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ACCESS TO CARE: HEALTH CENTERS AND PROVIDERS IN UNDERSERVED COMMUNITIES

HEARING

OF THE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

UNITED STATES SENATE

ONE HUNDRED SIXTEENTH CONGRESS

FIRST SESSION

ON

EXAMINING ACCESS TO CARE, FOCUSING ON HEALTH CENTERS AND PROVIDERS IN UNDERSERVED COMMUNITIES

JANUARY 29, 2019

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C O N T E N T S

STATEMENTS

TUESDAY, JANUARY 29, 2019

ACCESS TO CARE: HEALTH CENTERS AND PROVIDERS IN UNDERSERVED COMMUNITIES

Tuesday, January 29, 2019

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

The Committee met, pursuant to notice, at 10:00 a.m. in Room SD–430, Dirksen Senate Office Building, Hon. Lamar Alexander, Chairman of the Committee, presiding.

Present: Senators Alexander [presiding], Murray, Romney, Braun, Cassidy, Scott, Murkowski, Casey, Hassan, Jones, Rosen, Murphy, Baldwin, Warren, and Kaine.

OPENING STATEMENT OF SENATOR ALEXANDER

The CHAIRMAN. Good morning.

The Senate Committee on Health, Education, Labor, and Pensions will please come to order. Senator Murray and I will each have an opening statement and then we will introduce the witnesses. After their testimony, Senators will each have five minutes of questions. I am going to take just two, three minutes longer than I usually do in my opening remarks, which I hope everybody will allow me to do this morning because this is our first hearing of the year.

I want to begin by welcoming new Members of the Committee. Senator Romney from Utah, welcome, former Governor—always glad to have a former Governor in our midst, if I may say that. Mike Braun from Indiana is also a new Member of the Committee. We welcome him—he has a background in business. Jacky Rosen from Nevada is also a new Member of the Committee—we welcome you, Jacky.

I think you will find this a spirited Committee dealing with lots of difficulties, and on a fairly regular basis, we find ways, thanks to Senator Murray and her staff and our staff, to work together and come up with some pretty good results. So, we are proud of that. This is the first hearing, as I said—and let us talk about what we hope to accomplish in the next two years. In my view, number one, reducing health care costs—not just health insurance, but the overall health care cost. Number two, making sure a college degree is worth students' time and money.

On health care costs, we have had five hearings on reducing health care costs towards the end of last year. We heard from Dr. Brent James, a member of the National Academy of Medicine, that

up to half of health, spending in this country is unnecessary and no one seems to contradict that. That startled me and I hope it startles the American people. It is a massive burden on family, businesses, state and Federal budgets. So, I have sent a letter to experts, including witnesses at our five hearings, asking to suggest to Senator Murray and me and our Committee, specific recommendations to reduce health care costs. And I would like to renew that invitation to anyone to submit your comments by March 1, to lower healthcare costs, at *help.senate.gov*.

The second priority is updating the Higher Education Act, to ensure the expense of a college education is worth it for students. The last time we did that seriously was in 2007, and a lot has happened since then. For example, there was no iPhone in 2007, a microblogging named Twitter had just gained its own platform and started to scale globally, and Amazon released something called Kindle in 2007. Tom Friedman, the New York Times columnist puts his finger on 2007 as the technological inflection point. So, we need to take a look at Federal support for Higher Education that affects 20 million students, 6,000 institutions, and make sure we catch up with what is happening in the world.

Our goal includes simplifying Federal Aid application, a fair way for students to repay their loans, and a better system of accountability for colleges. I have been visiting with Members of the Committee, both Democrat and Republican Members, to ask their advice. They have a number of good suggestions. And we, over the last four years in Higher Education—actually, there are a number of bipartisan bills that have been introduced during that time that should be ready for us to consider. Senator Murray and I sat down with the leaders of the Finance Committee, Senator Grassley, Senator Wyden, on which a number of Members on this Committee serve. We have shared jurisdiction on much of healthcare, and we are trying to see, are there things we can do to work together. I hope we can complete our work on both, reducing healthcare costs and updating higher education, in the first six months of this year, so we can get something to the President before the end of the year.

In addition, on the next few months, we need to reauthorize the Older Americans Act, which supports the organization and the delivery of social and nutrition services to older adults and caregivers, and reauthorize the Child Abuse, Prevention and Treatment Act.

Today's topic, extending Federal funding for community health centers, as well as four other Federal health programs, all of which are set to expire at the end of the year—they fit into a larger topic, which is of great interest to this Committee, which is primary healthcare.

There are more than 300,000 primary healthcare doctors in the United States according to the American Medical Association—that is, the doctor that most of us go to for our day-to-day medical care. Our annual physical flu vaccine, helping to manage a chronic condition, is our access to healthcare, and a reference point usually for a specialist for such things as an MRI or hip replacement. Adam Boehler, who heads the Center for Medicare and Medicaid Innovation, estimated that while primary care is only up to say 7 percent

of healthcare spending, it could impact at least half of healthcare spending because that is how we get into the rest of healthcare spending. So, we will be having a hearing next week on how primary care can help control healthcare cost, but today, we are talking about a primary example of primary healthcare.

27 million Americans receive their primary care and other services at community health centers. For example, in Lewis County, Tennessee, the hospital closed. The closest emergency room for 12,000 people was 30 minutes away, so the old hospital building became Lewis Health Center, a community health center which operates as something between a clinic and a hospital. I visited there. It is a nice, clean place, a couple of doctors, nurses. They believe they can deal with 90 percent of the issues people walk in with every day. They have a full laboratory. They run tests, perform X-rays, give IVs, and keep an ambulance ready to take someone to a hospital if they need that. Because Lewis Health Center is a community health center, they charge based upon a sliding scale. Community health centers like Lewis are one way American families can have access to affordable healthcare close to home, and this includes a wide range of healthcare, including preventive care, which we hear in every hearing is the most important care, helping to manage chronic conditions like asthma, high blood pressure, vaccines, prenatal care—there are about 1,400 federally funded health centers that provide outpatient care to approximately 27 million people, including 400,000 Tennesseans, and about 12,000 sites across the United States. Those other locations could be a mobile clinic, or a homeless shelter or school. They have been especially important in battling the Opioid Crisis.

Last year, the Department of Health and Human Services provided over 350 million in funding specifically to support community health centers, providing care for Americans in need of substance use, disorder, or mental health services. These centers accept private insurance, Medicare, and Medicaid, and charge, based, as I said, up on the sliding scale. Community health centers also receive Federal funding. In FY2019, that was 4 billion in mandatory funds and 1.6 billion in discretionary funds. We must act by the end of September in Congress to make sure the community health centers receive this Federal funding and keep their doors open. That is why two weeks ago, Senator Murray and I took the first step by introducing legislation that will extend funding for community health centers for five years and $4 billion a year in mandatory funding. The legislation also extends funding for four additional Federal health programs set to expire in September, the Teaching Health Center Graduate Medical Education Program, the National Health Service Corps, Special Diabetes Program, and Special Diabetes Program for Indians. Today, we will hear about how the community health centers are working, and how to insure 27 million Americans closer to home.

These centers rely on a well-trained workforce. Two federally funded workforce programs, which train doctors and nurses, expire this year. The Teaching Health Center Graduate Medical Education Program is one. The National Health Service Corps is another. More than half of those doctors choose to work at one of the

12,000 community health centers and affiliated sites. We look forward to hearing more about that from witnesses.

Senator Murray.

OPENING STATEMENT OF SENATOR MURRAY

Senator MURRAY. Well, thank you very much Mr. Chairman. Thank you to all of our witnesses who joined us today. We appreciate it.

Mr. Chairman, my colleagues and I look forward to working with you again this Congress on behalf of workers, and communities, and families across our Nation, as we have under your leadership for the past two Congresses. This is the first time we have met since your announcement, and on behalf of all of us, thank you for your bipartisan approach to the work we do on this Committee and this institution. You and I, along with a lot of Members in this room, have been able to work in a really important bipartisan fashion to address a lot of the issues that our families face, as you will know, to 21st-century cures, Opioids epidemic, and a lot more. So on behalf of all of us on this side of the dais, I hope we continue that tradition and thank you for your tremendous work.

The CHAIRMAN. Thank you very much.

Senator MURRAY. I would also like to welcome our new Members of the Committee. I look forward to having our new colleagues, Senator Romney, welcome. Senator Braun, who has joined us. Senator Rosen. You joined a long tradition in this Committee of bipartisan work as we address, as the Chairman outlined, the primary care cliff, higher education, healthcare cost, retirement security, and many other issues. So, welcome to this Committee, look forward to working with all of you. And finally, I just want to say, I am really glad that President Trump listened to the workers and families, and communities who were harmed by this shutdown, and ended it. That pointless 35-day shutdown not only cost a lot of damage but also wasted the first month of this Congress. We have a lot of important work to do starting with the topic of today's hearing of primary care providers.

After hearing from families across my State of Washington about the role that community health centers play in their lives and visiting a lot of centers across my state to see the good work that they do firsthand, I am really looking forward to all of our witnesses' testimony and perspective on this issue. Community health centers serve over 27 million patients a year, many of them in rural and underserved communities. And teaching health centers and programs, like the National Health Service Corps, help bring qualified health professionals to communities who are in need. These programs make it possible for millions of patients and families to get the care they can afford close to their home, and they play a critical role in the local response to national health challenges like the Opioid Crisis. But at this time last year, they were in the middle of a different kind of crisis. Community health centers were left waiting without funding, and uncertain when Congress would extend funding for programs to support them and their staff, and give patients access to the care that they rely on.

This time last year, community health centers across the country were forced to cut back hours, and staff, and services, and halt

planned expansions like in Spokane, Washington, where a new Opioid addiction treatment services initiated to combat the Opioid epidemic was jeopardized by that funding freeze, or out on our Olympic Peninsula, where plans to expand behavioral health services was put on hold, or in Whatcom County where they considered canceling construction plans for new medical, dental, and behavioral healthcare facilities.

This time last year, community health centers were left wondering how to pay their current staff and attract new professionals. Ferry County is a rural area with fewer than four people per square mile, where the funding uncertainty left the center unable to sign annual contracts for needed medical staff and managers. This time last year, some community health centers had to figure out ways to cover basic but crucial annual reoccurring expenses like renewing the lease for their building.

In Yakima, Washington, clinics in some of our most vulnerable communities were at risk of closing, and it was not just Washington State. Senators across the country faced these challenges. Elsewhere, a teaching health center closed, meaning the residents there, the healthcare residents, healthcare providers who were willing to forgo the draws of an academic hospital, roll up their sleeves, and serve patients and families and communities with severe professional shortages, faced the harrowing prospects of having to scramble to find a new residency program and possibly redo an entire year of their residency.

Fortunately, one of our witnesses today, Dr. Waits, stepped in and helped many of them to avoid that catastrophe and I hope we will be able to hear more about that in his testimony today. In the end, Congress was able to come together in a bipartisan way to fund those community health centers and the other critical primary care funding. But if funding runs out again this year, we will be right back where we were a year ago that I was just talking about.

It is clear to Members of both sides of this isle, we need to do more to provide stability for communities and the health centers they depend on. So, I am very glad that Chairman Alexander and I were able to introduce legislation to do just that. Whilst it is not the bill either one of us would have written on our own, it lays down a very clear bipartisan marker for providing these programs with long-term funding. Our bipartisan bill will provide five years of stable funding for our community health centers and give them the certainty that they need to bring on new, skilled staff, and offer new services, and make sure patients have the care that they need close to their home. And as the Chairman said, it extends funding for teaching health centers and the National Service Corps, which encourages medical students and doctors to work in underserved communities and fund at least one entire cycle of a family medicine residency.

Funding these programs for the next five years will give health centers greater confidence. They can recruit the professionals that they need and medical students, residents, and others to have greater confidence in their decision to work in an underserved community. So, I am very pleased that we were able to introduce this. I very much look forward to the hearing today, Mr. Chairman, and thank you for all that.

The CHAIRMAN. Thank you Senator Murray, and thank you for your leadership on this legislation and for your remarks at the beginning of your statement. I suggest to people in Tennessee that they look at Washington, D.C. sometimes as a split screen television, and I said look at October, there you had the Kavanaugh hearing on one side with mud going on every direction, but on the other side you had 72 Senators working with Senator Murray and me, both sides of the aisle, on landmark Opioid legislation that helped nearly every community, which was then signed into law by the President the next month.

We know how to get things done, despite differences of opinion, and one reason we are able to do that is because of Senator Murray's skill and leadership at getting results, and the respect she has on her side of isle, but on our side of isle as well, and I thank her for that. This is an example of it, this bill—this is what we call a bipartisan hearing—that means we agree on who the witnesses are, we agree on what the subject is, and we hope to agree on a result.

I welcomed the other new Senators before, Senator Braun, it was just before you walked in and I want to welcome you as well. Well now, we will hear from our witnesses and then Senators, I am sure, will have questions. I would ask each of you summarize your remarks, please and within five minutes that will give us more time for conversation.

The first witness is Dr. Dennis Freeman, a licensed psychologist—he is the Chief Executive Officer of Cherokee Health Systems in Knoxville, Tennessee. It has 23 clinics in 14 counties in Tennessee and offers a full range of services, including primary care, behavioral health, and dental services to over 70,000 patients. Senator Jones, would you like to introduce the next witness?

Senator JONES. Yes, thank you Mr. Chairman and Ranking Member Murray. I am pleased to introduce Dr. John B. Waits this morning. Dr. Waits is the Co-founder and Chief Executive Officer of the Cahaba Medical Care, which is a community health center and teaching health center training program in Alabama. Dr. Waits opened his health center in rural Bibb County, which is just south of Birmingham, in 2004, and has since expanded to seven delivery sights in six different counties throughout central Alabama. He brings a unique perspective to our hearing because he trains residents and treats patients in both rural and urban underserved settings. I have had the pleasure of visiting the Bibb County facilities and seeing firsthand the impact, his team has on their community, and I am grateful for him being here with us today. Dr. Waits, thank you, we look forward to hearing your testimony.

The CHAIRMAN. Thank you, Senator Jones. The third witness is Dr. Andrea Anderson, Director of Family Medicine at Unity Medical Center, a system of community health centers around Washington, D.C.—she is chair of the Washington, D.C. Board of Medicine. She serves as a core faculty member with the Wright Center for Graduate Medical Education. And finally, Senator Murray would you like to introduce our fourth witness?

Senator MURRAY. Thank you very much Mr. Chairman. This morning I really have the pleasure of introducing a fellow Washingtonian, Thomas Trompeter. He is the President and CEO of

HealthPoint. It is an organization which runs health centers and communities across our state to provide affordable care in underserved areas. Last year HealthPoint served tens of thousands of people. Almost two-thirds of their patients relied on programs like Medicaid and CHIP, and many had no insurance at all. Mr. Trompeter himself has helped families and communities in the northwest stay healthy for years for the past two decades at HealthPoint, and at the Northwest Regional Primary Care Association a decade before that.

Thank you, Mr. Trompeter, for your ongoing dedication to making sure families across our state can find healthcare close to home regardless of their ability to pay. And thank you again for traveling all the way out here from, what we call, the better Washington to this Washington——

[Laughter.]

Senator MURRAY.——to be here today.

The CHAIRMAN. Thank you, Senator Murray. Dr. Freeman, why don't you begin.

STATEMENT OF DENNIS FREEMAN, PH.D., CHIEF EXECUTIVE OFFICER, CHEROKEE HEALTH SYSTEMS, KNOXVILLE, TN

Dr. FREEMAN. Mr. Chairman and my great Senator, Lamar Alexander, Ranking Member Murray, and Members of the Committee, it is an honor to be asked to share my views on the Health Center Program. I am Dennis Freeman, a psychologist and Chief Executive Officer of Cherokee Health Systems, a health center in Tennessee.

Before sharing my perspectives, I want to acknowledge the past support of this Committee, on a bipartisan basis, for community health centers. We are truly grateful for that support. Today I intend to share some insights gleaned from my long experience participating in the Health Center Program. I have submitted written testimony, which expands on the comments I am going to make, and I hope you will read my written testimony and consider me a resource in your ongoing discussion.

By mission and by law, health centers serve the Nation's least fortunate residents in the Nation's most remote and economically challenged communities. At Cherokee, we speak of going where the grass is browner, and we feel blessed to have this mission, knowing in many cases we are caring for those who really have few if any other, healthcare alternatives. Cherokee began providing services in 1960. Last year, we saw 70,000 people—30 percent were uninsured, 40 percent were on Medicaid. Many years ago, we recognized that primary care is really the most common access point for people with behavioral health concerns. And so, we began blending behavioral health into the primary care team. We have pioneered this work and we have shared our model of care with health centers across the country.

Our commitment to the provision of both, medical and behavioral healthcare in a truly integrated model, allows us to provide comprehensive care to patients who present with complex, chronic medical and psychiatric conditions. This model works well for patients suffering substance use disorders, including Opiate addictions—additions are clearly a complex disorder, and in most cir-

cumstances, chronic disorders. This Committee has recognized that health centers are in a unique position to lead the treatment response to the Nation in the Opioid Crisis, and have provided resources for us to do so. At Cherokee, we have used these grant funds to organize care teams to care for these patients. I do however want to caution against a singular focus on the Opioid addiction alone—both in terms of treatment approach and in terms of funding in inflexible, narrow funding streams. Addiction to opioids is commonly mingled with other addictions, other substances, not to mention the serious medical consequences that follow in the wake of addiction. So, health centers really need comprehensive clinical teams to address the complexity of addiction.

Over the years, the partnership between the Federal Government and the health center community has been enormously effective in improving health outcomes and in boosting access to comprehensive primary care, including behavioral health and substance use disorders. Our organization and every health center in the country is dependent on the core financial support we receive in our annual grant from HRSA. While we are able to generate much of our revenue from patient services and other sources, the 330 funding is the solid rock of our funding base.

Over the past several years, health centers have faced uncertainty over the renewal of this funding on several occasions. While demand for our services was always unrelenting, we were restrained from making investments in staff and programs to meet that demand. So, I am really grateful to learn legislation has been introduced by Members of this Committee, including Chairman Alexander, to assure that the Federal funding base for health centers is there in place for five years. When health centers are financially secure, we are able to respond to national concerns like the crisis of Opiate abuse and the pernicious problem of childhood obesity.

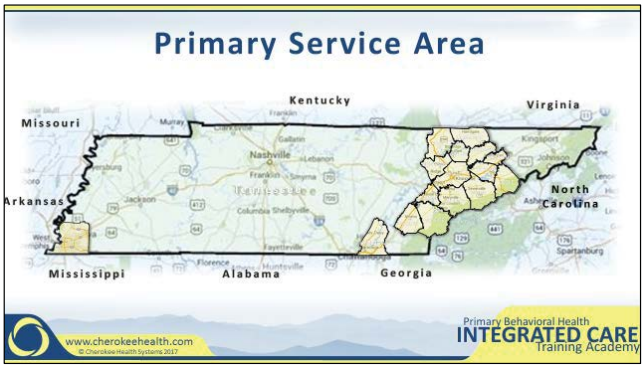
I am truly grateful for the opportunity to speak with you today, and I look forward to your questions.

[The prepared statement of Dr. Freeman follows:]

PREPARED STATEMENT OF DENNIS FREEMAN

Chairman Alexander, Ranking Member Murray and Members of the Committee.

