career and technical education is every bit as good as going to college.

This is something I look forward to working on with my colleagues. And I think it would have particular benefit in the health care professions. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Kaine.

Senator Murkowski.

Senator MURKOWSKI. Thank you, Mr. Chairman. Thank you, to the Ranking Member. Thank you to the witnesses here, and for all that you are doing. We had our—the community health centers had their annual fly in to Juneau last week.

I was with many of them as they were there talking about many of the issues that you have presented here today. The concern over 340B, some mentioned 330. Certainly, the workforce issue all over the place.

But again, I was reminded of the value that comes from our community health centers and the fact that it really is patient driven care, but understanding what the real issues are in the community and then being able to respond.

The folks at the Sunshine Clinic up in Talkeetna, their real challenge is a lot of the people in their service area, if you will, don't have running water. And so, when you are thinking about health concerns and considerations, and you don't have good water that you can count on, that adds a whole additional layer of complication and complexity to what you are dealing with.

Those people know what to do with it, and they are advocates in other areas. So, I am a huge fan for community health centers. I wanted to follow on just a little bit with Senator Kaine when we were talking about workforce. Where we are going to get these great people from.

One of the programs that has been helpful for us in Alaska is through the National Health Service Corps. I haven't heard any of you mentioned that this morning. I would be curious to know if you

feel that we can be doing more with National Health Service Corps to help bolster our workforce, Ms. Pears Kelly.

Ms. PEARS KELLY. Thank you so much for your understanding and your long history of support. And the National Health Service Corps could not be more important to health center workforce. So, I think as we are talking about investing in the community health center program, we also have to think about programs like the National Health Service Corps, which enables them to staff up.

If you are making the investment in health centers, you have to think about part of the access equation is that workforce. The National Health Service Corps has a decades long record of success, both in terms of diversity, but also in retention in the areas where they are doing the training.

There is a request for significant funding to at least keep intact what has been invested over the last couple of years to the rescue plan, which has been a huge enabling factor to making sure health centers have been able to bring in and retain the staff that they have. And so, I cannot echo and emphasize enough the importance of the National Health Service Corps specifically.

I would also say the Teaching Health Center Graduate Medical Education Program as well. That is really what enables health centers to train up. And just getting at what you also mentioned, Senator, around where are these people coming from.

There are so many individuals in the community who are poised and want to pursue a pathway within the health center, and it doesn't need to be just clinical. There is operations, there is technical, there is, you name it, and health centers need it, every bit of it.

I think the National Health Service Corps, the Teaching Health Center program, but also, frankly, giving health centers added investment to be able to innovate, to create these programs, to create homegrown opportunities for developing workforces, not just needed, but absolutely critical.

Senator MURKOWSKI. We are going to be working on that reauthorization. One of the other issues that folks were talking about back home, one of the larger facilities that had been open to Medicare eligible individuals had just closed. We have a real challenge in Alaska with access, for those who are Medicare eligible.

Our reimbursement rates are so out of whack in Alaska that it is a real challenge for us. And those Medicare eligible folks are just not able to find care. So, we are seeing more shifting over to our community health centers.

Then we also have this situation coming up at the beginning of April with Medicaid and the disenrollment or the redetermination of the Medicaid populations that is going to be required when the emergency, the public health emergency is taken down.

We are concerned or we are hearing that there's going to be concerns where you are going to have individuals who are not really able to navigate how they then gain access to new insurance plans, or they may be looking at plans that have potentially higher deductibles and co-pays.

The question is, do you have—is anybody doing anything to kind of anticipate this? Are there navigation assistance that might be made available? What are we doing to deal with this population that we may see coming to your doorstep?

Ms. VEER. That is an incredibly important question. The unwinding is going to have just a ripple effect. And it is—we are trying to invest right now in working with that population to make sure that correct addresses are in the system, etcetera, etcetera. One of the problems we are facing in South Carolina is the re-enrollment process is paper only. There is no electronic re-enrollment allowed.

Senator MURKOWSKI. In your state, or——

Ms. VEER. Just in our state. But looking at it across the Nation in terms of if there were a way to if there were some central way for these people to be re-enrolled or go through the re-enrollment process, it would be helpful. We expect to lose thousands, tens of thousands of beneficiaries from the Medicare rolls—Medicaid rolls.

Senator MURKOWSKI. Any handle on what it is, it is coming in just a matter of——

Ms. PEARS KELLY. May I, just to follow-up on that. So, it is a massive issue. And I think South Carolina is not alone in terms of some of the barriers. It really varies from state to state.

Health centers have been very active in coordinating with their states, but also taking the initiative independently to make sure that there is as much outreach and navigation as possible. But there is an enormous administrative burden.

The issue also is churning, which is something that has been an issue with Medicaid for years. But what happens is that, to your point about eligibility, you do have folks who will continue to meet eligibility requirements but getting them into the system is both costly to the state and to the health center.

Senator MURKOWSKI. Thank you, Mr. Chairman. Little over my time.

The CHAIRMAN. Thank you, Senator Murkowski.

Senator Baldwin.

Senator BALDWIN. Thank you, Mr. Chairman. I have been really amazed with the community health centers in my home state where they really led the way when it comes to expanding services to meet the needs of their patients.

It is especially true when it comes to behavioral health, substance use disorder treatment, as well as dental services. There has, however, been some frustration or challenge with the lack of funding for service line expansions, those grants.

I support additional funding for brand new community health centers, but I also want to make sure that we also explore ways to make funding go farther by investing in our existing health centers and allowing them to expand their service array to meet local need.

Mr. Harvey, can you talk about the importance for health centers to have the resources to expand service lines?

Mr. HARVEY. Yes, it is a great question. Thank you for pointing that out. Yes, particularly services like dental services, for example, historically very expensive and historically quite needed in areas that are served by health centers.

But that sustained investment is really going to be important for existing health centers to be able to expand their service lines in areas like oral health and dental services, areas like mental health. We have talked about substance use disorder.

That is really critical to enabling them to support both the operational, additional operational expense, the additional personnel expense, and just the general expense that comes into operating the community health center model and going deep and comprehensive with individuals to treat the issues that they face.

Senator BALDWIN. Well, thank you. Several of our witnesses today have noted that health centers are also supported by the Medicaid program. I will say that again, Medicaid, which helps support those with disabilities, families that need nursing home care, and new moms and babies, also supports health centers.

Cuts to Medicaid would be devastating to Wisconsin. It would put the more than 1 million vulnerable Wisconsinites who rely on Medicaid for their health care at risk and also would hurt our community health centers.

Ms. Pearce Kelly, can you describe what you expect to happen if there are significant cuts to Medicaid? Would this force community health centers to cut staff, reduce hours, see less vulnerable patients, or possibly force some clinics to shutter altogether?

Ms. PEARS KELLY. Unfortunately, yes. Health centers will be very challenged with the reduction in basically reimbursement that comes through Medicaid. They are required to treat everyone who walks through their doors and they will continue to do that. And I am proud of my colleagues that we can say that with full commitment.

But the reality is, is that loss in revenue, that loss in funding will mean additional strains to the workforce, which is already extremely burdened and burnt out. It will mean making difficult decisions around services, to your point, how can you continue to fully operate when you are facing a multimillion-dollar loss in revenue? It will absolutely have an impact on future predictions—or future ability to care for all of the real needs in the community.

Again, the needs are not going to go away just because they happen to fall off Medicaid. These are patients that are going to need someplace to go, and unfortunately, the alternative is they end up in an emergency room.

The health centers will do everything that they can to ensure that doesn't happen, but the loss of revenue is going to have a sharp impact on that. And I think it does go across services, across sites, across workforce, and possibly other areas as well.

Senator BALDWIN. Thank you. Well, let's stay with you, Ms. Pearce Kelly. We talked a lot today about how health care centers distinguish themselves from other providers because of the populations they serve and the value they add to the entire system. With that in mind, I wanted to get back to the 340B program.

I have been a long supporter of 340B and have serious concerns about how the actions of drug companies and PBMs have jeopardized this program, which helps low income and other vulnerable patients access more affordable medications. What is unique about the community health centers' participation in the 340B program?

Ms. PEARS KELLY. Well, for starters, they invest every single dollar back into patient access and community, and we can verify that. That is over and over again with every single data point of report that you are going to get with health centers.

It is also used to address a lot of the issues that we have been talking about today, whether it is workforce, expanded services, longer hours, transportation, enabling services, you name it. But all of these things can be documented, and every single dollar that comes from the 340B program is verifiable to be used in that way.

I can't speak to other entities, but I can say that the data exists and that there have been many hearings over years and years to verify that. And so, I think it does distinguish health centers that the intention of the 340B program, as it was designed, is being used and executed by health centers extremely accurately and properly.

Ms. VEER. If you don't mind my interrupting, but I have to also add one other distinguishing characteristic, is that we are, as a 340B covered eligible entity, we are required under 330 to provide all services regardless of ability to pay, which means we are required to provide affordable medication at a discount. So that is one of the distinguishing factors as well.

Senator BALDWIN. Thank you. Mr. Chairman, I yield back.

The CHAIRMAN. Thank you, Senator Baldwin. Senator Casey, do you want—Cassidy, do you want to ask some additional questions?

Senator CASSIDY. Yes, thank you. Great panel. Thank you very much. My goal coming in here is attempt to understand the business model. How do we in Congress ensure that we have a viable path forward for the good work you do?

Dr. Nocon, I looked up an article you had, factors associated with federally qualified health center financial performance, and it kind of goes with this growth in Medicaid funding. In your study, you did a multivariate analysis and you found that a higher percent of patient mix of Medicaid covered patients was associated with better margins, and that was socio of many other better things.

Dr. NOCON. Yes.

Senator CASSIDY. Now, Ms. Veer has talked about the struggles in South Carolina in which she probably has a higher percent of patients who are uninsured, I am guessing, because you are not a Medicaid expansion state.

Ms. VEER. Exactly.

Senator CASSIDY. Yes, that is my point. So, and it is my understanding that the grant funding is given irrespective of whether or not a state has done the Medicaid expansion or not.

As we look at that, did you find that—is there a difference between—intuitive—kind of inherent in your paper is that if you separate it out between those states that have done Medicaid expan-

sion and those not, that the federally qualified health center is probably doing a little bit better financially and therefore in the other means as well in those states that do the expansion versus those that did not. Is that a fair statement?

Dr. NOCON. Yes.

Senator CASSIDY. In the dollar spent per patient, we did the math, and based on your work, Ms. Farb, it was about $650 bucks in 2011 and $970 bucks in 2017. With inflation, that is probably about flat funding.

But I am guessing that in those states which did the Medicaid expansion, that their funding per patient probably grew more significantly and has pulled down a little bit, if you will, when you average across those states that did not do the expansion. Is that, again, a fair statement?

Dr. NOCON. Likely, yes.

Senator CASSIDY. Likely. And so, as I look at the business model, and again, we want to make—we want to make sure that you have an adequate business model. In those states that did the expansion, I am thinking I am hearing, because even in South Carolina without, congratulations to you, you all are managing to keep it together.

In states that did do it, they are just going to be better off financially with all that entails in terms of the ability, as you point out in your paper, better margins means better services. Again, is that a fair characterization of your paper?

Dr. NOCON. Could you repeat that, Senator Cassidy?

Senator CASSIDY. I am just trying to understand if in the business model, those states in which there is a Medicaid expansion, which also have federally qualified health centers, if they—if you are able to see that those federally qualified health centers had better margins than those states that did not do the Medicaid——

Dr. NOCON. Those appear to be doing better financially.

Senator CASSIDY. Therefore, they had the other positive things associated with those better margins?

Dr. NOCON. Presumably, yes.

Senator CASSIDY. Okay. Thank you.

The CHAIRMAN. Let me just ask——

Senator CASSIDY. Can I ask one more thing?

The CHAIRMAN. Sure.

Senator CASSIDY. I guess my other overall point, it does seem like a diversified income stream is also associated with clinics doing better. You are not dependent upon one thing. Rather, you have multiple things feeding into the overall financial health.

Dr. NOCON. I think that would be a reasonable statement in particular, because we also find that community health center funding is associated with more stable and stronger financial performance.

Senator CASSIDY. Yes. Okay, thank you.

The CHAIRMAN. Great. Thank you, Senator Cassidy. Let me just ask a few more questions and then we will wrap it up. We spend

over 18 percent of our GDP on health care. That is almost double what any other country spends.

