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THE HEALTH CENTERS RENEWAL ACT OF 2007; THE NATIONAL HEALTH SERVICE CORPS SCHOLARSHIP AND LOAN REPAYMENT PROGRAMS REAUTHORIZATION ACT OF 2007; AND THE SCHOOL-BASED HEALTH CLINIC ACT OF 2007

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

FIRST SESSION

ON

H.R. 1343, H.R. 2915, H.R. 4230

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THE HEALTH CENTERS RENEWAL ACT OF 2007; THE NATIONAL HEALTH SERVICE CORPS SCHOLARSHIP AND LOAN REPAYMENT PROGRAMS REAUTHORIZATION ACT OF 2007; AND THE SCHOOL-BASED HEALTH CLINIC ACT OF 2007

TUESDAY, DECEMBER 4, 2007

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

The subcommittee met, pursuant to call, at 2:09 p.m., in room 2322, Rayburn House Office Building, Hon. Frank Pallone, Jr., (chairman) presiding.

Present: Representatives Gordon, Green, Allen, Baldwin, Deal, Pitts, Murphy and Burgess.

Staff present: William Garner, Katherine Martin, Melissa Sidman, Brin Frazier, Bobby Clark, Chad Grant, and Ryan Long.

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

Mr. PALLONE. I call the meeting to order.

First let me welcome everybody back from our 2 weeks at home. I know we have got a lot to do over the next 2 weeks, so I wish us luck on a bipartisan basis. I know it is not going to be easy. But today we are having a hearing of the subcommittee on three bills, H.R. 1343, the Health Centers Renewal Act; H.R. 2915, the National Health Service Corps Scholarship and Loan Repayment Reauthorization Act; and H.R. 4230, the School-Based Health Clinic Act.

I would now recognize myself initially for an opening statement. And let me first mention those who have been the sponsors of these bills. The Health Centers Renewal Act was introduced by our Vice Chair Mr. Green, the National Health Service Corps Scholarship and Repayment Programs Reauthorization by Mr. Braley, and the School-Based Health Clinic introduced by Ms. Hooley from the committee. And I wanted to thank all of them for their hard work in putting together these different bills.

And I also want to call attention to the efforts of two of our colleagues on the subcommittee, Representative Bart Gordon and Representative Tom Allen. Both Mr. Gordon and Mr. Allen have

also introduced legislation that reauthorizes the National Health Service Corps Scholarship and Loan Repayment Programs. Though the hearing today is on H.R. 2915, I wanted them to know that the subcommittee will be working very closely with you and your staff as we move forward with this legislation, and I laud your efforts to address this important public health issue.

As far as the community health centers, the first bill, access to health care obviously has been a priority for this Congress, especially since the number of uninsured Americans continues to rise. And for the 47 million Americans without health insurance, as well as the millions more who are underinsured, there are simply too few options for them to receive the medical treatment they need. But for the past 40 years there has been one place that Americans have been able to go to receive the medical treatment that they need and deserve regardless of their ability to pay, and those are our community health centers. Since the mid–1960's our community health centers have served as a first line of defense to provide quality preventative and primary health care services in medically underserved communities.

But as more and more Americans join the ranks of the uninsured, the demands of our States' health centers are growing exponentially. Increased demand, coupled with aging facilities and difficulties in recruitment and retention of health professionals has placed tremendous strain on our health centers. Accordingly, it is critical that this Congress act quickly to strengthen our community health centers and help them fulfill the role they play in guaranteeing access to high-quality health services.

The most important step we could take to accomplish this goal is to pass this legislation that would reauthorize the community health centers program for another 5 years and provide them with adequate resources. And I think we can all agree that the community health centers provide a vital service to all of our communities. We shouldn't waste any time in helping them carry out a mission that is of fundamental importance to so many Americans.

Now the second bill on, the National Health Service Corps, as I mentioned, this bill would ensure that underserved American communities have access to health care through the recruitment and support of health service professionals. According to the Health Resources and Services Administration, which administers the National Health Service Corps programs, and we are going to be hearing from Dr. Williams today, approximately 50 million people live in communities with no access to primary health care. The National Health Service Corps works to address this disparity by recruiting and retaining health professionals through scholarships, loan repayment, and placement programs to serve in those communities, and the impact of this program is immeasurable. Since 1972, more than 27,000 health professionals have served in the National Health Service Corps, including 4,000 current Corps members, who are caring for 4 million people in underserved urban and rural areas. Many of these Corps members will continue to serve in the health professional shortage area even after fulfilling their 2-year commitment.

Ensuring that all Americans have access to quality health care is obviously important, but this bill would provide the necessary re-

authorization and funding in the amount of $300 million through 2011 to support the National Health Service Corps and promote expanded access to care. And again I want to thank Mr. Braley, Mr. Allen, and Mr. Gordon for all their diligent work in drafting this legislation. And obviously this is a collective effort, and we are going to work forward to move this legislation in the next few weeks, or I should say certainly in the new year. I don't think we are going to be doing much in the next few weeks. But in the new year.

The last bill is the School-Based Health Clinic Act of 2007. Of the 47 million uninsured Americans, nearly 9 million are children. We have spent a lot of time on SCHIP and trying to address that, and although some of our programs are aimed at insuring children specifically, some of those programs that we have are successful, obviously we need to do more. We went through all that with the SCHIP, which is still ongoing.

There still remain too many kids who have no access to the basic health care that they need. According to the AMA, children between the ages of 13 to 18 have the poorest health indicators. And over 70 percent of the children who need psychiatric treatment have no access to mental health services. We have the opportunity today to tackle this problem head on through this act, the School-Based Health Clinic Act.

School-based health centers treat children in a place that is convenient for parents and guardians, and children are seen by caregivers they know and trust. These health centers identify students at risk for health and behavioral problems, and can monitor and treat children with chronic illnesses, thus reducing health-related school absences. And school-based health centers are currently located in over 1,700 schools around the country. There are many in my district. I remember dealing with them both here in Congress, as well as a State legislator, and they provide health care to children regardless of their ability to pay. In fact, 45 percent of kids treated at school-based health centers are uninsured, and 44 percent of the children treated at these centers are enrolled in either Medicaid, SCHIP, or other public coverage.

Considering these statistics, it becomes clear that these health centers provide access to health care professionals to children who otherwise would have limited or no access to health care services.

I just want to say that I think all these bills are very important. Mr. Green and the others have been asking for this hearing for some time. We are going to try to move these bills when we come back in January of 2008.

And I just want to thank everybody for being here today, and I would now yield to our ranking member, Mr. Deal.

OPENING STATEMENT OF HON. NATHAN DEAL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

Mr. DEAL. Thank you, Mr. Chairman. First of all, I would like to welcome our witnesses on both of our panels, thank them for their attendance today. I would especially like to introduce and welcome Steven Miracle, who is the CEO of the Georgia Mountains Health Services, which has a health center in Morganton, Georgia, which is in my district. I really need to send Steven back to med-

ical school because how would you like to be able to tell somebody who asked you who is your doctor to say Dr. Miracle? You know, he does a great job as an administrator, but if we had that "doctor" in front of his name, that would be great. But thank you for being here today.

The Community Health Center Program has been a huge success, I think, and an asset, as community health centers are an integral part of this country's health delivery system which provide quality health care services to people and communities that would otherwise not have access to that care. Last Congress I showed my support for this program by introducing a bill that would have extended for 5 years the reauthorization of this plan. It did pass the House by a large margin, but unfortunately the Senate failed to act on the legislation.

I understand the measure we are considering today has a much higher authorization level than the bill last year, and I look forward to hearing a justification for these increases because I believe we have to all continue to be good stewards of the program and of the taxpayers' dollars that fund the program.

As we evaluate changes to the program during this reauthorization, I hope the witnesses will speak to the staffing needs of health centers during times of emergency. In particular, I know some health centers' medical staff had trouble as they sought to serve areas affected by Hurricanes Katrina and Rita because of the lack of liability protection. Some have also expressed an interest in expanding liability protection to physicians who volunteer their services at health centers, while others have some concerns about the composition of the board requirements for health centers. These are all issues that I hope we will have a chance to talk about briefly today as we consider reauthorizing this particular program.

The National Health Service Corps provides an important incentive for health care providers to serve an area with a shortage of health professionals, it certainly goes without question. This is done primarily through scholarships and loans. And having had constituent service issues on a particular situation, I know that firsthand that at times scholarship recipients don't always have the certainty about their career path when they accept the scholarship. And so therefore I look forward to hearing testimony about the effectiveness of the scholarships compared with the loan program in encouraging students to serve in shortage areas.

We also will be looking at school-based health clinics, and I hope our witnesses will be able to tell us the most effective way to provide services for school-age underserved populations.

This should be a good hearing as we evaluate these programs that help ensure that the medically underserved have access to care. I look forward to the testimony of the witnesses, and I yield back my time.

Mr. PALLONE. Thank you.

Next is the gentleman from Tennessee Mr. Gordon, who is one of the sponsors on the National Health Service Corps.

Mr. GORDON. Thank you, Mr. Chairman. As we all know, the National Health Service Corps is to provide primary health care providers to underserved communities. Unfortunately, when the Corps was restructured in 2002, primary eye care was unintentionally ex-

cluded from the program. As a result, access to basic eye-care services at community health centers has been severely curtailed. Today less than 17 percent of all centers have optometrists on staff. This is concerning, as the populations served by the community health centers are at high risk for vision loss from blindness caused by glaucoma or diabetes. Half of all these cases of blindness in this population can be prevented if we can get them screened and treated early.

Earlier this year I introduced legislation to address this problem by reinstating optometry as a covered service under the National Health Care Service Corps. Importantly, I would also note that the Institute of Medicine recognized optometry as a primary health care service in its report Primary Care: America's Health in a New Era.

Clarifying that optometry is a primary care service covered by the Corps is consistent with the Corps' primary health care mission and will prevent much suffering and costs to society. The bill has 81 cosponsors, including 15 from this committee, and is endorsed by the National Association of Community Health Care Centers—and to prevent blindness.

We have talked about this several times, and I appreciate your comments of trying to work together on this issue. I know that really the only argument that I have heard against it is that if optometry is allowed, or if we correct this error that was made with optometry, it could open the door for others. And I would just say that is not a good argument against this. I think all primary care services ought to stand on their own, and if there is other additions, then they should be made.

So again, Mr. Chairman, thank you for having this hearing, and thank you for your willingness to review these arguments.

Mr. PALLONE. The gentleman from Pennsylvania Mr. Pitts.

OPENING STATEMENT OF HON. JOSEPH R. PITTS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF PENNSYLVANIA

Mr. PITTS. Thank you, Mr. Chairman.

I strongly support reauthorization of community health centers and the National Health Center Services Corporation Scholarship and Loan Repayment Program. For more than 35 years, the NHSC has been recruiting caring health professionals to serve in medically underserved communities where the need is the greatest, in rural areas, where the closest provider is often many miles away, and in inner-city neighborhoods, where economic and cultural barriers prevent people from seeking and receiving needed care.

In the past, the NHSC has made great advances in improving access to quality health care services for millions of Americans who might otherwise be forced to do without. As we all know, the NHSC allows selected health care professionals engaged in delivery of primary care services to be reimbursed for student loans in return for establishing and maintaining their practices in geographic areas designated as medically underserved by the Federal Government. However, optometrists, the Nation's primary eye- and vision-care providers, are not eligible for participation in this program.

The NHSC program aims to unite communities in need with caring health professionals by easing the debt burden associated with a professional education, allowing carefully selected clinicians, including primary care physicians, nurse practitioners, dentists, and other health professionals to undertake a multiyear commitment to safeguarding public health. However, the exclusion of optometry from the program has had a devastating impact on the level and fullness of care with these communities which they receive.

Today, less than 20 percent of community health centers have an optometrist on staff, which severely restricts access to primary eye- and vision-care services, including comprehensive eye exams, detecting and diagnosing eye diseases, and treating eye diseases. Nonetheless, doctors of optometry have been active in some community and rural health centers despite optometry's omission from the NHSC priority.

Community health centers provide an invaluable service to those who need it most and promise to be a growing part of the U.S. health care system. They are seen to provide care in a more cost-effective manner than hospital emergency rooms, and as a result have enjoyed much more Federal support from administrators. It is critical that part of the comprehensive primary medical services that these centers provide include eye and vision care, as these services are central to better overall health outcomes.

Those living in the underserved communities in which CHCs are located are significantly more at risk of suffering vision impairment from high amounts of preventable vision loss from undiagnosed causes, such as diabetic retinopathy and glaucoma. And I am joined by the National Association of Community Health Centers, the National Rural Health Association, the American Optometric Association, and Prevent Blindness America in calling for the readmittance of optometry into the NHSC program.

Congressional intent with regard to the inclusion of optometrists in the NHSC loan repayment program is clear. However, HRSA has indicated that a legislative response, not a regulatory response, is needed in order for optometrists to be added as eligible providers to the student loan repayment program. And so I would commend to my colleagues' attention Representative Bart Gordon's bill, H.R. 1884, the National Health Services Corporation Improvement Act, which would allow optometrists to participate in the National Health Service Corps loan repayment program. And I would like to thank our witnesses for being here today, and again thank you, Mr. Chairman, for setting up this hearing. And I yield back.

Mr. PALLONE. Thank you.

Our next member is Mr. Green from Texas, who is our vice chair. And you should know that he has been lobbying, or whatever the word is, for a long time to have this hearing because he considers it so important, as we all do. But if it wasn't for him, I don't think we would be having this today. So thank you.