It is an honor to be asked to share my views on the Federally Qualified Health Center Program (Health Centers) and the National Health Service Corps (NHSC) with you today. I am Dennis Freeman, a psychologist and Chief Executive Officer of Cherokee Health Systems, a Health Center in Tennessee. In 2018 Cherokee served 70,000 patients in 23 clinics located in 14 Tennessee counties.



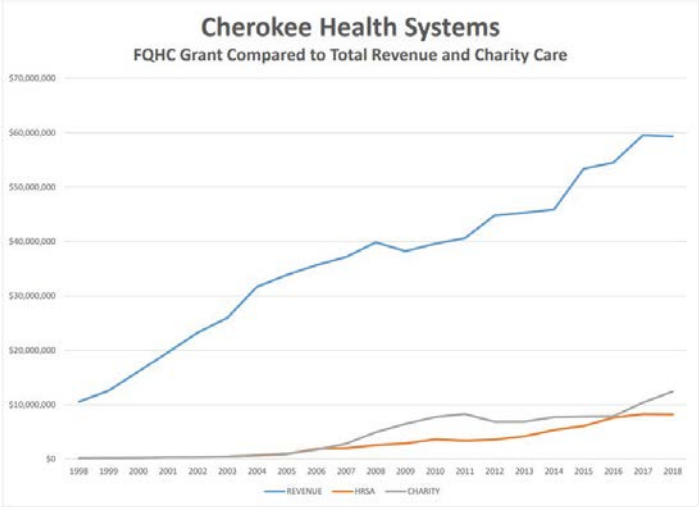
Cherokee operates clinics in isolated, rural mountain hamlets, mid-size east Tennessee communities and inner city Memphis, Knoxville and Chattanooga. Our staff outreaches into area schools, public housing complexes, homeless shelters, hospital emergency departments and patient's homes. Thirty present of our patients are uninsured and forty percent are on Medicaid.

Before I share my perspective on today's topic, I briefly want to acknowledge and recognize the depth of support that has been shown by this Committee, on a bipartisan basis, for the three programs we will discuss today. Thanks to that support, 1,400 health center organizations now serve 28 million patients in over 11,000 communities nationwide. The investments you've made have had a profound impact on the patients and communities we serve, not to mention the healthcare system as a whole, and for that we are truly grateful.

Cherokee Health Systems—A Federally Qualified Health Center

Cherokee Health Systems began providing services as a Community Mental Health Center in 1960. As was customary for Mental Health Centers in those days we did outreach into other parts of the healthcare delivery and social services sectors. Through our outreach into primary care we quickly saw primary care was the most common access point for people seeking help for behavioral health concerns. Our clinicians began circuit riding to area primary clinics on a regularly scheduled basis so we could increase access to behavioral health services to residents in our service area. After a few years we recognized that many portions of our service regions had a critical shortage of primary care providers so we began opening primary clinics with behavioral health professionals working in close collaboration with their primary care colleagues. When an opportunity to apply for a grant to become a Health Center presented itself in 2002, we seized upon it. Thankfully, our application was successful and we have been proud and contented member of the Health Center community ever since.

The graph below shows clearly how Cherokee's growth has been buoyed, but not totally dependent upon, our annual Health Center grant. Our overall revenue has grown at a faster pace over time than our federal Health center grant has. As expected, our trend line of patients in care parallels our growth in revenue. The graph shows that our grant has covered a good share of the amount of sliding fee discounts we offer our low income patients in many years. During economic hard times people lose employment, employers stop providing insurance and more people show up on our doorstep needing healthcare they can afford. As you can see, our grant has not covered our charity care the last two years and the widening gap is worrisome.



The increases in our grant over the years have been for expansions into new geographic areas or for new programs. The increases have allowed us to open new offices in underserved areas and expand or start new programs. For example, we have opened a clinic to serve homeless residents in Knoxville. We have opened services near public housing complexes. We have opened specialized services to treat patients addicted to opiates. Most of these grants fueled program expansions that decreased the percentage of our patients who had any healthcare coverage to pay for their care.

At Cherokee we act on our expansion strategy of going where the grass is browner. The program expansions cited above are fully in line with that development strategy. Typically, the increases in our grant are a critical piece but do not fully fund these expansions. We make the program work financially by being frugal and efficient. Our reward is reaching many of our neighbors who are in desperate need of care.

I expect a Member of Congress will look at the graph above and feel good about the government's investment. Our grant is a relatively small percent of our financing (currently 13.5 percent) but it spurs the growth, and helps sustain the operation, of an effective and efficient healthcare system. I'm quite sure the Cherokee picture is not unique but is replicated by the community of Health Centers who are extending primary care access into many, but by no means all, underserved areas of our country. Additional investment in Health Centers is needed in order to reach populations and communities not yet served by a Health Center.

Cherokee's Clinical Model

At Cherokee we have blended behavioral health services into our primary care clinical model and embedded behavioral health professionals in our primary care teams for many years. This approach to care is known, of course, as integrated care. This model of care is rapidly gaining traction across the country, especially among Health Centers. Without question, access to appropriate and timely care is the greatest challenge facing the mental health and substance misuse treatment sectors of the nation's healthcare system. In our experience providing access to behavioral health assessment and intervention within primary care goes a long way toward reducing the access barrier to behavioral healthcare so prevalent across the country.

Primary care is the front door to the health care system. It's the primary access point for all healthcare concerns and medical conditions, including behavioral health issues. In addition to the frequent presentation of psychiatric conditions and substance use disorders in primary care, the personality and the lifestyle of the patient are always factors in a patient's healthcare outcomes. Personal health habits; a history of trauma; and resiliency in response to stress all influence the etiology, the response to treatment and the prognosis of all medical conditions that are presented

in primary care. The patient's behavioral health is a factor in every primary care patient visit. This is especially true for patients coping with chronic medical conditions. Encouraging these patients to adopt appropriate health behaviors is the key to the medical management of complex and chronic conditions. The presence of behavioral health professionals within the primary care setting brings a clearer focus on the psychosocial factors which influence health status. The integrated care strategy has broadened the scope of primary care and enhanced the effectiveness and efficiency of primary care practice.

Over the past few years the Patient-Centered Medical Home (PCMH) model has come to be considered the best practice when it comes to primary care delivery. At Cherokee we have embraced this model and have enhanced it in a number of ways. We embed uniquely skilled behavioral health professionals, referred to as Behavioral Health Consultants (BHC), in the primary care team. BHCs are available to their primary care colleagues for consultation at the point of care. They provide assessment and intervention with patients during their primary care visit. Community Health Coordinators are available to help patients negotiate social determinates of health. In effect, they extend the exam room into the community. When indicated, psychiatric consultation is also available, in real time, to the primary care team. Psychiatric consultation is one of the telehealth services Cherokee makes available across its network of clinics. All providers on the team share an electronic health record, treatment planning and the responsibility for the overall care of all the patients on the panel.

Patients appreciate the comprehensiveness of the integrated care model. Our primary care providers are enthralled with the support the behavioral health and community-based staff provide them. The integrated care team lightens the individual burden on primary care providers and enhances their satisfaction with their work. Insurance companies are pleased because the overall cost of care declines. Best of all, patient outcomes improve.

The integrated Patient-Centered Medical Home is the best practice model for treating patients with chronic conditions. Patient with a chronic condition rarely present with only one chronic condition. This is especially true with persons suffering a psychiatric or substance use disorder. In our experience more than two-thirds of these patients have one or more co-existing medical problems that need treatment. The recent national attention on opioid addiction has illuminated the need to identify effective treatment models and has brought additional focus on integrated primary care as an effective treatment approach.

Treatment of Opioid Addiction in Context

The opioid epidemic has garnered the nation's attention for a number of very good reasons. Few if any families have been spared the devastating impact of a family member addicted to opioids. Healthcare, law enforcement, the courts, social services—every sector of our society has felt the impact. Death rates from opiate overdoses have skyrocketed, medical providers have been indicted for over prescribing and state Attorneys General are suing pharmaceutical companies for misleading marketing and advertising strategies. Obviously, bringing the opioid epidemic under control will require a multi-faceted approach beginning with more public awareness of the dangerous, addictive potential of these drug and much broader availability of effective treatment for those who become addicted.

It is tempting to isolate on opiate addiction as a singular problem and formulate overly simplistic treatment and financing strategies to address the problem. This has led to some targeted funding streams narrowly restricting providers in how grant funds may be use and how third party payers reimburse for services. Some grants will only support the treatment of patients with a specific diagnosis of opiate addiction; some grants require that certain medications which block the effect of opioids be part of the treatment; and some grants and payers limit reimbursement to those clinical activities that take place in the exam room.

Successful treatment of addiction, including treatment of those addicted to opiates, requires a more comprehensive approach. Most patients who present with opiate addiction are abusing other substances as well. Many have co-occurring psychiatric conditions that need treatment. Most have serious co-morbid medical conditions that need immediate attention, conditions that are the direct result of their substance abuse or an outcome of their unhealthy lifestyle. Many with addictions have alienated their families and are without positive social support. Addiction is a complex condition. The words of Cherokee's Director of Addiction Medicine, Dr. Mark McGrail, are instructive, "cross addiction is a real phenomenon and patients

who suffer from addiction will find something to fill the void if we "just take the opioids away".

At Cherokee we have adapted our integrated medical home model to treat patients presenting with opioid addiction. We provide accelerated, walk-in access because we know this is critically important for some patients. We use medication assisted treatment as appropriate. Patients participate in group treatment and receive additional individual behavioral health services when indicated. Most patients participate in an Intensive Outpatient Program which meets several times a week for several hours at each session. We've had a 30-day retention in treatment of 68 percent for these patients compared with national data cited in the professional literature in the 35-40 percent range. We have teams to care for women who are pregnant and abusing drugs and/or alcohol. We're beginning to incorporate pediatric care into the model in order to provide concurrent care for mother and infant after delivery. We always seek to become the healthcare home for these patients, just as we are for patients living with other serious chronic conditions. In 2018 Cherokee saw 6571 patients with a Substance Use Disorder, including 2003 with a diagnosis of Opioid Use Disorder. The integrated medical home has proven effective for the care of our patients with addictions, including those abusing or addicted to opiates.

The National Health Service Corps

Payment of educational debt by the National Health Service Corps is life changing for clinicians who receive it. I frequently hear heart-warming stories from a Cherokee staff member who speak passionately about how being relieved of their debt allowed them to see their way clear to follow their heart and work with their population of choice. Concerns about purchasing a home and starting a family are eased. The prospect of a financially secure future seems possible. At any point in time Cherokee has a couple dozen clinicians who are receiving loan repayment. Currently, seven clinicians are in the process of applying. The majority stay on after their loans are paid and many envision long careers at Cherokee. Cherokee has benefited greatly from the service of clinicians who have received scholarships or have had educational loans repaid by the NHSC.

Despite the success of the program, as an employer we are reluctant to use the NHSC as a recruiting tool when funding for the program remains uncertain. While the possibility for the payment of educational debt is there for a prospective hire, to dangle the NHSC before them is to ask them to make a leap of faith. In the black and white world of personal finance that would be unfair to the applicant. Every year there are many more applicants for NHSC slots than the program is able to pay for at the current funding level. We should be doing more to help support the recruitment of these applicants who have the will to practice in medically underserved communities. In order to maximize the effectiveness of the program we need to see long term, stable investment in the program as well as the opportunity for growth so more providers can be accepted into the program. It would be enormously beneficial if Health Centers had designated NHSC slots they could use as actual tools in recruiting clinicians.

Cherokee's Teaching Mission

At Cherokee Health Systems we consider training the next generation of healthcare providers a core part of our mission. We want professionals-in-training to have a good experience working in underserved areas and providing care to a needy population. We know most who enter the health professions do so with the motivation to help others. Given a positive experience of working alongside highly competent professional mentors who are committed to this work, many will make a commitment to follow suit. We partner with area academic institutions to train psychologists, nurses, nurse practitioners, social workers, pharmacists and primary care physicians.

Cherokee does not participate in HRSA's Teaching Health Center program, though we have been a wistful observer of the program and wished that it had the size and the stability of funding to make the impact needed in the Health Center community. At this point in time it would be hard to find a Health Center that doesn't have available positions for physicians.

Shortages in the workforce of Health Centers extends to other professions besides physicians. Dentists, pharmacists and behavioral health professionals are especially difficult to recruit for most Health Centers. Dentists willing to work with underserved populations seem to be in short supply. As we all know, professionals tend to stay in the environments where they trained. I'm not aware of many health centers who are training dentists and pharmacists. Heretofore, most behavioral health

professionals trained in behavioral health settings and upon graduation went to work in behavioral health organizations. These new graduates had neither the vision nor the skills to contemplate a career in a Health Center working as a member of a primary care team.

Fortunately, the education of healthcare professionals is changing. More training is occurring in team-based models and, when that is the case, the setting is usually in primary care. Health Centers are active in these training opportunities. A couple of small but visionary federal programs, the **Graduate Psychology Education program (GPE) and the Area Health Education Center's program (AHEC)**, are leading the team-based training agenda and provide support for training of health professionals in settings serving underserved populations.

The Area Health Education Center program (AHEC) was developed by Congress in 1971 to recruit, train and retain a health professions workforce committed to underserved populations. The AHEC program helps bring the resources of academic medicine to address local community health needs. The mission of AHEC is to enhance access to quality healthcare, particularly primary and preventive care, by improving the distribution of healthcare professionals via strategic partnerships between academic programs and community organizations. Recently, the national AHEC program has intensified its focus on multidisciplinary training. In September 2007 Cherokee Health Systems entered into a partnership with Meharry Medical College to serve as the east Tennessee Area Health Education Center. In 2017 Cherokee expanded its role with Meharry and is now the regional center for both east and west Tennessee.

The GPE program prepares doctoral level psychologists to provide behavioral healthcare, including substance abuse prevention and treatment services, in settings that provide integrated primary and behavioral health services to underserved and/or rural populations. This program supports the inter-professional training of doctoral level psychology interns and postdoctoral fellows while also providing behavioral health services to underserved populations such as older adults, rural populations, children, those suffering from chronic medical conditions, veterans, victims of trauma and victims of abuse. Grants are provided to accredited psychology internships and fellowships. Cherokee's training of psychologists is partially supported by a GPE grant.

Cherokee began an internship for psychologists in 2003 and started accepting psychology postdoctoral fellows in 2013. To date we have graduated 55 interns and 20 fellows with nine more currently in training. More than a third of the interns have stayed with us upon completion of their internship year. Nearly two thirds chose to work in safety net organizations. Most of the fellows accepted staff positions at Cherokee and the few who left all went to work with underserved populations. We have demonstrated, as has been shown many times over in many settings, training providers is the best recruitment strategy.

	Internship	Postdoctoral Fellowship
Current Trainees	5	4
Graduates	55	20
Stayed with Cherokee following graduation	35 percent	85 percent
Working with Underserved Populations	65 percent	100 percent
Received NHSC Loan Repayment	20 percent	35 percent

Conclusion

I commend the Committee for their review of the Teaching Health Centers, the National Health Service Corps and the Health Center program. These vital programs, and the synergy among them, have an important impact on the health of the nation and a profound impact on isolated, remote and disadvantaged communities. Without these programs many of our fellow citizens would not have access to timely and affordable health care.

I'm grateful to learn legislation was introduced and supported by Members of this Committee, including Chairman Alexander, to assure the federal funding base of these critical programs for an additional five years. If secured, this will enable us to continue to thrive and remain a trusted partner of the Federal Government to address the nation's healthcare challenges.

I encourage you to continue to build upon the prior investments you have made in these programs and assure the benefits they bring to the communities we serve. Your continued support is vital.

[SUMMARY STATEMENT OF DENNIS FREEMAN]

Mr. Chairman and my Senator, Lamar Alexander, Ranking Member Murray and Members of the Committee,

It is an honor to be asked to share my views on the Health Center program. I am Dennis Freeman, Chief Executive Officer of Cherokee Health Systems, a Health Center in Tennessee. Before sharing my perspectives, I want to acknowledge the past support shown by this Committee, on a bipartisan basis, for Community Health Centers. We are truly grateful.

Today I intend to share some insights gleaned from my experience participating in the Health Center Program. I have submitted written testimony which expands on the comments I will make this morning. I hope you will read my written testimony and consider me a resource in your ongoing discussion.

Cherokee Health Systems began providing services in 1960. Many years ago we recognized that primary care was the most common access point for people with behavioral health concerns and began blending behavioral health professionals into the primary care team. We've pioneered this work and have shared our model of care with our Health Center colleagues across the country.

Our commitment to the provision of both medical and behavioral care in a truly integrated model allows us to provide comprehensive care to patients who present with complex, chronic medical and psychiatric conditions. This model works well with patients suffering substance use disorders, including opiate addictions. This Committee has recognized that Health Centers are in a unique position to lead the treatment response to the nation's opioid epidemic and has provided resources to enable us to do so. At Cherokee we have these grant funds to organize care teams to care for these patients. I want to caution against a singular focus on opiate addiction alone. Addiction to opioids is commonly mingled with addiction to other substances, not to mention the other serious medical complications that follow in the wake of addiction. Health Centers need comprehensive clinical teams to address the complexity.

Over the years, the partnership between the Federal Government and the health center community has been enormously effective in improving health outcomes and boosting access to comprehensive primary care, including behavioral health and substances use disorder services. Our organization, and every Health Center in the country, is dependent on the core financial support we receive in our annual grant from HRSA. While we are able to generate much of our revenue from patient services and other sources, 330 funding is the solid rock of our funding base.

Over the past several years Health Centers have faced uncertainty over the renewal of federal 330 grant support. While the demand for our services was unrelenting, we were restrained from making investments in staff and programs to meet the demand. I'm grateful to learn legislation was introduced by Members of this Committee, including Chairman Alexander, to assure the federal funding base for Health Centers for five years. When Health Centers are financially secure, we are able to respond to national concerns like the crisis of opiate abuse and the pernicious problem of childhood obesity.

I'm truly grateful for the opportunity to speak with you today. I look forward to your questions.

The CHAIRMAN. Thanks, Dr. Freeman.
Dr. Waits.

STATEMENT OF JOHN B. WAITS, M.D., RESIDENCY DIRECTOR, CAHABA FAMILY MEDICINE RESIDENCY, CHIEF EXECUTIVE OFFICER, CAHABA MEDICAL CARE, CENTREVILLE, AL

Dr. WAITS. Chairman Alexander, Ranking Member Murray, and distinguished Members of the Committee thank you for inviting me to speak about the Teaching Health Center Graduate Medical Education Program. I am here on behalf of the American Association of Teaching Health Centers, as long with executives and clinicians from many of the Nation's teaching health centers and several medical residents who are in the audience.

I am a family physician and the CEO of Cahaba Medical Care, a federally qualified health center with 10 locations in Alabama. I also direct the Cahaba Family Medicine Residency. Cahaba is Alabama's only teaching health center and started its inaugural class in 2013. 71 percent of our graduates are now practicing in medically underserved areas, a rate almost three times higher than in traditional residency programs. We were honored to host Senator Jones at our Centreville campus, and are grateful that he is a leader on this issue.

Our experience proofs that the Teaching Health Centers Program works and deserves an extension. Without Congressional action, however, as has been alluded to, the program will lapse again on September 30th. So it is great that you are holding such an early hearing and that the Chairman and Ranking Member have introduced bipartisan legislation to extend it for five years. Cahaba employs 266 people, including over 50 healthcare providers, 31 of whom have utilized the National Health Service Corps loan repayment as a crucial incentive.