As broken as our general health care system is, it seems to me that our primary health care system is even more broken, with tens of millions of people not able to get to a doctor when they get sick.

I have talked to physicians in Vermont and around the country who tell me that people walk into their offices very, very sick and sometimes with incurable illnesses that could have been dealt with if they walked in the door on time. And they didn't because they didn't have insurance.

They were embarrassed, or not have any money to pay. In your judgment, No. 1, would at a time when we spend so much more than other countries on health care, if we provided at least primary health care to every man, woman, and child, we have had primary health care accessible to everybody, in the long run, would it save our health care system substantial sums of money? Ms. Veer, you are jumping to answer that.

Ms. VEER. I am, Senator. Thank you so much for the question. And I would say yes, maybe. But then because the maybe is you also need to make sure that they not only have access, but the work is being done to connect them to the appropriate services. Because just having the access, it doesn't connect people to the appropriate services. Quality and population health management——

The CHAIRMAN. But that runs us into another issue, again, having to do with the fact that we are the only major country not to have a national health care program. So, somebody walks in and you make a diagnosis and say, we are sorry, you have breast cancer. Oh, but I can't afford the other treatment that I need or I am going to go medically bankrupt as a result of it.

Who else wants to jump into the issue of the morality of providing health care for all people at a time when we lose—we don't talk about it very much, but studies that I have seen suggest that we lose over 60,000 people a year who don't get to a doctor on time, and that if we don't treat people, you said it, an ounce of prevention is better than a pound of cure.

Are we spending on the cure, the tertiary health care, the hundred-thousand-dollar surgeries, rather than making sure people have the medicine and the primary health care they need?

Amanda.

Ms. PEARS KELLY. I appreciate you putting it in that context, and I will just call out some of the comments that Senator Cassidy made earlier that this is the wise investment, and to your point, it is about keeping people healthy.

If you keep them healthy on the front end, if you keep them out of the emergency room, if you keep their chronic diseases managed, if you keep them from getting severely ill, which you can do in health centers, yes, it is going to serve and it is meaningful for the 100 million people that we have called out today, but really for everyone. Primary care is the path to success in health care, period.

The CHAIRMAN. Yes.

Dr. Nocon.

Dr. NOCON. I would just add that a long history of research on primary care generally, specifically looking at comparative performance of health systems across countries, has reinforced that a strong, high functioning primary care system is associated with a broad range of health system outcomes that we look for.

The CHAIRMAN. Is it fair to say that specifically in terms of primary care, we invest far less than other major countries?

Dr. NOCON. Absolutely.

The CHAIRMAN. That is perhaps one of the contributing factors why we end up spending so much per person on health care. Is that a fair?

Dr. NOCON. That would be fair.

The CHAIRMAN. Yes, Okay. All right, listen, let me thank the panel all for being here. You were great. We are talking about a major issue of concern to the American people, and it is my determination to do everything we can to come up with legislation that will improve and expand community health centers in this country and move us toward the goal of making sure that every person no matter where they may be, have access to primary health care.

That is the end of our hearing today. I want to thank all of our witnesses for their participation. For any Senators who wish to ask additional questions, questions for the record will be due in 10 business days. That is March 17th at 5.00 p.m.

Finally, I ask unanimous consent to enter into the record a statement from Senator Casey and statements from stakeholder groups outlining their priorities for community health centers.

[The information referred to can be found on page 105]

The CHAIRMAN. The Committee stands adjourned.

ADDITIONAL MATERIAL

STATEMENT OF SENATOR ROBERT P. CASEY, JR.

I regret that I was unable to attend the Committee on Health, Education, Labor, and Pensions (HELP) hearing on Thursday, March 2, 2023 due to medical leave. This hearing examined the critical ways in which community health centers (CHCs) provide care to patients across the Nation. This is an important priority of Chairman Sanders, and I am eager to work with him to strengthen our CHCs.

The Community Health Center Fund was created by the Affordable Care Act to fill gaps in primary care access. CHCs are required to provide a host of medical services related to family medicine, internal medicine, pediatrics, obstetrics, and gynecology, in addition to diagnostic testing, preventative health services, emergency medical services, and, in some cases, pharmaceutical services.

In 2021, over 30 million patients—or 1 in 11 Americans—visited their local CHC for their health needs. CHCs serve 1 in 5 uninsured Americans, 1 in 3 Americans living in poverty, and 1 in 5 rural Americans. In many rural areas, CHCs may be the only primary care providers. CHCs offer high quality services regardless of a patient's ability to pay, actualizing a commitment to health equity.

CHCs continue to serve as critical junctions in our Nation's COVID–19 response. As of August 2022, CHCs administered 22.2 million vaccines and 20 million diagnostic tests. In order to mitigate disease spread in health care settings, most CHCs proactively pivoted to telehealth appointments so as not to disrupt patient care plans.

CHCs employ 270,000 professionals from dentists to behavioral health specialists to nurse practitioners, serving as key employers in their communities. In order to combat workforce shortages, CHCs participate in programs like the National Health Service Corps, the Teaching Health Center Graduate Medical Education program,

and the Nurse Corps Scholarship Program. By placing eligible providers in CHCs, a reliable workforce takes shape in underserved communities.

Supporting whole person health is an essential component to comprehensive health care, which is why many CHCs provide mental and behavioral health services. There is evidence to show that co-locating and integrating primary care with mental health care yields stronger patient outcomes. CHCs lower the already high barriers to access mental and behavioral health services.

The Community Health Center Fund was most recently reauthorized in the Consolidated Appropriations Act, 2021 with approximately $4 billion in mandatory and $1.8 billion in discretionary funding through Fiscal Year 2023. Every year, I join Senator Stabenow in support of sustained funding for this essential program.

I have heard from CHCs across the Commonwealth of Pennsylvania devising innovative ways to spread resources. Congressionally directed spending requests, when available, offer one avenue for CHCs to make needed investments. The American Rescue Plan (ARP) offered a lifeline for CHCs in their response to the COVID–19 pandemic. The ARP Health Center Construction and Capital Improvements program offered a one-off, scaled funding opportunity for CHCs to update their infrastructure to better serve their communities. We need more opportunities like this to build the sustainability of CHCs moving forward.

With an upcoming opportunity to reauthorize the Community Health Center Fund, I look forward to working with my colleagues on both sides of the aisle to develop new ways to support CHCs as they continue to provide a breadth of services.

STATEMENT OF THE AMERICAN ACADEMY OF OPTHALMOLOGY

Chairman Sanders and Ranking Member Cassidy:

The American Academy of Ophthalmology appreciates the opportunity to share our perspective on the role community health centers can play in increasing access to eye disease screening ahead of the Committee's hearing, *Community Health Centers: Saving Lives, Saving Money*. The Academy is the largest national member's association of ophthalmologists—medical and osteopathic doctors who provide comprehensive eye care including medical, surgical, and optical care. The Academy seeks to protect sight and empower lives by setting the standards for ophthalmic education and advocating for our patients and the public.

For decades, community health centers have played a critical role in providing Americans with access to primary care. In many communities, they serve as the central or only healthcare access point. Their important role in protecting the public health of American communities was underscored by the COVID–19 pandemic, where community health centers served as a critical resource for patient care and access to life-saving vaccines. Because of their important role in community health, as well as reducing health disparities, the Academy is focused on identifying ways for our members to partner with community health centers to expand access to badly needed eye care services, increase eye disease screening rates, and promote better patient outcomes.

While community health centers have expanded their portfolio of healthcare services beyond primary care, including dental and mental health services, access to vision services remains limited. In 2020, only 26 percent of health centers had onsite vision services. Access currently varies dramatically state-to-state, with health centers in California, New York, and Massachusetts having strong vision services across site locations but other states facing significant limitations or a total lack of vision services, including in Vermont and Louisiana.[1] The financial costs of incorporating vision services into community health centers remains a significant barrier. Because of population growth and patients with a diverse set of clinical needs, health centers must make tough decisions on how best to allocate their resources. This can make significant investments in vision services unlikely, especially hiring full-time eye care providers, as well as allocating office space and providing administrative support. Yet, their patient populations are comprised of those at elevated risk of severe eye diseases like diabetic retinopathy and glaucoma, as well as uncorrected refractive error. The Academy believes that there are pathways for community health centers to provide patients with vision services that require less financial investment, while still providing tremendous benefits by detecting eye disease

[1] 2020 HRSA Uniform Data System. Bureau of Primary Health Care, Department of Health and Human Services.

that pose significant threats to their patient's quality of life. The increased utilization of telemedicine, including by community health centers, provides one avenue for expanding access.

Utilizing Telemedicine & Artificial Intelligence Technologies to Expand Access to Diabetic Retinopathy Screening

Diabetic retinopathy can cause vision loss or blindness in patients with diabetes and is the leading cause of blindness among working-age adults. In early stages, patients are often asymptomatic which can reduce the likelihood of detection and diagnosis without proactive efforts to screen patients with diabetes. Unfortunately, too many patients with diabetes do not get timely eye or retinal examinations. For patients with advanced diabetic retinopathy, the cost of treatment with anti-VEGF drugs can be substantial due to both the cost of the drugs and the need for frequent injections.

The Academy has championed the use of telemedicine to expand access to diabetic retinopathy screening, which has demonstrated value by increasing rates of significant disease detection and thereby promoting faster and often more effective treatment. Early identification of the diabetic retinopathy is important not only to patient outcomes but can dramatically lower the cost to the U.S. healthcare system.

Recent FDA-approvals of AI based technology for early detection of diabetic retinopathy provide another pathway for technology to provide a cost-effective way to expand access to screening in community health centers. Because the AI device can identify diabetic retinopathy severe enough to threaten vision, it can speed up and increase referral appointments for patients who have a need but would not otherwise seek out an eye or retinal examination. It can also be used as a tool by primary care providers or others that manage the treatment of patients with diabetes. While the use of AI for diabetic retinopathy screening in community health centers is currently limited to a few states, it is increasingly being incorporated as a tool in diabetic treatment models.

CDC-Funded Glaucoma Screening Programs-Expanding Access in FQHCs and Community Clinics

Expanding access to glaucoma detection and treatment is another area where the Academy believes community health centers can play an integral role. The Vision Health Initiative (VHI) at the Centers for Disease Control and Prevention (CDC) funded 5-year research programs to study the use of telemedicine to expand access to glaucoma detection and treatment for vulnerable populations. Two of the funded programs are working in collaboration with federally Qualified Health Centers (FQHCs), including one in Flint, Michigan and others in rural Alabama. While the research focus is glaucoma, these programs are providing screening for diabetic retinopathy, cataracts and uncorrected refractive error. As of January 2023, the CDC funded programs had screened nearly 4,000 patients, referred over 1,500 for follow-up eye care, and identified over 800 cases of glaucoma or suspected glaucoma. These rates of detection are significantly higher than national averages and underscore the risk of advanced eye disease faced by these patient populations. The Academy supports increased investment in the Vision Health Initiative at CDC. The research programs and existing models they have funded that work in collaboration with FQHCs have the capability to be scaled and offered in other communities.

Closing Remarks

The Academy appreciates the focus of you and your colleagues on the Committee on the important role that community health centers play in protecting public health and providing access to care for millions of Americans. The Academy knows that many health centers face financial constraints and that limits their ability to provide vision services, but we do believe that investments in health centers can pay significant dividends and promote increased attention on expanding pathways to addressing the visual health needs of their patient populations.

As you examine the important role of community health care centers, the Academy looks forward to the opportunity to partner with you and your colleagues on the HELP Committee to address the eye health needs of Americans.

Disclosure of Federal Grants or Contracts

Between 2013 and 2015, the American Academy of Ophthalmology (AAO) received funding from the Agency for Healthcare Research and Quality (AHRQ) under the Developing Evidence to Inform Decisions about Effectiveness (DECIDE) Program, to disseminate the Registry for Glaucoma Outcomes Research (RiGOR) study findings through the use of social media tools.

AAO is a 501c (6) educational membership association.

STATEMENT OF THE AMERICAN PHYSICAL THERAPY ASSOCIATION

Chairman Sanders, Ranking Member Cassidy, and Members of the Senate Health, Education, Labor, and Pensions Committee:

The American Physical Therapy Association represents more than 100,000 physical therapists, physical therapist assistants, and students of physical therapy nationwide. On behalf of our members and the patients we serve, we thank you for this opportunity to provide APTA's perspective on the critical role community health centers, or CHCs, play in delivery care to rural and underserved areas, and suggestions for improving access for the patients they serve.