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

Mr. GREEN. Thank you, Mr. Chairman. I appreciate your patience in putting up with me for months. I know our committee had

a full schedule with FDA, PDUFA, a host of other things, but I appreciate you again not just turning me out the door.

But thank you for holding the hearings on all three of these bills, and they are, all three, great bills. I especially am pleased we are discussing the Health Centers Renewal Act, a bill that I introduced with my colleague Mr. Pickering from Mississippi. We have 230 cosponsors in the full House and 70 percent of our committee.

Nearly 40 years after the health centers program began as part of LBJ's Great Society, more than 1,000 federally qualified health centers operate more than 5,000 sites, located in all 50 States, and serving about 16 million people. In order to qualify for Federal funding, health centers must be located in a medically underserved area, and be majority governed by community members utilizing the center for health care. The centers must also provide comprehensive primary and preventative care to all community residents regardless of the patient's ability to pay. Ninety-one percent of health center patients are low income; thirty-six percent are Medicaid beneficiaries. In 2006 alone, health centers provided services to 6 million uninsured individuals, which is 40 percent of all health center patients. Without a medical home at which to receive treatment, these patients were likely to forego care until their medical problems require emergency treatment or inpatient hospital care.

By providing primary, preventative and sometimes specialty care, health centers encourage patient treatment before medical problems escalate to emergency room visits and inpatient hospital treatment. As a result, health centers represent the Nation's largest primary care system, with one in nine Medicaid beneficiaries and one in five low-income individuals receiving care at a health center.

My State of Texas unfortunately ranks number one in the U.S. in the level of uninsured, with 25 percent of the population living without health insurance. More than 1 million uninsured individuals live in the Houston area, and we have fewer than 10 federally qualified health centers. And the demand for health centers is growing in our area.

Houston is not the only area in need of more health centers, with studies showing more than 56 million Americans lack access to a health care home and primary care. The Health Centers Renewal Act would reauthorize the health centers program, put the program on the path to meeting this need. In fact, our bill would allow health centers to serve approximately 23 million patients in the next 5 years. That is 50 percent more than today. This funding authorized in the bill would ensure that care is provided to existing patients as well as new patients. It would also allow health centers to provide additional service such as mental health and dental care.

This bill is a true investment in the future of health care of underserved communities across the country. And I am sure Mr. Pickering joins me in thanking the members of our subcommittee and the full committee and the Majority of the House who has co-sponsored this bill. Most of you know what an important issue this is to me and a number of members of our committee. And again, I

would like to thank my colleagues, thank our witnesses for being here, and I look forward to their testimony.

I yield back my time.

Mr. PALLONE. Thank you.

Mr. Murphy from Pennsylvania.

OPENING STATEMENT OF HON. TIM MURPHY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF PENNSYLVANIA

Mr. MURPHY. Thank you, Mr. Chairman.

When we hear about the number of the people who are uninsured in America, perhaps 45 million is a number often thrown out from the Census Bureau, when one begins to dissect that number, we find a number of interesting things. First, a sizable amount of that 45 million are people who are indeed covered by Medicare or CHIP programs, but are not aware of that. When you pare them out, then there are several million people who remain who actually can afford health care by their income, but decide not to, many of them being the invulnerable people between 18 and 26 or so who think they will live forever and don't need to buy health insurance.

But there is also a group within that, perhaps 10 to 15 million, by various estimates, who have no insurance, cannot afford it, and do not qualify. They are not old enough for Medicare and not poor enough for Medicaid. Interestingly enough, that is about the number of people who are served by community health centers. But community health centers, we just have too few of them. Some of the counties in my district and throughout Pennsylvania have no health centers, and so therefore someone has no doctor or no health care home. And I venture a guess from my many years of working in health care, people would much rather refer to their doctor than their insurance company as the source of their health care.

But one huge barrier exists with our community healthcenters, and that is there is simply not enough doctors. Right now it is estimated that federally funded community health centers that provide clinical services, there is a 13 percent vacancy rate for family physicians, 20 percent for OB/GYNs, and 22 percent for psychiatrists. Perhaps the numbers are even larger.

We could fill these vacancies and moreso, and expand community health centers with volunteers. Unfortunately, there is only 100 volunteer clinicians serving in health centers nationwide, 100 out of the hundreds of thousands that are out there who are specialists in the medical field. The reason is if you work in a community health center, you are covered under the Federal Tort Claims Act; therefore, your medical malpractice insurance is much less, and the clinic can afford to pay it. If you volunteer, however, you are not. And oftentimes, while characteristically that medical malpractice insurance is tens of thousands, perhaps scores of thousands of dollars more, then the clinic simply will not take on volunteers. They turn them away at the door. And yet there are OB/GYNs and family physicians and psychiatrists and dentists and podiatrists and others who would like to volunteer, perhaps as part of their ongoing practice, or they are nearing retirement and would like to dedicate some of their time to the community. That is why I introduced a bill last year and reintroduced it this year, it is H.R. 1626, to allow Good Samaritan doctors to volunteer.

And as we look at these issues about community health centers, yes, they are excellent; yes, they provide good care; they are vital parts of the community, and it is a great place for someone to have a health care home when they have their card saying that is where they get their services from, but I hope one of the issues we can address as we move forward in this legislation is also allowing medical practitioners to give of their time. Many of them have gone to school through scholarships and services provided by the government, and many of them want to return the favor to the community. We ought to open up the doors to them and not close the doors to them, and help provide more volunteer services as we deal with these issues in community health care. One of the bills we are dealing with, too, at this series, is also to provide some loan forgiveness. Perhaps we should allow them to have that loan forgiveness by giving their time back to the community that gave so much to them.

I yield back.

Mr. PALLONE. The gentlewoman from Wisconsin.

OPENING STATEMENT OF HON. TAMMY BALDWIN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WISCONSIN

Ms. BALDWIN. Thank you, Mr. Chairman.

And thank you, Dr. Williams, and the witnesses that are on our second panel for joining us today.

I am very pleased that this subcommittee is taking up such an important issue as providinghealth care to those without and those in need. The three programs that are the subject of the bills we are considering today all play a vitally important role in ensuring that those who are uninsured and those who live in medically underserved areas receive needed health care.

As my colleagues all know, almost 16 percent of Americans, that is 47 million Americans, are uninsured. And while these three programs are not a comprehensive cure for the epidemic of uninsurance, they certainly are a treatment. And I am proud to be a sponsor of all three programs.

I really can't say enough good things about the amazing work that community health care centers do. The community health centers in the district that I represent, which are located in Madison and Beloit, Wisconsin, are incredibly vital parts of their communities. And I am continually amazed at the variety of needed services that they offer. For some people the community health center is the only place where they can access dental care. For others, it is the only place that they can access affordable care. And for yet others it is the only place where they can easily communicate with their health care providers without interference of language barriers.

I am proud to be a cosponsor of Mr. Green's bill to reauthorize the health center programs, H.R. 1343. This bill provides a much-needed increase in the program's authorization level, and will put health care centers on a path to serve 23 million patients within the next 5 years, and that is nearly 50 percent more than they serve today.

As we know from our rising number of uninsured Americans, the need for care at community health centers is very great. In Wisconsin, the number of patients receiving care at community health centers has doubled in the past 8 years from 85,000 annually to 170,000 annually. This level of growth is significant, and we need to make sure that the program is updated with sufficient authorization levels to ensure that community health centers can continue to provide this much-needed care, continue to grow and provide care to more Americans, expand the services they provide to include much-needed mental and dental health care, and update their health services to keep up with changing technology. I thank my colleagues for their work on these bills, and I look forward to today's discussion.

Thank you, Mr. Chairman, for holding this hearing.

Mr. PALLONE. Thank you.

Our ranking member of the full committee is next, Mr. Barton.

OPENING STATEMENT OF HON. JOE BARTON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. BARTON. Thank you, Mr. Chairman. Thanks for holding this legislative hearing on the community health centers, the National Health Services Corporation, and school-based health clinics.

Last year the committee reauthorized the Community Health Center Program for 3 years. The legislation was endorsed by the National Association of Community Health Centers. It was passed by a voice vote in the committee, and also passed the House of Representatives overwhelmingly. Sadly, the Senate was not able to get its act together—what else is new—and the program failed to be reauthorized. I am glad to see that the committee intends to fulfill its obligation and responsibility this year and once again beginning to move forward on a bipartisan basis to reauthorize not only that program, but the other two programs that are on your legislative hearing agenda today.

Community health centers have received widespread support not only at the Federal level, but at the local level. It is important to note that these centers are great sources of preventative health care, which helps to control the ever-increasing health care costs. It is our responsibility as Federal representatives to ensure that taxpayers' money is being spent efficiently, and community health centers have demonstrated that they are effective in achieving this goal.

As with any program, there is always room for improvement. I am going to be interested later in the hearing to hear from some of the witnesses how certain aspects of the program can be improved. For example, in Tarrant County, which both I represent and Dr. Burgess represent, along with Congresswoman Kay Granger, that particular county has had a very difficult time establishing a community health center. I think that right now in a county of well over a million people, approaching 2 million people, we may have two community health centers that have been designated, despite great need for such programs.

I am concerned that there is a great geographic disparity in the establishment of new centers. I am very interested to understand

the application process and the issues that go into those particular reviews of those particular applications.

Another issue of concern for members of this committee is the need for portable liability coverage during times of emergency. This need was greatly evidenced during Hurricane Katrina. I want to personally thank Mr. Jones for coming here from Mississippi to share his personal story with us.

I am also interested in pointing out the President's expansion initiative has been completed, and that there are over 1,200 new or expanded centers. The authorization levels dramatically spike upwards. I know it is a popular program, but it is still the responsibility to be good stewards of the taxpayer dollars.

In addition to community health center reauthorization, we are considering legislation to reauthorize school-based health centers and the National Health Service Corporation. I have some concerns about these bills. I have got a little bit of a problem understanding why we want to create a new pot of money for a school-based health center program when they are already able to access a wide variety of Federal funding streams, one of which is the Community Health Center Program that I just talked about. There are other concerns inherent in the school-based health center program that should be explored regarding contraceptive distribution, confidentiality, and abortion referral, to name just a few noncontroversial items.

The final bill that we are going to consider today is the reauthorization of the National Health Service Corps. The authorization amounts for the next 5 years are more than double current funding. That seems to me to be a bit much, but I am sure there may be a justification in this, so we want to hear what that justification is.

I would like to know where the administration is in the process of redefining health professional shortage areas, or HPSAs.

In examining this legislation, we should consider all the various sources for loan repayments and how this one is somehow unique.

Again, Chairman Pallone, thank you for holding these hearings. They are very important in the oversight work of the committee as we move forward to reauthorize these programs. Thank you, and I yield back.

Mr. PALLONE. Thank you.

Mr. Burgess.

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

Mr. BURGESS. Thank you, Mr. Chairman. And I will try to be brief, because I know we have heard from everyone already.

The issue with reauthorizing the federally qualified health center program, Ranking Member Barton is quite correct, we did do that last year. It unfortunately did not get across the finish line. It is an important program. It needs to be reauthorized. But Ranking Member Barton has touched upon what is a very, very important point: There does seem to be geographic disparities. There seem to be winners and losers in this program, and this committee, I think, needs to address that.

I represent an area of the city of Fort Worth, TX, that has two ZIP Codes with some of the highest infant mortality rates in the country. In fact, they rival some of the infant mortality rates in other areas of the world that we wouldn't normally think of as being medically adequately served. And at the same time, we do not qualify, we do not meet the test, we do not meet the criteria for a federally qualified health center. I have spent the better part of the last 3 years, with full support of the hospitals in the area offering financial support. I have been unable to get this across the finish line. It is personally very troubling to me, and it makes me question whether or not the system indeed works as intended.

One of the other bills before us, H.R. 2915, the National Health Service Corps and Loan Payment Reauthorization Act of 2007, is an attempt to address an issue also about which I spend a lot of time worrying and being concerned, and that is the issues surrounding the physician workforce for the future. The high cost of medical education keeps many qualified students from becoming doctors, and indeed keeps many interested high school students from even investigating a career in health care. But rather than just increasing the funding, perhaps we also could look for a way to address some of the underlying issues that drive students away from practicing primary care medicine in needed areas.

An alternate bill, H.R. 2584, that was introduced much earlier in the year would provide targeted investments into our future medical workforce. And I, in fact, would look forward to working with the Chairman on this bill before we get to the final markup.

Another issue, as was touched on by Ranking Member Barton, with the National Health Service Corps, is how the HRSA defines a health profession shortage area. Despite pleading with CMS, HHS, and HRSA, Louisiana officials at the highest levels in the last 3 years since Katrina just are absolutely baffled as to why the most devastated parishes in New Orleans have not been classified as health professional shortage areas.

I know that the National Health Service Corps gives preference to sending providers to health profession shortage areas. Also these are areas which are still in great need and not getting the health professionals that they need.

Mr. Chairman, I will submit the entirety of my statement. It is well written and very important. I encourage Members to read it and I will submit it for the record, and I will yield back.

Mr. PALLONE. Thank you.

The gentlewoman from Tennessee.

OPENING STATEMENT OF HON. MARSHA BLACKBURN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TENNESSEE

Mrs. BLACKBURN. Thank you, Mr. Chairman. And I thank you for our meeting today and for the discussion of what I think are three very important public health programs.

The community health centers really are playing an important role in providing adequate care for many of our Tennessee families. And by providing health services to those in need, such centers are vital to the well-being of our Nation's communities, and certainly to the continued quality of life of many in these communities. And

in my State, we have seen growth in these—just tremendous growth, and we are pleased with the expanded opportunities that are there for our constituents.