We have grown from 2,100 patients in 2012 to over 17,000 unique patients served and over 80,000 patient encounters in 2018. Each of our sites sits within a health professional shortage area and offers comprehensive care. 46 percent of our patient population lives at or below the Federal poverty level, and 15 percent are uninsured. There is also a high burden of uncontrolled chronic diseases. The Teaching Health Centers Program helps us respond to these medical needs. For example, before we opened a new clinic in 2015, the small rural town of Maplesville, Alabama had not seen a new physician in over 50 years, and its one physician was active only part-time and nearing retirement.

We purchased a building and renovated it into a modern primary care clinic, equipped with X-ray and in-house lab, then, a graduating resident from Cahaba's first Teaching Health Center class, Dr. Andrea White who is in the audience, joined a nurse practitioner and provides primary care in that community. Since then, Cahaba has been able to serve 50 percent of the low-income population within Maplesville and has also helped revitalize the economy and the small downtown square.

As you know, our Nation faces a severe doctor shortage. By 2030 the U.S. will require nearly 50,000 more primary care physicians, and the shortage is felt most deeply in health professional shortage areas and medically underserved areas. As many as 84 million people experience disparities in health care access because they are uninsured, or because they live in rural and urban areas without enough primary care physicians.

While patient care increasingly occurs in ambulatory settings, such as community health centers, traditional medical education in the U.S. occurs mainly in inpatient hospital facilities. Hospital-based training produces a health care workforce whose skills and experiences are often poorly matched to the primary care needs of the ambulatory population, and who rarely choose to practice in rural or underserved urban locations. By contrast, the Teaching Health Center model uses community-based ambulatory health centers to train primary care residents who will practice in urban

and rural underserved communities during their training and after they complete their residencies.

Evidence has shown that resident physicians who train in health center settings are nearly three times as likely to practice in underserved settings after graduation. Only investment in the community health workforce pipeline will overcome recruiting difficulties and meet the demand.

We were very grateful that in 2018 Congress generously brought the per-resident allocation back up to a more sustainable level, but the last two reauthorizations were each for two years and did not always provide sufficient certainty for teaching health centers to make binding three-year commitments to the recruits we were authorized to hire and train. We are so glad that Chairman Alexander and Ranking Member Murray have listened so carefully to our concerns over the years, and have expressed strong support for Teaching Health Centers by offering legislation to extend funding five years. What a difference it will make if Congress gives us stable funding for five years. We can budget more efficiently, keep our doors open. The Alexander-Murray bill recognizes that the Teaching Health Centers Program will improve medical education and save lives in many of our communities.

I also want to encourage the Committee to consider reauthorization legislation that we are working on with Senators Collins and Jones, which would fund three of our other needs. First, we need to restore some resident slots that were authorized by HRSA but not filled during the last couple of years of uncertainty. Second, we need a very modest increase in the per-resident allocation because our clinics and residency programs will face rising costs during this five-year authorization period.

Lastly, the Collins-Jones bill would fund an expansion of the Teaching Health Center Program to meet pent-up demand in many communities for residency programs such as Cahaba's. Thank you for giving me the time to testify this morning.

[The prepared statement of Dr. Waits follows:]

PREPARED STATEMENT OF JOHN B. WAITS

Chairman Alexander, Ranking Member Murray, and Distinguished Members of the Committee.

Thank you for inviting me to speak to you about the Teaching Health Center Graduate Medical Education Program, which we call "THCGME." I am a family physician and serve as the Chief Executive Officer of Cahaba Medical Care ("CMC"), a Federally Qualified Health Center with ten locations serving Bibb, Chilton, Perry, and Jefferson Counties. I am also the Residency Director of the Cahaba Family Medicine Residency, based in Centreville, AL. Cahaba Family Medicine Residency is Alabama's only Teaching Health Center and started its inaugural class in 2013. I am pleased to share that 71 percent of our graduated residents are now practicing in a Medically Underserved Area, a rate almost three times higher than in traditional residency programs.

As you can see, Cahaba's experience is proof that the THCGME program works and deserves to be extended this year. In 2018, Congress enacted a two-year reauthorization of the THCGME program through Fiscal Year 2019, getting us back to a more sustainable level of $150,000 per resident by providing $126.5 million in appropriations per year for FY18 and FY19. Without Congressional action, the program will lapse again on September 30, so I am very grateful that the Committee is holding such an early hearing and that the Chairman and Ranking Member have introduced bipartisan legislation to provide a five-year extension. The leadership shown by Chairman Alexander and Senator Murray in recognizing the need for a robust extension of our program is greatly appreciated by the many teaching health

center representatives here in the Committee room and our medical residents here and across the nation.

Members of the Committee can best understand why reauthorization is so critical, please permit me to share some background about our own teaching health center programs, our residents, and our patients.

Cahaba Medical Care—Teaching Health Centers in Alabama

CMC serves a portion of central Alabama that includes Bibb, Perry, Chilton, and Jefferson Counties and currently employs 266 people. Prior to becoming a FQHC/THC, CMC employed 11 people. Today, CMC employs over 50 providers, including physicians, resident physicians, physician assistants, nurse practitioners, and licensed behavioral health counselors. Since the National Health Service Corps program is also the subject of today's hearing, I want to note that over 30 Cahaba providers, including faculty physicians, have utilized the National Health Service Corps loan repayment as a crucial incentive, since there are often salary constraints for physicians working in an non-profit setting.

The growth CMC experienced on the employee side has logically enabled us to serve far more patients, increasing from approximately 2,100 patients in 2012 to over 17,000 unique patients served and over 80,000 patient encounters in 2018. Each of CMC's 10 sites sits within a Health Profession Shortage Area for medical, dental, and behavioral health and offers comprehensive care to everyone no matter their insurance status. In our service area, 46 percent of the population lives at or below the federal poverty level, and 15 percent are uninsured. Among the patients seen by CMC, 17 percent are uninsured, 35 percent are Medicaid and 25 percent are Medicare. Also, there is a high burden of uncontrolled chronic diseases such as diabetes, hypertension, heart disease, mental health conditions, kidney disease, and late presentation of diseases such as lung and colon cancers. In order to meet the wide array of medical conditions that are also often coexistent with significant social, emotional, financial, and transportation barriers to receiving adequate care, CMC also employs a team of social workers and counselors to help address the patients care holistically.

CMC serves eight distinct communities, each of which has its own story, its own strengths, its own challenges, and its own gaps in the healthcare and other industries. One such community is Maplesville, AL, a small rural town in Chilton County. Prior to our opening a new clinic in 2015, Maplesville hadn't seen a new physician enter the community in over 50 years, and the one physician in the community was active only part time and nearing retirement. CMC purchased three buildings in the historic, but antiquated, downtown, and renovated them into a modern primary care clinic, fully equipped with a x-ray and in-house lab capabilities. Patient care began in late 2015 with a nurse practitioner. Then, a graduating resident from CMC's first THCGME Residency class, Dr. Andreia White, DO, originally from Marengo County, AL, joined as the second provider in August of 2016. Since that time, according to the Federal Uniform Data Services Mapper (UDSMapper), CMC has served over 50 percent of the low income population within Maplesville and has also helped to revitalize the small downtown square.

We were honored to host Senator Doug Jones at our Centreville campus after he had heard this and other stories about the communities we serve. During his visit, he learned more about our FQHC and the integral part the Teaching Health Center has played in training, recruiting, and retaining Family Medicine physicians to underserved communities in Alabama.

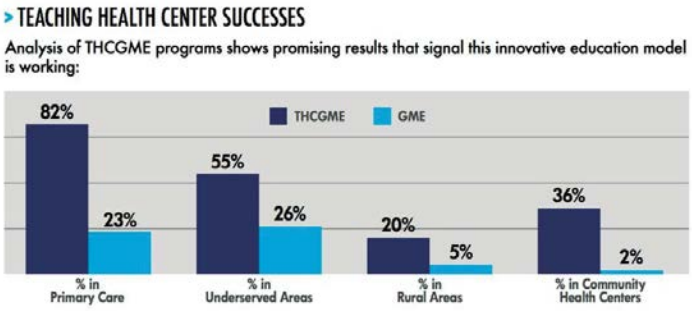
The Primary Care Physician Shortage and Teaching Health Centers

Beyond the borders of Alabama, the entire nation also faces a severe doctor shortage. In fact, by 2030 we will need more than 120,000 physicians to meet the growing demand for health care services across the country. According to the Association of American Medical Colleges, by 2030, the United States will require nearly 50,000 primary care physicians, and the shortage is being felt most deeply in health professional shortage areas (HPSAs) and medically underserved areas (MUAs). As many as 84 million people living in these areas experience disparities in health care access either because they are uninsured, or because they live in rural, urban, or suburban areas without enough primary care physicians. Additionally, we are reaching a critical time when the number of medical school graduates will be greater than the number of residency slots. Without a residency, medical school graduates are unable to obtain a medical license.

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

According to the 20th Report of the Council on Graduate Medical Education (COGME), "the shortage in primary care providers, particularly those capable of caring for adults with chronic disease (Family Medicine and General Internal Medicine), overshadows the deficits in all other specialties." One way to address the physician workforce shortage is to train resident physicians in underserved settings, based on the precept that training providers in areas of need will produce the workforce with the necessary skills to serve in underserved areas. Evidence has shown that resident physicians who train in health center settings are nearly three times as likely to practice in underserved settings after graduation. They are also 3.4 times more likely to work in a health center, compared to residents who did not train in health centers. The difficulties in recruiting community-based primary care physicians is also well documented; only investment in the community health care workforce pipeline will help meet the workforce demands. By moving primary care training into the community, THCGME programs are on the leading edge of innovative educational programming dedicated to meeting future health care workforce needs.

Analysis of the THCGME programs continue to show promising results:



Reauthorization Legislation

With the looming primary care shortage on the horizon, investments in graduate medical education training will be critical to meet the needs of the evolving healthcare delivery system. The THCGME program is one of the most reliable training models for primary care physicians and has an overwhelming documented success, but has been critically underfunded and is at the brink of collapse. Without immediately strengthening and expanding, the program will unravel just as it is beginning to produce the urban and rural primary care workforce that is desperately needed.

As I noted earlier, we were very grateful that as an initial step last year, Congress provided sufficient funding to bring the per resident allocation back up to a more sustainable level. We are very heartened that the Alexander-Murray bill would provide another element of sustainability by reauthorizing the THCGME program for five years. The last two reauthorizations were each for two years and did not always provide sufficient certainty for teaching health centers to make binding three-year commitments to all the recruits that they were authorized to hire. The longer timelines are so important because the training itself three years in duration

and the medical student recruiting process starts one to two years prior to the training, and certainty of sustainable funding for training is utterly essential to recruit qualified medical graduates into Teaching Health Centers. We are so glad that Chairman Alexander and Ranking Member Murray have listened so carefully to our concerns and have expressed such strong support for THCGME by offering legislation to extend funding through FY24. What a difference it will make if Congress gives us stable funding for five years! We can budget more efficiently and ensure that we can keep our doors open for enthusiastic future doctors who are committed to practicing medicine in underserved communities. Primary care saves lives and saves money and it is clear that the Alexander-Murray five-year reauthorization bill recognizes how the Teaching Health Center Graduate Medical Education program helps solve our primary care crisis. Simply put, the Alexander-Murray reauthorization proposal will improve medical education and save lives in many of our communities.

In addition to the Alexander-Murray proposal, I want to encourage the Committee to consider reauthorization legislation that the teaching health centers have worked on with Senators Collins and Jones, which would augment the $126.5 million current funding level by adding some additional appropriations to meet three of our other needs. We are grateful to Senators Collins and Jones for their willingness to work with supporters of the Teaching Health Centers. We are hopeful that Congress will consider favorably any proposal to help THCs restore some resident slots that were authorized by HRSA but not filled during the last couple years of uncertainty. Second, we are hopeful that Congress will include funding for a very modest increase in the per resident allocation to help offset inflation over the next five years. While Congress was very generous in restoring the $150,000 PRA in last year's law, our clinics and residency programs facing rising costs and we are hopeful that Congress can find some funds to help us preserve our purchasing power during this five-year reauthorization period.

Lastly, we are hopeful that Congress will include additional funding for expansion of the THCGME program to meet pent-up demand in many communities for a residency program such as Cahaba's. It has been five years since HRSA last approved a new Teaching Health Center in 2014 and many potential sponsors of such centers have reached out to our association asking for advice on how they can obtain such a designation and the accompanying funding. HRSA has correctly prioritized trying to sustain existing Centers for the past two years and we are hopeful that this reauthorization process will include additional funds that permit HRSA to solicit proposals and approve entirely new centers or expansion of programs offered at existing centers. Every dollar spent on expansion will generate tangible benefits for your communities and those of other Senators. Lives will be saved, economic growth generated, and we will make a dent in the medical care shortage that plagues too many parts of our country to this day.

Thank you for giving me the time to testify this morning.

[SUMMARY STATEMENT OF JOHN B. WAITS]

Chairman Alexander, Ranking Member Murray, and Distinguished Members of the Committee: Thank you for inviting me to speak about the Teaching Health Center Graduate Medical Education Program.

I am here on behalf of the American Association of Teaching Health Centers. Cahaba is Alabama's only Teaching Health Center. 71 percent of our graduated residents are now practicing in Medically Underserved Areas, a rate almost three times higher than in traditional residency programs. Many of them are in Alabama, in underserved areas that haven't seen a new physician come to town in decades.

Our experience is proof that the THCGME program works and deserves extension. Without Congressional action, the program will lapse again on September 30.

In 2018, Congress gave us a two-year extension and a more sustainable level of $150,000 per resident by providing $126.5 million in appropriations per year. The Alexander-Murray bill would further sustain us by reauthorizing the THCGME program for five years. The last two reauthorizations were each for two years and did not always provide sufficient certainty for teaching health centers to make binding three-year commitments to all the recruits that they were authorized to hire. The Alexander-Murray reauthorization proposal will improve medical education and save lives in many of our communities.

Additionally, legislation that the AATHC has worked on with Senators Collins and Jones, would add funding to meet three of our other needs.

1. restoring some resident slots that were authorized by HRSA but not filled during the last couple years of uncertainty.

2. a very modest increase in the per resident allocation to help offset inflation because our clinics and residency programs will face rising costs

3. funding expansion of the THCGME program to meet pent-up demand in many communities for a residency program such as Cahaba's. HRSA last approved a new Teaching Health Center in 2014 and many potential sponsors of such centers have reached out to our association asking how they can obtain such a designation and the accompanying funding.

Every dollar spent on expansion will generate tangible benefits for communities with a new THC. Lives will be saved, economic growth generated, and we will make a dent in the medical care shortage that plagues too many parts of our country to this day.

The CHAIRMAN. Thank you, Dr. Waits.

Dr. Anderson, welcome.

STATEMENT OF ANDREA ANDERSON, M.D., DIRECTOR OF FAMILY MEDICINE, UNITY HEALTH CARE, INC., CORE FACULTY, WRIGHT CENTER FOR GRADUATE MEDICAL EDUCATION, WASHINGTON, DC

Dr. ANDERSON. Good morning. My name is Dr. Andrea Anderson, and I am a Family Physician, with Unity Health Care here in Washington, D.C. In addition to caring for my patients, as the Medical Director of Family Medicine, I direct clinical policy for the care of all of our patients. I signed my National Health Service Corps contract in 1997, as a young medical student, and came to Unity in 2004 to fulfill my obligation. I subsequently became an NSHC loan repayer, and I have stayed ever since – a total of nearly 22 years with the NHSC. I am proud to care for multiple generations of families through all the phases of life. In addition to carrying for them medically, I advocate for my patients, helping them to navigate their way through a complex healthcare system. I have held my patients as newborns, visited them in the hospital, cared for their pregnancies, celebrated their birthdays and graduations, and mourned at their funerals.

I run into them at the grocery store and the playground, and smile when they wave and rush over to me to report how they are heeding my advice to eat more vegetables, or to walk more, or whatever the small victory of the moment is. Even in a big city, I can enjoy the personal relationships that one might only imagine possible in a small town. The NHSC has a national reach with an individual face. By making it possible for physicians like me to serve these populations, the NHSC addresses provider workforce shortages, health disparities, and the social determinants of health. I am proud to be part of such a profound legacy.

Since it is founding, the NHSC has placed more than 50,000 providers in underserved communities, with more than 10,000 placements in the last year alone. Despite this level of service, it would still take more than 20,000 additional providers to meet the existing need across the country. The NHSC supports a wide variety of primary care providers, including physicians like me. It includes PAs, NPs, dentists, mental and behavioral health professionals, just to name a few. Our providers serve in more than just FQHCs. We are in critical access hospitals, mental health centers, prisons,

Indian health service, and rural health clinics—places where primary care is needed most.

I also provide that NHSC providers tend to reflect the communities they serve. Underrepresented minority students are often the very ones who are more likely to serve populations similar to their cultural background, and studies show that having providers in underserved communities has a positive benefit on the health outcomes of the patients, especially the patients of color.

In addition, their presence is impactful and inspirational to the next generation, fostering a positive cycle of representation and encouragement. I am here today to ask your help funding this incredibly important program. In October 2017, funding for the NHSC expired and the program's future was uncertain. Without Congressional, before this October the NHSC will once again face a funding cliff.

We are very thankful for the introduction of legislation that has already shown the bipartisan support for the NHSC, including S. 192 and S. 106 in this Congress, and S. 1441 in the last Congress. And we look forward to working with this Committee to ensure that the NHSC is stable and strengthened for years to come. To accomplish this goal, we ask you to consider expanding the funding for the NHSC to ensure all current applicants are funded. There are clinicians across this country ready and willing to serve in our highest need areas. It is imperative to the health of our Nation that we do not miss this opportunity. Today, the NHSC is only able to fund 10 percent of the scholarship applications, and less than half of the loan-repayment applicants. To fund all these clinicians who are ready to serve, and on behalf of the 41 national organizations and the friends of the NHSC coalition, I would ask you to consider a systematic doubling of the current funding for the program.

It is clear the need exists today. This would be tremendously beneficial to the program, to primary care clinicians, but mostly, to the families and the friends, I serve each day. They have hopes and dreams. They are the babies that I welcome to this world and the wrinkled hands that I hold as they exit this same world. They are the present and the future of America, and I know this program works for all of us. I appreciate the opportunity to testify before you today, and we thank you for making the National Health Service Corps a priority. I would be glad to answer any questions that you have.

[The prepared statement of Dr. Anderson follows:]

PREPARED STATEMENT OF ANDREA ANDERSON

Chairman Alexander, Ranking Member Murray, and Members of the Committee,

Thank you for inviting me to speak to you today on this very important topic. My name is Dr. Andrea Anderson, a Family Physician, and the Medical Director of Family Medicine at Unity Health Care here in Washington DC. Unity is the largest federally qualified health center network in the District, and I have had the honor of serving patients there since 2004. I came Unity in fulfillment of my National Health Service Corps (NHSC) scholarship, subsequently became a NSHC loan repayor, and I have stayed ever since – a total of nearly 15 years. I am here today on behalf of the Association of Clinicians for the Underserved (ACU), the American Academy of Family Physicians (AAFP), and 39 other organizations that participate in the Friends of the NHSC Coalition. In all, these organizations represent thousands of physicians, nurse practitioners, physician assistants and other health related professionals who are united in their support for this crucial program.

As you know, the NHSC was created 45 years ago in a bipartisan manner, and since then has proven to be a highly effective program placing quality health care providers in the highest need areas of our country. As both a NHSC Scholar and Loan Repayor, I am honored to be here today to give you a firsthand perspective of the significance this program has on medical students, health professionals, underserved communities, your constituents, and ultimately the country as a whole.