Background

CHCs provide primary health services to more than 30 million people at over 14,000 delivery sites nationwide, including nearly 3 million Medicare beneficiaries and 1 in 5 Medicaid beneficiaries. These facilities provide a lifeline to communities in need of essential health services whose barriers to health care include cost, lack of insurance, and distance. Presently, CHCs offer a range of health services, including access to physicians, advanced practice nurses, dentists, clinical laboratory, emergency medical, and behavioral health.

Community health centers depend upon a network of over 255,000 clinicians, providers, and staff to deliver on the promise of affordable and accessible health care. The currently limited list of reimbursable health care providers is a particular barrier for health centers, including access to physical therapist services. Recognizing these additional billable provider types, such as physical therapists, will help facilitate care coordination with health care providers, connect patients with community-based services, and support community health center efforts as they address multiple health care challenges, including the current opioid crisis and the impact of patients with long COVID. In addition, reimbursement must recognize activities such as interdisciplinary team training and other support services patients need to navigate complex and siloed care as well as connect with other community resources.

Adding Physical Therapists as Billable Providers in CHCs to Help Address the Opioid Crisis and Long COVID

Between 2015 and 2018, 73 percent of community health centers reported an increase in opioid use disorder, and 69 percent reported an increased number of patients addicted to prescription opioids. This public health emergency is widespread in rural and medically underserved areas where CHCs are often the only option for medical care. COVID–19 has caused health, social, and economic stress that has exacerbated the opioid epidemic.

Data collected by the Overdose Detection Mapping Application Program demonstrated that drug overdoses generally were 18 percent higher in March, 29 percent higher in April, and 42 percent higher in May 2020 than in their respective months in 2019. There is a growing realization that current strategies for managing pain have to change—that opioid-centric solutions for dealing with pain, at best, mask patients' physical problems and delay or impede recovery and, at worst, may prove to be dangerous or even fatal. Physical therapists evaluate individuals for risk factors for pain to help prevent future pain issues. These services often can reduce, if not eliminate, a patient's pain, and help a patient avoid surgery, hospitalizations, and opioid use.

Physical therapists also treat patients with long COVID for musculoskeletal conditions such as fatigue, weakness, and muscle or joint pain. Physical therapy is essential to long COVID recovery, and can improve strength, stamina, and quality of life for patients with long COVID symptoms.

Physical therapist services play an essential role in addressing the challenges caused by the opioid epidemic and long COVID, especially in rural and underserved

areas. However, CHCs are restricted in how physical therapist services are delivered and reimbursed. Currently, PTs working in a CHC are not authorized to independently bill for the therapy services they provide. In many cases, a CHC will need to refer a patient out to receive physical therapy at another location, preventing them from getting treatment in a timely and cost-effective way.

To address this problem, APTA urges Congress to pass legislation that would allow CHCs the option to permit PTs to independently bill for the services they provide to patients in CHCs who are covered by Medicare and/or Medicaid. In the 117th Congress, H.R. 5365, the Primary Health Services Enhancement Act, was introduced in the U.S. House of Representatives by Reps. Jackie Walorski, R-Ind., Ron Kind, D-Wis., Diana DeGette, D-Colo., and Don Bacon, R-Neb., to achieve this purpose. This bipartisan legislation, endorsed by the National Association of Community Health Centers, would expand patient access to essential physical therapist services to children and adults who receive care at CHCs. H.R. 5365 would not mandate that CHCs furnish physical therapist services, but rather provide CHCs with the necessary flexibility in the delivery of physical therapy to patients who may require such services. APTA anticipates reintroduction of this important legislation in the 118th Congress in the near future.

Adding physical therapists to the list of providers who can bill for their services in CHCs increases patient access and provides flexibility to CHCs. It should be noted that adding physical therapists to the list of billable providers does not create a new benefit; it simply enables CHCs flexibilities in how patients access physical therapy, a benefit that is already provided for under Medicare and Medicaid. Doing so also would provide options for CHCs to create innovative service delivery models. Patients would be accessing vital therapy services in the same clinic they are receiving other services, eliminating the need to travel to another location to receive physical therapy.

Conclusion

APTA thanks the Committee for focusing attention on the importance of community health centers and the critical health care services they deliver to millions of Americans. Enacting legislation to add physical therapists to the list of providers who can independently bill in CHCs would be an important step toward improving consumer access to more health care services and improving health outcomes. APTA stands ready to work with Congress on this issue and others affecting our Nation's health care system. Should you have any questions regarding our comments, please contact Steve Kline with APTA congressional Affairs.

UNITED STATES SENATE,
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS.
WASHINGTON, DC.
March 1, 2023

The Honorable Gene Dodaro
Comptroller General of the United States
U.S. Government Accountability Office
441 G. Street, N.W.
Washington, DC.

DEAR MR. DODARO:

As we consider the reauthorization of the Community Health Center Fund we must study the effectiveness of the overall program in achieving its statutorily defined goals. We will also need to examine all funding streams that community health centers receive to understand the health of the program and ensure proper stewardship of American taxpayer dollars.

I request that you update your report, "Health Centers: Trends in Revenue and Grants Supported by the Community Health Center Fund," with up-to-date data. The current report covers community health center revenue from fiscal years 2011–2017 and the purposes for which grants were awarded during that time period. Specifically, I request that your updated review also include funding for health centers provided by COVID–19 related legislation, and the American Rescue Plan Act.

I hope that you can prioritize this project as we will look to it as we reauthorize the program by the end of this fiscal year. I appreciate your attention to this matter.

Sincerely,

SENATOR BILL CASSIDY, M.D.,
RANKING MEMBER,
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS.

QUESTIONS FOR THE RECORD

RESPONSE BY AMANDA PEARS KELLY TO QUESTIONS OF SENATOR CASEY, SENATOR SMITH, SENATOR HICKENLOOPER, SENATOR MURKOWSKI, AND SENATOR TUBERVILLE

SENATOR CASEY

Question 1. Community Heath Centers are intended to meet the needs of medically underserved populations (MUPs), including racial and ethnic minorities. One in four Black Americans have a disability. One in six Hispanic Americans have a disability. The CDC has reported that 3 in 10 American Indians and Alaskan Natives have a disability. The Department of Agriculture reports that 9 percent of migrant farmworkers have a disability. The Department of Housing and Urban Development reports that 40 percent of unhoused individuals have a disability. MACPAC reports that 10 million of those eligible for Medicaid have a disability. All of these populations are designated as underserved. What is necessary to ensure that members of these MUPs who have disabilities are able to be served by Community Health Centers in an accessible manner to reduce racial, ethnic, and income disparities?

Answer 1. Senator Casey, thank you so much for this question and for your deeply held commitment to Americans living with disabilities.

Health centers that receive funding under Section 330 of the Public Health Service Act are required to provide accessible health care to all patients. Each one of our members provides comprehensive, culturally competent primary health care services to a wide range of vulnerable populations such as (but not limited to) school children, the elderly, pregnant women and infants, immigrants, minority populations, the LGBT community, people with disabilities, and military veterans. These communities' needs evolve over time, and in many cases, become more complex and expensive. We are proud of our tireless commitment to meet these needs, but we cannot do it without support.

With the right investment, community health centers can fulfill their mission as hyper-local health care hubs—treating the full range of patients' needs, supporting community transformation, and achieving true health equity. ACH's vision for community health center funding—$30 billion by 2030—isn't rooted in dollars and cents. It's rooted in a vision of what can be achieved for our patients, our communities, and all those in need.

Question 2. Community Health Centers are intended to meet the needs of medically underserved populations, including rural populations with few health care resources. In many rural areas, CHCs may be the only primary care providers. The Centers for Disease Control reports that over 30 percent of people living in rural regions have a disability, the highest rate of disability of any Census urban-rural classification. What steps should be taken to ensure rural residents with disabilities can be accessibility served by Community Health Centers?

Answer 2. We really appreciate this question and would love to work with you more closely on this issue. Americans in our rural communities are facing a health care crisis—one that is only compounded when families are also living with disabilities. Between 2010 and 2021, 136 rural hospitals closed. Nineteen of these closures occurred in 2020, the year the COVID pandemic hit the United States. Community health centers have responded to the growing health care access crisis in rural areas. Based on the most recent data, community health centers serve one in five rural residents, and those numbers are rising. Research has shown that in areas previously served by a rural hospital, there is a higher probability of new community health center service delivery sites post-closure. Over time, most rural areas are seeing an increase in access to community health centers. We would welcome the opportunity for additional funding to open new sites and centers in rural areas that focus on inclusive, accessible care.

SENATOR SMITH

Question 1. Community health centers across Minnesota are working to integrate physical, behavioral, and dental care to improve health outcomes. I have led legislation with Senator Moran to improve access to integrated care—our *Improving Access to Behavioral Health Integration Act*, which was signed into law as part of last year's omnibus spending package, will enable community health centers (CHCs) to apply for grants to implement integrated care models and will make it easier for CHC patients to get the behavioral health care they need.

1 (a) How can grant programs like this one help CHCs improve health outcomes in their communities?

Answer 1 (a). Senator Smith, thank you for your leadership on integrated health care, which is a priority that we share at ACH.

In a recent survey of our members, we found that the majority of patient visits now include some element of behavioral health care. Centers are constantly looking to expand and strengthen their behavioral health capacity, integrating services wherever they can and referring patients for more specialized services. Grant programs like the one you and Senator Moran championed support community health centers—the largest source of primary care in the country—as they make integrated behavioral health care a more routine way to deliver care.

1 (b). What are the specific health and economic benefits of integrating physical and behavioral health care in CHCs, and how do these benefits impact rural communities in particular?

Answer 1 (b). Studies of integrated behavioral health care at CHCs have shown increases in both provider and patient satisfaction.[1] Integrated behavioral health care has been associated with increased utilization of medical services and decreased hospitalizations for individuals with severe mental illness and has also been shown to promote access to mental health services particularly in the underserved populations that FQHCs typically serve, including rural communities.[2,3]

1 (c). What resources do community health centers need to implement integrated care models?

Answer 1 (c). Currently, while CHCs prioritize integrated care and other behavioral health services in order to provide the most comprehensive care, it is not a required service under Section 330. We strongly support the President's fiscal year 2024 Budget request to require that all health centers provide behavioral health services. The Budget also proposes $7.1 billion for Health Centers, which includes $5.2 billion in proposed mandatory resources, an increase of $1.3 billion above fiscal year 2023 enacted, in part to help support the new behavioral health requirement.

1 (d). What more can we do at the Federal level to expand integrated care models, especially in rural communities?

Answer 1 (d). Two of the barriers preventing more widespread use of integrated health models are workforce shortages and Medicaid billing limits. At ACH, we propose addressing both of these barriers with one comprehensive solution—supporting more health centers in the journey to value based health care.

Within the Prospective Payment System under Medicaid for FQHCs, certain staff are not able to trigger an encounter payment. If more FQHCs received value-based payment arrangements that included a broader interdisciplinary care team, they could more effectively integrate critical staff and deliver more efficient, effective care. Currently, some clinicians are currently having to work on issues outside of their scope of work, including billing and payment issues. If a therapist, psychiatrist, or addiction medicine physician does not have to perform roles that typically a case manager, behavioral health specialist or community health worker could do more effectively, their time is freed up to serve more patients and they experience less burnout.

Similarly, many states prohibit same day billing of Medicaid encounters—meaning, behavioral health and primary care cannot be billed on the same day, effectively ending the integrated care approach. If FQHCs are able to receive capitated pay-

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[1] Petts, R.A., Lewis, R.K., Brooks, K. *et al*. Examining Patient and Provider Experiences with Integrated Care at a Community Health Clinic. *J Behav Health Serv Res* **49**, 32–49 (2022). *https://doi.org/10.1007/s11414-021-09764-92*.

[2] Krupski A, West II, Scharf DM, et al. Integrating primary care into community health centers: impact on utilization and costs of health care. *Psychiatric Services*. 2016;67(11):1233–1239.