A great example of this is in 2008, Hardiman County Community Health Center will receive 1.2 million in grant funding to provide discounted medical services in rural west Tennessee. This is for a population that is largely unserved or underserved. These funds are critical to those in our district. In the past year, this center has served over 6,200 patients in approximately 20,000 medical visits. Next year a new clinic will open in Chester County, Tennessee, to serve 1,000 more patients and 2,000 more visits in the first year. And it is an important development, and I look forward to working with the community health centers as they continue to provide the services and to fulfill this need. I do believe they have been tremendously successful, and are the right-type idea for delivering health services.

While I appreciate the focus of this hearing on important public health programs, I believe this committee should and could be using some of this time to work on more critical and time-sensitive issues facing our Nation's most vulnerable citizens. Those are children and also the elderly. While Congress is only scheduled to be in session until the end of next week, the House leadership has been unsuccessful in forging a compromise that will reauthorize and fund SCHIP in a responsible fashion. For many States, SCHIP funding runs out at the end of next week. We should get down to business and work out differences on SCHIP before moving forward on anything else.

The committee should also focus on the impending 10 percent pay cut for physicians under Medicare, which is scheduled to go into effect on January 1, 2008. I have repeatedly supported congressional efforts to provide physicians with Medicare payment relief. It is unfortunate that Congress is waiting until the eleventh hour to prevent this payment cut from going into effect. The Sustainable Growth Rate, we all hear a lot about the SGR, has proven to be a flawed formula that does not account for the rapidly increasing volume of Medicare patients, and fails to accurately reflect the rising costs of caring for these patients. This negative fee schedule update presents an unacceptable situation, and I fear that many physicians will cease to serve Medicare beneficiaries if a solution is not implemented to fix the physician payment reduction. Congress should be focusing its efforts to reform Medicare's physician payment scheme to ensure both access to care for beneficiaries and fair payment to our physicians for the services that they are providing, and, I will add, providing in good faith.

A future Medicare package should not cut the Medicare Advantage program, which has expanded choice in the Medicare program through partnerships with private-sector plans. More choice means more control for beneficiaries over the provisions of their own health care.

First and foremost, this committee has an obligation to reauthorize SCHIP with its original intent and to reform the Medicare physician payment formula. It is imperative that this Congress and the committee act on these critical issues immediately and stop playing politics with the issues behind closed doors.

Thank you, Mr. Chairman, and I yield the balance of my time.

Mr. PALLONE. Thank you.

I think that concludes our opening statements. Any other statements for the record will be included at this time

[The prepared statements follow:]

PREPARED STATEMENT OF HON. EDOLPHUS TOWNS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. Chairman and Ranking Member, thank you for your leadership in holding this informational hearing, concerning these very important pieces of legislation.

Mr. Chairman, I am a proud co-sponsor of each item that we are addressing here, today. I will not waste time, by reiterating my previously documented support for this legislation. However, I would like to address my committee colleagues for the purpose of posing a question regarding H.R. 2915, "The National Health Service Corps Scholarship and Loan Repayment Programs Reauthorization Act of 2007," which will continue the valuable program to recruit and retain healthcare professionals to work in underserved American communities. This program is certainly very worthy of our discussion today, and should be reauthorized. As an aside matter, I would like to ask this committee why it has chosen to address this piece of legislation without also considering H.R. 1134, "the Physical Therapists Student Loan Repayment Eligibility Act," which has been referred to this subcommittee. H.R.1134 will add physical therapists practicing in underserved areas to the list of providers eligible to participate in the National Health Service Corps Student Loan Repayment Program.

I believe that H.R. 1134 is worthy of our consideration. Therefore, I ask my colleagues why are we neglecting to consider this very relevant piece of legislation, today; and urge my colleagues to, also, contemplate this legislation, as we move forward. Additionally, I have a series of questions about the current measures, I am submitting for inclusion in the record to be addressed by the witnesses, subsequent to the hearing. I, respectfully, ask the chairman to honor this request.

Thank you, Mr. Chairman and Ranking Member for this opportunity.

PREPARED STATEMENT OF HON. TOM ALLEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MAINE

Thank you Chairman Pallone for calling this important hearing to consider legislation to reauthorize three important programs which are critical to meeting the health care needs of millions of American's across the country, and together comprise some of the strongest cords in our health care safety net.

I want to thank Representative Green for his work on the Health Centers Renewal Act. The 5-year authorization funding levels specified in his bill would allow Health Centers to serve 23 million patients within the next 5 years, nearly 50 percent more than today.

In 2005, federally-funded health centers served 125,255 individuals in the State of Maine. We have 16 grantees, of which 88 percent are rural. The funding targets in H.R. 1343 represent an investment not only in reaching new patients but ensuring that the care provided to new and existing patients is comprehensive and sustainable.

The National Health Service Corps is a vital resource for underserved communities experiencing shortages of health professionals. Maine has 43 clinicians at 36 sites, many in the most remote areas of our State. For over 35 years, National Health Service Corps clinicians have expanded access to primary and preventive health care, dental care, mental health and behavioral health services in underserved areas of the country and have improved health outcomes among difficult to reach populations.

During the last reauthorization of the National Health Service Corps, this Committee granted Federally Qualified Health Centers and Rural Health Clinics automatic facility designation as Health Professional Shortage Areas (HPSAs) for the purposes of recruiting National Health Service Corps clinicians. The intent of this provision was to ensure that all such providers, already required to be located in medically underserved areas, be eligible to apply for National Health Service Corps personnel.

Despite this, many health centers have continued to face difficulty in obtaining NHSC personnel, due to lack of overall funding and so-called "threshold scores"

within HPSA designation limiting placements to only those health centers with the highest scores.

Community health centers across the country are finding it difficult to recruit and retain clinical staff. And even though more than half of National Health Service Corps placements go to community health centers, hundreds of those centers, representing millions of underserved patients, can't access doctors from the National Health Service Corps.

H.R. 4205, the bill that I introduced on November 15, would reauthorize the National Health Services Corps Scholarship and Loan Repayment programs, doubling the current investment, and also ensure that providers like health centers and rural health clinics, those who are serving rural and underserved populations, have the first opportunity bringing in these National Health Service Corps clinicians to serve.

The number of new medical residents choosing a primary care discipline as a medical specialty is declining, and the National Health Service Corps Scholarship and Loan Repayment programs provide an important incentive for students to choose to pursue a career in primary care.

I hope that the committee will consider the merits of making the HPSA designation permanent for Federally Qualified Health Centers and Rural Health Clinics for the purposes of recruiting National Health Service Corps clinicians.

PREPARED STATEMENT OF HON. DARLENE HOOLEY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OREGON

Thank you for holding this important hearing, Mr. Chairman.

I am very excited that the Subcommittee on Health is hearing testimony on my legislation, H.R. 4230, the School-Based Health Clinic Act of 2007, which will authorize funds to improve health care access for our Nation's children.

I also want to thank Congresswoman Shelly Moore Capito for working with me on this bill and for her strong leadership on school-based health.

The School-Based Health Clinic Act authorizes a grant-based program for the operation and development of school-based health clinics (SBHCs), which provide comprehensive and accessible primary health care services to medically underserved children. My legislation gives priority to schools in communities with proven barriers to access to health care for children. Resources are thus targeted to schools with the greatest need.

As a former school teacher, I know all too well the negative impact that poor health has on a child's ability to learn and thrive at school. Unfortunately, far too many of our children do not have access to health care. Nearly 9 million children in the U.S. are currently uninsured.

SBHCs bring care right to the child at his or her school—where it can most easily reach underserved students. This allows students to stay in school and prevents their health problems from becoming more severe.

SBHCs play an important role in addressing high uninsurance rates by providing care to all children regardless of their ability to pay. Nationally 45 percent of children treated at SBHCs have no insurance and 44 percent are enrolled in Medicaid, SCHIP, or other public coverage. In Oregon, surveys indicted that 60 percent of clients are unlikely to receive care outside their school-based health clinic. SBHCs are therefore a critical lifeline for many of the approximately 2 million children currently attending a school with a clinic.

The School-Based Health Clinic Act will help increase the number of clinics and expand their ability to reach even more children by providing much needed Federal funding. Because 45 percent of SBHC patients are uninsured, SBHCs need Federal funding to fill the gap between the cost of providing care and revenue collected from billing Medicaid, SCHIP, and private insurers. Although Federal funds are critical to expanding SBHCs, clinics will continue to effectively utilize resources by leveraging State and local government funds, private contributions, and Medicaid, SCHIP, and private insurance payments where possible.

This legislation is a good start toward a brighter future for our youth by keeping them healthy and in school.

Thank you Mr. Chairman.

PREPARED STATEMETN OF HON. HEATHER WILSON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW MEXICO

Mr. Chairman, I would like to thank you for holding this hearing today on these bills before the committee. Today, we are meeting to discuss important issues regarding programs that improve access to health care for people in the United States,

and particularly in New Mexico. House Resolution 1343, the Health Centers Renewal Act, would reauthorize the community health center program for the next 5 years, with funding increases each fiscal year. This funding would allow the Community Health Centers to establish new sites, add services such as mental health and dental care, and undertake other measures that will improve the quality and cost-effectiveness of delivery. I am proud to be a cosponsor of this legislation.

Last year, I cosponsored House Resolution 5573, which renewed the health centers program grant for 5 additional years. The legislation was passed in the House but there was no action in the Senate regarding this legislation.

Health centers are a beacon of hope for the most vulnerable populations- low income, uninsured, or underinsured individuals. Many of whom are struggling with chronic diseases, teen pregnancy, substance abuse, and HIV/AIDS infection. A large portion of these same people cannot afford even the most basic medical care. I proudly cosponsor this legislation, and believe that by reauthorizing this program, we can put community health centers on the path toward serving 30 million patients by the year 2015.

In New Mexico, we have 15 federally qualified health center grantees, 79 percent of which are in rural areas. The centers serve predominantly low-income and uninsured patients. These centers provide a medical home for many, and for most, the community health center is their only point of access to primary care. In 2005, federally-funded health centers were the family doctor and medical home for approximately 223,000 individuals in New Mexico.

I have visited community health centers in my district, and I have been impressed with the concept of "health commons" where low income patients can go to get medical, dental, mental health, substance abuse, and pharmacy benefits all in one location. These health centers help reduce health disparities and provide cost effective care in the most medically underserved communities.

Health centers have both immediate and long-term benefits. Health centers reduce the need for more expensive hospital in-patient and specialty care, which result in significant savings for taxpayers. We are also here to discuss H.R. 2915, the National Health Service Corps Scholarship and Loan Repayment Programs Reauthorization Act of 2007. I support reauthorization of the program. It is vital to improving access to health care in rural and underserved parts of New Mexico by encouraging doctors and other health care providers to practice in Health Professional Shortage Areas. Thank you, Mr. Chairman.

Mr. PALLONE. We will now turn to our witness on our first panel, which consists of Dr. Dennis P. Williams, who is Deputy Administrator for the Health Resources and Services Administration. We will recognize you for a 5-minute opening statement. And as I think you know, the statements are made part of the hearing record, but you may, in the discretion of the committee, submit additional brief and pertinent statements in writing for inclusion in the record. And thank you for being here, Dr. Williams.

STATEMENT OF DENNIS P. WILLIAMS, DEPUTY ADMINISTRATOR, HEALTH RESOURCES AND SERVICES ADMINISTRATION

Mr. WILLIAMS. Thank, Mr. Chairman. Good afternoon. And good afternoon to the members of the subcommittee. Thank you for the opportunity to meet with you today on behalf of the Health Resources and Services Administration to discuss the health center and National Health Service Corps programs. I appreciate your support and awareness of the importance and critical role these safety net programs play in ensuring the access to care for millions of Americans.

I want to recognize the outstanding effort of the clinicians and the staff of the Nation's health centers. Their contributions to remedying the problems of the underserved and uninsured are undeniable and significant. Their patients and communities know and rely on them.

Health centers are community-based and consumer-directed organizations that serve populations with limited access to health care. These include low-income populations, the uninsured, those with limited English proficiency, migrant and seasonal farm workers, individuals and families experiencing homelessness, and those living in public housing.

Health centers provide comprehensive primary and preventative health services, as well as supportive services that promote access to health care. Services are available with fees adjusted based on one's ability to pay.

Health centers must also meet performance and accountability requirements regarding administrative, clinical, and financial operations.

Health centers are located in medically underserved areas and/or serve medically underserved populations. Nearly 82 percent of health center funding is awarded to community health centers, with the remaining 18.5 percent divided across migrant, public housing, and homeless health centers. This community-based primary care service delivery model has worked effectively over many years. We thank the committee for their efforts in reauthorizing this program.

Let me update you on the success and growth of the program to date. By any measure, we have been enormously successful in implementing the President's Health Center Expansion Initiative. In 2001, the President committed to create 1,200 new or expanded health center sites to increase access to primary health care across the country. By 2006, these centers were serving over 15 million patients, an increase of 46 percent since 2001. The final fiscal year 2007 congressional appropriation included an increase of more than $203 million for health centers. These additional funds are supporting the establishment of over 330 new and expanded health center sites. Of these awards, 80 are supporting new health center sites in counties with high rates of poverty that currently do not have access to health center services. These centers are part of the President's initiative to provide a health center in every poor county that lacks a health center site and can support one, thus extending the benefits of health centercare to the hardest-to-reach, poorest areas of the country. As a result, health center sites will exist in more low-income counties than ever before, and some 300,000 people in some of the poorest communities in the country will gain access to primary care, many for the first time. These expansion efforts continue to be a priority, because we know these funds go to provide direct health care services for our neighbors who are most in need.