Personal History/Mission

I deeply believe in the mission and purpose of the National Health Service Corps. As you can see in my background document, I have served many roles at Unity in addition to delivering primary care to my patients for close to 15 years. Currently, I serve as the Director of Family Medicine. In this capacity I direct clinical policy for over 80 Family Medicine clinicians. I am the former Medical Director of the Upper Cardozo health center, the largest of our 13 community health centers serving approximately 25,000 active patients. Previously, I directed Student and Resident placements at Unity for over 300 learners who passed through our doors during my tenure. Finally, I also directed our Health Literacy and Cultural Competency program and our Reach Out and Read Early Childhood literacy program because we know that research demonstrates direct and indirect effects on health outcomes, especially in vulnerable communities. In addition to delivering care to my patients, I also to help train the next generation of providers in my work as a core faculty member for the National Family Medicine Residency, a Teaching Health Center program with the Wright Center for GME. In this way I am actively involved with molding the next generation of culturally competent, community minded, dedicated, and committed members of the physician workforce. So I am a NHSC provider, at a Federally-Qualified Health Center, who teaches at a federally-supported Teaching Health Center. I am very happy to see the Committee take up all three programs today as I can positively attest to how they all work together to help us fill the shortage areas of the country and truly enable everyone to have access to primary care.

I signed my contract with the NHSC as a first-year medical student at Brown University because I believed as much then as I do now, and if not more today, in the mission and ideals of this program. The knowledge that I had committed to serving my community after school shaped the way I approached my studies and enhanced my outlook as a young student physician who would ultimately be assigned to an area somewhere in America in high need of health care professionals. By addressing the primary care shortage, NHSC physicians and other health professionals ensure access to healthcare for everyone, regardless of their ability to pay. We prevent disease and illness as we care for the most vulnerable people who have limited access to health care and might otherwise go without needed primary health care services.

As a Family Physician, I received rigorous training to care for children, adults, and pregnant women during my residency and Chief Resident/Academic Fellowship year at Harbor-UCLA in Southern California. Family physicians care for patients of all genders and every age through an ongoing, personal patient-physician relationship. Family doctors conduct one out of every five office visits – about 192 million visits annually. I am proud as a family physician to provide front line medical care to people of all socioeconomic strata and experiences.

In my time at Unity Health Care, I have cared for thousands of patients, walking with them through the challenges and choices of life and everything in between. I am proud to care for multiple generations of families through all the imaginable phases of this thing we call life. In addition to caring for them medically, I advocate for my patients, helping them navigate their way through a complex community and health care system. I have held my patients as newborns, visited them in the hospital, cared for their pregnancies, attended their school recitals and career days, celebrated their birthdays and graduations, and mourned at their funerals. I run into them at the grocery store and the barber shop and smile when they wave and rush over to me to report how they are heeding my advice to eat more vegetables, or to walk more, or whatever the small victory of the moment is. Even in a bustling metropolis, I can enjoy the personal relationships that one might only imagine possible in a small town. The NHSC has a national reach with an individual face. By making it possible for physicians like me to serve these populations, the NHSC addresses provider workforce shortages, health disparities and the social determinants of health. I am proud of be a part of such a profound legacy and urge you to continue the funding that would make it possible for the NHSC to continue recruiting top primary care providers to serve your constituents and all Americans.

Current Status of NHSC Funding

Beginning in 1972, funding for the NHSC had been through regular, annual appropriations. This changed under the American Recovery and Reinvestment Act (ARRA) and the Affordable Care Act (ACA). Both of these laws provided new mandatory funding to expand the program to additional communities. However in FY2011, recognizing this new program funding stream, Congress dramatically decreased the regular appropriation. By FY2012, all regular appropriations had been eliminated and the program became 100 percent reliant on the mandatory trust fund created under the ACA. When that initial funding stream expired at the end of FY2015, Congress extended the fund for two additional years within the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. Unfortunately that funding expired in October of 2017 without a new agreement, sending the program into turmoil and unable to make any new awards. By February of 2018 Congress was able to extend funding for the NHSC for another two years, through FY2019. That bill, the Bipartisan Budget Act of 2018, maintained level funding for the NHSC at $310 million.

Without Congressional action before October of this year, the NHSC will once again face the prospect of losing the $310 million currently provided through the mandatory trust fund. We are very thankful for the introduction of S. 192, by Chairman Alexander and Ranking Member Murray that shows your clear support for extending NHSC funding for an additional five years. This kind of stability is critical to the program's future. In addition, we are very grateful for S. 106, introduced by Senators Blunt and Stabenow, which calls for increased funding for the NHSC over the same five year period. We are also aware that other Senators on this very Committee previously introduced legislation calling for even more rapid growth for the NHSC, meeting the need in all shortage areas across the country. We are very grateful for this bipartisan show of support and look forward to working with Congress and the Administration to ensure the NHSC is stable and strengthened.

NHSC Background

The NHSC program, established in 1972, is designed to incentivize primary care professionals to work in urban, rural, and frontier communities designated as having a health professional shortage. Since its founding, the NHSC has placed more than 50,000 providers in underserved communities, with more than 10,000 placements in the last year alone. In exchange for their service, the program helps to alleviate the burden of debt accumulated during the course of their education through scholarship and loan repayment programs.

The four NHSC programs are:

The Scholarship Program (SP)—Provides a full scholarship for eligible medical, dental, mental and behavioral health students in exchange for service after their training in high need health professional shortage areas (HPSAs). Awards are very competitive, with the program only able to fund 10 percent of current applications. They look for students who have a real interest in delivering care to underserved communities, and have a high probability of success in their primary care careers. There are about 1,000 scholars now, who will be serving in the field in the years ahead.

The Loan Repayment Program (LRP)—This is by far the largest part of the NHSC program, with over 8,800 of the current field strength receiving loan repayment. The program helps students repay school loans in exchange for service, starting with a two year commitment at $25,000 per year. In order to fund the highest need areas, the program awards loan repayment contracts to applicants serving in the highest scoring HPSAs first. Last year the program was only able to fund applicants down to a HPSA score of 16.

The State Loan Repayment Program (SLRP)—This program provides matching funds for qualifying state loan repayment programs. Not all states take advantage of this program, but there are 1,350 placements in the field through the state loan repayment programs. This is a very cost-effective program from a federal perspective because of the state matching requirement. In addition, since the state is putting up half the funding, they also have more flexibility on how they structure their program within their state. Some fund lower scoring HPSAs and others fund additional provider types not currently eligible under the federal loan repayment program, such as pharmacists and nurses.

The Students to Service Program (S2S)—The Students to Service program is the most recent addition to the NHSC toolbox, and the smallest in terms of field strength. However, it is a critical link between the scholarship program and the

loan repayment program. The S2S program enables those students who are at a key decision point in their education to be able to choose the primary care path with financial support from the NHSC program.

NHSC placements are made at approved sites providing primary medical, dental and/or mental and behavioral health services. All NHSC providers must be open to all, regardless of ability to pay. Eligible facilities include:

- Federally-Qualified Health Centers
- Indian Health Facilities
- Correctional or Detention Facilities
- Certified Rural Health Clinics
- Critical Access Hospitals
- Community Mental Health Centers
- State or Local Health Departments
- School-Based Clinics
- Certain Private Practices
- Mobile Units
- Free Clinics

Current provider types include:

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

The NHSC has proven to be a successful, sustainable solution to the shortage of providers in thousands of communities across the United States. According to HRSA, 82 percent of NHSC clinicians who complete their service obligation continue to practice in a shortage area up to one year later, and a majority continue to practice in a shortage area for more than 10 years after completing their service obligation. Despite this level of service, it would still take more than 20,000 additional providers to meet the existing need in the more than 15,000 federally-designated HPSAs across the country.

NHSC Impact on Clinicians and Communities

I can say without hesitation that the more you dig into the statistics on the NHSC, the more supportive you will be. I want to highlight a few more things that I believe show the value of the program as well. First of all, NHSC providers tend to reflect the communities they serve. This means that NHSC placements in rural areas tend to come from other rural areas, underrepresented minority communities tend to see more of their NHSC providers with similar cultural and geographic backgrounds. This is because the NHSC gives students a chance to see themselves as clinicians, whether that be a PA, a dentist, or a physician. The Scholarship program enabled me to envision how I could finance my path to become a doctor. The Loan Repayment program enables literally thousands of students to afford to repay their loans and work in the communities that they care about and are committed to. Over the years, medical school debt has increased some 20-fold. According to the Association of American Medical Colleges, the median four-year cost to attend a public medical school is about $240,000 and a private medical school degree can be more than $340,000. The average medical school graduate comes out carrying about $190,000 or more in debt. Fourteen percent start their residency training owing $300,000 or more. These debt levels are larger than most mortgages. I can tell you first hand that my family could not have afforded to send me through medical school alone. When I was in high school I couldn't even imagine how I could possibly afford to be a doctor. Like most physicians, I was a top student. I was accepted into several highly competitive universities. I was accepted to an eight-year combined medical program out of high school at Brown University. Fortunately, I learned of the NHSC from an advisor at Brown when I was an undergraduate. I already had a desire to work in community medicine and public health with underserved populations and I was glad to know that there was a way this could be possible. I had to apply, and

I was so grateful to be accepted as a scholar to fund my attendance of the Warren Alpert Medical School of Brown University. We know that the NHSC is a resource for all providers, regardless of their background who are committed to serving the most vulnerable communities. However, one hidden benefit of the NHSC is the opportunity that it affords for educationally or economically disadvantaged students. Research shows that among students who incur debt, Underrepresented Racial Minority (URM) students face similar levels of total debt. However, URM students are twice as likely to carry some educational debt because they are often more likely to hail from low-income families.

These astute student doctors are often the very ones who are more likely to serve populations similar to their cultural background and studies show that having these doctors in communities actually has a positive benefit on the health outcomes of the patients, especially the patients of color. In addition, their presence is impactful and inspirational to the next generation, fostering a positive cycle of representation and encouragement. Having the NHSC Scholarship Program available was one of the things that encouraged me and allowed me to see myself as a physician. I know it helps diversify the field of clinicians among all the eligible provider types.

In addition to enabling lower-income, rural, urban, and underrepresented minority students to become clinicians, there is one other aspect I would like to emphasize for the Committee. As you know, many times rigid structures discourage our best and brightest from helping those most in need. It is easier to take a job in a well-off community, often making much more in salary alone, than to fight your way through the red-tape in order to help an underserved community. Fortunately, with some urging from Congress, the NHSC has enabled more and more part-time placements. This flexibility has enabled a new generation of providers to serve in high need areas, while maintaining the mission of the program. For example, the part-time commitment allows participants to care for a new family, obtain a public health degree, or work in academia or health policy enacting research or policies that can reach a wider breath and impact these communities while providing face to face clinical care part-time. More importantly, this improves and extends retention and increases patient access to their regular primary care provider. There is still room for improvement, but these communities also benefit by ensuring that the next generation can participate in the NHSC, by extending their commitment concomitant to their part-time status.

NHSC Funding Request

While thankful for the support shown by this Committee, we remain very concerned about the base funding for the program provided through the trust fund. As evident during the last extension debate, even strong bipartisan support may not enable passage before October. The loss of this base funding will cause even greater damage to the program as people lose faith in the stability of the program. This will result in a dramatic decrease in field strength, jeopardizing access to care for millions of people.

We understand that our country faces record debt levels and there are nearly continuous negotiations on federal spending levels. However, I truly believe that based on the merits of the program, the NHSC can withstand any kind of debate that focuses on value, impact, and long—term savings. We know that access to primary care saves lives and saves money, and the NHSC is designed to increase access to primary care services where we need it most. For this reason, we urge the Congress to fund the NHSC at a level that would enable it to fund at least the current applicants for the program.*This is possible through a systematic doubling of the current funding for the program.*

Doubling the funding for the NHSC would enable an additional 11 million people to have access to primary care. We know the need far exceeds this, with more than 72 million people living in primary care shortage areas, 54 million living in dental shortage areas, and more than 111 million living in mental health shortage areas. We know there are thousands of applicants already looking to serve.

The current funding level for the program allows for only 40 percent of Loan Repayment applicants and a mere 10 percent of scholarship applicants to be granted awards. I mention this to bring attention to the fact that although it is usually difficult to recruit primary care clinicians to these shortage areas, the NHSC is clearly an effective and popular way to overcome this difficulty. As we look for ways to increase access to primary care, we have literally thousands of passionate health professionals applying to the NHSC to serve in our most needed areas of the country. I would urge you to fund as many of these applicants as possible and help our rural and underserved communities get the primary care access they need today.

Conclusion

Today, more than 10,000 NHSC clinicians serve 11 million people across the country. I stand before you proud to be one of them. We are hopeful that we can strengthen and grow the program to help address the urgent need of millions of people for primary health care services. These millions of people have faces and names. They have hopes and dreams. They are my patients that I see every day. They are our neighbors. They are your constituents. They are the babies that I welcome to this world and the wrinkled hands that I hold as they exit that same world. They are you and they are me. They are the present and the future of America. Without action by Congress, $310 million in funding for the NHSC will expire later this year. The NHSC program has proven time and time again to be an effective program, and I can assure you, as an alumnus, in my opinion, that the NHSC is one of the best programs this country has devised to incentivize primary care medical providers to be able to choose primary care and to serve in underserved communities. I appreciate the opportunity to testify before you today, and we thank you for making the National Health Service Corps a priority. I would be glad to answer any questions you may have.

[SUMMARY STATEMENT OF ANDREA ANDERSON]

My name is Dr. Andrea Anderson, a Family Physician, and the Medical Director of Family Medicine at Unity Health Care here in Washington DC. Unity is the largest federally qualified health center network in the District, serving over 100,000 patients. I have had the honor of serving patients there since 2004, and I am proud to care for multiple generations of families through all imaginable phases of life. I came to Unity in fulfillment of my National Health Service Corps (NHSC) scholarship, subsequently became a NSHC loan repayor, and I have stayed ever since—a total of nearly 15 years. I deeply believe in the mission and purpose of the NHSC program; a program with a national reach and an individual face. By making it possible for physicians like me to serve high need communities, the NHSC addresses provider workforce shortages, health disparities and the social determinants of health. I am here today on behalf of the ACU, AAFP, and 39 other organizations that participate in the Friends of the NHSC Coalition.

Since its founding, the NHSC has placed more than 50,000 providers in underserved communities, with more than 10,000 placements in the last year alone. Despite this level of service, it would take an additional 20,000 providers to meet the existing needs across the country. In exchange for their clinical service in high need areas, the NHSC helps to alleviate the burden of debt accumulated during the course of their education through scholarship and loan repayment programs. The program includes the Scholarship Program, the Loan Repayment Program, the Students to Service Program and the State Loan Repayment Program. Eligible providers include nurse practitioners, physician assistance, certified nurse-midwives, mental and behavioral health professionals, physicians, dentists and dental hygienists. Eligible organizations include Health Centers, IHS facilities, rural health clinics, critical access hospitals, community mental health centers, correctional facilities and more.

NHSC providers tend to reflect the communities they serve. Underrepresented Racial Minority students are often the very ones who are more likely to serve populations similar to their cultural background and studies show that having these doctors in communities actually has a positive benefit on the health outcomes of the patients, especially the patients of color. In addition, their presence is impactful and inspirational to the next generation, fostering a positive cycle of representation and encouragement.

We know that access to primary care saves lives and saves money, and the NHSC program has proven time and time again to be an effective federal program. Unfortunately, without Congressional action before October of this year, the NHSC will once again face the prospect of losing the $310 million currently provided through the mandatory trust fund. Additionally, the NHSC is only able to fund 10 percent of scholarship applicants and less than half of loan repayment applications today. For these reasons, *we urge Congress to extend and increase the funding available for the NHSC to enable all current applicants to receive awards.* This would be possible through a systematic doubling of the current funding for the program.

We are very thankful for the introduction of legislation that has already shown the bipartisan support for the NHSC (S. 192, S. 106, and S.1441 in the 115th Congress) and look we forward to working with this Committee to ensure the NHSC is stable and strengthened for years to come.

The CHAIRMAN. Thank you, Dr. Anderson, and Mr. Trompeter, welcome.

STATEMENT OF THOMAS TROMPETER, PRESIDENT AND CHIEF EXECUTIVE OFFICER, HEALTHPOINT, RENTON, WA

Mr. TROMPETER. Chairman Alexander, Ranking Member Murray and Members of the Committee, thank you for the opportunity to provide testimony in support of the Community Health Center Fund, the National Health Service Corps, and the Teaching Health Center program, and to address the importance of fixing the primary care funding cliff we face this year.

My name is Thomas Trompeter, and I am the President and Chief Executive Officer for HealthPoint. We are a federally qualified health center, serving people in need in suburban King County, outside the City of Seattle.

We provide the full spectrum of primary medical, dental, and behavioral health care through ten full-service clinics, three school-based clinics, three out-stationed primary care clinics, and a mobile medical van that focuses on the homeless. In 2018, we took of 89,000 people, 17 percent of whom had no insurance, and 65 percent of whom relied on Medicaid and CHIP for their coverage.

In addition to emphasizing the essential role our base federal grant plays, I would like to thank you for the recent supplemental funding for integrated mental health and substance use disorder services. The opioid epidemic in our area continues to increase. This funding allows us to expand services for existing as well as new patients and has allowed us to add a behavioral health consultant, a chemical dependency counselor, and a psychiatric nurse practitioner.

Like many health centers, we participate in the National Health Service Corps Loan Repayment Program. We also participate in Washington's own Health Professions Loan Repayment Program, which is made possible by federal matching funds. These programs support medical and dental providers, behavioral health providers, and pharmacists working at HealthPoint. 20 percent of our current workforce receives this support. Another 30 percent has received this support in the past—so that is half our providers relying on these programs, this is key.

Loan repayment is our most effective tool to introduce new clinicians to our work and to keep them in that work for the long haul. We are also a teaching health center through The Wright Center National Family Medicine Residency Consortium. We have graduated three classes of residents—that is 11 new physicians. Of that 11, seven are working in community health centers, including four at HealthPoint and two other at other Washington community health centers. Here is a great success story. In 2017, we graduated from our residency a woman who began her journey as one of our patients. She was inspired by her primary care provider, and after completing her undergraduate degree and her medical degree, entered our residency and is now a practicing physician in our community.

For the last two authorization and appropriation cycles, HealthPoint and health centers everywhere have experienced serious uncertainty because of the cliff. In the fall of 2017, when fund-

ing for all three programs expired and we actually went over the cliff, we scrambled to make sure that we would not have to cut services or disrupt the education of our future doctors. This was especially acute for our family medicine residents and the faculty who were really afraid that we would renege on our promise to complete their education.

It is understandable that some might question the ongoing need for Federal grant support in a state like Washington with our adoption of the Medicaid expansion. However, like the other health centers in Washington, we serve a significant number of people with no insurance—over 15,000 every year. And many of our insured patients are still low-income and have insurance plans that have copays and deductibles that are simply not affordable for them. In addition to all that, we provide a wide array of wrap-around services that are not reimbursed by most insurances, including things like interpretation services and care coordination. Our support through the Federal program also helps us leverage other needed grant support. Like all the health centers, we are supported with a patch-work quilt of grants and reimbursements, all of which are critically important to our ability to serve the underserved. The Federal 330 grant is the essential support for our ability to provide care to these uninsured and underinsured patients—it is often the seal of approval that others look to, to provide us with support.