[3] Bridges AJ, Villalobos BT, Anastasia EA, et al. Need, access, and reach of integrated care: a typology of patients. *Family, Systems, and Health*. 2017;35(2):193–206.

ment for patients and leverage resources for a more efficient, patient-centered approach, we believe more FQHCs could more readily deploy integrated health care.

For both of these issues, Federal legislation could either require or incentivize states to work on value based care for Medicaid safety net providers, including FQHCs. We would be glad to work with your office on this issue.

SENATOR HICKENLOOPER

Question 1. How are community health centers particularly well equipped to recruit and retain providers that reflect the communities they serve? How can we further support health care workforce training, particularly in supporting diversity?

Answer 1. To recruit, train and retain workers, community health centers leverage HRSA's health care workforce scholarships and education loan programs which help train a diverse workforce, including dentists, dental hygienists, mental health professionals, community health workers, nurses, midwives, primary care professionals, and faculty. These programs provide care in community-based settings to the most vulnerable patients, and help retain a workforce who are most likely to serve those communities after training.

These vital programs include:

- National Health Service Corps (NHSC)
- Health Careers Opportunity Program (HCOP)
- Scholarships for Disadvantaged Students (SDS)
- Teaching Health Center Graduate Medical Education Program. (THCGME)

In total, in 2021–2022, there were over half a million participants nationwide and over 368,000 graduates from these programs. Among these, over 42,000 participants reported being from an underrepresented minority, disadvantaged, or rural background. Over 25,000 participants focused on the Department of Health and Human Services (HHS) priority of health equity and addressing social determinants of health. 69 percent of recent graduates now practice in a medically underserved community, primary care setting, or rural area.

Further, NHSC providers represent a diverse group of clinicians. Thirty 3 percent of the Nation's total population identifies as Black or Hispanic/Latino. This same population only represents 11 percent of physicians in the U.S. However, roughly 25 percent of physicians serving through the NHSC identify as Black or Hispanic/Latino, a key indication that the NHSC is successfully driving clinician diversity.

As I testified to before the HELP Committee, we are requesting investments in health centers that total $30 billion in funding by the year 2030. In addition to expanding and improving the care centers deliver, we believe that this investment would allow health centers to train an additional 25,000 providers.

SENATOR MURKOWSKI

Question 1. All Witnesses: As you all know, the National Health Service Corps (NHSC) program plays a critical role in training and recruiting providers to Health Professional Shortage Areas (HPSAs) in Alaska and throughout the country. Could you speak to how CHC's utilize NHSC to bolster the rural primary care workforce? What updates are needed to the existing programs to address the shortage we are seeing in Alaska and across the country in primary care providers and mental health professionals?

Answer 1. Senator Murkowski, thank you for your longstanding commitment to the NHSC and your support for Alaskan patients and clinicians. Today, the NHSC receives $310 million in mandatory funding via a dedicated trust fund (which will expire at the end of fiscal year 2023) and received $121.6 million in annual discretionary appropriations in fiscal year 2023. The 2021 American Rescue Plan (ARP) COVID–19 relief package provided an historic one-time investment of $800 million for the NHSC, with a further $100 million directed toward the Corps in 2022.

However, if current funding levels are continued in the years to come, only a portion of Loan Repayment and Scholarship applicants will be granted awards, particularly once ARP funds run out. Collectively, more than 158 million individuals reside in HPSAs, including nearly 300,000 in Alaska (*source*). Yet, thousands of NHSC applications could go unfunded due to lack of resources.

Furthermore, the COVID–19 pandemic had dire effects in communities already suffering challenges with provider shortages. Without long-term, sustainable funding to accommodate the existing and growing need, underserved areas across the

country which can least afford to deal with additional strains and shortages on their clinical workforce may reach a breaking point.

Now more than ever, it is crucial to continue to fund and grow the NHSC to ensure access to care for millions of people living in shortage areas. The estimated cost to eliminate all existing HPSAs through the NHSC is approximately $1.5 billion annually. We ask that Congress support legislation that ensures adequate and sustainable funding for the National Health Service Corps program and expands the program to address the urgent need for primary care in underserved communities across the country now and in the future.

SENATOR TUBERVILLE

Question 1. In preparing for this hearing, I reached out to CHCs in Alabama to get their perspective on how telehealth has impacted their practice abilities and the rural and underserved areas where they operate.

These stakeholders have let me know that, in fact, telemedicine is a major part of the solution, but there are some important caveats. It is important to see what steps need to be taken first, to stretch Federal dollars as far as possible. We need to realize that money spent on telehealth infrastructure could potentially be wasted if not invested carefully—and how there could even be adverse consequences to different patient populations.

There are many ways that people define "telehealth" and "telemedicine," and what that looks like in practice can depend on many different factors. The entire system can get overwhelming if we try to build it from scratch—so some CHCs in Alabama have voiced support for enhancing our current infrastructure and helping existing systems and providers reach patients through a myriad of "telehealth" options.

These stakeholders are recommending a version of telehealth that integrates and supports the existing healthcare system. However thin and fragmented it is currently, telemedicine designed correctly can de-fragment and re-integrate healthcare for the 21st century.

Providers at multiple CHCs in Alabama have recommended the following principles to help telehealth services support rural and underserved communities:

(a). Patients should be able to access their local MDs via telephones.

(b). Local MDs should be able to bill for these visits.

(c). There should be transparency and appropriate regulation.

(d). Safeguards should be put into place regarding far-out-of-network telehealth.

(e). Local MDs should have robust access to sub-specialists—perhaps the specialist gets a consult fee, and the local doctor gets an administrative origination fee.

In outlining these proposed principles, providers have emphasized the funding of programs like THCGME and maintaining pandemic-era innovation. They also recommend that the overwhelming majority of any Federal telehealth funding should go to two places: proven, major subspecialty units, and high-speed internet in rural and underserved urban areas.

Please provide comments, concerns, and recommendations on how to achieve the principles laid out above for rural and underserved communities.

Answer 1. Senator Tuberville, thank you for your strong relationship with your CHCs in your state and your thoughtful approach to this important policy issue. We absolutely share the five principles that the Alabama CHCs suggested to guide telehealth expansion and, we hope, permanency in rural and underserved communities.

All ACH members successfully increased access to care for clients with the implementation of telephonic/telehealth services during the pandemic, and we believe these access improvements should continue. In particular, behavioral health clients are experiencing increased intensity of symptoms and behaviors and need more frequent and intensive interactions and services. FQHCs are also seeing increased high-risk behaviors (suicide attempts, relapses, substance use disorders) as well as an increase in requests for services from prospective clients seeking behavioral health care.

We would especially like to underscore your centers' principle (a). With the availability of telephonic services during the pandemic, our FQHCs have seen a dramatic increase of clients keeping their appointments, even among those with serious and persistent mental illness. In one center, the no-show rate pre-COVID was generally

above 30 percent; during COVID it has dropped below 5 percent. This level of access to care helps patients with moderate illness to get treated early, stay out of the hospital, and return to the workforce.

Behavioral health providers report that they have also seen an increase in client engagement, including increased comfort in sharing interpersonal challenges and traumas. Telemedicine has allowed millions of people who have been struggling for a long time but did not have access to care or had many barriers, to come out and seek care. The ability to talk to clients where they are, and avoid many anxieties associated with going to and from face-to-face visits has increased our ability to serve our clients with limited barriers. Maintaining telephonic services to this population post-COVID would strengthen our communities and allow for continuity of behavioral care in a time where we are experiencing a provider shortage.

RESPONSE BY BEN HARVEY TO QUESTIONS OF SENATOR CASEY, SENATOR HICKENLOOPER, SENATOR MURKOWSKI, AND SENATOR TUBERVILLE

SENATOR CASEY

Question 1. People with disabilities are part of all medically underserved populations and medically underserved areas. People with disabilities also often face significant barriers to accessing basic preventive medical and health services. What resources are necessary to ensure Community Health Centers are able to provide reliable, consistent, and low-cost access to primary and preventive care for people with disabilities?

Answer 1. This is a fantastic question, and one I very much appreciate as a father of a son with a disability/special needs.

Community Health Centers are access points for Americans across populations, geographies and needs. Community Health Centers benefit from many of the same resources as other care providers who provide services to individuals with disabilities. In addition, Community Health Centers coordinate care with other care providers and services, which is particularly important for individuals with disabilities as they often have multiple care providers and services due to their medical complexities. Ongoing, predictable Federal funding is a core resource for Community Health Centers to continue to provide care to their communities in this way.

Community Health Centers would benefit from resources dedicated directly to training their workforce to provide more robust care for individuals with disabilities. A good example is the provision of dental services for individuals with disabilities, which is often a difficult and intensive experience for the individual and the dentist. Dentists and dental hygienists can benefit directly from training on best practices for providing dental care to individuals with disabilities, and would also benefit from additional resources to support the additional time and treatment costs related to providing those services. Training programs supported by HHS would be of significant benefit.

SENATOR HICKENLOOPER

Question 1. How are community health centers particularly well equipped to recruit and retain providers that reflect the communities they serve? How can we further support health care workforce training, particularly in supporting diversity?

Answer 1. Community Health Centers are particularly well equipped due to their foundational requirement to have a majority patient Board of Directors. Additionally, Community Health Centers are bounded by the service areas and populations for whom they receive Federal funding to provide services to. This unique positioning of being patient-driven and locally based provides a unique opportunity to recruit and train the community being served.

Diversity in the healthcare workforce is a long-standing aim of programs from HRSA which support Community Health Centers, such as the National Health Service Corps. Continued, robust funding for the National Health Service Corps, the Teaching Health Center Graduate Medical Education, and the Nurse Corps Program, is crucial to enable Community Health Centers to continue to recruit and train a robust workforce.

Additionally, one initiative here in Indiana which has proven to be massively successful, and could be enhanced at the Federal level, is providing resources to Community Health Centers to recruit and train positions such as medical and dental assistants, which are typically left out of Federal loan repayment programs. Creating a Health Care Workforce Innovation Fund within HRSA, and providing incen-

tives to Community Health Centers to further enhance and establish additional formal agreements with training programs and educational institutions would significantly support the Community Health Center workforce.

SENATOR MURKOWSKI

Question 1. All Witnesses: As you all know, the National Health Service Corps (NHSC) program plays a critical role in training and recruiting providers to Health Professional Shortage Areas (HPSAs) in Alaska and throughout the country. Could you speak to how CHC's utilize NHSC to bolster the rural primary care workforce? What updates are needed to the existing programs to address the shortage we are seeing in Alaska and across the country in primary care providers and mental health professionals?

Answer 1. The NHSC is a vital lifeline for Community Health Centers (CHCs), particularly CHCs in rural areas. Without NHSC loan repayment and scholarship opportunities, CHCs would struggle to recruit providers due to disparities in ability to pay, driven mostly by reimbursement rates due to lower rates of commercial insurance in rural areas. Rural CHCs in Indiana leverage the program to recruit and retain providers who otherwise may not be willing to live or work in a rural setting.

There are a number of updates to the NHSC program which would help improve workforce shortages in rural areas. First, the vast majority of health workforce training programs are not located in rural areas. In particular, less than 10 percent of physician residency slots are located in rural communities, and most are based within or adjacent to major metropolitan areas. Targeting NHSC funds to providers who have been trained in rural communities, and leveraging NHSC dollars to support rural training programs, would provide critical support to the rural workforce. Additionally, providing more flexibility in who can receive NHSC loan repayment and scholarship funds would help expand the health workforce. CHCs and rural providers are struggling to fill their workforce needs at all levels, not just at the advanced level of providers (e.g. physicians, dentists). This includes medical assistants, dental assistants, and laboratory staff.

Question 2. Community Health Centers can play a vital role in training physicians in underserved communities. Unfortunately, as you are well aware, many CHCs—both in Alaska and across the United States—are experiencing a shortage of primary care providers. The issue is especially acute in Alaska. We struggle to recruit and retain providers even in our largest cities. Our state does not have its own medical school, and many Alaskans live in rural areas and are off of the road system. Can you share some of the biggest challenges you face with workforce recruitment and retention, both currently and as you look into the next decade? As Congress considers additional efforts to increase the health care workforce pipeline, how can we incentivize more physicians to serve in rural and underserved communities, and especially in areas far removed from where physicians are typically trained?