Health centers provide comprehensive, culturally competent, high-quality primary health care services to a diverse patient population. In 2006, health centers served 15 million individuals at an average cost of about $538 per patient, and provided over 59 million patient visits. The proportion of uninsured patients of all ages held steady at nearly 40 percent, while the number of uninsured patients increased from 4 million in 2001 to 6 million in 2006.

A key goal of HRSA is to transform the systems of care for safety net populations through the effective use of health information technology. In order to improve the quality and safety of health

care, HRSA awarded in fiscal year 2007 a total of 46 grants, worth $31.4 million, to expand the use of health information technology at health centers. And 2 years ago HRSA created an Office of Health Information Technology within our organization in order to help deploy this new technology not only to health centers, but to all of our grantee service delivery programs. We partnered with the Agency for Health Care Research and Quality in order to provide information to our grantees so that they can make good business decisions as they consider the use of this technology, and we have also been partnering with the Office of the National Coordinator for Health Information Technology so that as he and his group sets health information technology standards for the country, that he understands the needs of the health care safety net in this country, and we have worked very closely together over the last 2 years.

HRSA is also currently involved in an agencywide effort to improve quality and accountability in all of HRSA-funded programs that deliver direct health care. One of the steps we have taken in this area is to establish a core set of clinical outcome measures for all health centers. In the past, we have measured how many patients we serve. We have measured and kept track of what kind of services we provide to them. But it is important to us to understand what is the outcome of all of these services that we are providing? What is the health outcomes of these services?

In our view, help for the poor should not be poor health care, so we have identified a core set of measures related to immunization, prenatal care, cancer, cardiovascular disease and hypertension, and diabetes, and these measures will help us assess how well our patients are doing relative to national norms and national statistics.

Let me now talk briefly about the National Health Service Corps. The National Service Corps was created to place clinicians in areas of need. In 2002, the National Service Corps was reauthorized by Congress through fiscal year 2006, and was given greater flexibility to distribute funds between the scholarship and loan repayment programs. This change in the law enabled the National Health Service Corps to direct more funding to loan repayment.

By 2006, the National Health Service Corps field strength grew to 4,109, a nearly 50 percent increase in the field strength since reauthorization in 2002. This is due in part to the increased flexibility the program now has to shift more funding to help meet the immediate needs of underserved communities and vulnerable populations, and in response to communities' demand for services.

In 2006, as throughout the history of the program, approximately 60 percent of National Health Service Corps clinicians served in rural areas——

Mr. PALLONE. Dr. Williams, sorry to interrupt you, but you are up to 7 minutes, and I know you are about halfway through, so if you can kind of summarize because we want to ask you questions. But go ahead, but maybe just summarize.

Mr. WILLIAMS. I will finish the one paragraph.

As a significant source of highly qualified, culturally competent clinicians for the health center program, as well as other safety net providers, the National Health Service Corps can build on its success in ensuring access to residents of health professional shortage areas, removing barriers to care, and improving the quality of care

to these underserved populations. The National Service Corps program is working with many communities in partnership with State, local, and national organizations to help address their health care needs, and to help reduce the health disparities gap.

We are proud of the accomplishments of the Health Center Program and the National Service Corps. These programs are delivering care to millions of underserved Americans with few health care alternatives. We look forward to working with the committee in reauthorizing these programs, and I would be happy to answer any questions you might have.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Williams follows:]

Statement of

Dennis P. Williams, PhD, MA
Deputy Administrator
Health Resources and Services Administration
U.S. Department of Health and Human Services

Before the

Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives

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Good afternoon, Mr. Chairman, Members of the Subcommittee. Thank you for the opportunity to meet with you today on behalf of the Health Resources and Services Administration (HRSA) to discuss the Health Center and National Health Service Corps (NHSC) Programs. I appreciate your support and awareness of the importance and critical role these safety net programs play in ensuring access to care for millions of Americans.

Background

I would like to begin with the Health Centers Program, its history, administration, and budget. Health centers are community-based and consumer-directed organizations that serve populations with limited access to health care. These include low income populations, the uninsured, those with limited English proficiency, migrant and seasonal farmworkers, individuals and families experiencing homelessness, and those living in public housing. I also want to recognize the incredible efforts of the clinicians and staff of the Nation's health centers. Their contributions to remedying the problems of the underserved and uninsured are undeniable and significant. Their patients and communities know and rely on them.

Health Centers: Forty-Two Years of Essential Service to America

In 1965 health centers were first funded by Congress to provide primary health care services to communities in need. These centers were designed to provide accessible, dignified personal health services to low-income families. Community and consumer participation in the organization and a patient-majority governing board were and continue to be hallmarks of the Health Center model.

Specifically, health centers are governed by community boards composed of a majority (51 percent or more) of health center patients who represent the population served. HRSA believes that the patient-majority governance requirement is a cornerstone of the Health Center program that assures community input and representation in the leadership and decision making of the health center.

Health centers provide comprehensive primary and preventive health care services as well as supportive services (education, translation, and transportation) that promote access to health care. Services are available to all with fees adjusted based on one's ability to pay. Health centers must also meet performance and accountability requirements regarding administrative, clinical, and financial operations. Health centers are located in medically underserved areas and/or serve medically underserved populations. Nearly 82 percent of Health Center funding is awarded to community health centers, with the remaining 18.5 percent divided across migrant (8.6 percent), public housing (1.2 percent), and homeless health centers (8.7 percent).

Honed by years of bipartisan efforts from a supportive Congress, this community-based primary care service delivery model has worked effectively over many years. We thank the Committee for their efforts in reauthorizing the program.

Health Services for School-Aged Children

HRSA recognizes that school-aged children are an important segment of the underserved population served by health centers. Approximately 23 percent (over 3.4 million) of health

center patients are school-aged children (ages 5-18). In addition, 37 percent (5.5 million) of health center patients are children under the age of 19. As a result of the ongoing support of the Administration and Congress in expanding health centers, services to school-aged children continue to grow. We believe new authority for school based clinics is unnecessary as the existing statute provides us with the authority and flexibility to help reach millions of school-aged children and provide them with much needed primary care services, either in school based sites or traditional health center settings. Moreover, the Nation's health centers are located in communities of great need and serve the entire family, not just one age group.

Also, HRSA provides services to school-aged children through the Maternal and Child Health (MCH) Block Grant. Approximately $100 million of the Federal block grant goes to this population. About 16 million school-aged children are served by the block grant. The funding is provided to State health departments, local health agencies, local education agencies, and pediatric specialty providers. The MCH Block Grant provides a variety of health services and health education programs. Examples of activities which States have reported include: in Kansas, the Coordinated School Health programs provide grants for schools to form School Councils and complete the School Health Index. These grants can be used to prevent obesity and encourage physical activity. In Maryland, in 2006, the grants supported 20 of the State's 24 local health departments' provision of oral health care, ranging from some preventive services to comprehensive clinical programs including restorative services. The MCH Block Grant also provides direct services to special needs school-aged children. MCH grant funds can be used to provide pediatric specialty services including cardiology, neurology, and orthopedic services.

The President's Health Center Initiative

I am proud to update you on the success and growth of the program to date. By any measure, we have been enormously successful implementing the President's Health Center Expansion Initiative. In the 2000 campaign, the President committed to create 1,200 new or expanded Health Center sites to increase access to primary health care, which has served over 15 million patients in 2006—an increase of 46 percent or 92.5 million since 2001. The final FY 2007 Congressional appropriation included an increase of more than $203 million for Health Centers. These additional funds are supporting the establishment of over 330 new and expanded health center sites in FY 2007. Of these awards, 80 are supporting new health center sites in counties with high rates of poverty that currently do not have access to health center services—as part of the President's Initiative to provide a health center in every poor county that lacks a Health Center site and can support one, thus extending the benefits of health center care to the hardest-to-reach, poorest areas of the country. As a result, health center sites will exist in more low-income counties than ever before, and some 300,000 people in some of the poorest communities in the country will gain access to primary care, many for the first time. These expansion efforts continue to be a priority because we know these funds go to provide direct health care services for our neighbors who are most in need.

Health Center Patients

Health centers provide comprehensive, culturally competent, quality primary health care services to a diverse patient population. This includes access to pharmacy, mental health, substance abuse, and oral health services. In 2006, health centers served 15 million individuals at an

average cost of about $538 per patient, and provided over 59 million patient visits. The proportion of uninsured patients of all ages held steady at nearly 40 percent while the number of uninsured patients increased from 4 million in 2001 to 6 million in 2006. In 2006, the current health center population served is 23 percent African American, 36.1 percent Hispanic, 4.5 percent Asian/Other (American Indian, Alaskan Native, Pacific Islander) and 36 percent White. These percentages represent almost twice the proportion of African Americans and over two and a half times the proportion of Hispanics reported in the overall U.S. population. Health Centers serve over 807,000 Migrant and Seasonal Farmworkers and their families, nearly 829,000 individuals experiencing homelessness and over 129,000 residents of public housing.

Health Center Effectiveness in Delivering Care and Reducing Disparities

The value and effectiveness of the Health Center Program has been proven in numerous studies and evaluations. Peer reviewed literature and major reports document that health centers successfully improve access to care, improve patient outcomes for traditionally underserved patients, and are cost effective. Studies have also shown that health centers facilitate the use of preventive care, especially among minority and low income patients. Health centers provide continuous and high quality primary care and reduce the use of costlier providers of care, such as emergency departments and hospitals.[1] Additionally, uninsured people living within close proximity to a health center are less likely to have an urgent unmet medical need.[2]

Health centers have been found to improve patient outcomes and reduce racial and ethnic disparities in health care.[3] For example, the health center low birth weight rate for African

[1] Proser. Journal of Ambulatory Care Management 28(4), 2005.
[2] Hadley J and Cunningham P. Health Services Research 39(5): 2004.

American patients is lower than the national rate for African American infants.[4] Also, health centers show demonstrable success in chronic disease management, and a high proportion of health center patients receive appropriate care. Researchers have also found that quality of care (e.g., patient rates of blood pressure control) delivered by health centers was comparable to and sometimes better than the quality of care delivered in other settings for the underserved.

In addition, Medicaid beneficiaries receiving care from a health center were less likely to be hospitalized than Medicaid beneficiaries receiving care elsewhere. Health center Medicaid patients were 11 percent less likely to be inappropriately hospitalized and 19 percent less likely to visit the emergency room inappropriately than Medicaid beneficiaries who had another provider as their usual source of care.[5]

Health Information Technology and Quality

A key goal of HRSA's is to transform systems of care for safety net populations through the effective use of Health Information Technology (HIT). In FY 2007, HRSA awarded a total of 46 grants worth $31.4 million to expand the use of health information technology at health centers. Grants were awarded to support implementation of Electronic Health Records (EHRs) at health centers and in networks that link multiple health center grantees, to help health centers in planning activities that will prepare them to adopt EHR or other HIT innovations such as electronic prescribing, physician order entry, or personal health records. As a condition of grant

[3] O'Malley AS, et al. Health Affairs 24(2): 2005, Shin P, Jones K, and Rosenbaum S. George Washington University: 2003, Shi, L., J. Regan, R. Politzer, and J. Luo. International Journal of Health Services 31(3): 2001.
[4] Shi et al. Health Services Research, 39:2004.
[5] Falik M. et al. Journal of Ambulatory Care Management 29, 2006.

funding, recipients are required to utilize certified HIT products where available and to implement data standards that will make HIT interoperable.

HRSA is currently involved in an agency-wide effort to improve quality and accountability in all HRSA-funded programs that deliver direct health care. Our vision is to have HRSA-funded programs provide the highest-quality clinical care in the entire American health care sector. One of the key steps we have taken in this area is to establish a core set of clinical performance measures for all health centers. Among health centers, advancing quality is not a new concept. Health centers have been on a quality quest since their inception, grounded in the principles of community-oriented primary care.

NHSC: Thirty-Five Years of Quality Service to America

The NHSC was created with the Emergency Health Personnel Act of 1970 to address a need: too few clinicians were training in needed specialties, practicing in unserved areas, or seeing people who needed health care. Its charge was simple: place clinicians in areas of need. Within six months of its initial operation in 1972, the NHSC had placed 180 volunteer clinicians in over 100 communities. Also in 1972, the Emergency Health Personnel Act Amendments established the NHSC Scholarship Program, which linked award of a full scholarship (tuition, fees, stipend) to a commitment on the part of the scholar to serve in an underserved area. The NHSC continued to place volunteers in the interim years while the first scholars were chosen, completed their training, and began service in 1977.

By 1980 the NHSC had a Field Strength of 2,080 in service to the underserved. By the mid-1980s, it became clear that despite an increase in the number of physicians nationwide, the problem of lack of access was becoming acute among increasingly larger segments of the population. In 1987, the NHSC was augmented by the establishment of the NHSC Loan Repayment Program. This new Program recruited already trained and qualified primary care clinicians by offering incremental annual payments to be applied against their student loans in return for service in an underserved area. This enabled the NHSC to fill an immediate need for a clinician, as opposed to waiting for one to be produced out of the scholarship pipeline.