We must arrive at a more durable solution and provide stable and adequate long-term funding for the care we provide. Without your continued support, all this work is in serious jeopardy.

I am grateful that the Chairman and Ranking Member, who just happens to be my own Senator, have introduced legislation to extend funding for the Community Health Center Fund, the National Health Service Corps, and the Teaching Health Centers program for an additional five years. I know other Members of the Committee have also sponsored legislation to extend long term funding and we are grateful for all of this support. I urge the HELP Committee to move this legislation forward in order to provide stable and full funding for the health center programs and to prevent a repeat of the uncertainty and disruption that occurred in the last two authorization and appropriation cycles. Our staff, our patients, and our community are counting on you. Thank you.

[The prepared statement of Mr. Trompeter follows:]

PREPARED STATEMENT OF THOMAS TROMPETER

Chairman Alexander, Ranking Member Murray and Members of the Committee, thank you for the opportunity to provide testimony in support of the Community Health Center Fund, the National Health Service Corps, and the Teaching Health Center Graduate Medical Education program, as well as the importance of addressing the Primary Care Funding Cliff we face in Federal Fiscal Year 2020.

My name is Thomas Trompeter. I am the President and Chief Executive Officer for HealthPoint. HealthPoint is a Federally Qualified Health Center, founded in 1971, serving people in need in suburban King County, outside the City of Seattle.

In 2018, we provided care to underserved communities in King County through 10 "full service" health centers, 3 school based clinics, 3 out-stationed primary care clinics, and a mobile medical van which focuses on serving people who are homeless. We provide the full spectrum of primary medical, dental, and behavioral health care.

Here are a few key metrics for HealthPoint in 2018:

- We served 89,000 patients
- 16 percent of our patients have no insurance
- 65 percent of our patients are covered by Medicaid/CHIP
- We provided $8.5 million in care that was not paid for by our patients or their insurance

In addition to emphasizing the essential role our base federal grant plays in providing high quality primary care to underserved communities, I would like to thank you for the recent supplemental funding for increased access to critical integrated mental health and substance use disorder services. With funding through the recent AIMS and SUDS service expansions, HealthPoint has added (and is adding) new personnel to expand access to integrated SUD and MH treatment for our patients. The opioid epidemic in our service area continues to increase, with no end in sight. As a Federally Qualified Health Center, HealthPoint is at the forefront of responding to this community-wide crisis. We are dedicated to meeting the challenge by removing barriers and providing opportunities for more high-risk patients to access care. With the epidemic creating the need for increased staff capacity, these supplemental awards provide critical funding needed to better respond to this crisis. Our increase in integrated SUD and MH personnel (Behavioral Health Consultant, Chemical Dependency Counselor and a Psychiatric Nurse Practitioner) will expand access to services for existing as well as new patients and strengthen our capacity and commitment to making sure that care is within reach for everyone who seeks help.

Like many health centers across the country, we participate in the National Health Service Corps Loan Repayment Program, as well as Washington State's own health professions loan repayment program, which is made possible by federal matching funds. These programs provide support for medical and dental providers, behavioral health providers and pharmacists working at HealthPoint.

- About 20 percent of this workforce at HealthPoint is currently receiving support through these programs.
- Nearly 50 percent of all our providers are either currently receiving support or have received support in the past.

This is key. Loan repayment is an essential recruiting tool for HealthPoint and for health centers in general. It is the most effective tool we have at HealthPoint to introduce new clinicians to our work. It is not uncommon for providers—once exposed to the rewarding work we do—to decide that working in a Health Center is a truly worthwhile career and to stay with us.

We are also deeply engaged in training the next generation of health center providers. We are a community campus of the AT Still School of Osteopathic Medicine in Arizona (SOMA). 79 percent of our graduates pursue residencies in primary care—a percentage that is far greater than in most medical schools.

We are a Teaching Health Center through The Wright Center National Family Medicine Residency Consortium. We have graduated 3 classes of residents for a total of 11 new physicians. Of that 11:

- 7 are working in Community Health Centers—4 at HealthPoint, 2 at other Washington CHCs, and one in a California CHC
- Of the remaining 4, 3 are working in our local area and 1 is practicing out of state.

It is worth noting that for each of the three years we have operated the residency program, the number of graduates choosing to work in a Health Center has increased. We are thrilled with the Teaching Health Center program.

I would like to offer one example of the success of our involvement with the Teaching Health Center program. In 2017, we graduated from our residency a woman who was a patient at HealthPoint. She was inspired by her HealthPoint provider and, after completing her undergraduate degree, entered our SOMA community campus and then was accepted into our residency program. She is now a practicing physician in our community.

I am grateful that the Committee is holding this hearing to discuss the importance of resolving the Primary Care Funding Cliff. For the last two authorization and appropriation cycles, HealthPoint and CHCs in Washington State and around the nation have experienced serious uncertainty due to the challenges we have faced with the Cliff. We must arrive at a more durable solution and provide stable and adequate long term funding for the critical care we provide for underserved communities.

In the fall of 2017, when funding for all three programs expired and we actually went over the cliff, we at HealthPoint scrambled to make sure that we would not have to curtail services to people in need and to the medical students and residents who rely on us. Fortunately for us, the gap in funding was ultimately resolved prior to the end of our own grant budget period, thereby saving us from having to make even more difficult decisions. Nonetheless, the level of uncertainty created serious difficulty for us as an organization. And, while I remained relatively confident that a solution would be found, I cannot say the same for our staff. Perhaps the most powerful example of the effects of this uncertainty is with our Family Medicine Residents and faculty. Our residents were understandably concerned that the promise we made to them would be unfulfilled due to loss of THC funding. Our faculty were understandably concerned that we would be forced to renege on our commitment to these future Family Physicians. This, then, created serious concern that our Federal Government would abandon a program that has shown great promise in helping to address the shortage of primary care physicians dedicated to caring for underserved populations.

It is understandable that some might question the need for federal grant support in a state like Washington with our adoption of the Medicaid expansion under the Affordable Care Act. However, like the other CHCs in Washington, HealthPoint still serves a significant number of people with no insurance. 17 percent of our patients have no insurance. In addition to that, many of our insured patients are still low-income with policies that have copay and deductible provisions that are not affordable for them. The federal 330 grant is *the essential* support for our ability to provide care to these uninsured and underinsured patients.

I would also point out that in many ways—our support through the federal CHC program helps HealthPoint leverage other needed grant support. Like all CHCs, we are supported by a "patch-work quilt" of grants and reimbursements—all of which are critically important to our ability to serve our communities. Chief among these sources is the support we receive through the CHC programs—it is in many ways the seal of approval that our other sources of support look to as an assurance that we are a high quality organization worth their investment.

All the programs I have briefly described here—whether directly supported with federal funding or indirectly supported because of the foundation that federal support provides—are made possible by the stable and adequate funding we have historically received through the CHC programs portfolio. Without your continued support, all this work is in serious jeopardy.

I am grateful that the Chairman and Ranking Member, who just happens to be my own Senator, have introduced legislation to extend funding for the Community Health Center Fund, the National Health Service Corps, and the Teaching Health Centers program for an additional five years. I know other esteemed Members of this Committee have also sponsored legislation to extend long term funding. On behalf of health centers in Washington and across the country I want to thank you all for these efforts. I urge the HELP Committee to move this legislation forward in order to provide stable and full funding for the CHC programs, and to prevent a repeat of the uncertainty and disruption that occurred in the last two authorization and appropriation cycles. Our staff, our patients, and our community our counting on you.

[SUMMARY STATEMENT OF THOMAS TROMPETER]

HealthPoint is a Federally Qualified Health Center, founded in 1971, in King County, Washington.

- 10 "full service" health centers; 6 ancillary sites; one mobile van
- Full spectrum of primary medical, dental, and behavioral health care.
- 89,000 patients; 17 percent uninsured; 65 percent Medicaid/CHIP
- $8.5 million in care that was not paid for by our patients or their insurance

Our base federal grant is critical to our ability to care for the uninsured and underinsured

The opioid epidemic in our service area continues to increase, with no end in sight. Recent expansions funds have let us add needed staff and expand services.

NHSC is a critical resource for HealthPoint. It provides (a) direct assistance and (b) leverages resources for a state program that also provides similar assistance;

- 20 percent of our provider workforce currently receives support; 50 percent of all our providers are current or past recipients
- Loan repayment is the most effective tool recruitment we have, and recipients often stay.

We are a community campus of the AT Still Medical School and a THC through The Wright Center National Family Medicine Residency Consortium.

- 79 percent of our medical school graduates pursue residencies in primary
- Our residency has graduated 11 new physicians. Of that 7 are in CHCs

In the fall of 2017, when funding for all three programs expired and we actually went over the cliff, we at HealthPoint scrambled to make sure that we would not have to curtail services to people in need or to the Family Medicine Residents who rely on us. For HealthPoint, the level of uncertainty created serious difficulty. The effects of this uncertainty were especially acute with our Family Medicine Residents and faculty. Our residents were understandably concerned that the promise we made to them would be unfulfilled due to loss of THC funding.

Our 330 grant is essential to our ability to provide care to uninsured and underinsured people. It also leverages other resources for our "patch work quilt" of support—it is the seal of approval for other funders.

Without your continued support, all this work is in serious jeopardy.

I am grateful that the Chairman and Ranking Member, who just happens to be my own Senator, have introduced legislation to extend funding for the Community Health Center Fund, the

National Health Service Corps, and the Teaching Health Centers program for an additional five years. I know other esteemed Members of this Committee have also sponsored legislation to extend long term funding.

On behalf of health centers in Washington and across the country I want to thank you all for these efforts. I urge the HELP Committee to move this legislation forward in order to provide stable and full funding for the CHC programs, and to prevent a repeat of the uncertainty and disruption that occurred in the last two authorization and appropriation cycles. Our staff, our patients, and our community are counting on you.

The CHAIRMAN. Thank you, Mr. Trompeter and all the witnesses, thank you very much. We will now begin a round of five-minute questions. Senator Cassidy.

Senator CASSIDY. Hey, thank you all for your good work. My work as a physician was in an inner-city hospital, so I applaud what you do. Dr. Anderson, my wife did her residency at Harbor-UCLA. A good friend of hers was probably one of your part-time faculty. So anyway, just to say that and I did mine at a big County. So anyway, I am going to probe, and I probe not to do anything but to be able to explain this program better to others. Dr. Waits, you mentioned the $150,000 per position per year. Now, the average resident earns about $57,000 a year, maybe 20 percent benefits will move it up to $65,000 because of the delta there. Now obviously you have to pay faculty, but faculty are also billing. So, if I am defending the program to others, how do I defend that delta between the average salary of a resident and the $150,000 we are allocating per year?

Dr. WAITS. Well, thanks for the question. I guess the first thing I would say is a lot of the delta is very understandable, with fringe benefits——

Senator CASSIDY. From 25 percent right?

Dr. WAITS.——and then their malpractice insurance and the efficiency of a resident in a health center that is already seeing uninsured patients and nonprofit—our interns typically see three patients in a half day, whereas a faculty member might see 15 or 20. And so they are just cost to the institution that it takes to host an accredited training program. This number was independently as-

sessed in the peer-reviewed literature by George Washington University and it is it is consistent with the cost of graduate medical education in the CMS program that has been somewhat standard for decades.

Senator CASSIDY. Sounds great.

Dr. WAITS. Yes.

Senator CASSIDY. Mr. Trompeter, are these grants kind of stackable if you will? Can someone get loan forgiveness, but also fill a slot that is financed by the—whenever I say THC I think of THC meaning something else—but THC Graduate Medical Education Program. Can you have somebody who is loan forgiven and then put into one of those slots?

Mr. TROMPETER. I am not quite following the question.

Senator CASSIDY. Can we have two different incentive programs to try and move people to these areas? Maybe Dr. Waits should be the one to answer. And in the question—ideally, they were both operating independently, but if we have the loan forgiveness program that would attract somebody, but we attract them into a residency position, which is otherwise financed by the THCGME, then you are using two different incentive programs to attract one person. I do not know the answer. That is why——

Mr. TROMPETER. Well let me try and maybe Dr. Waits can help me out here. The loan repayment program is for providers who are hired on as full-time staff providers. They are not residents——

Senator CASSIDY. I see. That is not the residency that comes out.

Mr. TROMPETER. That is correct.

Senator CASSIDY. Okay. Got you. Okay and that helps me tremendously. I assume you all are 340b providers?

I see a lot of his nodding behind you. Dr. Freeman, how does that 340b program interact with what you all are doing? I say that because obviously, that could be a source of revenue. Do you pass those savings on to your patient if you have a drug, which is coming to you to at a below cost?

The CHAIRMAN. Microphone, please.

Dr. FREEMAN. Yes. In our state with Medicaid patients the revenue really is subbed out to a subcontractor. So we are paid only a filing fee on Medicaid patients. You know, it is a great benefit to our patients to give them lower-cost prescriptions.

Senator CASSIDY. Dr. Waits, Mr. Trompeter, do you all also pass those savings on to your clients?

Dr. WAITS. Absolutely. It is a crucial revenue stream to pass on the savings on the cost of medications to our uninsured patients from our in-house dispensaries.

Senator CASSIDY. If you bill insurance, do you similarly pass those savings on to the insurance company? I see, Mr. Trompeter, 16 percent of your patients are insured.

Mr. TROMPETER. 17 percent are uninsured, Senator Cassidy. We do pass those savings on to our patients. It is the tool that allows us to provide medications to our uninsured patients at a sliding scale discount.

Senator CASSIDY. Got you. Yes, but also to the insurance company? I am sorry. I got the wrong percentage, but a certain percent of your patients do have private commercial insurance, at least as

I was trying to figure out your statistics. Are those savings passed on to them as well?

Mr. TROMPETER. We normally do not use the 340b program for those patients.

Senator CASSIDY. Oh, really?

Mr. TROMPETER. Yes.

Senator CASSIDY. An honest man, so I just say most——

Mr. TROMPETER. Well and they will go to a commercial pharmacy. It is a very small portion of our patients.

Senator CASSIDY. Got it. Okay. Mr. Chair, thank you for deferring to me. I appreciate that. I yield back.

The CHAIRMAN. Thank you, Senator Cassidy, for your usual, well-informed questions.

Senator Murray.

Senator MURRAY. Thank you. And thank you to all of our witnesses—really appreciate again your testimony and being here today. It really seems to me that our community health centers are sort of the backbone of our country's primary care infrastructure. And Mr. Trompeter, you talked a little bit about it, but can you speak more broadly to the importance of the community health center grants and how they have supported your mission in strengthening communities in Washington and providing access to all?

Mr. TROMPETER. Sure. The grants, as I said, really are the fundamental support that we have for taking care particularly of the uninsured, but also the underinsured and for our whole program. They also help us provide services that are not covered by most insurances, including Medicaid and these include things like care coordination, social work, referral coordinator, interpretation services. There is a wide variety of sort of wrap-around services that, particularly the patients that we all take care of, really need in order for the medical and dental care that we provide to be effective.

Senator MURRAY. Okay, and can you describe for us the impact of the lapse in funding that occurred last year on your day-to-day operations and strategic planning? Just tell us what happened.

Mr. TROMPETER. Sure. We had a lot of conversation. It really did throw things into uncertainty, and like I said in my testimony it was particularly acute with our teaching health center folks who were really very nervous. Our faculty was also very nervous that we were going to have to renege on a promise that we made in order to help people complete their medical education. From a strategic planning standpoint, it made us just kind of step back and say we are not really ready to make certain kinds of expansion decisions or service depth decisions until we are more confident that we have actually got the support that we need in order to do these things. It created enough uncertainty that it was kind of like no way to run a business, and it really did make us slow down and reconsider things that we knew we needed to do in order to serve our communities.

Senator MURRAY. Thank you for that. Dr. Waits, thank you for being here. My home state has six teaching health centers, and I have really seen the importance of how they helped get physicians into rural communities as a result of those teaching centers. From your experience, talk a little bit about how training providers in

rural areas better prepare them to actually practice in those kinds of settings.

Dr. WAITS. Well, thank you. A rural area or an inner city underresourced clinic is challenging. I have been in practice in central Alabama for 15 years and it is very different when you are the doctor in the hospital or in the clinic, and maybe the only one that is on call for a weekend in a county of 25,000 people and your nearest consultant is an ambulance ride or a helicopter away, and that is often daunting for someone that has trained for a decade of their medical education in a university-based, city-based training program. The beauty of these teaching health centers that are situated in rural or urban community health centers is that it matches the training to the very needs that our society needs. And so a graduate of a teaching health center would not be deterred from practicing in a community health center environment, either rural or urban because they were not trained in that environment. So there is a degree of nervousness that is alleviated from choosing that job and that career path.

Senator MURRAY. Okay. Thank you. Dr. Anderson, thank you for your testimony. The National Health Service Corps is so important, providing loan repayments and scholarships, and I think I heard you in your testimony talk about how you yourself were helped by the National Health Service Corps. Can you describe how that got you involved and what it has meant for you?

Senator MURRAY. I—turn on your mic there.

Dr. ANDERSON. Thank you. I always had a heart to serve the underserved. When I signed my contract in 1997, I made a pledge to serve these communities. I graduated in the year 2000 from Brown University and I took an oath. I brought it with me today. It is scratched up and tattered, but it talks about my commitment to serve humanity regardless of their social standing, and the National Health Service Corps made it possible for me to serve to the truest letter of this promise that I made 22 years ago. I signed that contract eight years before I was even in the workforce and I came to Unity Health Care, as I mentioned. I served in a community health center, and I now teach in a teaching health center residency. Some of my residents are behind me today and I can say that I would send any one of my family members to those residents because I am confident that they have the skills and the passion to serve and to stand in the gap of what America's healthcare needs are today.

Senator MURRAY. Okay, thank you. Thank you very much. Thank you to all of our witnesses.

The CHAIRMAN. Thank you Senator Murray, and welcome to the residents of Dr. Anderson.

Senator Romney.

Senator ROMNEY. I am going to ask my first question to Mr. Trompeter, but then ask a question to all of you from Mr. Trompeter on down. First, I just wonder how you were able to make this patchwork of financial resources fill the gap when the Federal Government backed away. You said you had to scramble. Just what did you do? But then we let me turn with a second question for you and for the other Members of the panel, and this may be particularly attuned to you and also to Dr. Freeman, but that

is, to what extent is their involvement on the part of the state for the program that you administer, and what coordination is there between Federal and state dollars and direction? And is that a help? Is that a hindrance? I know that we on this side of the dais, and I mean on this side of the bench all the way around, sometimes we are overwhelmed with all the programs that exist—my guess is that you have to, not only deal with us but the states and counties and so forth. So what is the involvement of the state, and how coordinated is that with what is happening at the Federal level? But first, how did you make it work? How did you make that patchwork work when things fell through at the Federal level?

Mr. TROMPETER. Senator, fortunately, our grant period was outside the bubble of the cliff, when the cliff happened the last time around. Many of my colleagues were not in that position. Nonetheless, we were still very nervous about whether the cliff would actually get fixed until it actually did get fixed. And there is a certain amount of faith that all of us have got to have in order to do this work. And frankly, this Committee is one of the reasons we get to have that faith because this Committee has done such a good job of working in a bipartisan way to make sure that the folks that we take care of are getting taken care of. So personally, I had faith and I was by hook or by crook, we are not going to close our doors. We are going to make sure that they stay open.