Answer 2. This is a fantastic question, and one I have wrestled with for a longtime. The biggest challenges we see as CHCs are a continually shrinking primary care physician workforce as physicians select to enter other specialties at a higher rate, chronic and exacerbated shortages of providers, increased burn-out rates, and non-traditional workforce shortages (e.g. medical assistants). Certainly, the effects of the COVID–19 pandemic are still lingering and causing disruption to the workforce, and will for at least the rest of this decade.

A long-standing truism in labor-related studies is that people tend to reside where they train, or in an area similar to where they were raised. The physician workforce in particular adheres to this truism, as most physicians are not raised in rural areas nor do they train in rural areas, which creates little surprise that they do not then practice in rural areas. Congress, through Medicare GME funding, has the most substantial lever to address how and where physicians are trained. Directing this funding in a more substantial way toward rural training, would create a positive retention effect, while minimizing the difficulties in creating new incentives and the long-term retention of physicians after the incentives end.

It is critical to identify, educate, and train physicians in rural areas, in addition to incentivizing practice in rural areas after training through programs like the NHSC, or enhanced geographic reimbursement rates through Medicare. CHCs through programs like the Teaching Health Center Program, demonstrate the efficacy of training providers in rural and underserved areas, which are the areas where you want the providers to be located.

Question 3. A large fraction of CHC revenues comes from Medicare and Medicaid reimbursements. As we look toward the end of the public health emergency and Medicaid continuous enrollment provisions end, can you share how you may be impacted by the disenrollment that will follow? Assuming that many disenrolled patients are eligible for Marketplace plans and subsidies, what capacities do CHCs have to help patients apply for and navigate new insurance plans? Are there specific policy changes Congress can make to support a smooth transition for patients and CHCs, with limited gaps in coverage? For patients navigating new plans with potentially higher deductibles and copays, what financial resources are available? Can community health centers apply sliding fee scales for these individuals?

Answer 3. CHCs will be impacted directly by a reduced amount of individuals covered by the Medicaid program, and most likely those individuals previously covered will now become uninsured. In Indiana, the state Medicaid program estimates that 400,000 individuals will lose coverage, and some CHCs estimate they will have upwards of a $3 million loss due to this (roughly 5–10 percent of their annual budget).

CHCs do have a good level of capacity, through Navigators and Community Health Workers, to help transition those individuals who lose coverage. However, the disenrollment period we are now in, is of historic levels, and Congress should seek to provide additional resources to CHCs to assist in this period.

SENATOR TUBERVILLE

Question 1. In preparing for this hearing, I reached out to CHCs in Alabama to get their perspective on how telehealth has impacted their practice abilities and the rural and underserved areas where they operate.

These stakeholders have let me know that, in fact, telemedicine is a major part of the solution, but there are some important caveats. It is important to see what steps need to be taken first, to stretch Federal dollars as far as possible. We need to realize that money spent on telehealth infrastructure could potentially be wasted if not invested carefully—and how there could even be adverse consequences to different patient populations.

There are many ways that people definite "telehealth" and "telemedicine," and what that looks like in practice can depend on many different factors. The entire system can get overwhelming if we try to build it from scratch—so some CHCs in Alabama have voiced support for enhancing our current infrastructure and helping existing systems and providers reach patients through a myriad of "telehealth" options.

These stakeholders are recommending a version of telehealth that integrates and supports the existing healthcare system. However thin and fragmented it is currently, telemedicine designed correctly can de-fragment and re-integrate healthcare for the 21st century.

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In outlining these proposed principles, providers have emphasized the funding of programs like THCGME and maintaining pandemic-era innovation. They also recommend that the overwhelming majority of any Federal telehealth funding should go to two places: proven, major subspecialty units, and high-speed internet in rural and underserved urban areas.

Please provide comments, concerns, and recommendations on how to achieve the principles laid out above for rural and underserved communities.

Answer 1. Telehealth services have exploded in utilization since before the pandemic, and have become an essential tool for health care providers. Pre-pandemic, less than 1 percent of CHC services were provided via telehealth, but utilization has never gone below 10 percent since the pandemic started. Providers across the care spectrum utilize telehealth as both a primary means of connecting with patients, and also as a way to provide follow-up or ancillary care.

Audio-only telehealth is an important "extender" of telehealth services, particularly for individuals who have limited access to broadband in both rural and urban areas. A number of studies have shown the primary utilizers of audio-only telehealth services are economically disadvantaged, which makes audio-only services an important tool for providers to improve access for these populations.

Care coordination is key with telehealth, and Medicare has a developed a good framework for originating site fees and specialist consulting fees/codes within their most recent physician-fee schedule regulations. One area of continued important is telehealth payment parity, which means telehealth services are reimbursement at the same rate as an in-person visit. While the facility costs of seeing a patient in-person are not present when utilizing telehealth services, many other costs remain, including the cost of technology and personnel. Providers should not be penalized for providing access to their patients in the most effective way for the patient.

Additional Federal telehealth funding should continue to support the development of broadband infrastructure across the country. In Indiana there are still significant portions of the population who do not have access to broadband services.

RESPONSE BY SUE VEER TO QUESTIONS FROM SENATOR CASEY, SENATOR SMITH, SENATOR HICKENLOOPER, SENATOR MURKOWSKI, AND SENATOR TUBERVILLE

U.S. Senate Committee on Health, Education, Labor, and Pensions

Hearing entitled "Community Health Centers: Saving Lives, Saving Money"

March 2, 2023

Questions for the record: Sue Veer

Questions for the Record from Senator Casey

1. Community Health Centers are intended to meet the needs of medically underserved populations (MUPs), including racial and ethnic minorities. One in 4 Black Americans have a disability. One in six Hispanic Americans have a disability. The CDC has reported that 3 in 10 American Indians and Alaskan Natives have a disability. The Department of Agriculture reports that 9 percent of migrant farmworkers have a disability. The Department of Housing and Urban Development reports that 40 percent of unhoused individuals have a disability. MACPAC reports that 10 million of those eligible for Medicaid have a disability. All of these populations are designated as underserved. What is necessary to ensure that members of these MUPs who have disabilities are able to be served by Community Health Centers in an accessible manner to reduce racial, ethnic, and income disparities?

   A: This is such an important question and I appreciate the opportunity to address it. Federally Qualified Health Centers (FQHCs) are the backbone to the U.S health care system; however, in order to achieve the exceptional health outcomes we (the health centers) are known to achieve, people must first be brought into care. I discuss this often with Carolina Health Centers' Chief Medical Officer. We have observed that among our established patients, racial and ethnic disparities in health outcomes are minimal; however, when the lend is expanded to the community as a whole, the disparities are glaring. We must activity engage the medically underserved in ways that affect their health literacy and access to a comprehensive medical home. In addition to comprehensive primary and preventive care, health centers provide critically important, non-clinical enabling services to do just that. These enabling services help reduce barriers to care and are essential to overcoming the health disparities that plague our health care system. Nationwide, in 2023 health centers employed 33,000 caseworkers, community health workers, interpreters, patient education specialists and other staff dedicated to addressing the social determinants of health that drive racial, ethnic and income disparities. Studies have shown that enabling services when offered by health centers reduce barriers to primary care services, increase patient visits and protects continuity of care.[1] Insurers do not reimburse for these services, and health centers rely on their 330 grant dollars, the contribution 340B pharmacy makes to their operating margin, or other funding sources to support these important investments.

   Of utmost concern to health centers is the ability to effectively cope with and respond to infrastructure needs to continue effectively serving diverse communities. The ability of

[1] Yue, D., Pourat, N., Chen, X. D., Lu, C. C., Zhou, W., Daniel, M., Hoang, H., Sripipatana, A., & Ponce, N. A. (2019). Enabling Services Improve Access To Care, Preventive Services, And Satisfaction Among Health Center Patients. *Health Affairs*, *38*(9), 1468–1474. https://doi.org/10.1377/hlthaff.2018.05228

health centers to fund infrastructure remains limited, yet the need for investment continues to grow. An increase in federal funding would allow health centers already at capacity to expand, including building additional exam rooms and new sites, renovating aging facilities, or increase access to enabling services such as language interpretation, transportation, and other nonclinical services.

2. Community Health Centers are intended to meet the needs of medically underserved populations, including rural populations with few health care resources. In many rural areas, CHCs may be the only primary care providers. The Centers for Disease Control reports that over 30 percent of people living in rural regions have a disability, the highest rate of disability of any Census urban-rural classification. What steps should be taken to ensure rural residents with disabilities can be accessibility served by Community Health Centers?

   A: Support for Telehealth services is a key strategy to expand access to needed services to rural patients and patients with disabilities. In 2021, over 99% of health centers nationwide offered telehealth services compared to just 43% in 2019. As a result of the pandemic various Medicare and Medicaid flexibilities that were put in place and health centers have proven highly effective at utilizing telehealth to continue providing primary and preventive care to patients and communities who struggle to access care. Flexibilities that have positively impacted health centers and need to be made permanent include removing distant site restrictions, permitting delivery of telehealth services via audio-only technologies, and permitting reimbursement at an amount equal to an in-person visit. An immediate next step to build a foundation for telehealth services is to address the lack of definition and clarity on medical virtual visits in the Medicare program. Telehealth medical visits are not currently in the telehealth definition allowing FQHCs to be paid the same rate as an in-person medical visit. The Centers for Medicare & Medicaid Services (CMS) needs to revise the definition of medical visit to include services furnished using interactive, real-time, audio and video telecommunications or audio-only interactions under defined circumstances.

Questions for the Record from Senator Smith

1. Community health centers across Minnesota are working to integrate physical, behavioral, and dental care to improve health outcomes. I have led legislation with Senator Moran to improve access to integrated care—our *Improving Access to Behavioral Health Integration Act*, which was signed into law as part of last year's omnibus spending package, will enable community health centers (CHCs) to apply for grants to implement integrated care models and will make it easier for CHC patients to get the behavioral health care they need.
   a. How can grant programs like this one help CHCs improve health outcomes in their communities?
   b. What are the specific health and economic benefits of integrating physical and behavioral health care in CHCs, and how do these benefits impact rural communities in particular?

c. What resources do community health centers need to implement integrated care models?
d. What more can we do at the federal level to expand integrated care models, especially in rural communities?

A: Integrated care is a core principle inherent in in the community health center medical home model. Health centers are well known for providing comprehensive services including primary and preventive care, oral health services, behavioral health and substance use disorder treatment, and access to affordable prescription medication. As a comprehensive medical home, we assume responsibility for the care of our patients across the full continuum of care, providing inpatient and specialty care often through referral agreements.

Of note – given the escalating need in our country - health centers are at the forefront of providing behavioral health care and integrating into the primary care medical home. In 2023, health centers employed more than 17,000 behavioral health providers, making up 11 percent of the entire care team. In 2021, health center performed evidence-based screening, intervention, and referral procedure for 1.5 million patients.[2] During the first 13 years of my tenure with Carolina Health Centers, we provided behavioral health and SUD treatment through a collaborative relationship with our local mental health agency. However, bringing that care inhouse and integrating it with all the other services allows us to provide truly whole person care, an in an environment free of the stigma that still exists throughout the communities served. Today we employ six behavioral health professionals but could use double that number to meet the needs of our patients if the resources were available. Unfortunately, most adult behavioral health services have no form of reimbursement.

Grant opportunities that recognize a broad array of health care providers help with the resources necessary for health centers provide integrated care to their patient populations; however, without changes to reimbursement policies, it is not enough. Currently under Medicare, FQHC mental health visits are narrowly defined to include only a limited range of services and Medicare regulations recognize only a narrow group of behavioral health clinicians. For Medicaid patients, CMS currently allows states to limit the number of visits a FQHC can be paid for the same patient on the same day. Many states allow a health center to bill a maximum of three visits per day, one for a medical visit, one for mental health, and one for dental. However, patients may need to address multiple health problems at once with different providers, and health centers should be able to bill for multiple visits instead of scheduling the patient for another time, or not getting paid for services provided. The lack of flexibility poses barriers for patients who may not have access to affordable, reliable transportation and/or childcare or cannot afford to take off work often. A study conducted by the California Health Care Foundation found that allowing same-day medical and mental health visits would benefit the patients served at FQHCs and enhance FQHCs' financial viability. Federal guidance to encourage states to

[2] National Association of Community Health Centers. Community Health Center Chartbook. March 2023. https://www.nachc.org/wp-content/uploads/2023/04/Community-Health-Center-Chartbook-2023-2021UDS.pdf

allow FQHCs to bill for multiple visits in one day, specifically multiple medical visits, dental, and/or behavioral health visits. This would not only create more efficiency for health centers and cut down on administrative burden, but most importantly would improve patients' access to care by reducing the number of appointments they have to schedule. There are Medicaid policies that encourage integration, such as the health homes option under the Medicaid state plan, however it excludes participation by FQHCs. States are also required to adjust Medicaid payment rates to reflect increases in the intensity of services, though some states do not have comprehensive policies to ensure health centers are compensated for innovations in their primary care practices to incorporate behavioral health. The inclusion of FQHCs in any effort to improve Medicaid-focused behavioral health integration efforts is critical.