In 1990, the NHSC was reauthorized for ten years, and by 1994, the NHSC, in response to community demand, expanded eligibility for loan repayment to several mental and behavioral health disciplines. In 2000, the NHSC conducted a large study of NHSC alumni (i.e., those clinicians who had completed their service obligation up to 15 years before). Fully 52 percent of those clinicians continued to serve the underserved in their practice. The NHSC of 2002 had a Field Strength of 2,765, of which approximately 54 percent were primary care physicians. Also in that year, the NHSC was reauthorized by Congress through fiscal year 2006, and was given greater flexibility to distribute funds between the Scholarship and Loan Repayment Programs. This change in the law enabled the NHSC to direct more funding to loan repayment, with the effect that in 2006 the NHSC Field Strength grew to 4,109, a nearly 50 percent increase in the Field Strength since reauthorization in 2002. This is due in large part to the increased flexibility the program now has to shift more funding to help meet the immediate needs of underserved communities and vulnerable populations. In response to communities' demand for services, the number of NHSC dentists increased by 62 percent and the number of mental and behavioral

health professionals grew by 176 percent from 2002 to 2006. In addition, in 2006, as throughout the history of the Program, approximately 60 percent of NHSC clinicians served in rural America.

The current NHSC statute sets a funding floor for the Scholarship program, 10 percent of total NHSC appropriations. HRSA supports this existing statutory authority that provides us the administrative flexibility to determine the level of support between the Scholarship and Loan Repayment Programs, in response to community requests and areas of greatest need. This flexibility also helps us to respond quickly to changes in the health care environment across the U.S.

Current NHSC Field Strength

As a significant source of highly qualified, culturally competent clinicians for the Health Center Program, as well as other safety net providers, the NHSC can build on its success in assuring access to residents of Health Professional Shortage Areas (HPSA), removing barriers to care and improving the quality of care to these underserved populations. The NHSC Program is working with many communities in partnership with State, local, and national organizations to help address their health care needs, and help reduce the health disparities gap. The current Field Strength (clinicians in service to the underserved) of the NHSC is 4,109. Of this amount, 2,051 are in HRSA grant-supported health centers, with the remaining 2,058 NHSC clinicians in "free-standing" sites. It is noteworthy that the percentage of NHSC clinicians working in health centers has been at 50 percent or higher since 2004, the highest, and longest sustained,

percentage in recent years. The NHSC made 1,100 NHSC placements in HPSAs in FY 2007—in response to community requests and the level of need.

Other NHSC Activities

In getting the word out to the communities about our programs, the NHSC's Student/Resident Experiences and Rotations in Community Health (SEARCH) Program is offered to State-based organizations on an annual, competitive basis. Under this program, health professions students and medical residents get experience in primary clinical care. This potentially leads to greater numbers of clinicians serving in primary care centers, including health centers. In FY 2007, 20 States and Puerto Rico participated in SEARCH at a funding level of $1,823,068.

The NHSC Ambassador Program is a membership organization comprised of a dedicated group of volunteers on campuses and in communities across the Nation. These volunteers, or "Ambassadors," work in partnership with the NHSC, serving as mentors and trainers to Scholars and Loan Repayers.

The word is spreading. The NHSC's recruitment efforts have led to its Job Opportunity List utilized so successfully that more vacancies were filled last year by non-NHSC clinicians than by NHSC Scholars and Loan Repayers.

Conclusion

We are proud of the accomplishments of the Health Center Program and NHSC. These programs are delivering care to millions of underserved Americans with few health care

alternatives. We look forward to working with the Committee in reauthorizing these programs.

I would be happy to answer any questions at this time.

Mr. PALLONE. Thank you. And we will submit your whole statement for the record.

I apologize for interrupting, but we do want to ask you some questions, and I will recognize myself initially for 5 minutes.

I cannot stress enough how important these community health centers are nationally, as well as in my own district. We have quite a few in my district. And with the increased number of uninsured, and with a lot of people who are undocumented, the needs of these health centers have just grown dramatically in my district, and I am sure that reflects the rest of the country.

I want to commend the Bush administration for its initiative, which began when the President was first elected, to try to provide money for new centers, the infrastructure. I think, as you said, that has been very successful. But my questions really kind of go back to the same thing in some ways that Dr. Burgess mentioned.

If I could use my own hometown as an example, we a few years ago built a new community health center which is federally qualified, unlike, I guess, some of the ones that Dr. Burgess mentioned which are not, but yet they have been denied the grants under the Section 330 program several times. So I guess, as you know, in this bill, in Mr. Green's bill, we have increases in the authorized funding levels. The administration has not commented on those so far. So my question really relates to whether or not you or the administration would take a position on these authorized funding levels. I think they are needed, because I know that even though I have a qualified health center, we haven't been able to get any money. And obviously Dr. Burgess is talking about those who haven't even qualified. So if you could tell us what the administration's or your position is on the authorizing levels and what the need is, because clearly there is a need for a lot more money, in my opinion.

Mr. WILLIAMS. Well, there certainly is a lot of demand for health centers. When the President's initiative started 6 years ago, and the amount of money devoted to the expansion of these health centers began to grow, I think a lot of us felt at that time that the—it might be difficult to attract the number of applications we would need to spend the money that was given to us and to get the quality of applications that we wanted in order to make these health centers successful. But as the initiative went on, to our surprise we got rapidly a very large number of increases in the number of applications every year. And as the initiative went on, the quality of those applications has also grown substantially over the 6-year period, so that by this time we are in a very—it is a very competitive market.

About a third of all of the people who apply to us for a health center are successful, and many of them are not successful on the first try, but are successful after two or three attempts. And we, through the primary care associations and also through State governments, have been providing a lot of technical assistance to communities in order to prepare them to be successful applicants.

Mr. PALLONE. So clearly you do see a need for additional funding?

Mr. WILLIAMS. Well, I can say to you there is a demand for additional funding. Quality is important. But in any budget situation like this, it is a matter of priorities and balances. There are a lot

of things which this government supports, and what is the proper amount really comes down to a question of establishing a balance in one's priorities.

Mr. PALLONE. All right. Let me ask you this, because I only have 5 minutes. You mentioned HIT, and I understand that the authorization under this bill or maybe under existing law doesn't specify grants specifically for HIT. But I think that is very important.

I visited one of my community health centers that in many ways is a model. I am not going to mention the name right now. But one of the things that I noticed is that they were not—they had no—you know, their records were still paper. Half of the building was devoted to the records, which seemed such a waste.

It seems to me if you have more HIT, you can really save some money and use the money for other things. So would you advocate that we specifically provide in the legislation authorization for HIT, or how do you decide when you are dealing with these grants, how to allocate your funds for HIT versus other things?

Mr. WILLIAMS. I don't think it is a question of authorization. I think we have the ability to support health information technology in our grantees. It is a question—again, it is a question of how you wish to spend the money available to you. And we have worked hard to try to make money available within the appropriations given to us to support this new technology.

Now, I think in our view it is not—we would like to support broader networks of grantees. We have what are called Health Center Controlled Networks. These are collections of grantees who come together for the purpose of managing this technology either as practice management systems or electronic health records. By coming together and pooling their resources, they are much more successful because this technology is expensive, and by coming together it makes it cheaper for people to afford it. But even more important than the cost is that the knowledge, the people who know how to use the technology, is as scarce or even more scarce than the money. So by becoming part of a network, that scarce knowledge base can be made available to a lot more of our grantees. That makes investment in health care technology a lot less risky because you have got—you are working with people who know how to use this technology.

But we are never going to be probably in a position to buy all this technology for everybody, so we are also trying to provide information to our grantee base through ARC. We have set up a Web site dedicated to community health centers, and we have brought our health center community together in that Web site. They can talk to each other. They can learn from each other's experiences. And we make available on that Web site information about electronic health records and other technology to help educate those who are going to buy this technology so they can make a good business decision. So those are some of the things we are trying to do.

Mr. PALLONE. Thank you.

Mr. Deal?

Mr. DEAL. Thank you.

Dr. Williams, I want to talk primarily about the National Health Service Corps. As I understand, about half of the people who go

through that program wind up working in community health centers. Is that generally true?

Mr. WILLIAMS. That is about right, yes.

Mr. DEAL. All right. Is the Department currently examining ways in which changes can be made to the health professions shortage areas? And if so, what changes would you anticipate there?

Mr. WILLIAMS. We are looking at that regulation. The regulation in place has been around for many years, and we are in the process of reviewing that regulation. And we hope in the short period of time to be putting out a proposal that the public can comment on with respect to that regulation.

Mr. DEAL. Could you elaborate as to the kind of changes you are anticipating?

Mr. WILLIAMS. I can't at the moment because it is still on the decision side of the Department. We are talking with OMB about it, but we do expect to soon put it before the public as a notice of proposed rulemaking. And we will give the public the opportunity to comment, and then we would see whether the ideas are good or not.

Mr. DEAL. OK. Would you explain the breakdown that exists now between the scholarship side of the program and the loan side? And which of those programs yields the best results?

Mr. WILLIAMS. Under current law, we are required to provide a minimum of 10 percent of the National Service Corps recruitment dollars for scholarships. So we have a floor, which gives us actually a lot of flexibility as to how the money might be allocated between loan repayments and scholarships. There is a real trade-off that one has to think about here. On the one hand, when you invest in a scholarship, you might be investing a fair amount of money, let us say 4 years of medical school, and then that person would graduate from medical school, go off into residency, and 6, 7, 8 years later are available for service in an underserved area. That is a very long wait time to get the benefit of the money that we really put up front.

The other dimension to that is—that you alluded to is somebody who is just starting medical school at the age of 22, by the time they are 30 and have to go out and serve, they may look at the world differently. Their circumstances might be different than they were when that individual was 22. So with that long lead time, people's willingness to serve sometimes is different at the end than at the beginning.

The advantage of a loan repayment is that they have already gone through—the individual has already gone through all that process. They have finished their medical school, they have finished their residency, they are ready to go to work. So we can give them incentives to come to work in underserved areas by buying—helping to buy down their loans, pay back their loans; and the service is immediate.

There is a big advantage, in order to maximize the number of people you have in the field, to use loan repayment. Scholarships can also be useful to some extent to support those who might otherwise not go to medical school because of their income, but they

can't get a scholarship until they have already been admitted to medical school. They would have wanted to have gone anyway.

But there is some use to scholarships, I think, to promote the diversity in our workforce, but the long lead time has to be considered.

Mr. DEAL. But in addition to having an available workforce, make your dollars buy up front as you have talked about, isn't there also a difference in the retention rates that you see between a scholarship and a loan program?

Mr. WILLIAMS. Yes. We—well, I don't know the exact statistics on that, but certainly most people going into loan repayment are well committed to the work that they are going to do. In the overall program, our retention rate of scholars and loan repayers is very, very good. Fifty percent of the people we put into medically underserved areas are there many years after their commitment is over. It is a very cost-effective program either way you look at it.

Mr. DEAL. Do you feel that the legislation before us today, which would require $30 million to be dedicated to scholarships, would that hurt or help your program?

Mr. WILLIAMS. I think, in our view, it would reduce the flexibility that we have now. Right now, we have a floor of 10 percent for scholarships. That gives us a lot of room to maneuver and balance between scholarships and loan repayers.

At the present time, we are devoting about 20 percent of our money to scholarships and 80 percent to loan repayers, so we are actually giving scholarships a little bit higher than the floor requires. $30 million, depending on the amount of money available, can be a substantial amount. Right now, we are—in 2007, we had $85 million for recruitment. If we would have had to devote $30 million of that to scholarships, then we would have had to put 35, 36, 37 percent of our money into scholarships.

That reduces our ability to put our money where we think we can get the best return.

Mr. DEAL. Thank you, Mr. Chair.

Mr. PALLONE. The gentleman from Tennessee.

Mr. GORDON. Thank you, Mr. Chairman.

Dr. Williams, in 2005, the House and Senate appropriators directed HRSA to include optometry in the National Health Service Corps loan forgiveness program.

Per this directive, do you believe that HRSA has the authority to include optometry in the Corps?

Mr. WILLIAMS. No, I don't believe we do.

Mr. GORDON. Well, you are consistent with your statement. I don't agree with it, but you are consistent, which I think demonstrates much more why we need to have legislation to accomplish that need.

Thank you.

Mr. PALLONE. Mr. Pitts.

Mr. PITTS. Thank you, Mr. Chairman.

Dr. Williams, what types of providers are eligible for the National Health Service Corporation loan repayment program?

Mr. WILLIAMS. Doctors, dentists, nurses, a range of midlevel providers, psychiatrists—an exhaustive list.

Mr. PITTS. Is that list exclusive?

Mr. WILLIAMS. I think that is most of them, but I could give you an exhaustive list for the record.

Mr. PITTS. In your opinion, what would be the effect of adding additional skills to this list?

Mr. WILLIAMS. Again, I think it is a matter of priority and tradeoffs. Right now, I think if you listen to community health centers, half our national service corps are going to community health centers, for example. That represents probably somewhere in the range of—I don't know—10, 15, 20 percent of their clinicians.

They buy a lot of health professionals outside of the National Health Service Corps in order to manage their program. They have increased their total staffing by about 50 percent in the course of this growth in the Health Center Initiative, so there is opportunity for health centers and others to make decisions about whether they buy an optometrist, which they are perfectly free to do, or to buy a clinician.

What people tell us is that they need clinicians, they need doctors, they need dentists, they need nurses. I think, given the demand for those skills, adding additional professions to this list may not serve the purpose that it is designed to do.

Mr. PITTS. I understand that only 17 percent of community health centers have an optometrist on the staff. In my home State of Pennsylvania, only 6 of our 29 community health centers have an optometrist on the site.