Like I said earlier, I think it was—the conversations were the most involved with the folks who were relying on us for their medical education because they are new in the world here and they are still uncertain about who is going to fulfill their promise and how that is going to happen. And when they hear all of the news and the talk around that cliff, you made them very nervous. So I spent a lot of time calming people down, which kind of goes with the territory. So we made it, but that way. And I do know that some of the examples that Senator Murray spoke to early on are very close to us. I know those folks and I know that they went through them. I know that bank loans were denied. I know that bank loans were put on hold. I know that expansions were delayed and I know that providers who were looking to come to work in some of those health centers decided to go to work elsewhere because they read the news and they did not understand whether they were going to have a secure job.

The recruitment cycle for physicians particularly is long, and if people are uncertain, it creates not just an immediate problem but a problem further on down the road. So I just want to emphasize that this was no small thing that we faced there. With regard to the answer for the state, we are fortunate to live in a—I am fortunate and Senator Murray is fortunate to live in a state with a really great state government and a really great health care approach. And we are well coordinated with the state. We do not get state grant dollars. So the coordination that we do with the state is really through the Medicaid program. But yes, I think we have had the good fortune of working with folks in our state both at the governor's office, and the legislature on both sides of the aisle, and with the healthcare authority, who understand the work that we do and really try to be additive to that work rather than duplicative.

Dr. ANDERSON. I would say that any degree of uncertainty in any of these programs causes a ripple effect. I would say from the perspective of the National Health Service Corps, especially for loan repayment extenders—so the way the program works is you get a certain lump sum the first two years, but then you have the option to continue to extend it as long as you have a loan balance. And so, this creates stability within the community when your patients have the same doctor that they come to for years and years. I am fortunate to have taken care of multiple generations of patients. Some patients I saw for their school physicals, and now I am taking care of their children 15 years later. So the importance of the funding cannot be emphasized enough. That in order to capture the talent, the providers, the medical students, to interest them to stay in these communities, we need consistent sustained funding, especially for the residents. Funding that will cover their entire residency and not be renewed every day every two years. So we thank you for your support in keeping this funding stable.

The CHAIRMAN. I am afraid the five minutes has expired. Maybe the two of you will have a chance to answer Senator Romney's question a little later.

Senator Casey.

Senator CASEY. Mr. Chairman, thank you very much. I want to thank you and the Ranking Member for the legislation that you have—I guess it is Senate Bill 192—and the work you have done. Dr. Anderson, I will direct my questions to you principally. I wanted to ask you about teaching health centers generally, but in particular, to use by way of example as a—I guess a predicate for my question. We are joined today by individuals from my hometown of Scranton who are here from the Wright Center, Dr. Thomas Hemak and two residents here with this on this side of the room—I am sorry, that side of the room. And the Wright Center in Scranton is well known as both, a community health center and a teaching health center. They have been able to respond to and serve the specific needs of that particular community. They have programs to assist patients with addiction, with pain management, and also with counseling, to help patients adhere to their medication program. So my first question to you is, can you discuss how teaching health centers are able to both adapt their programs to meet those unique needs of a community, and also how they are able to train residents to respond to those particular needs? I know some of this you may have provided by way of your testimony, which I was not here for, at least the oral version of the testimony.

Dr. ANDERSON. Yes. Thank you. The teaching health center program is incredibly important to train the next generation of physicians who are interested and willing to stay in these types of communities. Actually, the program that I teach is also a part of the Wright Center. It is the National Family Medicine Residency Program. It is a consortium model that happens in four sites throughout the country including a HealthPoint. So these residents have signed on to train in the community health centers. And even in our current graduating class alone, there are seven graduates coming out, five have signed contracts to stay at our center. So this shows that this is a pipeline where students are willing to stay in these communities, and I would agree this is a skill set that is

learned. It is incredibly daunting for a physician who has trained in a site where they do not have any type of experience with patients or underserved patients who do not have insurance, patients who might speak another language, patients who have an addiction or mental health challenges, or any of these things that we deal with every day in the community health center. So by training these residents in these settings, they are more likely to stay in these settings afterward.

Senator CASEY. Do you have, in particular, any specific examples of models or good examples for us to follow?

Dr. ANDERSON. Training models?

Senator CASEY. Right.

Dr. ANDERSON. For example, our site employees group visits. Now this is a very important innovation where instead of me telling each individual person one after the other about healthy eating for example or weight loss, we can combine the patients together in a group of 10 or 12 and the residents can be part of that, thus employing the expertise of the medical professional and the collective wisdom of the group. So for example, if I say, hey, everyone has to eat more vegetables, and one of the other patients might say, oh I tried it and look I have lost 10 pounds, and then the other patient says, oh, yes, and these vegetables are on sale this week at Safeway, and the other patient says, oh, yes, let's all go afterwards.

[Laughter.]

Dr. ANDERSON. You know, that kind of community model is what these centers are invested in. It is said that once you see one community health center, you see one community health center because we are trained to respond to the individual needs of those patients and be flexible in adapting our training to the needs that the patients are exhibiting at that time.

Senator CASEY. Dr. Waits, anything on this that you would want to add?

Dr. WAITS. Yes. Thank you for the question. I would just add that the Teaching Health Center Program itself is an innovation. You know, as we have alluded to, it is such an accountable program. It has such transparent outcomes of—it is targeting the training to the exact location where the workforce need is the greatest in our community health centers. We have got great outcomes of graduates staying with the program, being comfortable in taking care of patients in the program, and it is a transparent program where you can see those outcomes. And I think that is innovation itself, and it is a reproducible model. That looking at this reauthorization, there could be more teaching health centers to do what we all have done.

Senator CASEY. Before I wrap up and you can answer it more fully in a written form, but as you know, we have had—recent events have proved we are really good at stopping, starting government. The Congress now has expertise in short term, really short-term government. And one of the problems here is of course the authorization period. We have had a lot of examples of two-year authorization periods, so maybe, for a fuller written version—I will just present the question now, you can answer in writing—but the positive impact, which I will assume, of a five-year authorization,

reauthorization as opposed to the shorter term. So I will leave that for the record. Thanks to Chairman.

The CHAIRMAN. Thank you, Senator Casey.

Senator Murkowski.

Senator MURKOWSKI. Thank you. Mr. Chairman, and I want to thank you and the Ranking Member for your introduction of this package that focuses on our community health centers, and the training, and our National Health Service Corps. My colleagues here on the Committee know very well that when I ask, questions are always very Alaska centric because I listened with great, almost envy, that we have these opportunities for some training facilities, the teaching health centers, the opportunities to really work to build this is workforce of professionals, but we struggle in Alaska to be able to attract those good folks that you are training up, whether they are in Alabama or whether they are in Tennessee, wherever they may be, we would like to have them up north——

[Laughter.]

Senator MURKOWSKI.——and we don't have our own medical school and that is not going to happen anytime soon. And so you point to a real reality, Dr. Waits, that when you have somebody who has been trained and in perhaps a more urban setting and when they get the Alaska bug and they decide they want to have this great adventure up there, they get into a setting where they are it. They don't have any support that you have mentioned, Dr. Anderson, and it is not that they are an ambulance away or an airlift there. They are hours, perhaps even days, from being able to be with anybody else that can help them with this particular issue. So you really have to be an independent individual. So I am recruiting for independent, smart people——

[Laughter.]

Senator MURKOWSKI.——who really want to practice medicine.

Dr. FREEMAN. You will be pleased to know Senator, we lost a really good physician who moved to Alaska.

[Laughter.]

Senator MURKOWSKI. Loving it. Thank you. Thank you, we will keep them coming, but my question to you and the challenge is, what more can we be doing? We have looked at National Health Service Corps as an opportunity to again be able to attract those individuals into these medically underserved areas. Is there more partnering that we can do—we do a lot of partnering obviously with the State of Washington, our closest neighbor with some of the training and the residencies—but what more can we do? What more can you offer us in these very remote, often frontier practice areas? And I throw that out to any one of you. I am looking for good ideas, help me.

Dr. ANDERSON. I would go back to the as you know, we are asking for a doubling of funding for the National Health Service Corps, and even if we could have a tripling of funding because right now we are only able to fund 10 percent of the scholarship applicants and have less than half of the loan repayment applicants——

Senator MURKOWSKI. 10 percent of scholarship applicants?

Dr. ANDERSON. Right. And had less than half of the loan repairs. So there might be great people who want to go back to Alaska but

they don't get the scholarship that year, or they don't get the loan repayment, and what cannot be underemphasized is that these health professional shortage areas, the money goes to the highest need and then it trickles down until the funding runs out. That doesn't mean that the numbers at the bottom of the list don't have need——

Senator MURKOWSKI. Right.

Dr. ANDERSON.——they do but we cannot fund them. And so those areas go—the needs go unmet. And I just want to emphasize the recruitment tool of having a provider, let us say from Alaska, who grows up in Alaska, sees a doctor who is from Alaska come back to Alaska—that is inspirational for a young boy, a young girl who is thinking, you know what, I can be a doctor too, I can do this too. I can come back and serve my community, and there is a way for them to do it.

Senator MURKOWSKI. Other ideas?

Dr. Waits.

Dr. WAITS. I would just add additionally from the educational standpoint, in terms of the reproducibility of the teaching health center model, this legislation, the Alexander-Murray legislation and the Collins-Jones legislation, goes a long way. This five-year reauthorization is so critical. So if we were going to set up a teaching health center in Alaska, the organization itself would need to know if we take the two or three years to get accredited as a teaching institution and then we start recruiting first, second, third year medical students. Well, we have used that five-year reauthorization building the program and looking at medical students and convincing them to come train with us. And so the stability, the permanence, and the growth of this program, that again is so accountable, has such good outcomes. I think that is one of your key models right there. It could be done if there was stability for that funding.

Dr. FREEMAN. Here is a suggestion. You know, with the National Health Service Corps, great program, life-changing for people who receive it but when we are recruiting providers, we cannot promise them that they are going to receive it. You know, we can tell them about it. They can apply, but if Alaska health centers had slots and your providers could say this is loan repayment. This is part of the deal. You know, I think that would really help in the recruitment there. I have been of your health centers. We have done consulting. I have been in Talkeetna. I have been in the Kenai Peninsula. Wonderful places, wonderful providers. You can get them there. I think you can keep them there. But if they could use the core as a certain recruitment tool, I think that would really help recruit providers.

Senator MURKOWSKI. Thank you.

Mr. Chairman.

The CHAIRMAN. Thank you, Senator Murkowski. Senator Hassan.

Senator HASSAN. Thank you, Mr. Chairman and Ranking Member Murray for holding this hearing. And thank you to all the witnesses for being here, but also for all that you do to help people throughout our country.

I think there is a question for each of you. As I am sure you all know, we are experiencing a significant healthcare workforce short-

age, particularly when it comes to the behavioral health workforce in my home State of New Hampshire. Communities are especially in need of help to fill shortage of behavioral health. Professionals community health centers in New Hampshire have played a key role in addressing the deadly fentanyl, heroin, and Opioid Crisis that has devastated our communities, and they have done it in part by incorporating medication-assisted treatment into each of the eleven health centers in our state. Last Congress I worked with Democrats and Republicans on this Committee to help pass the Support Act, which included a provision I helped to introduce, to expand access to substance use disorder services by taking steps to increase the number of behavioral health professionals who can provide those services. It is an important step, but we obviously have a lot more to do.

Maybe starting with you, Dr. Freeman, I am interested in hearing from all of you about how additional funding for community health centers could be used to address the need for behavioral health services and professionals, particularly in those states hardest hit by the Opioid epidemic?

Dr. FREEMAN. It is interesting—we trained behavioral health professionals typically in behavioral health settings——

Senator HASSAN. Right.

Dr. FREEMAN. They generally then go to work in behavioral health settings. The primary point of access though, for folks who have behavioral health needs, are in primary care.

Senator HASSAN. Right.

Dr. FREEMAN. If we did more training, a behaviorist within primary care settings—many, many more would stay in those settings——

Senator HASSAN. Yes.

Dr. FREEMAN.——and the efficiency of practice would be much greater than if they were in isolated behavioral health silos. There are a few programs that are kind of like the Teaching Health Center Program. There is a Graduate Psychology Education Program. It really trains—psychologists, who work in primary care settings—the AHEC program is another model—where we could get more behavioral health training and primary care psychology internships. You know, any of these models where we train—I have got some data in my written testimony that shows kind of when we train interns or fellows in psychology at Cherokee, we retain a high percentage of them and I would to see those programs expand to community health centers.

Senator HASSAN. Thank you. Does anybody else quickly want to add anything to that?

Dr. ANDERSON. I can add as a provider, as a family physician, in a community health center. It is invaluable to my practice to have a mental health provider working alongside me. About 10 years ago in our clinic, we abolish the mental health department and we co-located those providers along with the primary care. This takes off the stigma for someone to have to go to mental health department and we teach our patients their brain is a part of their body. So it is the same kind of illness and we are here to help them take care of their total health. And so it is invaluable if the patient gets up the courage to reveal depression, to reveal an

addiction, to their primary care provider, I can say, you know what, thank you for telling me that. I want to help you with that. Here is my colleague right down the hall and I can walk you down the hall and do what we call a warm handoff.

Senator HASSAN. Right.

Dr. ANDERSON.——here, we are going to help you together and the patient feels taken care of as a member of the team. So it is not just me as the physician caring for the patient. It is the entire brevity of the healthcare staff.

Senator HASSAN. Thank you.

Mr. Trompeter.

Mr. TROMPETER. Senator, I would simply add to what my two colleagues have said, we train postdoc psychologists and it is the kind of thing that we are able to do when we have a stable base to work from.

Senator HASSAN. Yes.

Mr. TROMPETER. The first thing you could do is fund the health centers, and then I think additional resources would be great. But the first thing is to make sure we are working on a stable base.

Senator HASSAN. Thank you. And Dr. Waits, did you have anything to add?

Dr. WAITS. Just echoing that point—the stability is important. This is something that we are training our residents to do as well. And so as we begin to co-locate behavioral health and primary care, reducing that stigma, taking care of addiction and depression, and these sorts of things. Just a reduction in sometimes the regulatory burden of reporting—are you a mental health facility? Are you primary care facility? We are bringing down these barriers and so that can be an important point as well.

Senator HASSAN. Thank you. I think you are all echoing the need for the right treatment, at the right place, at the right time. And so I appreciate it. You all anticipated my second question, which was about the need for stability for the program and funding, so thank you for touching on that as well.

Thank you. Mr. Chair.

The CHAIRMAN. Thank you Senator Hassan.

Senator Braun.

Senator BRAUN. Thank you. First of all, it is a real pleasure to be on this Committee. I told you that in my own backyard of Southern Indiana, health care delivery through my own company has been a challenge in a taken on the effort and mantle to try to do the best we can through employer-provided insurance, and have really been looking into different ways to make this more effective. I was in Indiana last week and spoke to the folks that—they have 196 health center delivery sites there and was surprised the voids that they were filling in to provide services in underserved areas. In all my discussions on this and anything else, it is such a complicated dynamic where health care delivery is going in his country. You know, it is way too large percentage of our GDP.

It has got to be more effective. You got to cover pre-existing conditions and no cap on coverage, generally speaking, and you got to fill the voids that are in many places. You had mentioned, and I am going to be interested in revenue sources, if you could whoever feels comfortable with it, describe—you mentioned patient serv-

ices—and tell me how much revenue you generate, and you don't have to get detailed but generally, from folks that are not availing themselves of something that would be supplemented through government? Patient services—somebody referred to that earlier in terms of what component that is. Anyone that feels comfortable with it?

Dr. FREEMAN. Let me tell you a little bit about how our revenue comes. We are a $60 million company.

Senator BRAUN. Yes.

Dr. FREEMAN. You know, we get a Federal grant of a little bit over $8 million. So, 13.5 percent of our revenue comes from our HRSA grant. We get a few other Federal grants, but the bulk of the revenue comes from patient services. You know, 30 percent of our patients are uninsured. You know, our minimum fee for those patients is $30—$20, I am sorry. We sometimes collect that. If we have homeless folks, we don't charge any fee at all. 40 percent of our patients are Medicaid. Medicaid is our best payer. There is some Federal regulation that helps support—a special rate for us to get basically a cost base rate with Medicaid. About 15 percent of our patients are commercially insured. We negotiate those contracts as best we can, and about 15 percent are Medicare. With almost all of our contracts now, we have value-based provisions—so that if we show good clinical outcomes, if we can reduce the total cost of care, we will sometimes earn bonus dollars from the insurer.

Senator BRAUN. To tally that up. It was roughly 83 percent. Do you get some folks that just come in and pay a fee because they are not income constrained but need the service because it is in an underserved area?

Dr. FREEMAN. We do—we get some full fee patients. Yes. Yes, but it's 40 percent Medicaid, 30 percent uninsured, 15 and 15, I think 100 percent, right——

Senator BRAUN. Of the 13.5 percent were the grant source, and that is going towards uninsured. So what makes up the difference between the 13.5 percent and the 30 percent that is uninsured? How do you fill that gap?

Dr. FREEMAN. Of the payer base—I gave you that break down which is 100 percent of how those patients are classified. The Federal grant, basically, underwrites the sliding fee scale discounts.

Senator BRAUN. Okay, very good, I get that. One other question on recruiting, I understand how we are getting residents and doctors into the system. What do you do with other staff? How hard is it to staff locations outside of the doctor or resident? Is that tougher? Is it easy to staff?

Dr. FREEMAN. Go ahead.

Dr. WAITS. It is tough as well. And we have, I think, each of us in our own way. For example, we have created a medical assistant orientation program where we start with the high school health professions courses, where they volunteer some of their time and take coursework, and we work with them in the sciences and in the health professions education. And some of them stay on. And typically, their first six months, to sometimes a year or two, it takes to take to train them to be able to assist the providers, and it is difficult to staff each of the positions.

Senator BRAUN. Thank you.

The CHAIRMAN. Thank you, Senator Braun.

Senator Jones.

Senator JONES. Thank You, Mr. Chairman. And Mr. Chairman, I would like to submit two statements for the record. First is a statement from the American Academy of Family Physicians in support of the Teaching Health Center Graduate Medical Education Program, the National Health Service Corps Program, and the Community Health Center Program. The second is a statement from the American Osteopathic Association, the American College of Osteopathic Family Physicians, the American College of Osteopathic Internist, the American College of Osteopathic OBGYNs—surreal osteopathic class for sure.

[Laughter.]

Senator JONES. The American College of Osteopathic Neurologists and Psychiatrists, and the American College of Osteopathic Pediatricians in support of the Teaching Health Center Graduate Medical Education Program.

[The following information can be found on pages 53 and 59 in the Additional Materials:]

The CHAIRMAN. Order.

Senator JONES. Thank you. Mr. Chairman. Dr. Waits, thank you so much for being here again. I really appreciate it, and I have been so impressed with what you have been able to do in Alabama. And we have still got a long way to go, particularly in our rural areas in underserved areas. I particularly want to thank you for mentioning the bill that Senator Collins and Tester and Capito and I will be introducing, the Training The Next Generation Of Primary Care Doctors Act of 2019, which will increase the authorization for the Training Health Center Graduate Medical Education Program and reauthorize it for five years, and I would like to ask you about that a little bit. I would like for you, if you would, just to explain to the Committee a little bit more about how your teaching health center could benefit from an increase in funds over the next five years. How do you use those funds to help folks in the areas in Alabama, would you expand? And how the bill would allow for the creation of new teaching health centers throughout the area, because Alabama is certainly one of those states that is beginning to suffer from a drain of physicians and a drain of health centers in our rural areas. So I will just give you the floor for a little bit.