Questions for the Record from Senator Hickenlooper

1. How are community health centers particularly well equipped to recruit and retain providers that reflect the communities they serve? How can we further support health care workforce training, particularly in supporting diversity?

   A: As the central primary care provider for underserved populations and communities, health centers rely on several critical federal programs with long-term demonstrated success to retain, recruit and prepare the next generation of the healthcare workforce. There are several key strategies that are effective solutions to addressing health center workforce needs.

   There must be continued investment in long-standing primary care provider recruitment and retention workforce programs, including the National Health Service Corps (NHSC) and the Nurse Corps under the Health Resources & Services Administration (HRSA). The NHSC connects primary healthcare clinicians to people with limited access to health care in high-need areas and invests in the next generation of primary care providers. The NHSC supports seven types of programs that place clinicians at NHSC-approved sites and provide scholarships and loan repayment to primary care, dental, and behavioral health providers with varying levels of support for their commitment to serve in medically underserved urban and rural areas. The Nurse Corps program awards loan repayment and scholarships to nurses, nursing students, and nurse faculty who commit to service at approved critical shortage facilities.

   The expansion of community-based training models to retain, recruit and prepare the next generation of health care professionals will support health centers' reaching a more diverse workforce. The Teaching Health Center Program (THCGME) and the Nurse Practitioner Residency Training Program are proven pathways to train providers in Community Health Center settings. Sixty-five percent of THC graduates end up practicing in primary care settings, and 26% are practicing in FQHCs. Of the Teaching

Health Center graduates 56% practice in medically underserved and/or rural areas. Approximately 20% of THC graduates practice in rural settings.[3]

Federally funded programs to support new graduate nurse practitioners with an additional year of training are a critical component of meeting the health center provider workforce challenge. The model for this program – the Nurse Practitioner Residency Training Program – provides a year of postgraduate training and has its roots in health centers. In her 2022 testimony before the HELP Committee, Dr. Margaret Flinter, a leader in this effort, discussed studies that have shown primary care nurse practitioners with residency training are more likely to mirror their patient populations and were more diverse, and more likely to provide care for underserved populations with limited English proficiency.

Another opportunity to retain and recruit non-clinical workforce is to support a new flexible innovation fund within the HRSA Bureau of Health Workforce (BHW) to support allied health pre-apprenticeship, apprenticeship, and career laddering programs and incentivize health centers to participate in preceptorship/faculty programs with academic institutions.

Retaining and recruiting medical and dental assistants, pharmacy technicians, and other allied support staff is one of health centers' most persistent problems. There are limited options to promote these fields despite the significant need. A new flexible fund would enable new pipeline programs, such as pre-apprenticeship, apprenticeship, and career laddering programs that offer certifications for participants and provide a pathway to a rewarding career in healthcare. A new grant program would enable existing health centers and other community-based programs to be scaled and replicated, particularly in rural and frontier communities.

The Committee should consider creating incentives, including financial support, to health centers for establishing formal agreements with academic institutions that educate nurse practitioners, physician assistants, nursing, dental and medical students under which the health centers accept their students for formal clinical training experiences and provide preceptors as part of that training. Examples include the Area Health Education Center (AHEC) Program, which provides continuing education and training activities for practicing health professionals and the Health Careers Opportunity Program (HCOP), which recruits individuals from economically and educationally disadvantaged backgrounds to develop skills needed to compete, enter, and graduate from health profession or allied health programs. According to HRSA, funding for these programs is awarded to the academic institutions that administer them, and it is unclear how much of this funding goes to community-based organizations, such as health centers. Often, Community Health Centers partner with academic institutions to support participants' experience in a community-based setting. However, often health centers are not

[3] THCGME, Teaching Health Center Graduation Medical Education Program. February 2023. https://www.thcgme.org/wp-content/uploads/2023/04/230330-THCGME-InfoSheet.pdf

compensated for their training which involves significant provider and staff time to operate the program.

Questions for the Record from Senator Murkowski

1. As you all know, the National Health Service Corps (NHSC) program plays a critical role in training and recruiting providers to Health Professional Shortage Areas (HPSAs) in Alaska and throughout the country. Could you speak to how CHC's utilize NHSC to bolster the rural primary care workforce? What updates are needed to the existing programs to address the shortage we are seeing in Alaska and across the country in primary care providers and mental health professionals?

   A: There must be continued investment in long-standing primary care provider recruitment and retention workforce programs, including the NHSC and the Nurse Corps. The NSHC connects primary healthcare clinicians to people with limited access to healthcare in high-need areas and invests in the next generation of primary care providers. The NHSC supports seven types of programs that place clinicians at NHSC-approved sites and provide scholarships and loan repayment to primary care, dental, and behavioral health providers with varying levels of support for their commitment to serve in medically underserved urban and rural areas. Supporting multi-year base funding for the National Health Service Corps will result in a projected increase in field strength to 20,696 clinicians, including dentists, mental and behavioral health providers, and clinicians who provide opioid and substance use disorder treatment.

   The National Association of Community Health Centers (NACHC) provided me with the data below, which is specific to Alaska:

Alaska Field Strength Dashboard https://data.hrsa.gov/topics/health-workforce/field-strength			
Year	**#**	**BHW Programs**	**Provider Type**
2022	253	5 SPs; 248 LRPs	15 dentists, 94BH, 124 PCPs, 19 Pharm

   According to Bureau of Health Workforce (BHW) data, https://data.hrsa.gov/topics/health-workforce/clinician-dashboards?tab=AlumniDashboards between FY2012 and FY2021, 97% of NHSC clinicians who completed their program in an Alaska HPSA stayed in a HPSA. In FY2021, the breakdown is as follows:

   - 50% of NHSC alumni in HPSA, stayed at the same site
   - 25% of NHSC alumni in HPSA, stayed in the same census tract
   - 10% of NHSC alumni in HPSA, stayed in the same county
   - 5% of NHSC alumni in HPSA, worked in a different county

10% of NHSC alumni are not in the HPSA and moved to states including OR, CA, WY, UT, FL, GA, VA, PA, KS https://data.hrsa.gov/topics/health-workforce/clinician-dashboards?tab=AlumniDashboards

Senator Hickenlooper asked a similar question related to the need to address the health workforce challenges. Rather than repeat my full answer, I would respectfully direct you to those comments, as they include important suggestions for investing in meaningful solutions.

2. I recently had the opportunity to join a roundtable with providers and health care professionals, including Community Health Centers, from around Alaska and listen to their concerns and the challenges they face as they provide care to patients in our state. The importance of the 340B drug pricing program to CHCs was raised several times, and this topic became a central focus in our discussion. As you know, unlike hospitals, CHCs are required to primarily serve areas or populations that are medically underserved and invest all 340B savings into activities that promote access to care for those populations. While CHCs are not the target of recent challenges that many facilities under the 340B program are currently facing, contract pharmacy restrictions are arguably harming CHCs more than any other type of 340B provider, as CHCs are the most dependent on contract pharmacy arrangements. Can you share from your perspective how impactful the 340b drug pricing program is to your CHC, and how 340B revenues directly benefit your patients? What steps can we take to ensure that the CHC perspective is heard in national discussions regarding the 340B program?

A: Thank you Senator, for raising the topic of how important the 340B program is maintaining the full scope of programs and services provided by the nation's community health centers. Never has this been this been a more critical concern as more and more health center patients are losing access to 340B purchased drugs and the contribution 340B makes to health center operating margins is being severely diminished.

First and foremost, it is important to recognize that pharmacy is a core component of a primary care medical home … just as essential as the care of medical, behavioral health, and oral health providers. Prior to the 340B statute most health centers did not have the resources necessary to provider pharmacy services either directly or through a contract model. Consequently, in many cases patient access to affordable prescriptions was extremely limited. Today, nearly all health centers offer pharmacy services either directly or through a contract arrangement. In the case of Carolina Health Centers (CHC), we operate two entity-owned community pharmacies, both of which are open to the public as well as CHC patients. 340B purchased inventory is used for only established patients of CHC and only for those prescriptions that emanate from CHC's medical practices and HRSA Scope of Project. The 340B program enables us to offer deeply discounted prescription medication to our patients living at or below 200% of the federal poverty

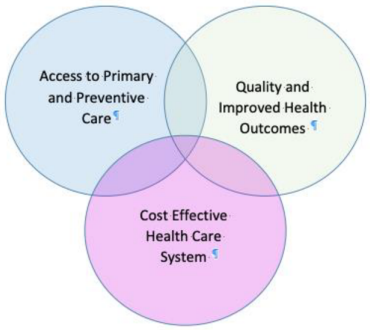
level. To ensure access for our patients given our large and very rural service area, the pharmacy operates a daily courier service that delivers prescriptions for established CHC patients to our outlying medical practice sites. We also provide mail-order medications and implemented home delivery within a limited range during COVID. We also provide prescriptions through several contract pharmacy arrangements, which are necessary due to both geographic barriers and limited payer networks, especially related to specialty drugs. In addition to operating a dispensing pharmacy, clinical pharmacists serve as part of the patient care team, assisting with patient and staff education and medication adherence.

In 2018 I had the honor of testifying about the 340B Frug Pricing Program before the Senate HELP Committee. In the follow-up questions for the record, Senator Lamar Alexander asked: "What do you believe is the purpose of the 340B program?" My response to Senator Alexander then, and what I continue to hold as truth is that the purpose of the 340B program is to help ensure that the nation has a viable and effective health care safety net. The 340B Program contributes to the effectiveness and viability of that safety net in two extremely critical and dynamic ways. The first and most obvious is that 340B pricing provides access to affordable prescription medication for low income, uninsured, and underinsured patients. Access to affordable prescription medication is critical as it is well recognized as one of the key drivers of improved health outcomes. This is not only important in terms of quality for the individual; improved health outcomes also drive cost effectiveness across the entire health care delivery system. Put another way, when health centers are able to effectively manage acute illness and chronic disease, we keep people out of the emergency room and reduce the use of more costly specialty and inpatient services. Access to affordable prescription medication is a critical piece of that puzzle.

The second and more far-reaching role of the 340B Drug Pricing Program is that it enables covered entities like Carolina Health Centers (CHC) to provide access to more patients and ensure that the safety net is comprised of comprehensive primary and preventive health care services. Congress was clear in its intentions for the 340B Program when it enacted the statute in 1992. It is important to remember that the origin of the 340B program was manufacturers reducing voluntary discounts to safety-net providers (who became covered entities) in the wake of the Medicaid drug rebate statute. These safety-net providers relied heavily on federal financial assistance, as well as other sources of community support, and the loss of those voluntary discounts posed a real threat to their viability. Consequently, as stated in the House Report that accompanied the Veterans Health Care Act of 1992, which created the 340B program, the 340B program was intended to "enable [covered] entities to stretch scarce Federal resources as far as possible, reaching more eligible patients and providing more comprehensive services."

The 340B program allows Carolina Health Centers, Inc., along with all of the nation's community health centers, to provide patients with access to affordable pharmaceuticals. However, consistent with the stated intent of the statute, after covering pharmacy operating costs, savings from the 340B program contribute to a health centers operating margin and we invest 100% of that operating margin into programs and services that lead to improved patient health outcomes, and ultimately, greater cost-effectiveness across the entire health care delivery system.

As the diagram below illustrates, the overarching value of the 340B Drug Pricing Program lies at the intersection of Access, Quality, and Cost Effectiveness. Access to affordable prescription medication and comprehensive primary and preventive health care drives improved population health, which in turns reduces the burden on the costliest components of the health care delivery system. Simply put, when we use the contribution 340B makes to our operating margin to manage chronic disease – including mental and behavioral health conditions – we are keeping people out of hospital emergency rooms and intensive care units.