Wouldn't including optometric care in an HSC help achieve the goals of the program and HRSA's public health goals?

Mr. WILLIAMS. Well, I don't think it would necessarily help the health center who wants an optometrist. If a health center wants an optometrist, and an optometrist is willing to serve, they can pay an optometrist to provide services in their health center.

If the National Health Service Corps were to make an optometrist available, they would also have to pay the salary to that optometrist, so the question is, I think really in the end, are there optometrists willing to serve in medically underserved areas on their own, or would they need to be provided some additional incentive? I don't think I know the answer to that question.

Mr. PITTS. Are there any providers not on the list that you think should be added?

Mr. WILLIAMS. Not at the moment, no.

Mr. PITTS. Let me shift to H.R. 4230, the School-Based Health Clinic Act. Are school-based health clinics reimbursed for prescription contraception or the morning-after pill?

Mr. WILLIAMS. I have no idea. We don't manage school-based health clinics as you are describing it in this legislation.

Some of our health centers do run—have sites that are located in schools, but they are part of the community health center normal operations. They just happen to have a site located at a school.

But the school-based health clinics you are talking about authorizing in this program are freestanding. They are not associated with a community health center program, they would be a separate activity, a business that we don't have any association with.

Mr. PITTS. With the ones that you are involved in, are there any age restrictions or parental consent requirements for reimbursement?

Mr. WILLIAMS. To the extent that we—that a community health center manages one of its—has a site in a school, it would be subject to the same State and local rules, laws, as any other health care provider would be. That is going to vary by every State and local jurisdiction.

Mr. PITTS. But as far as the Federal Government is concerned, there are no age restrictions or parental consent requirements?

Mr. WILLIAMS. In terms of primary care services, no. In fact, we fund about—30, 35, 36 percent of the people we serve in health centers are kids under the age of 19. About 23 percent of the people we serve are school-aged kids, mostly in primary care settings outside of the school, but about 10 percent in school settings.

Mr. PITTS. My time is up.

Thank you, Mr. Chairman.

Mr. PALLONE. Mr. Green.

Mr. GREEN. Thank you, Mr. Chairman.

Dr. Williams, I understand that HRSA provided funding for roughly 700 new community health center sites and more than 500 expanded sites since the beginning of the health center expansion initiative in 2002. I know President Bush and this Congress and I supported that bipartisan effort to secure this increase.

During that same time, however, I understand that upwards of 1,000 additional applications were submitted and met all the program requirements, but were not approved due to the lack of available funding; is that correct?

Mr. WILLIAMS. Well, some were certainly not funded because of the lack of available funding, but some did not meet our quality standards also.

Mr. GREEN. Even though they met the program requirements, the quality standards are different from the program requirements?

Mr. WILLIAMS. Well, it is a competitive situation; to be in the competition, you have to meet the standards of the law. After that, it then becomes a matter of what is the degree of need, how good is the program relative to others who are applying.

It is a competitive environment in that sense, and about a third of the people who apply to us get funded in any given year.

Mr. GREEN. What I am saying, I guess, I am trying to get to, is that there were 1,000 additional applications that were submitted and met all the program requirements, but they didn't score as high because of the funding availability.

I would assume my colleague from Tarrant County, maybe his FQHC they were seeking may have been in those 1,000 applications. I don't know either.

Mr. WILLIAMS. Possibly, it is; possibly, yes.

Mr. GREEN. But when you have upwards of 1,000 that were submitted and met the program requirements, but weren't funded because of the competition, it stands to reason that we might need more funding.

Mr. WILLIAMS. Well, I am not saying that the program couldn't use more funding.

Mr. GREEN. That is fine.

Mr. WILLIAMS. You have to be concerned about the quality of the applications that you end up funding. Again, it is a question of budget priorities.

Mr. GREEN. Oh, sure. I understand that. That is why I wish I could say we appropriate money in this committee, but we don't. We just authorize it, and we still have to fight within the appropriations process to do that.

I was looking at the numbers. Fiscal year 2008, the President requested $1,988,467,000, which is a little more than $400 million more than the year before for fiscal year 2007. The House actually appropriated—although again Labor-H didn't pass, wasn't signed, but about another $200 million. The House passed $2,188,000,000.

Again, no matter what we authorize, we are still going to be struggling with getting $2,188,000,000. We are dealing with authorizations, and I think your point was made.

Mr. WILLIAMS. Let me correct your numbers a little bit. The President's budget in 2008 was actually—it was about $200 million more than the 2006 level, but it was about the same as the actual enacted level in 2007.

Mr. GREEN. OK. But again, getting back to the original one, there were 1,000 additional applications that were submitted that met the program requirements, but because of competitiveness, they couldn't be funded.

While we support the expansion of the community health centers, it is no surprise to members of our committee that the need remains high for affordable and effective community centers. Earlier this year, a study found that 56 million Americans are medically disenfranchised, that is, without a regular source of care or lack a community health center. As we plan for the future, it is critical we know how many would-be health centers are out there that still haven't received grant funds and, as a result, how many more patients we could reach through this successful program.

What I would ask you, and I know you don't have it today, if you could provide the committee with the total number of applications submitted for each year, beginning in fiscal year 2002, and the number that were scored as fully acceptable or higher, and the number that were actually funded, so we can look at it and base our authorization levels, hopefully, on the number of clinics that weren't—that meet the requirements, but because of budget constraints, couldn't qualify.

Mr. WILLIAMS. We would be happy to do that.

Mr. GREEN. Your testimony mentioned HRSA's goal of improving quality health care at centers throughout with expanded health information technology. I agree with you.

I am pleased that the agencies awarded grants to health centers for health IT expansion. Despite the increased emphasis on health IT in HRSA, we know that health IT adoption is not widespread among our centers.

A recent "Health Affairs" article published the results of a national survey of FQHC's foci on health IT. A study found that a quarter of health centers have some capacity for electronic health records, but only 13 percent of health centers have truly functional electronic health records.

It should be no surprise that the lack of capital is a cited as a top barrier to the health center adoption of IT. With more than 100 health centers in this country and with only 13 percent truly functional for electronic health records, I can only imagine that HRSA has more than 46 centers in need of health IT grants.

Can you speak to HRSA's needs for health resources for those health IT grants?

Mr. WILLIAMS. Yes. Let me say one thing. I think the health center community is a very diverse community, and it ranges from very small health centers and isolated rural areas to larger, one would say, almost big businesses.

If you look at the very best of what we have—and not all of them are just the biggest, but if you look at the very best of our health center operations, especially with respect to health information technology, they are—our best health centers are on the cutting edge in the use of this technology, especially for clinics and medical operations of the size that we are talking about.

A lot of—we are not a big hospital center where a lot of this technology is now deployed. But if you look at doctors' offices or clinics, the best of our health centers do very well with this technology.

There is more that we can do, and we are trying to encourage them to be wise in their business decisions, to come together as networks so that they can reduce the risk of the implementation of this technology. And we have also been working with—going around the country talking with foundations.

States are also now investing in this technology and trying to make marriages, so to speak, between foundations that want to invest in the safety net and promote this technology, States that want to do the same thing and bring our health center community to the table and say we are a vehicle where this technology can be deployed to the very good benefit of the people we serve.

Mr. GREEN. I agree, and I know my time is running out and ran out, Mr. Chairman, but that is the beauty of our community health center program, that they can draw money from lots of other sources, including foundations; but we are only dealing with authorization level.

Mr. Chairman, I would like to submit that our increased authorization level fits the future needs of the health center program; and also the health IT adoption is a perfect example of the growth tool that our bill seeks and needs to provide to health centers. We can go to foundations, and I know lots of centers do that, but they still need that basic assistance from the Federal Government.

I have one other question I will submit, basically on Dr. Williams' testimony that driving the health centers program is cost-effective. I would like to follow up on that, but we will do that to show they are cost-effective, particularly with Medicaid.

Mr. PALLONE. So ordered.

Mr. Murphy.

Mr. MURPHY. Thank you, Mr. Chairman.

Dr. Williams, good to have you here. I saw a study that was reported a while ago from the National Association of Community Health Centers that stated that the community health centers even save Medicaid about 30 percent per Medicaid patient, or about $17

billion annually, due to reduced specialty referrals and fewer hospital admissions.

Does that number sound about right, or do you think it is higher than that now?

Mr. WILLIAMS. I don't have any other information that would say it is any different, so I would guess that is probably correct.

Mr. MURPHY. I am just thinking in terms of it not only saves people money when they don't have any insurance, but it even saves money, the government money, on Medicaid.

Also, a question with those professionals who participated in the National Health Service Corps: They are paid for their services?

Mr. WILLIAMS. They are paid by the people who employ them, yes.

Mr. MURPHY. They are employed by the community health centers, and I am assuming they are covered under the Federal Torts Claim Act. And you heard my earlier comments.

Mr. WILLIAMS. Yes.

Mr. MURPHY. Were aware of the issue out there, that volunteers are not covered by that?

Mr. WILLIAMS. Yes.

Mr. MURPHY. Do you know, has the Government in any way—looked in any way at what the cost savings would be if we allowed people to volunteer at these centers?

Mr. WILLIAMS. Volunteer at community health centers?

Mr. MURPHY. Yes.

Mr. WILLIAMS. I don't know the answer to that question. The statute clearly requires us to employ physicians. It doesn't allow us to provide tort coverage to volunteers.

Mr. MURPHY. The law would allow us to change that.

Mr. WILLIAMS. There is, though, and this is worth looking at—the Congress authorized a program a couple of years ago, free clinics program. Their volunteers, if the clinic itself accepts no payment, and the physicians who practice there accept no payment, they can—if they apply to us and meet certain criteria, can get FTCA tort coverage.

Mr. MURPHY. I always thought it was ironic that a community health center, if you are paid, you are covered by the Federal Torts Claim Act, and if you are volunteering, not. If you volunteer at a free clinic, you are covered, but if you are paid, you are not.

Maybe we should look at what is the best way to help the patients out. I mean, only government could figure out that kind of a mess, how to do that. Yet if we recognize that just the savings alone from Medicaid may be upwards of $17 billion—and that was a couple of years ago—and we are trying to provide other open direct access of care for patients without even having to go through insurance carriers alike—without having to go through Medicare, Medicaid, everything, but directly with the physicians—it seems to me that it is an issue whose time is due. I hope that is something you all can look at.

My understanding in the past—unfortunately, our CBO doesn't score savings. Any time a Member tries to present legislation that saves the government money, the government says. We don't know how to score that. And we hope that is something you can address to the chairman of the subcommittee and the full committee too.

I wanted to ask, of those who are part of the National Health Service Corps, those are generally people right out of school too?

Mr. WILLIAMS. Right out of medical school and usually right after their residency—they complete their residency.

Mr. MURPHY. You need just to draw attention that those who might want to volunteer—sometimes it is a physician who, oftentimes because of the cost of medical malpractice insurance—you may be aware of this—there may be an OB/GYN who declares it is too costly to deliver any more babies, so they stop doing prenatal care. They stop deliveries.

I see many of these folks who say, I would love to volunteer some of my time somewhere. But, of course, if they do that, then their insurance climbs back up again and they can't do it. It is a way of getting people who are highly experienced at these centers as well.

I think we all agree in this community, these centers are just a tremendous asset for communities. It is sad, though, when I read an article that came out the other day in way off, faraway Anchorage, Alaska, that they are struggling to hire. They don't have enough physicians there, and some funding issues. But again, it is an issue if someone could volunteer, they could do well, and I can save some money.

I just want to leave my questions with the part of I hope that is something you will take a careful look at and provide some information back to the chairman of this committee.

Mr. WILLIAMS. We would be happy to do that.

Mr. MURPHY. I yield back.

Mr. PALLONE. Thank you.

Ms. Baldwin.

Ms. BALDWIN. Thank you, Mr. Chairman.

Dr. Williams, I have a couple of questions that actually relate pretty closely to the first question that Mr. Murphy just asked, basically the interrelationship between the Medicaid program and the community health centers.

First, I just want to recall that obviously Congress a few years ago passed a Deficit Reduction Act which included cuts to the Medicaid program, giving the States the authority to figure out how they would extract those savings, but including increasing the amount of cost-sharing that Medicaid beneficiaries would have to pay for their health care.

I know that during the debate those several years ago, many of my colleagues and I argued that we expressed our concerns about the cost-sharing provisions and how it could make health care unaffordable to some Medicare beneficiaries and potentially force them to forgo needed care.

I am curious to know whether we are seeing any pivot of these people, turning to community health centers.

As the representative of the agency that administers the grants for the health—for community health centers, has HRSA evaluated the data from community health centers of late, to measure the impact that increased Medicaid cost-sharing provisions have had on utilization of community health centers and the people they serve?

I would invite you also, if any of the other DRA requirements that were put in have increased utilization—I know there were numerous provisions, obviously, in the DRA.

Mr. WILLIAMS. I can go back and take a look. I am not aware of any research that we have done that would pinpoint the answer to the question that you raised.

Certainly, health centers are by law obligated to serve whoever comes to them. Whether more people are coming because they have higher copayments outside of Medicaid, I don't know. Certainly, as the number of uninsured has grown, there are more people, I think, coming to health centers because they have no alternative.

I will see what information we may have, but I am not sure that we can answer your question precisely.

Ms. BALDWIN. OK.

Also, following directly on Mr. Murphy's first question, we certainly as a committee struggle with ensuring that American people have access to quality health care, but also maintaining fiscal discipline in our entitlement programs such as Medicare and Medicaid.