Dr. WAITS. Well, thanks. So the increase in your debt legislation would be critical. There is rising cost of inflation for our centers, for our residents, for the Residency Education Program, all costs go up. And so this rising a little bit over the course of the five years is critical for our bottom line and for us to run a good non-profit business and educational center. In terms of the five-year authorization, it is so critical. We are persuading medical students to follow through on their dream. Often in the application to medical school you write a personal statement saying that you want to go to an underserved area, you want to take care of the least of these, and we feel like we get to wake up every day and live out the dream that we wrote in our medical school personal statements. As you get to the end of medical school, as in the third or fourth year, you find yourself with often on average $200,000-$250,000 in debt.

And if you look at training in a program that may not have funding for two more years and you may find yourself in the middle of a training program without funding, it becomes daunting when you think about your family and your career. So that is just speaking to the fact that the five-year reauthorization is so critical. And then, was there another question that you had——

Senator JONES. I think you covered most of that. I am assuming that you would consider expanding, much like you did in Maplesville, to help folks down in those areas. If we can get this reauthorized for five years?

Dr. WAITS. Right. And you know the last the last teaching health center that was funded with 2014 and we have heard from the Senator from Alaska, and there are many places in Alabama that could open a teaching health center. It is such a reproducible model. The new funding for new centers is really something that could speak to the health workforce crisis that we have in this country.

Senator JONES. Just out of curiosity, do you assume, even though it is primary care, you probably still see a lot of women who come in who are pregnant who are having babies and there is a need for that in those rural areas. Would that be correct?

Dr. WAITS. That is right.

Senator JONES. You handle that as well those centers?

Dr. WAITS. That is right. Among our 54 healthcare providers, seven of us are family doctors who deliver babies. In our center, we have three different labor and deliveries that we help staff, one of them rural, and so it is definitely a part of family medicine, especially underserved rural family medicine—delivering babies, taking care of women and children.

Senator JONES. Well, we are going to be looking at some legislation dealing with that, too. So thank you very much again for being here. Thank you all for being here, by the way. Thank you very much. Thank you.

The CHAIRMAN. Thank you, Senator Jones. Let me pose a question to all of you, in our hearings on reducing health care costs last year, as I mentioned, the uniform testimony was as much as one half of healthcare spending in the United States is unnecessary. And Senator Murray and I, Senator Grassley and Wyden sat down recently and I said look, if that is even close to true given the positions we have here, we ought to be able to agree on something to help reduce the cost of healthcare, which is an enormous tax on family's budgets, states, Federal Government. And one of the obvious ways into that seems to be through primary care, because while primary healthcare is only 2 points to 7 percent of the total spending the access, the access that most of us have to healthcare is through our primary healthcare doctors, which includes many of the people who are part of your part of your systems.

One of the things we hear most frequently is that well we need more transparency. If people just knew what the prices were of everything, prices would go down. Well, I wonder about that because most people who are sick or who are busy, get a bunch of information about healthcare and they are not likely in a very good position to do anything about it. Others might say, well if this hip replacement costs more, it might be like going to Harvard, if it costs more, it is a better place to go and so they don't go for the lower

price. Again, the primary healthcare doctor is a person who might help if you want to use a Papa John's Pizza analogy, looking for better outcomes, better experience, lower cost, your primary healthcare doctor should be the person who might be able to help you do that. So, let me ask you based on your experience. What could we do to remove barriers or create incentives so the primary healthcare doctors throughout our country, so the 300,000, I am including those at your centers, can help us help patients, get better outcomes, better experience, but at a lower cost? Doctor Freeman.

Dr. FREEMAN. Yes, I know the data is really clear. You know, the systems in other countries that stress utilization of primary care have lower costs. Australia is a good example—it is often written about. There is really good data to show that health centers are cost-effective. There is published data that health centers are cheaper than other primary care system.

The CHAIRMAN. A lot of that is, as Dr. Anderson was saying, eat your vegetables type of advice as a primary care doctor. Dr. Roizen at the Cleveland Clinic will tell you that 80 percent of the costs of chronic conditions has to do with wellness.

Dr. FREEMAN. Certainly, the patient is the most important person in the primary care team, so getting patient engagement in their care and really helping.

The CHAIRMAN. But what can we do in Congress to remove barriers or create incentives that would make the primary care doctor more effective in creating better outcome, better experience, lower costs? What specifically can we do? Any of you.

Mr. TROMPETER. Senator, I would urge you to support the models that we already know work.

The CHAIRMAN. Such as?

Mr. TROMPETER. Teaching Health Centers, Community Health Center Program, the National Service Corps. If we are to build——

The CHAIRMAN. You cannot think of anything that we could be doing?

Mr. TROMPETER. I would expand on it.

The CHAIRMAN. Just more of what we are doing?

Mr. TROMPETER. Double down on it.

The CHAIRMAN. Yes.

Mr. TROMPETER. We know that this works. We know that we don't have enough primary care in this country. It is true that most people with what we would normally consider regular insurance, get access to care through their primary care physician. It is also true that a lot of folks who are underserved don't have access to a primary care physician, unless they are coming to a health center and they get their care through an emergency room. And that is more expensive in the system and less effective for health. We also know that the health centers help people address, what Dr. Anderson termed the social determinants of health. This has to do with what you spoke about, diet, exercise, and things like that, which are harder to come by and underserved communities. So I think if we really want to start bending the cost curve, we in that portion of the primary care system that is really shown to be effective in helping bend that curve and in the communities that probably need it most.

The CHAIRMAN. Okay. I have got another 40 seconds.

Dr. FREEMAN. I am not sure what the mechanism is, but anyway that you can help get healthcare data to the primary care provider. You know, when we start getting information on our patients from insurance companies, we are shocked about the doctor hopping that is going on—the referrals out to specialists that we don't know anything about.

The CHAIRMAN. Well, that is something we can do. And one of the problems I have had my own mind is if we make that data available, generally many people don't know what to do with it.

Dr. FREEMAN. Yes.

The CHAIRMAN. Primary care doctors should know what to do with it.

Dr. FREEMAN. They should and what has to happen is—it is very complicated and so really healthcare systems really have to have data analytics. You know, so we modified our electronic health record so that when a chart is open on a primary care patient, our primary care provider can see was that patient in the hospital—where they recently in the emergency room—what other kinds of claims, information, do we have from the insurer? So I think first data has to flow from the payer to the system, and then there has to be some massaging of that data so it comes to the providers at the point of care. They say they see what their patient has had and what their patient needs.

The CHAIRMAN. Thank you very much. Senator Smith—Senator Rosen, excuse me, Senator Rosen.

Senator ROSEN. Thank you. Thank you Chairman Alexander. Thank you. Thank you. I appreciate that. And I thank you Ranking Member Murray, I want to tell you how thrilled I am to be part of this Committee and excited for our first hearing and I really appreciate everything that you have done for your patients, for your communities, and for this Nation, it really makes a huge difference.

I want to tell—I am from Nevada, my home state. We ranked 48th in the nation in terms of primary care physicians per capita, but community health centers have made a tremendous contribution for us, not only in our low income population, but also in our rural and underserved communities in Nevada, and we serve over 93,000 patients each year, including more than 29,000 children. So I am really deeply concerned about the pending primary healthcare cliff and its impact on Nevada and across our Nation. I know we have talked a lot about what we can do, the funding, how much more robust we can make it, how you can plan a long-term strategic planning, and funding really makes a difference for people and removing that uncertainty. But I want to go in just a little bit different way to expand on what I like to think of as our people pipeline. So, of course you have the physician, my husband is a physician, and so that is one kind of provider. There is nurses, there is a respiratory tax. There is people who wrap your arm if you break it——

[Laughter.]

Senator ROSEN. But across the medical spectrum, there are a variety of jobs from A to Z. No one-job being more important than the other—a person who draws your blood as important as the person who does the surgery, you need it all. So you have these wonderful models of the community health centers, the teaching health cen-

ters and in underserved communities that often have issues with people getting good paying jobs that are going to last or being able to get trained for that. So, how can we expand on this with some of our funding or do you think that would be a good thing to do to grow that people pipeline? Like you said, right from the community, giving those jobs across the across the medical spectrum. How can we help you do that, if you think that is a viable way to grow on these healthcare teaching centers?

Dr. ANDERSON. I can say as a provider that in your state there were 83 National Health Service Corps placements last year. These providers are working in team-based models. In our Center, we employ the patient-centered medical home model, meaning that when the patient comes in they always have the same person that registered them, the same doc, the same MA, the same this, the same that. They develop a familiarity with that team. Many times the patient might reveal something to my MA that they don't tell me. It is part of the whole team based model. So I think investing in all of those levels of the team makes the center be solvent and makes for better healthcare outcomes. Actually touching on what Senator Alexander had mentioned, funding the community health centers funds proven success because the community health centers have to report everything. We have to account for every dollar. We have to account for healthcare outcomes. We have to look at how are we doing with diabetes? How are we doing with blood pressure? How are we doing with this and with that, and make changes that tweak even to the very point, one or point two of the hemoglobin A1C, for example, for diabetes.

Senator ROSEN. Right.

Dr. ANDERSON. Funding those models actually does result in positive healthcare outcome. And what you said, it is a pipeline for people in the community to see—I become an MA. I can become a nurse. We have this all the time in the center. They grow, they go to med-school, they come back to serve the same community. And so it is a great cycle to invest in.

Senator ROSEN. Thank you. I have one other question and you were talking about sharing of electronic health records and all of that information and course you are serving rural communities, so we have the issue of course of rural broadband across this Nation, and how that is going to impact your ability to get data across platforms in, I guess we will say a speedy fashion, or any fashion at all if you will. And so do you think that an investment in rural broadband in telemedicine would help amplify the ability of your community health centers and teaching health centers to provide better and more access to specialized care if necessary, or care in general?

Dr. WAITS. It is absolutely critical for our electronic medical records—they are often in the cloud. And so you need any broadband just to access the patient's charts. We are sending X-rays and other secure encrypted images of patients broken bones and other images, so it is critical and the USDA—there are some USDA programs that help with some rural broadband, but definitely that level of investment would help, not only the hospitals and the community health centers in rural areas, but the education systems as well.

Senator ROSEN. Thank you.

The CHAIRMAN. Thank you, Senator Rosen.

Senator Warren.

Senator WARREN. Thank you. Mr. Chairman. Community health centers provide essential services to our communities, but they need Federal funding to do their work and they need that funding to be predictable and sustainable. So exactly one year ago right now, community health centers across the country were running out of funding because Congress failed to reauthorize critical programs before they expired—some of you may remember that. For four uncertain months until Congress finally acted in February of 2018, health centers and their patients were in limbo. They held back on hiring new people, on replacement staff. They deferred opportunities to make vital improvements in their programs. And while most funding directed to health centers was still flowing during the government shutdown that ended last week, other vital funding sources that patients rely on were cut off.

The next primary care cliff is only eight months away. So today I wanted to dig into the impact of unpredictable funding streams on the patients who are served by health centers. Mr. Trompeter, your health center has several sites in Washington State. Do many of your patients rely on federal food and nutrition programs like SNAP and WIC, or Federal housing vouchers all programs that were affected by the recent government shutdown?

Mr. TROMPETER. They do.

Senator WARREN. How did your patients deal with the uncertainty caused by the 35-day shut down?

Mr. TROMPETER. Senator, we have seen an increase in anxiety amongst our patients. Most of this is anecdotal at this juncture, but we have queried our front desk who are usually the folks who get told this stuff first, and we do know that a lot of our patients, particularly those that rely on benefits like SNAP and WIC, have been worried about whether or not they were going to have the nutrition that they needed in order to follow that advice of their doctors. I am also aware of two patients, and this is small-scale stuff, but who made what we might consider short-term smart financial decisions, maybe not so much in the long term. One of our patients just decided that he was going to stop paying his bills for a while.

If you don't pay your rent, sometimes you don't have a house. Another patient decided that he would just use his credit card in the meantime, and we have tried to counsel these folks, but in the face of the kind of uncertainty that they were facing, it is really kind of futile.

Senator WARREN. Yes. I understand. These are people who don't have a lot of financial alternatives. Now, health centers also saw other impacts. In Massachusetts, on Cape Cod, one health center was not able to pay the bills on a critical facility replacement projects because they were no longer receiving funding allotted for the projects from the U.S. Department of Agriculture. The shutdown also had indirect effects on health centers in the DC area. Dr. Anderson many of your patients livelihood depends on Federal Government functioning, with some family members of your staff as Federal employees. What impact did the shutdown have on your patients and staff?

Dr. ANDERSON. Thank you, Senator Warren. I can definitely say that anecdotally the shutdown did have an effect on both staff and patients. Many staff members are married to Federal workers who rely on that two-income household to live in the Washington, D.C. area and pay their bills, but I would say also for our patients, many of them rely on the foot traffic generated by the Federal workers. So for example, I might not be seeing the actual Federal worker, but I am seeing the person they buy coffee from. I am seeing the person they stop and get a hot dog from on the way in, or the person that maybe that is a shoeshine guy or, there is the person that delivers food to the to the corporate boardroom meeting those are the unseen patients that we see and we give dignity to at the health center level. And for so many of Americans, as we all know, that live from paycheck to paycheck and don't have an emergency plan, there was definitely a huge impact and a lot of anxiety in our patients when that type of supplemental income was not was not guaranteed.

Senator WARREN. Thank you. Dr. Anderson. I appreciate that and I am sure everyone has stories around this. You know, while President Trump demanded a border wall and Republicans let him hold our government hostage, American families were struggling to make ends meet. I am glad that the government is open again, but we cannot do this again in two and a half weeks when the next deadline comes. And whether it is due to a shutdown or because Federal programs aren't reauthorized until months after funding expires, we cannot keep putting our community health centers and their patients in these uncertain and unsustainable positions. I am glad that Chairman Alexander and Ranking Member Murray have proposed a five-year extension of primary care programs so that health centers have more certainty and predictability. Patients are depending on us to make sure that they have consistent access to care.

Thank you. Mr. Chairman.

The CHAIRMAN. Thank you, Senator Warren.

Senator Murray do you have any other comments?

Senator MURRAY. No, thank you again. Mr. Chairman, for this hearing and for working with us on this bipartisan legislation. I think we have heard today how critical this certainty is, and hopefully we can move this long get it through. And thank you again to all of our folks who are here today testifying.

The CHAIRMAN. Senator Romney, I think you get the attendance award for today coming early.

[Laughter.]

The CHAIRMAN. Do you have any other comments you would like to make?

Senator ROMNEY. Let me ask one closing question, that is I am astonished by the idea that 50 percent of healthcare cost might be unnecessary, but I am curious as to whether you and your positions see that kind of unnecessary health care costs or expenditure. And if not—and my guess is you are going to tell me everything you do is entirely necessary—if not, where do you think that kind of excess lies and why it might exist in our system today?

Dr. WAITS. You are right in anticipating that we would not say 50 percent of our healthcare is unnecessary. But this is the commu-

nity health center program and the other programs is a proven model. And let me make it granular from a patient care standpoint. You know, when a community health center opens up in a community, we often find dozens if not hundreds of patients who have gone a decade without getting a pap smear or taking care of their diabetes, and often what comes to the floor is 20 years of undiagnosed diabetes or, God forbid, a cancer case and all of that could have been prevented by preventative care. That is why we recommended, not meaning to be self-serving, but doubling down on this type of program. Across the world primary care has been proven as reducing health care costs as well as enhancing access and enhancing quality of care. Having a patient center medical home, having a primary care physician as your healthcare quarterback, can help reduce unnecessary referrals. So if someone is in a rural area without a reliable primary care physician and they are commuting to different big cities, different emergency rooms, getting unnecessary scans, and no one person is advising them that we need to do this, you have already had this done, this is how community health centers primary care physicians and interdisciplinary teams can really make a dent in the healthcare costs.

The CHAIRMAN. Thank you. Well thanks to the all four of you and Senator Romney. I was startled to when that testimony came from people who are affiliated with the National Academy of Medicine about the estimate of as much as 50 percent unnecessary, now I am not saying wasted, just saying unnecessary. I asked all the other witnesses if they agreed with that and they all did. They thought 30 to 50 percent was. And so we began to ask for suggestions for what to do that might create better outcomes, better experiences, and lower cost, and obviously empowering primary care doctors to be more effective in what they are able to do is one obvious way to do that. So, Dr. Freeman has suggested better access to data. The witnesses from Cleveland Clinic suggested tying employer healthcare to wellness so that more people eat vegetables, keep their weight under control, do other things that are proven to lower costs. So we are looking for specific steps we can take to remove barriers, create incentives, to do that. You have been very helpful. If you have further suggestions, we would like to have them in writing.

I want to thank Senator Murray for working, as she so often does, in effective and bipartisan way to get ahead of the game here introducing five-year legislation so there can be some resolution of funding for our primary care community health centers. So, you can plan ahead and do the things that you did, so your testimony today will be very——

[Laughter.]

Mr. CHAIRMAN. I spoke too long.

[Laughter.]

Senator KAINE. Mr. Chairman, I yield my time back to you——

Mr. CHAIRMAN. No, I just gave Senator Romney the attendance award for staying the whole time. But you are welcome to have five minutes of questions if you would like to do that, Senator Kaine, and then we will conclude the hearing.

Senator KAINE. Well, let me just jump in and I apologize for being late because of an Armed Services hearing, but what I am

most interested in and you all have a wonderful perspective on it, and I am sure you have talked a good bit about it already is making sure we have an adequate healthcare workforce, especially in rural Virginia. We have had real challenges and obviously as part of the Higher Education Act reauthorization will do will have an opportunity to deal with programs like public service loan forgiveness that could impact upon rural workforce. But I think, is it Dr. Freeman, your work is in Tennessee and touches on Virginia, correct?

Dr. FREEMAN. Right.

Senator KAINE. Talk to me a little bit about some of the workforce challenges that you guys grapple with and how you deal with them in rural Tennessee and Virginia.

Dr. FREEMAN. I think what we found—is training is the best recruitment. So, whenever we can get different health professionals into our place and train—so we train a lot of psychologists. We train social workers. We train nurse practitioners, we train nurses and then we are able to keep many of those. You know, we have looked wistfully at the teaching health center program and if it had more stability in funding longer-term, that is something else we might do. But I think training within our workforce, if you look at people who enter the health professions—they come in there because they want to help. You know, they want to help other people and there is often a lot of passion about going and helping those who really need it the most—but then the cost of education is so high—that especially positions are drawn to higher-paying specialties so they can get those paid off. If we have got training tracks—where—idealistic young medical students are working with my colleagues here—and they see they see how rewarding it is to work in that environment, they stay.

Senator KAINE. For each of you, how important is well-designed public service loan forgiveness programs to attracting health care professional, not just Physicians but all healthcare professions, especially to underserved communities?

Dr. ANDERSON. Yes, thank you. I can say that I had the National Health Service Corps scholarship when I was a medical student. And then I also have the National Health Service Corps loan repayment program after my scholarship commitment finished and I can say that these programs are critical in recruiting the workforce that we need to serve our communities. Even at my site, I would say a large number of our providers have been either currently in the program or in the past, and I would say a majority of those also teach in our residency program. And so continuing the pipeline like Dr. Freeman was saying, training the next generation and showing people how it is possible to help these communities.

Senator KAINE. Mr. Trumpeter, where you going to speak a word about public service loan forgiveness also?