I will close with a list of some of the programs and services provided by Carolina Health centers that are either totally or partially supported by the contribution 340B makes to our operating margin:

- Delivery of medically necessary prescriptions to patients at our medical sites in rural and remote locations where access to pharmacy may otherwise be unavailable. CHC delivers over 25,000 medically essential prescriptions via courier service to our outlying medical sites, where they are then picked up by the patient.
- Prescription medication provided at below cost for low-income, uninsured, and underinsured patients when even the 340B cost of that medication is prohibitive. There are countless times that patients are unable to afford even the 340B cost of a medication

and CHC is able to absorb that operating loss because of the overall contribution of 340B to our operating margin.

- Integrated behavioral health counselors that treat patients who are uninsured, not eligible for, or have long waits to access the public mental health system. Primary care practices have seen a dramatic increase of patient presenting with escalating mental and behavioral health issues. We now have 5 behavioral health counselors integrated into our primary care practices. These counselors are able to receive a "warm hand-off" from the medical provider and intervene in situations that could otherwise evolve into a crisis.
- Otherwise unfunded treatment of substance use disorder. Not only are we providing Medication Assisted Treatment for the management of addiction, we are also a community distributor of Naloxone. These services, many of which have no source of funding or reimbursement, are saving lives and enabling individuals to be productive members of their community.
- Comprehensive Early Childhood Development services integrated into our pediatric medical home model. We offer 4 evidence-based programs, some with a home visitation component, that have made an immeasurable difference in the lives of children and their families. If given the opportunity, I could share countless stories of young mother leaving abusive relationships, going back to high school and even becoming college graduates. Our Nurse Family Partnership has more than once identified pre-term labor and prevented premature birth or even the loss of a life. These stories are endless, and though we receive partial funding through the Maternal Infant and Early Childhood Home Visitation Program, without the contribution 340B makes to our operating margin we would have to turn many families away.
- A voucher program that subsidizes oral health care services provided by a network of private dentists for our low income, uninsured, and underinsured patients.
- Outreach and care coordination that brings vulnerable populations into a primary care medical home.
- The continued viability of primary care practice sites in communities with a disproportionate uninsured population.

These are programs that, without the contribution 340B pharmacy makes to CHC's operating margin, will be unsustainable at the current level. The question is, who will fill the gap to keep whole the scope of service provided by the nation's community health centers provide?

What is needed to sustain the 340B Program considering the assaults that are being played out in courts across the country is meaningful reform of the statute codify the framework that has enabled health centers to optimize the value of the program for patients and communities served. This framework must include the use of contract pharmacy to reach all patients and protection against discriminatory reimbursement by third party payers and pharmacy benefit

managers (PBMs) for the purpose of shifting resources away from the health centers and increasing their own profit margins.

The community health centers are unable to wait for the assaults to play out in the courts. The losses are mounting, and many health centers are already faced with reducing or eliminating patient care programs and services. Because of this urgency the National Association of Community Health Centers (NACHC) has joined forces with other concerned entities in the formation of The Alliance to Save America's 340B Program (ASAP 340B). The core principles for reform that are supported by these entities can be found at https://www.asap340b.org .

3. A large fraction of CHC revenues comes from Medicare and Medicaid reimbursements. As we look toward the end of the public health emergency and Medicaid continuous enrollment provisions end, can you share how you may be impacted by the disenrollment that will follow? Assuming that many disenrolled patients are eligible for Marketplace plans and subsidies, what capacities do CHCs have to help patients apply for and navigate new insurance plans? Are there specific policy changes Congress can make to support a smooth transition for patients and CHCs, with limited gaps in coverage? For patients navigating new plans with potentially higher deductibles and copays, what financial resources are available? Can community health centers apply sliding fee scales for these individuals?

A: The end of the Medicaid continuous enrollment requirement is putting significant financial pressure on Community Health Centers. The George Washington University estimated that Medicaid redeterminations could decrease total health center revenue by 4% to 7% nationally, with an associated loss in patient capacity of 1.2 to 2.1 million patients and a staffing capacity loss of 10.7 to 18.5 thousand staff members.4 Health centers rely on federal grant funding to provide services to uninsured patients on an income-adjusted sliding-fee scale and ensure they can provide affordable care to all patients who walk through their doors, regardless of income or insurance status.

Loss of Medicaid benefits could negatively impact patients' access to essential health services. Health centers are concerned that Medicaid disenrollments will interrupt patient care, especially for patients undergoing continuous treatment for a chronic condition, such as diabetes or cancer, or patients receiving prenatal care. Medicaid disenrollment will not only delay care for some patients, but could also lead to higher costs, as health conditions could worsen during a gap in treatment.

Funding for outreach and enrollment services would allow these health centers to minimize coverage gaps for their patients during the Medicaid redetermination process. Health centers

[4] Geiger Gibson Program in Community Health, Milken Institute School of Public Health. (n.d.). The Potential Effect of Medicaid Unwinding on Community Health Centers. Geiger Gibson Program in Community Health | Milken Institute School of Public Health. https://geigergibson.publichealth.gwu.edu/potential-effect-medicaid-unwinding-community-health-centers

employ dedicated staff, such as health navigators and enrollment assisters, who help patients understand and enroll in health insurance plans like Medicaid and CHIP. Health centers provide each patient with an individual assessment to determine their eligibility for health insurance, striving to connect the most vulnerable patients with the most affordable and comprehensive coverage. Some health centers are not able to ramp up outreach and enrollment services at a time when staff are already under strain. CMS should take action to ensure essential information, such as patient renewal dates, is available to health center and all those impacted by redeterminations to ensure smooth transitions and minimize coverage losses. Providing advance notice and utilizing health centers is the best strategy to meet the needs of medically underserved populations in maintaining access to coverage. If states are not sharing this information expeditated federal guidance or clear policy pathways for these states must be provided to ensure this baseline information is available.

Another policy that would support health centers in Medicaid redeterminations is expedited federal guidance and waiver approvals for section 1902(e)(14)(A) of the Social Security Act. This waiver process allows states facing significant operational issues with income and eligibility determination systems to apply for waivers to ease administrative burdens within the state Medicaid agency. This waiver process was put in place to protect eligible beneficiaries from inappropriate coverage losses during the unwinding period following the end of the COVID-19 PHE. To date only one state has an approved waiver to permit applicants to designate an authorized representative via the telephone without requiring signed documentation to be submitted to the state Medicaid agency. This waiver should be offered as a blanket policy vs. waiting for states to apply for this flexibility.

Questions for the Record from Senator Tuberville

1. In preparing for this hearing, I reached out to CHCs in Alabama to get their perspective on how telehealth has impacted their practice abilities and the rural and underserved areas where they operate.

   These stakeholders have let me know that, in fact, telemedicine is a major part of the solution, but there are some important caveats. It is important to see what steps need to be taken first, to stretch federal dollars as far as possible. We need to realize that money spent on telehealth infrastructure could potentially be wasted if not invested carefully – and how there could even be adverse consequences to different patient populations.

   There are many ways that people definite “telehealth” and “telemedicine,” and what that looks like in practice can depend on many different factors. The entire system can get overwhelming if we try to build it from scratch – so some CHCs in Alabama have voiced support for enhancing our current infrastructure and helping existing systems and providers reach patients through a myriad of “telehealth” options.

These stakeholders are recommending a version of telehealth that integrates and supports the existing healthcare system. However thin and fragmented it is currently, telemedicine designed correctly can de-fragment and re-integrate healthcare for the 21st century.

Providers at multiple CHCs in Alabama have recommended the following principles to help telehealth services support rural and underserved communities:

a. Patients should be able to access their local MDs via telephones.
b. Local MDs should be able to bill for these visits.
c. There should be transparency and appropriate regulation.
d. Safeguards should be put into place regarding far-out-of-network telehealth.
e. Local MDs should have robust access to sub-specialists – perhaps the specialist gets a consult fee, and the local doctor gets an administrative origination fee.

In outlining these proposed principles, providers have emphasized the funding of programs like THCGME and maintaining pandemic-era innovation. They also recommend that the overwhelming majority of any federal telehealth funding should go to two places: proven, major subspecialty units, and high-speed internet in rural and underserved urban areas.

Please provide comments, concerns, and recommendations on how to achieve the principles laid out above for rural and underserved communities.

A: The principles outlined by the Alabama Community Health Centers are necessary to address in building a foundation for telehealth services. Since the onset of the pandemic, all 50 states plus the District of Columbia and Puerto Rico have expanded telehealth in Medicaid for patients. While states have significant flexibility in how they choose to cover Medicaid telehealth services, the federal government has yet to provide clarity about the ability of states to make Medicaid audio-only telehealth permanent after the PHE and receive federal matching funds for these services. We need CMS to release clear guidance on audio-only, which is critical to reaching rural and underserved communities.

Earlier this year CMS, released Medicaid guidance[5] to states that addressed interprofessional consultation, when a patient's physician requests the opinion and/or treatment advice of a specialist to assist with the patient's care without the patient being present. CMS defined interprofessional consultation as a distinct, coverable service in Medicaid and CHIP, for which payment can be made directly to the consulting provider. This consultation also allows providers to utilize telehealth technology. This policy is also implemented within the Medicare program and continues to strengthen patient centered care while developing integrated and coordinated care teams. This is a positive step to address geographic workforce challenges and appropriate reimbursement for providers.

[5] SHO#23-001. Re: Coverage and Payment of Interprofessional Consultation in Medicaid and the Children's Health Insurance Program (CHIP). January 5, 2023. https://www.medicaid.gov/federal-policy-guidance/downloads/sho23001.pdf

Additionally, in the Medicare program, telehealth medical visits are not currently in the telehealth definition allowing FQHCs to be paid the same rate as an in-person medical visit. Over 10% of health center patients are Medicare beneficiaries, receiving essential preventive and primary care services at their local health centers. The same patients who benefit from mental health services through remote access deserve that same access to medical services. CMS needs to revise the definition of medical visit to include services furnished using interactive, real-time, audio and video telecommunications or audio-only interactions under defined circumstances.

Previously, CMS has cited proven benefits of virtual care, including improved access to care for those with physical impairments, increased convenience from not traveling to an office, and increased access to specialists outside of a local area. Health center patients deserve the same benefits, regardless of if remote access is for medical or mental health FQHC services. Access to technology based FQHC care is just as critical for medical services as for mental health services.

As identified by the Alabama Community Health Centers, a priority should be placed on ensuring that every community has access to reliable broadband, both patients and providers need this access. The expansive growth in the use of telehealth by providers during the pandemic amplified the glaring disparities and unequal access to care for patients without broadband or reliable internet or smartphones. Patients in poverty rarely can afford data plans that support the time and technology necessary for video visits. While telehealth has the potential to reduce geographic and workforce barriers for the nation's most vulnerable, its ultimate success in reaching all communities relies heavily on broadband access. Increasing the availability of high-speed internet and associated platforms with appropriate technology will help remove structural barriers to telehealth access. Some health centers have implemented Wi-Fi hotspots and access to tablet devices for patients who do have access to the needed equipment but would like a telehealth appointment however resources and appropriate reimbursement are needed to meet the needs of rural and other hard to reach patients in the community.

Lastly, according to https://data.hrsa.gov/topics/health-workforce/training-programs, in the academic year 2020-2021, there is one (1) teaching health center program in Alabama that had 36 participants that practiced at six (6) sites in Alabama. Training sites provide opportunities for programing and continuing education that can support enhancing current infrastructure and existing systems.

2. Some believe that Congress should increase mandatory authorized spending through the Community Health Center Fund. You have discussed other revenue sources available to the CHCs, including Medicare and Medicaid reimbursement and federal grants. I don't necessarily agree that the answer to every problem is more federal spending. I think in order to get results, it's helpful to have government and private industry work together toward a shared goal. In Alabama, we have a lot of fantastic industry growth across a lot of sectors. Our companies and businesses and their leadership have shown a desire to really become a part of the community and give back in many ways.

a. What other sources of revenue to CHCs have, outside of the Community Health Center fund?
b. Are CHCs allowed to accept donations from private businesses or donors? Could that possibly be a way to supplement boost the success of these centers and expand their effectiveness, without the federal government footing all the bill?