In your testimony, you described health centers and their programs as cost-effective. I certainly and wholeheartedly agree with that, but I wonder if you could elaborate on the relationship between health center programs and the Medicaid programs, particularly with regard to the savings that the care provided in health centers translate into for the Medicaid program.

Mr. WILLIAMS. A lot of the Medicaid reforms have shifted decision-making to the State level, so States have a lot more flexibility on how to design their programs and how to operate.

That has been, actually, an incentive for our community health centers to talk and come to their States to lay out what they can do, demonstrate what they can do in the context of providing a value for the Medicaid services which they provide.

Incidentally, health information technology, electronic health records, actually is a good tool to document the services you are providing and the results that people get. Chronic disease management with diabetes, for example, a lot of health centers are very good at controlling chronic disease. For Medicaid, it is a real value.

I think, as we go around and talk to State Medicaid directors, a lot more of them are now conscious of the fact that health centers actually produce very good results and are willing to work with health centers as part of their managed care or other operations at the State level.

I think it is beginning to penetrate that health centers are a very good deal.

Ms. BALDWIN. That is great, and that is a really interesting point you raise about health centers actually approaching Medicaid administrators at the State level.

Are there any States that have provided a role model for others to look at in terms of that collaboration and the cost savings that are generated from that?

Mr. WILLIAMS. Well, let me take that back, and I will give you some feedback on that question.

I know in some States—Texas, for example, understood early on that health centers were a very good investment and they actually

created what is called an incubator program in Texas and they worked with communities, States, that invested in the development of FQHC, what are called FQHC look-alikes. They would then apply for FQHC status, and that would give them good experience to apply to us for a section 330 grant.

Other States, Louisiana and others, have picked up this idea and are also investing in their communities to try to develop good, competitive applications for the health center program because they have understood that it is a good investment.

But I will see what other additional information I can give you that might point to some States that are very good at this.

Mr. PALLONE. Thank you.

Mr. Burgess.

Mr. BURGESS. Thank you.

Dr. Williams, you heard me reference Orleans Parish and Jefferson Parish in my opening remarks. As far as the National Health Service Corps is concerned, do you think that during the public health emergency that existed in the fall of 2005 and, really, to my understanding, persists to this day, do you think the National Health Service Corps has adequately addressed the needs of Orleans Parish and Jefferson Parish in Louisiana?

Mr. WILLIAMS. Absolutely. We have worked—from the immediate aftermath of Hurricane Katrina in Louisiana, we worked very closely with the State as they provided us information for designating geographic areas in Louisiana as health professional shortage areas.

The State has a very good mechanism. We gave it a high priority, and we told them that as they assembled information, brought applications to us, that we would turn them around in a very short period of time, and we have kept that promise.

If you look at the number of health percentage—health professional shortage areas designated in Louisiana today, versus prior to Hurricane Katrina, you will see that we have kept our word.

With respect to Orleans Parish, a lot of the health care providers live there. It is difficult to identify some geographic areas as health professional shortage areas, and actually I think Orleans is one, because there are so many providers that are there. We have tried to work with the State to actually identify shortage populations and other ways to try to make these designations available to the State.

Mr. BURGESS. I don't want to interrupt you.

Mr. WILLIAMS. They have done a very good job working with them, and I think the State would say we have too.

Mr. BURGESS. Well, but every time we have a hearing on either Oversight and Investigations, or this committee, that deals with health care in Louisiana, we hear about the fact that it is not working as it was intended.

I will just tell you my own observation from being down there. In October of 2005 I met with groups of doctors in both Jefferson Parish and Orleans Parish, and they were struggling to keep the doors open. They were spending their kids' college money to keep their doors open, and they couldn't get any help out of Washington. I heard it over and over and over again.

Then our committee, the Subcommittee on Oversight and Investigations, went back down in January. It was pretty clear to me then that doctors were leaving the area in large numbers. If the doctor was not married to someone who was born and raised in the area, they were not very likely to stay there.

Now—again just my personal observation, but again, it has been borne out by testimony we have had before this committee on numerous other occasions. I would just ask, in the interest of time, if you could detail some of those things for me in writing.

Mr. WILLIAMS. We are not the only ones involved in this. CMS and others have also been very much engaged. Secretary Leavitt has been very much engaged in trying to make resources available.

Mr. BURGESS. I understand. I will just tell you the level of frustration that is coming before this committee time and again does not indicate that a good job has been done. Quite honestly, I don't know, really it been several months since we have had another hearing, and perhaps we need to go back down there, Mr. Chairman. I would be very interested in doing that.

Let me just ask you a question, because we are going to run out of time. You talked a little bit about not having the availability to tie into the kinds of things that a big hospital system would and that you would rely on foundations and States that want to invest in the health care, the federally qualified health care system.

What about partnering with some of the integrated health systems that are out there like Ascension Health, Covenant Health out in West Texas. What are the barriers that prevent the federally qualified health center from partnering with some of those groups?

Mr. WILLIAMS. Partnering in the investment and information technology.

Mr. BURGESS. Well, trying to get a specialist, trying to get a patient referred to a specialist, for example, when their primary care is a federally qualified health center—difficult to get them referred to a specialist, might be difficult to get them into a hospital.

You have groups like Ascension Health and Covenant Health out in Lubbock that would welcome the opportunity to work with a federally qualified health center and that would be a win-win situation for both sides.

Mr. WILLIAMS. Sure.

Mr. BURGESS. Yet, they have had no success in getting past the starting blocks.

Mr. WILLIAMS. Well, I think what Ascension—if you are talking about a health center making referrals for specialty care to Ascension Health, I don't see that there are any barriers to that. If what you mean is that Ascension Health itself wishes to become designated as a FQHC, that is a different matter.

It really has to do not with Ascension Health's ability or—it could qualify. It does nothing about Ascension Health and its clinics that couldn't qualify if it met all of the requirements of the statute. For a big hospital system like Ascension, traditionally the biggest stumbling block has been governance requirements, that the requirement for a majority, consumer-based board has been one of the biggest obstacles to big hospital systems.

Mr. BURGESS. But, in concept, you would not be averse to that type of partnering if the governance issues could be worked out.

Mr. WILLIAMS. I think the governance issues are very important.

Mr. BURGESS. If they can be worked out, then an amendment to our reauthorization bill that addressed that would be in accordance with HRSA's desires.

Mr. WILLIAMS. No. I think if Ascension Health can qualify for the section 330 health center requirements as they exist today, we would obviously like that. We wouldn't necessarily propose to change those.

Mr. BURGESS. Let me ask you this. Would it be possible for you to provide the committee with a map where the federally qualified health centers are located across the country?

Mr. WILLIAMS. Yes. In fact we do have such a map. We have geospatial data capability. We can do that.

Mr. BURGESS. You can provide that to the committee?

Mr. WILLIAMS. Yes.

Mr. BURGESS. When Congressman Green talked to you about the scoring and that some facilities might not score as high as others, do you ever look at the maps to see that you have six clinics in Chairman Pallone's district and five in Congressman Green's and none in Ranking Member Barton's district and none in Congressman Burgess' district?

Mr. WILLIAMS. We don't look at things that way.

We do look at the maps and see where we have gaps. We have done that. One of our motivations for the President's initiatives on high poverty counties was our recognition that some of the poorest counties in the country were not as competitive in the Presidential initiative, and so we felt the need to try to create a competition that would allow those poor counties to better compete. That was the motivation for that by looking at the map.

Mr. BURGESS. The counties themselves are not amorphous. There can be pockets, deep pockets, of poverty within a county that otherwise just demographically can look quite affluent.

Mr. WILLIAMS. Yes, people have pointed that out to us. I think that is a fair comment.

Mr. BURGESS. Let me ask you this. You talked about performance and accountability standards within the federally qualified health center. Who draws up the business plan? Is that entirely drawn up by the board?

Mr. WILLIAMS. They are responsible for doing that, yes.

Mr. BURGESS. You have oversight over the business plans as they are drawn up?

Mr. WILLIAMS. We do have oversight. We need to make certain that they meet statutory requirements and that they are doing what they are telling us what they are going to do in their applications.

Mr. BURGESS. Decisions like the ratio of the number of administrators to the number of practitioners, who makes those decisions?

Mr. WILLIAMS. That is a local board decision.

Mr. BURGESS. Who makes the decisions about how many patients per day are seen by a given practitioner?

Mr. WILLIAMS. We have some standards that we like to hold people—give people objectives to try to meet. In the end, it is a board decision.

Mr. BURGESS. I have got to tell you, in trying to work through some of these problems locally in Fort Worth, thinking back to my days of having run a clinic, looking at the guidelines that were provided by the existing federally qualified health center, I don't know how in the world the thing could cash flow with the number of constraints they put on themselves.

But those are entirely local board decisions and not decisions coming out of HRSA?

Mr. WILLIAMS. We have some of productivity standards that we lay out for people, and we want them to try to meet them. They are not absolutes, but we do set some goals for them. We don't want to subsidize very expensive health care.

If you look at the cost per patient that I have cited to in my testimony, I think we are, by and large, a very productive system.

Mr. BURGESS. Now, in a community where you have a federally qualified health center and a private practitioner side by side, a Medicaid patient comes to each facility, is the reimbursement rate different in a federally qualified health center than it would be for a private practitioner who is just out trying to earn a living next door?

Mr. WILLIAMS. FQHCs do have some cost reimbursement advantages.

Mr. PALLONE. Dr. Burgess, I am going to have to stop you, even though I like your questions, but you are 4 minutes over, so let's wrap up.

Mr. BURGESS. I guess what I am getting at is, would there ever be a situation where we would reimburse the actual physician in a neighborhood that doesn't have a federally qualified health center?

Why don't we encourage the participation of physicians in those neighborhoods who are out there doing our work for us, seeing the Medicaid patient, seeing the SCHIP patient, seeing then insured patient? Why do we favor the physician who is working in a federally qualified health center when the physician who is working in a private practice in a similarly poor neighborhood is doing just as much good work?

Mr. PALLONE. We will let you answer that, and that is going to be it.

Mr. WILLIAMS. I think the underlying argument here is that in a health clinic setting such as we have, we are providing health care and a lot of wraparound support services for that individual and for the patients who come to that clinic; and the return for that is very good.

Mr. BURGESS. Mr. Chairman, I would just submit if we paid physicians in poor areas fairly to begin with, maybe we wouldn't have had to create this entire other bureaucratic structure. But that is another day's question.

Mr. PALLONE. Fair question. I know you are going to get back to us with some materials, particularly that map is of great interest to me as well.

Mr. WILLIAMS. We would be happy to do that.

Mr. PALLONE. Thank you very much. We appreciate your responses, and it has been very helpful in what you have been doing.

Thank you.

Mr. WILLIAMS. Thank you.

Mr. PALLONE. I will ask the next panel to come up.

Our second panel—I will go from the left here: We start with Mr. Wilbert Jones, who is chief executive officer of the Greater Meridian Health Clinic in Meridian, Mississippi.

Then we have Steven Miracle, who is executive director of the Georgia Mountain Health Service, Inc., in Morgantown, Georgia. I like that name, "Miracle."

We have Mr. Ricardo Guzman, who is chief executive officer of the Community Health and Social Services Center in Detroit, Michigan.

Finally, Dr. Michael Ehlert, president of the American Medical Student Association. He is from Reston, Virginia.

As I said before, we have 5-minute opening statements from each of you. They will be made part of the record. We may ask you to submit additional statements in writing for inclusion into the record.

I recognize, first, Mr. Jones for an opening statement or for a statement. Thank you.

STATEMENT OF WILBERT JONES, CHIEF EXECUTIVE OFFICER, GREATER MERIDIAN HEALTH CLINIC, MERIDIAN, MS

Mr. JONES. Mr. Chairman, good afternoon, Chairman Pallone, Representative Deal and members of the subcommittee.

I am honored to speak with you about health center programs and several pieces of Federal Tort Claims Act legislation that would help centers to deliver better care for the systems for the underserved communities.

As chief executive director of the Greater Meridian Health Clinic, I am grateful to this subcommittee for supporting health center programs.

I want to thank my Congressman, Representative Pickering, and Representative Green for introducing H.R. 1343, the Health Centers Renewal Act. All the health centers in my area support this bill and wish to renew the core elements of this program. This program would also authorize much-needed additional funding so that we can serve even more individuals in our communities.

Mr. JONES. The Greater Meridian Health Clinic was established in 1986 to serve medically underserved residents in five counties in our rural areas. We operate six sites and a mobile health unit, and we pride ourselves on being a one-stop shop for the provision of primary care, preventive care, on-site dental, pharmacist services and important enabling services.

I am very proud of the board of directors, who make sure that we are connected to our community, and I am equally proud of our staff, which now number over 100 employees, including health care providers, administrative staff, to support patient care in over seven sites.

As the health center program has grown over the past 5 years, Congress has recognized key challenges that could keep health centers from maximizing delivery of health services to the medically underserved individuals. With this in mind, in 1992, Congress enacted legislation that would allow health centers to be covered

under FTCA in order to expand the availability of care and ensure that our providers are accountable for the care they provide.

In the wake of Hurricane Katrina, the urgent need for further clarification of the FTCA statute came to light. The number from medically underserved individuals in our community has swelled as Greater Meridian Health Clinic served not only our regular patients, but a tremendous number of evacuees that were fleeing the storm. Three of our sites were directly affected by the hurricane, and our main site went off land for a short period of time. We estimated that we sustained over half a million dollars in damage and revenue losses.