Mr. TROMPETER. I was and it is, like Dr. Anderson said, critical. 50 percent of our providers are either current recipients or past recipients of loan repayment programs. It is the way that we could get people and the way that we can keep them.

Senator KAINE. Let me ask go switching to another topic, I notice when I am in rural Virginia that there is a significant percentage of doctors, especially, but some of their health professionals, who

are immigrants, who have come from other countries and may be trained in other countries. Sometimes they have done a medical training in other country and done a residency after matching in the United States. And I have gone through other parts of rural America and seen the same thing—in terms of meeting our workforce needs, and I think Dr. Anderson, you are bilingual, correct?

Dr. ANDERSON. Yes.

Senator KAINE. In meeting our workforce needs to deal with a diverse population, isn't it important that we think about the immigration topic—we often of the immigration topic as a security issue, is not it also important that we really think about workforce and the need especially in some harder hit communities. The right immigration policy can help us even in healthcare workforce. Would you not agree with that?

Dr. ANDERSON. I would say that the community health centers serve everyone that comes to our doors regardless of their ability to pay and we serve everyone in the community regardless of where that community is. Earlier in the in the testimony, I held up the oath that I took at Brown University to serve patients and serve humanity and the National Health Service Corps and the community health center program has made it possible to serve all patients regardless of their ability to pay or their social standing.

Senator KAINE. Let me focus on the work force though as I conclude. Do you also believe that for the workforce that you need to serve populations may be especially in rural America, that thinking about immigration policy is one way of dealing with meeting workforce needs in rural America?

Dr. WAITS. Definitely, we are here representing the idea of training local high school students that go through the pipeline to medical school and to our training programs, but we all definitely have colleagues who did medical school in another country and have provided awesome service to our rural communities to our inner city communities. We have had colleagues that we were residency and did fellowship with that were from other countries, and so a very clearly articulated set of rules for our colleagues that did medical school in other countries and come here to train and graduate medical education and often choose to stay as a destination to serve—this exact workforce need we are talking about—A clearly articulated policy around that would be would be helpful in terms of workforce.

Senator KAINE. Thank you.

Mr. Chairman.

The CHAIRMAN. Thank you Senator Kaine. The hearing record will remain open for 10 days. Members may submit additional information for the record within that time if they would like.

The CHAIRMAN. Our Committee will meet again on Tuesday at 10:00 a.m. for a hearing on how primary care affects health care costs. Thank you for being here. The Committee will stand adjourned.

ADDITIONAL MATERIAL

AMERICAN ACADEMY OF
FAMILY PHYSICIANS.

Hon. LAMAR ALEXANDER, *Chairman,*
Committee on Health, Education, Labor, and Pensions,
428 Dirksen Senate Office Building,
Washington, DC 20510.

Hon. PATTY MURRAY, *Ranking Member,*
Committee on Health, Education, Labor, and Pensions,
428 Dirksen Senate Office Building,
Washington, DC 20510.

On behalf of the American Academy of Family Physicians (AAFP) thank you for the opportunity to submit this Statement for the Record for the U.S. Senate Health, Education, Labor, and Pensions Committee's hearing, Access to Care: Health Centers and Providers in Underserved Communities.

The AAFP appreciates the Committee's interest in examining health care access and underserved communities. Consistent with the World Health Organization's definition, the AAFP believes that health is "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity." As the largest society of primary care physicians, we are committed to helping patients achieve health and in supporting initiatives that build healthy communities. It is also our view that community health does not occur by coincidence. Healthy communities develop through robust research as well as investments from citizens, community-based organizations, educational institutions, governments, and the private sector.

Primary Care is Associated with Healthier Communities

The AAFP acknowledges that family physicians play an important role in community health, both as clinicians, but also as community partners who understand that factors outside of the doctor's office (the social determinants of health) impact patient health and the health of a community. Still, primary care (comprehensive, first contact, whole person, continuing care) is the foundation of an efficient health system. It is not limited to a single disease or condition, and can be accessed in a variety of settings. Primary care (family medicine, general internal medicine and general pediatrics) is provided and managed by a personal physician, based on a strong physician-patient relationship, and requires communication and coordination with other health professionals and medical specialists. The benefits of primary care do not just accrue to the individual patient. Primary care also translates into healthier communities. For instance, U.S. states with higher ratios of primary care physician-to-population ratios have better health outcomes, including lower rates of all causes of mortality: mortality from heart disease, cancer, or stroke; infant mortality; low birth weight; and poor self-reported health. This is true even after controlling for sociodemographic measures (percentages of elderly, urban, and mi-

nority; education; income; unemployment; pollution) and lifestyle factors (seatbelt use, obesity, and tobacco use).[1]

The dose of primary care can even be measured – an increase of one primary care physician per 10,000 people is associated with an average mortality reduction of 5.3 percent, or 49 fewer deaths per 100,000 per year.[2] High quality primary care is necessary to achieve the triple aim of improving population health, enhancing the patient experience and lowering per capita costs.[3]

Patients, particularly the elderly, with a usual source of care are healthier and have lower medical costs because they use fewer health care resources and can resolve their health needs more efficiently.[4] In contrast, those without a usual source of care have more problems accessing health care and more often do not receive appropriate medical help when it is necessary.[5] Patients with a usual source of care have fewer expensive emergency room visits, unnecessary tests and procedures. They also enjoy better care coordination.[6] We believe it is in the national interest to support programs with the potential to help improve patient access for primary medical care, particularly for vulnerable populations.

Primary Care Workforce and Underserved Communities

The current physician shortage and uneven distribution of physicians impacts population health. A U.S. Centers for Disease Control and Prevention study indicated that patients in rural areas tend to have shorter life spans, and access to health care is one of several factors contributing to rural health disparities.[7] The report recommended greater patient access to basic primary care interventions such as high blood pressure screening, early disease intervention, and health promotion (tobacco cessation, physical activity, healthy eating).[8] The findings highlighted in the CDC's report are consistent with numerous others on health equity, including a longitudinal study published in JAMA Internal Medicine, indicating that a person's zip code may have as much influence on their health and life expectancy as their genetic code.[9] Therefore, it is imperative that physician care is accessible to all.

The current primary care physician shortage and maldistribution remain significant physician workforce challenges. An Annals of Family Medicine study projects that the changing needs of the U.S.

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[9] Dwyer-Lindgren L, Bertozzi-Villa A, Stubbs RW, Morozoff C, Mackenbach JP, van Lenthe FJ, Mokdad AH, Murray CJL. Inequalities in Life Expectancy Among US Counties, 1980 to 2014Temporal Trends and Key Drivers. JAMA Intern Med. 2017;177(7):1003–1011. doi:10.1001/jamainternmed.2017.0918

population will require an additional 33,000 practicing primary care physicians by 2035.[10] A 2017 Government Accountability Office (GAO) report indicates that physician maldistribution significantly impacts rural communities.[11] The patient-to-primary care physician ratio in rural areas is only 39.8 physicians per 100,000 people, compared to 53.3 physicians per 100,000 in urban areas.[12] According to GAO, one of the major drivers of physician maldistribution is that medical residents are highly concentrated in very few parts of the country. The report stated that graduate medication education (GME) training remained concentrated in the Northeast and in urban areas, which continue to house 99 percent of medical residents.[13] The GAO also indicated that while the total number of residents increased by 13.6 percent from 2001 to 2010, the number expected to enter primary care decreased by 6.3 percent.[14]

Primary care workforce programs, such as the Teaching Health Center Graduate Medical Education Program and the National Health Service Corp Program, are essential resources to begin to increase the number of primary care physicians and to ensure they work in communities that need them most. The THCGME program appropriately trains residents who then stay in the community. THCGME residents are trained in delivery system models using electronic health records, providing culturally competent care, and following care coordination protocols.[15] Some are also able to operate in environments where they are trained in mental health, drug and substance use treatment, and chronic pain management.[16] Residents who train in underserved communities are likely to continue practicing in those same environments.[17]

American Medical Association Physician Masterfile data confirms that a majority of family medicine residents practice within 100 miles of their residency training location.[18] By comparison, fewer than 5 percent of physicians who complete training in hospital-based GME programs provide direct patient care in rural areas.[19] Thus, the most effective way to encourage family and other primary-care physicians to practice in rural and underserved areas is not to recruit them from remote academic medical centers but to

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[10] *http://www.annfammed.org/content/13/2/107.full*

[11] U.S. Government Accountability Office, May 2017, GAO 17–411, *http://www.gao.gov/assets/690/684946.pdf*

[12] Hing, E, Hsiao, C. US Department of Health and Human Services. State Variability in Supply of Office-based Primary Care Providers: United States 2012. NCHS Data Brief, No. 151, May 2014

[13] GAO, 2017

[14] Ibid

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

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

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

[18] E. Blake Fagan, MD, et al., Family Medicine Graduate Proximity to Their Site of Training, Family Medicine, Vol. 47, No. 2, at 126 (Feb. 2015).

[19] Candice Chen, MD, MPH, et al., Toward Graduate Medical Education (GME) Accountability: Measuring the Outcomes of GME Institutions, Academic Medicine, Vol. 88, No. 9, p. 1269 (Sept. 2013).

train them in these settings. Similarly, the National Health Service Corps (NHSC) offers financial assistance to recruit and retain health care providers to meet the workforce needs of communities across the nation designated as health professional shortage areas (HPSAs). The NHSC is vital for supporting the needs of our nation's vulnerable communities. The AAFP believes building the primary care workforce is an important return on investment. We also believe that workforce programs help ensure high quality, efficient medical care is more readily available. By reducing physician shortages and attracting physicians to serve in communities that need them, these programs also help improve the way care is delivered and help meet the nation's health care goals.

Community health centers (CHCs) play an important role in primary care graduate medical education as well. The nation's 9,800 CHCs provide care for 25 million patients, 71 percent of whom are low-income.[20] CHC facilities, along with other safety net providers, are also valuable training settings for THCGME residents who care for patients like those they are likely to treat in primary care outpatient settings. Residents who train in CHCs also have the unique opportunity to be trained in delivery system models using electronic health records, providing culturally competent care, and following care coordination protocols.[21] Some are also able to operate in environments where they are trained in mental health, drug and substance use treatment, and chronic pain management.[22] Residents who train in underserved communities are likely to continue practicing in those same environments.[23] An important, but unique element within the THCGME program is that its accountability measures require an evaluation of the number of physicians who continue practicing after residency and if they continue serving in rural and underserved communities.

We appreciate Senators Lamar Alexander and Patty Murray's leadership in introducing S. 192, a bill that will reauthorize the Teaching Health Center Graduate Medical Education program, National Health Service Corps program, and Community Health Centers programs. This five-year reauthorization will help lay the foundation for much-needed stability and funding adequacy for these important programs.

Family Physicians and Health Care for All

The AAFP also supports health care for all, consistent with the public health mission of the specialty of family medicine. The AAFP promotes health care for all in the form of a primary care benefit design featuring the patient-centered medical home, and a

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

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

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

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

payment system to support it for everyone in the United States.[24] AAFP believes that all Americans should have access to primary care services (e.g. in the case of infants and children, immunizations and other evidence-based preventive services, prenatal care, and well-child care), without cost sharing. The AAFP believes that health care for all should also include services outside the medical home (e.g. hospitalizations) with reasonable and appropriate cost sharing allowed, but with protections from financial hardship. Supporting access to care for everyone in the United States is consistent with the "triple aim" of improving patient experience, improving population health, and lowering the total cost of health care. Having both health insurance and a usual source of care (e.g., through an ongoing relationship with a family physician) contributes to better health outcomes, reduced disparities along socioeconomic lines, and reduced costs.[25]

The AAFP urges each and every one of its members to become involved personally in improving the health of people from minority and socioeconomically disadvantaged groups. The Academy supports: cooperation between local family physicians and community health centers; promotion of health education in schools, faith-based organizations, and community groups; continuation of beneficial programs that serve to promote health and disease prevention; simplified regulations and improved payment to encourage the establishment and success[26] of physician practices in underserved areas; and development of programs to encourage the provision of services by physicians and other health care professionals in underserved areas.

Health care access is also a significant barrier, especially for low-income individuals. The AAFP first adopted a policy supporting health care coverage for all three decades ago. For the past 28 years the AAFP has advanced and supported policies that ensure a greater number of Americans enjoy the security of health care coverage. The AAFP appreciates the bipartisan support for the Medicare Access and CHIP Reauthorization Act's (MACRA) landmark reforms that have the potential for improving patient care outcomes by emphasizing value over fee-for-service. We welcome the opportunity to work with policymakers to evaluate MACRA's implementation process and the potential to improve patient outcomes.

It is also important to acknowledge that passage of the Patient Protection and Affordable Care Act represented a sea change for millions of patients. We are pleased the Committee has engaged in bipartisan hearings to examine ways to improve the individual market as well as proposals to maintain cost-sharing reduction payments. Medicaid expansion and the law's Essential Health Benefits were particularly important for vulnerable populations. Medicaid assists the most vulnerable patients who are often members

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

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

[26] AAFP, Medically Underserved (2013), available at *https://www.aafp.org/about/policies/all/medically-underserved.html*

of minority groups, homeless, formerly incarcerated, foster and former foster youth, mentally ill, addicted, and/or in military families. Insurance coverage rates among minorities are lower than rates among the non-Hispanic white population. [27] Minorities experience disproportionate rates of illness, premature death, and disability compared to the general population. [28] In addition, virtually all of the estimated individuals nationally who are homeless could be eligible for Medicaid. Many in this population would benefit from the mental health and addiction treatment requirement included under the law. [29] Forty percent of our nation's veterans who are under 65 years of age have incomes that could qualify them for Medicaid under the ACA's expanded coverage. [30] In general, family members of veterans are not covered by the Veteran's Administration, but may seek coverage through Medicaid or the marketplace. [31] Many patients in this category are unaware that they qualify for health benefits.

A New England Journal of Medicine article indicates that the law's coverage expansion was associated with higher rates of having a usual source of care, greater access to primary care access, and, higher rates of preventive health screenings. [32] Anecdotal evidence among family physicians also reveals that health care access is saving lives and improving patient health for those who are accessing much-needed care for chronic diseases or detecting health challenges in their initial stages. Again, achieving optimal health does not occur by accident. Realizing the vision of healthy communities, like other national priorities, requires that we identify goals, invest resources, and eliminate barriers, especially for vulnerable citizens.

Conclusion

The AAFP appreciates the opportunity to share these comments on health access and vulnerable communities and welcomes the opportunity to work with policy makers to achieve positive outcomes on these and other policies. For more information, please contact Sonya Clay, Government Relations Representative, at 202–232–9033 or sclay@aafp.org.

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[27] Center for Health Care Statistics (CHCS), Reaching Vulnerable Populations Through Health Reform, April 2014, available at*http://www.chcs.org/media/Vulnerable-Populations—April-2014.pdf*

[28] Center for Health Care Statistics, April 2014

[29] Id.

[30] Id.

[31] Id.

[32] Benjamin D. Sommers, M.D., Ph.D., Atul A. Gawande, M.D., M.P.H., and Katherine Baicker, Ph.D., N Engl J Med 2017; 377:586–593

AMERICAN COLLEGE
OF OSTEOPATHIC
FAMILY PHYSICIANS

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Washington, DC 20510.

Hon. PATTY MURRAY, *Ranking Member,*
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Washington, DC 20510.

On behalf of the more than 145,000 osteopathic physicians and medical students we represent, we applaud the Committee's leadership and bipartisan effort to address the shortage in our health care workforce. We are thankful for the Chairman and Ranking Member for introducing legislation that would reauthorize the Teaching Health Centers Graduate Medical Education Program (THCGME). In anticipation of the upcoming hearing, Access to Care: Health Centers and Providers in Underserved Communities, we would like to highlight the need, and encourage the Committee, to support funding for growth in the reauthorization of the THCGME program to help address the shortage in our health care workforce.

The majority of THCGME programs are currently accredited by the AOA or are dually accredited (DO/MD) programs, supporting nearly 800 osteopathic resident physicians through their training since the program's inception. Located in 27 states and the District of Columbia, THCGME programs train residents in much-needed primary care fields that have the largest shortages nationally, including family medicine, internal medicine, pediatrics, obstetrics and gynecology, psychiatry, geriatrics, and dentistry. It is a vital source of training for primary care residents to help expand access to care in rural and underserved communities throughout the country.

Osteopathic physicians (DOs) are fully-licensed to practice in all specialty areas of medicine, with nearly 57 percent of active DOs in primary care. Our training emphasizes a whole-person approach to treatment and care, where we partner with our patients to help them get healthy and stay well. Osteopathic medical education also has a long history of establishing educational programs for medical students and residents that target the health care needs of rural and underserved populations. Given this strong presence in primary care, osteopathic medicine aligns naturally with the mission and goals of the THCGME program that has proven successful in helping address the existing gaps in our nation's primary care workforce.

Residents who train in THC programs are far more likely to specialize in primary care and remain in the communities in which they have trained. Data shows that, when compared to traditional postgraduate trainees, residents who train at THCs are more likely to practice primary care (82 percent vs. 23 percent) and remain in underserved (55 percent vs. 26 percent) or rural (20 percent vs. 5

percent) communities. It is clear that a well-designed THCGME program not only plays a vital role in training our next generation of primary care physicians, but helps to bridge our nation's physician shortfall. The program also tackles the issue of physician maldistribution, and helps address the need to attract and retain physicians in rural areas and medically underserved communities. In the 2016–2017 academic year, nearly all residents received training in primary care settings and 83 percent of residents trained in Medically Underserved Communities.

However, reauthorizing the THCGME program at its current level funding, for the next five years, would lead to a reduction of approximately 70 residency slots from the currently funded 737 residency positions.

We respectfully ask the Committee to consider legislation by Senators Susan Collins (R–ME), Doug Jones (D–AL), Shelley Moore Capito (R–WV), Jon Tester (D–MT), and John Boozman (R–AR) the "Training the Next Generation of Primary Care Doctors Act of 2019." In addition to reauthorizing the THCGME program for the next five years, this bill also provides funding and a pathway for growth in the number of residents trained in underserved rural and urban communities. This represents a much needed expansion to address the physician shortages in our country.

We would also like to briefly highlight the broader role osteopathic physicians have in reducing our nation's physician shortage. Since 2010, the number of DOs has increased by 54 percent. Today, more than 65 percent of all DOs are under the age of 45, and if current enrollment trends continue, DOs are projected to represent more than 20 percent of practicing physicians by 2030. Because of the whole-person approach to patient care that is inherent in osteopathic medicine, the increasing share of DOs in the physician workforce, and the number of DOs in primary care specialties, we have a unique and important perspective on the needs of our nation's health care workforce and would welcome the opportunity to contribute to your work on this issue.

We appreciate your bipartisan effort to address the shortage in our country's health care workforce, and we stand ready to assist in your effort.

Sincerely,

AMERICAN COLLEGE OF OSTEOPATHIC FAMILY PHYSICIANS
AMERICAN COLLEGE OF OSTEOPATHIC INTERNISTS
AMERICAN COLLEGE OF OSTEOPATHIC OBSTETRICIANS AND GYNECOLOGISTS
AMERICAN COLLEGE OF OSTEOPATHIC NEUROLOGISTS AND PSYCHIATRISTS
AMERICAN COLLEGE OF OSTEOPATHIC PEDIATRICIANS
AMERICAN OSTEOPATHIC ASSOCIATION

[Whereupon, at 11:55 a.m., the hearing was adjourned.]

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