A: Community health centers are expected to operate as sustainable business models, an expectation that is supported when health centers maintain a balanced payer mix including patients with sources of third-party reimbursement. The effectiveness of this strategy is impacted by the socio-economic makeup of the community served, as well as the low rates of reimbursement by commercial payers – often falling below the cost of providing comprehensive care and enabling services that the health centers are known for. Severe short falls in operating resources occur in those health center sites with a high proportion of uninsured and underinsured patients – a problem that is exacerbated in states that have not expanded Medicaid, resulting in a much of the adult patient population having no source of reimbursement of primary and preventive care. The problem with health centers operating other lines of business is that many of the businesses that would align with the mission and operation of the health center fall outside of the HRSA Scope of Project, in which case the health center looses essential protections such as FTCA coverage.

One allowable source of additional revenue is that generated by providing 340B pharmacy services either directly at a health center entity owned and operated pharmacy or through contract pharmacy partners. I would respectfully direct you to my answer to senator Murkowski's question about what could be done to protect and strengthen the 340B Program to the benefit of patients and communities served by community health centers. That discussion begins on page 7 of this document; however, I will reiterate here that the contribution 340B pharmacy makes to a health center's operating margin is often the only thing keeping the doors of a family medicine practice open or enabling the health center to provide critically needed services such as behavioral health and substance use disorder (SUD) treatment. It is this contribution from 340B savings that often makes the difference between a patient with well-managed chronic disease and one that is frequently using the emergency department at an exponentially higher cost to the health care system.

Unfortunately, the 340B program as we know it is under attack and health centers across the country are losing millions of dollars in contribution to their operating margins, resulting in reduced and in come cases eliminated services. At my health center the loss of contribution resulting from manufacturers refusing to honor 340B safety net pricing at contract pharmacies is now exceeding $900,000 per year. Like all health centers, we operate on a tight margin; hoping to end each year in the black, with a positive margin of at least a 3%. Facing the loss of nearly a million dollars a year will result in significant consequences to our patients and the communities we serve.

What is needed to sustain the 340B Program considering the assaults that are being played out in courts across the country is meaningful reform of the statute codify the

framework that has enabled health centers to optimize the value of the program for patients and communities served. This framework must include the use of contract pharmacy to reach all patients and protection against discriminatory reimbursement by third party payers and pharmacy benefit managers (PBMs) for the purpose of shifting resources away from the health centers and increasing their own profit margins.

The community health centers are unable to wait for the assaults to play out in the courts. The losses are mounting, and many health centers are already faced with reducing or eliminating patient care programs and services. Because of this urgency the National Association of Community Health Centers (NACHC) has joined forces with other concerned entities in the formation of The Alliance to Save America's 340B Program (ASAP 340B). The core principles for reform that are supported by these entities can be found at https://www.asap340b.org .

3. The CARES Act permitted federally qualified health centers to furnish telehealth services as a distant site, allowing them to receive Medicare reimbursement for telehealth services, and also provided hundreds of millions of dollars for hospitals and health centers to invest in resources to expand connected care efforts.
    a. What can we do to encourage further use and innovation in telehealth?
    b. How can it be best utilized to help address the current workforce shortage?

A: Health centers are leading innovative efforts to expand access to needed services in their communities through telehealth among both rural and urban areas. In addition to expanding primary care, telehealth has extended the reach in behavioral health, oral health and management of chronic conditions. In 2021, health centers conducted 26.1 million virtual visits.[6] Health centers have also been innovative in the modality of how telehealth is delivered. Beyond the traditional video or audio only options, health centers have also utilized technology for remote patient monitoring, mobile health, and store-and-forward. Recognizing these innovative practices in policy definitions and regulatory guidance encourages health centers to explore various care team models, promotes and allows for further innovations in telehealth.

Telehealth not only allows providers to reach patients in remote locations but 20% of health centers use telehealth to coordinate with specialists outside of their organization. Telehealth creates more opportunities for providers to coordinate and integrate care. Specialty care in rural and remote areas has continually been a barrier to patient access. Until the health care system can build a sustainable pipeline to shore up the health care workforce at all provider types and specialties telehealth is an opportunity that is available now to wrap services around patients but to support primary care providers with limited access to health care partners as well. After the public health emergency, to continue the achievements of telehealth interstate licensure laws may become a barrier.

[6] National Association of Community Health Centers. Community Health Center Chartbook. March 2023. https://www.nachc.org/wp-content/uploads/2023/04/Community-Health-Center-Chartbook-2023-2021UDS.pdf

Incentivizing these agreements will continue to allow providers to deliver services beyond their state of residence and strengthen the workforce in areas with more significant shortages of providers.

4. Community Health Centers have been lifelines in so many rural areas of the country, and in Alabama in particular. But our entire health care system is now hurting for staff. The health care worker pipeline is broken, and what we have determined is that there are many causes, not just one.

   Our CHCs in Alabama have always faced unique challenges when it comes to not only recruiting physicians to rural areas and remote clinics, but they have had success over the years – because they have to.

   a. Can you describe these workforce challenges in recruiting physicians to remote clinics?

A: Nearly half of all health centers across the country are in rural communities, and 1 in 5 rural residents are served via the health center program. From 2022 health center workforce survey, the top reason for staff leaving health centers is due to financial opportunity at a larger health care organization. Stressors from the pandemic impacting staff wellbeing, professional growth and difficulties securing childcare were additional top reasons for staff to leave their health center. It was specifically noted from that survey that staff were leaving rural areas for a more urban setting.

There must be continued investment in long-standing primary care provider recruitment and retention workforce programs, including the National Health Service Corps and the Nurse Corps. The National Health Service Corps (NHSC) connects primary healthcare clinicians to people with limited access to healthcare in high-need areas and invests in the next generation of primary care providers. The NHSC supports seven types of programs that place clinicians at NHSC-approved sites and provide scholarships and loan repayment to primary care, dental, and behavioral health providers with varying levels of support for their commitment to serve in medically underserved urban and rural areas. Supporting multi-year base funding for the National Health Service Corps will result in a projected increase in field strength to 20,696 clinicians, including dentists, mental and behavioral health providers, and clinicians who provide opioid and substance use disorder treatment.

Below is data specific to Alabama:

Alabama Field Strength Dashboard https://data.hrsa.gov/topics/health-workforce/field-strength			
Year	#	**BHW Programs**	**Provider Type**
2022	114	5 SPs; 109 LRPs	9 dentists, 31 BH, 74 PCPs

According to Bureau of Health Workforce (BHW) data, https://data.hrsa.gov/topics/health-workforce/clinician-

dashboards?tab=AlumniDashboards between FY2012 and FY2021, 98% of NHSC clinicians who completed their program in an Alabama HPSA stayed in a HPSA. In FY2021, the breakdown is as follows:

- 59% of NHSC alumni in HPSA, stayed at the same site
- 12% of NHSC alumni in HPSA, stayed in the same census tract
- 18% of NHSC alumni in HPSA, stayed in the same county
- 12% of NHSC alumni in HPSA, worked in a different county

In closing, I would like to thank the Committee for the opportunity to testify on the important topic of Community Health Centers: Saving Lives, Saving Money. I also appreciate the questions that have been asked for the record as it provides yet another opportunity to expand on the vital role the Community Health Center Program play in the health and well-being of our nation.

I also want to recognize and give thanks to the staff of the Public Policy and Research division of the National Association of Community Health Centers (NACHC) for assisting me with compiling the data and information that supports the reality of the work of health centers, as well as what is needed to sustain and grow this model of care. Below is contact information for those key individuals at NACHC, who will be happy to answer any questions or provide additional information. My information is also listed, and I too welcome questions and comments.

Thank you again for this opportunity.

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RESPONSE BY JESSICA FARB TO QUESTIONS OF SENATOR MURKOWSKI AND SENATOR TUBERVILLE

SENATOR MURKOWSKI

Question 1. All Witnesses: As you all know, the National Health Service Corps (NHSC) program plays a critical role in training and recruiting providers to Health Professional Shortage Areas (HPSAs) in Alaska and throughout the country. Could you speak to how CHC's utilize NHSC to bolster the rural primary care workforce? What updates are needed to the existing programs to address the shortage we are seeing in Alaska and across the country in primary care providers and mental health professionals?

Answer 1. We have not conducted the work necessary to directly answer this question. However, in 2021 GAO examined the National Health Service Corps (NHSC) program, including how many providers served and where. For example, in fiscal year 2020, the majority of NHSC providers (60 percent) served at federally qualified health centers. At these health centers, primary care providers represented the most common type of NHSC providers. We also found that NHSC providers practiced in every state, the District of Columbia, and five territories. Nationwide, 44 percent of participating sites were in areas classified as rural. Through our review of the literature, we identified studies that found that NHSC programs have been effective in increasing capacity in community health centers and underserved areas. For example, two studies found that NHSC providers helped alleviate shortages in mental health professional shortage areas by attracting other staff and increasing capacity for mental health care, particularly in rural areas. Further, one study noted that these rural NHSC providers increased mental health care capacity at these sites by roughly twice as much as non-NHSC providers in rural areas or NHSC providers in urban areas. The authors attribute this difference to a higher need for NHSC providers in rural areas to address staffing gaps than in urban areas, and they also attribute this to requirements that NHSC providers spend 80 percent of their time in clinical tasks and direct patient care.

SENATOR TUBERVILLE

Question 1. In preparing for this hearing, I reached out to CHCs in Alabama to get their perspective on how telehealth has impacted their practice abilities and the rural and underserved areas where they operate.

These stakeholders have let me know that, in fact, telemedicine is a major part of the solution, but there are some important caveats. It is important to see what steps need to be taken first, to stretch Federal dollars as far as possible. We need to realize that money spent on telehealth infrastructure could potentially be wasted if not invested carefully—and how there could even be adverse consequences to different patient populations.

There are many ways that people definite "telehealth" and "telemedicine," and what that looks like in practice can depend on many different factors. The entire system can get overwhelming if we try to build it from scratch—so some CHCs in Alabama have voiced support for enhancing our current infrastructure and helping existing systems and providers reach patients through a myriad of "telehealth" options.

These stakeholders are recommending a version of telehealth that integrates and supports the existing healthcare system. However thin and fragmented it is currently, telemedicine designed correctly can de-fragment and re-integrate healthcare for the 21st century.

Providers at multiple CHCs in Alabama have recommended the following principles to help telehealth services support rural and underserved communities:

(a) Patients should be able to access their local MDs via telephones.

(b) Local MDs should be able to bill for these visits.

(c) There should be transparency and appropriate regulation.

(d) Safeguards should be put into place regarding far-out-of-network telehealth.

(e) Local MDs should have robust access to sub-specialists—perhaps the specialist gets a consult fee, and the local doctor gets an administrative origination fee.

In outlining these proposed principles, providers have emphasized the funding of programs like THCGME and maintaining pandemic-era innovation. They also recommend that the overwhelming majority of any Federal telehealth funding should

go to two places: proven, major subspecialty units, and high-speed internet in rural and underserved urban areas.

Please provide comments, concerns, and recommendations on how to achieve the principles laid out above for rural and underserved communities.

Answer 1. We have not conducted the work necessary to answer this question.

Question 2. Some believe that Congress should increase mandatory authorized spending through the Community Health Center Fund. You have discussed other revenue sources available to the CHCs, including Medicare and Medicaid reimbursement and Federal grants. I don't necessarily agree that the answer to every problem is more Federal spending. I think in order to get results, it's helpful to have government and private industry work together toward a shared goal. In Alabama, we have a lot of fantastic industry growth across a lot of sectors. Our companies and businesses and their leadership have shown a desire to really become a part of the community and give back in many ways.

(a) What other sources of revenue to CHCs have, outside of the Community Health Center fund?

(b) Are CHCs allowed to accept donations from private businesses or donors? Could that possibly be a way to supplement boost the success of these centers and expand their effectiveness, without the Federal Government footing all the bill?

Answer 1(a)–1(b). Health centers' revenue comes from a variety of sources. In addition to the Community Health Center Fund, these revenue sources may include:

- Medicaid,
- Medicare,
- other public insurance,
- private health insurance,
- Federal and state grants,
- private grants and individual monetary donations, and
- other non-patient related revenues, such as rent from tenants and medical record fees.

Based on our reviews of HRSA's Health Center Program Uniform Data System, community health centers may receive private grants or individual monetary donations, which they are to report as revenues. However, we have not reviewed the extent to which community health centers receive such donations.

[Whereupon, at 12:03 p.m., the hearing was adjourned.]

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