A number of health centers from outside of Mississippi were glad to come down to help relieve my staff. Unfortunately, the Health Resource and Service Administration clarified, in a program information notice, that health center medical staff would not be covered under the FTCA once they crossed State lines even if they were serving in a covered health center.

Our center is located 14 miles from the Alabama border, and I am concerned that this process severely affected the health center response in my State and other States. I don't want to see the same situation arise in other emergencies, potentially preventing health centers from going where patients need their services.

H.R. 870, sponsored by Representatives Diana DeGette and the late Paul Gillmor, would cover health centers under FTCA to help in disaster situations, and I urge the committees to support it.

Additionally, Greater Meridian Health Clinic would welcome a clarification to the FTCA statute that would allow volunteer physicians to serve at health centers and become accountable to our patients. As specified in H.R. 1626, this bill was sponsored by Representative Tim Murphy and Representative Susan Davis.

We have been very pleased to have several physicians who have donated their time to see our patients, and we would like to accommodate more providers who want to volunteer at Greater Meridian Health Clinic. However, the confusion surrounding medical liability coverage often makes this a very challenging situation.

At our center, we take pride and volunteerism to heart. We believe that extending the FTCA coverage, as outlined in H.R. 1626, would provide an incentive for clinicians who would volunteer to deliver critically needed health services to our patients at our health centers.

Health centers look forward to working with members of the subcommittee to ensure that centers can continue to deliver high-quality, cost-effective health care services, and we thank this committee for your work and would be happy to answer any questions from this committee.

[The prepared statement of Mr. Jones follows:]

TESTIMONY OF

Wilbert Jones
Chief Executive Officer, Greater Meridian Health Clinic
Meridian, Mississippi

Before the House Energy & Commerce Committee
Subcommittee on Health
On December 4, 2007

Chairman Pallone, Rep. Deal and Members of the Subcommittee, I am honored to have the opportunity to be here today to speak with you about the Health Centers program and several pieces of Federal Tort Claims Act legislation that would help health centers to better deliver care in underserved communities. As Chief Executive Officer of the Greater Meridian Health Clinic, in Meridian, Mississippi, I want to express my deep appreciation for the support that the Subcommittee has demonstrated for the Health Centers program and the patient-centered model of primary health care that we practice everyday in our rural Mississippi community.

Importance of Reauthorizing the Health Centers Program

First, I want to take a moment to extend a heartfelt thank you to my Congressman, Rep. Pickering and Rep. Green for introducing H.R. 1343, the "Health Centers Renewal Act," legislation that would reauthorize the program for the next five years. Our patients, Board and staff support this bill, the number one priority of health centers across the country. H.R. 1343 would renew the core elements of the program, especially the patient-majority community board and would authorize much needed additional funding so that we can serve even more individuals in our community who need our help. I'm happy to hear that H.R. 1343 is supported by a majority of the Members of the Subcommittee and full Committee and 230 Members of Congress, and we are pleased that the bill is the vehicle for the Committee's consideration of health centers reauthorization.

I also want to thank Chairman Pallone and Rep. Deal for leading the effort to secure FY 2008 increased funding for my health center and centers across the country, with their successful Dear Colleague letter to the House Appropriations Committee earlier this year that called for an $200

million increase in funding, to bring health centers to an $2.188 billion overall funding level for FY 2008, the same level proposed in H.R. 1343. That letter was also signed by a majority of Congress.

Rep. Deal, I am particularly grateful to you for asking me to talk to the Committee about the importance of enacting several clarifications to the Federal Tort Claims Act statute that will allow health centers like mine to successfully confront public health emergencies and stem workforce shortages at our health centers.

The Greater Meridian Health Clinic Story

To better understand the importance of these needed changes, allow me to tell you a little about our health center. Greater Meridian Health Clinic, Inc. (GMHC) was established in 1986, and serves the medically-underserved residents of the rural Lauderdale, Kemper, Noxubee, Winston, and Oktibbeha Counties. A private, non-profit organization, we have six sites and a mobile health unit located in towns in our service area. We pride ourselves on being a one-stop shop for the provision of basic primary, preventive medical care, onsite dental care and pharmacy services

Additionally, our center provides key enabling services, such as transportation, and outreach that help ensure that our patients truly have access to the care we deliver. Further, we have arrangements to provide medical care and dental screenings for our local Head Start programs, medical and dental screenings for residents of public housing and homeless shelters in our area, and primary care clinical training arrangements with several colleges and universities.

I am very proud of our Board of directors. Greater Meridian Health Clinic would simply not be the same without our Board, who make sure that we are constantly connected with our community. Our Board members reflect the residents of the neighborhoods that we serve. I am equally proud of our staff, which now is over 100 employees strong, including health care providers, and administrative staff to support our patients in our seven sites.

Importance of the Health Centers Federal Tort Claims Act in Removing Barriers to Care
As the Health Centers program has grown over the past five decades, Congress has recognized and removed a number of key barriers that could potentially keep centers from expanding and enhancing the delivery of health care services to medically-underserved individuals.

Congress addressed one such barrier in 1992, when it enacted legislation to allow Federally Qualified Health Centers to be covered under the Federal Tort Claims Act (FTCA). Prior to the 1992 law, health centers were purchasing malpractice insurance to cover their medical and professional staff and ensure that centers were held accountable for the care that they provide. Congress extended FTCA coverage to Health Centers (42 USC 233 section (g)), in order to expand the availability of care, subject to appropriations specifically identified for this purpose. Health center appropriations were first identified for FTCA coverage in 1996 and have continued since. For FY07, Congress appropriated $45 million within the Health Center program for FTCA coverage. A recent estimate put the savings for health centers compared to similar malpractice insurance coverage at nearly $200 million.

In the wake of Hurricane Katrina, which passed over our community in 2005, the urgent need for further clarification of the FTCA statute came to light. Greater Meridian Health Clinic was severely affected by the storm, as we sought to serve its patients and participate in the response to the disaster. Three of our sites were directly affected by the hurricane, and our main site was offline for a short period of time. When considering the toll the storm took on our sites, we estimate that we sustained over $500,000 in damage and lost revenue. Additionally, my entire staff were affected in some way by the devastation, as they coped with damage to their homes, cars, fallen trees and impassable roads. In fact, several of my employees had to be helped out of their garages because they couldn't lift the non-functioning electric doors by themselves.

Despite the personal challenges our center faced in dealing with Katrina, our staff rose to the occasion, and didn't abandon our patients. In the wake of Hurricane Katrina, the number of medically-underserved individuals in our community swelled, as we struggled to serve not only our regular patients, but a tremendous number of evacuees fleeing the storm. However, additional

assistance from our sister health centers from across the country would have been extremely helpful in those days, weeks, and months after the storm.

A number of health centers from outside Mississippi would have gladly come down to help relieve my staff dealing with a tremendous influx of patients and to provide respite for our weary providers. I know that this is also true of my fellow health centers in the Gulf, some of which were devastated by the Hurricane. Health centers from across the country packed their vans and sent their mobile teams to our states to help.

Unfortunately, the Health Resources and Services Administration "clarified" in a Program Information Notice (PIN #2006-9) that health center medical staff would not be covered under FTCA once they crossed state lines even if they were serving in a covered health center. I am concerned that this policy severely affected the health center response in my state and other states, and don't want to see the same situation could arise in other public health emergencies, potentially preventing health centers from going to where patients need their services.

We need assurances that FTCA coverage is updated in order to ensure a timely and effective response to a public health disaster. My center and others would have benefited from having the assistance of health center staff, willing to assist them in these efforts in the future. Health centers have great experience in treating medically-underserved individuals and it is common sense and good policy to allow our sister centers to assist in times of public health emergencies. There is legislation, H.R. 870, sponsored by Rep. DeGette and the late Rep. Paul Gillmor, which would amend the FTCA statute to allow health centers' FTCA coverage to extend across state lines in public health emergencies.

For many communities, including Greater Meridian, the health center is the first place people may turn in the event of a public health emergency. Many health centers sit near state lines and draw patients from several states, and may be the nearest source of primary care should an emergency occur. The FTCA-deemed health center at which the clinicians are employed or contracted would offer clinical services on a temporary basis and continue to pay their clinicians to provide preventive and primary health care services at these new sites. Their clinicians have

already been credentialed and privileged in the center's home state. While the patients served have not been health center patients previously, they will become so at the point at which the health center provides them with clinical services. I believe this legislation is a positive step for health centers and urge the Committee to support it.

Additionally, GMHC would welcome a clarification to the FTCA statute that would allow volunteer physicians to serve at health centers and be accountable to patients, as specified in H.R. 1626, sponsored by Rep. Tim Murphy and Rep. Susan Davis. In the original statute, FTCA coverage was provided for "any officer, governing board member, or employee of such an entity, and any contractor of such an entity who is a physician or other licensed or certified health care practitioner". In addition, the employees must be full-time staff, thereby eliminating volunteers from coverage. H.R. 1626 adds volunteer physicians (including licensed psychologists) to the list of covered individuals.

This legislation would be a welcome development for health centers, including Greater Meridian, for whom recruitment and retention of medical staff is a continual challenge. We have been pleased to have several physicians who have donated their time to see our patients, and we would like to accommodate more providers who want to volunteer at Greater Meridian. However, the confusion surrounding medical liability coverage often makes this challenging and sometime prohibitive. Unfortunately, the liability protection afforded to health center physicians under the Federal Tort Claims Act (FTCA) does not currently cover doctors who wish to volunteer their time – causing undue confusion at health centers. In turn, many health centers have been reluctant to recruit volunteer physicians for fear that the current malpractice coverage may be inadequate or insufficient.

At Greater Meridian, we take the spirit of volunteerism to heart. We believe that extending FTCA coverage as outlined in H.R. 1626 will provide an incentive to clinicians who would volunteer to deliver critically needed health care services to patients at health centers. H.R. 1626 will help the workforce shortages with which health centers are struggling and, most importantly, give more doctors an opportunity to further contribute to the collective health of their communities.

Conclusion

Greater Meridian Health Clinic deeply appreciate the commitment and support of Congress for the Health Centers program over the past four decades, including the enactment of Federal Tort Claims Act legislation that has allowed health centers to be covered for medical liability and be held accountable for services provided at their centers. Since the enactment of the FTCA statute, several key challenges, such as health centers growing role in the response to public health emergencies and the looming primary workforce shortage have arisen. Health centers look forward to working with Member of the Subcommittee to ensuring that not only is the Health Centers program reauthorized this year but that clarifications to the FTCA statute can also be considered in order for centers to continue to deliver high-quality, cost-effective health care services. Thank you once again and I would be happy to answer questions from the Committee.

Mr. PALLONE. Thank you, Mr. Jones.

Next we have Steven Miracle.

STATEMENT OF STEVEN MIRACLE, EXECUTIVE DIRECTOR, GEORGIA MOUNTAIN HEALTH SERVICE INC., MORGANTOWN, GA

Mr. MIRACLE. Thank you.

Mr. Chairman and members of the subcommittee, thank you for the opportunity to speak about the health centers bill and H.R. 1343, the Health Centers Renewal Act. I appreciate the unwavering support that this subcommittee has offered to health centers as we seek to expand and enhance access to health care services for medically underserved individuals and their families.

The health centers program should be swiftly reauthorized. A special thank-you to Representative Green and Representative Pickering for introducing H.R. 1343, which provides for a straightforward 5-year reauthorization of the program with funding authorization levels which will allow centers to serve additional individuals.

With 230 cosponsors, including a majority of the members of this subcommittee and the full committee, I believe that passage of H.R. 1343 is the best way to guarantee the successful renewal of the program. In this reauthorization, nothing is more important than retaining the patient majority board governance of health centers and ensuring the enactment of the funding authorization levels included in the bill.

I also applaud Chairman Pallone and my Representative, Congressman Deal, for their leadership this year in authoring a letter to the Appropriations Committee in support of a $200 million increase in fiscal year 2008 funding for the health centers program equal to the initial year funding in H.R. 1343, which will help fuel the next phase of the program's growth. This expansion is supported by the funding levels in the bill and will put health centers on a path to eventually serve 30 million patients by 2015.

The community empowerment and patient directed care model that began over 40 years ago is alive and well in my health center. Georgia Mountain Health began in 1984 as a result of a public-private initiative, in part to provide primary care services to residents of the Appalachian area in the northern part of our State.

The first provider at our health center worked in a trailer, which, incidentally, doubled as her home as well as the medical office. Since then, that trailer has been replaced with a building with five exam rooms and our corporate office.

We have grown to five service sites, including one site that provides dental services. We currently employ over 30 full-time employees. We have 11 health care providers and a bilingual staff to address the needs of our Spanish-speaking patients.

Georgia Mountain Health provides services to over 6,500 individuals and over 16,000 total patient encounters. Almost 55 percent of our patients are uninsured. Nearly 27 percent are Medicaid recipients. The Latino population in our community is rapidly growing and accounts for nearly 15 percent of our patients today.

Our patient majority board is made up of retired people, small business owners, Latinos and Caucasians, and is a good reflection of both our service area and our patient population.

Our board is committed to ensuring that the care we provide to our patients is community driven. Our board has been centrally involved in developing our strategic plan and identifying new service areas needing local access to medical services. In addition, individuals on our board are active volunteers and supportive of various outreach efforts in which our organization is engaged.

We are proud of the high-quality, cost-effective care we provide, including basic family and geriatric medical care, dental services and key enabling services that make our care truly accessible.

Nationally, the health centers program wins top marks for efficiency and performance from the Office of Management and Budget, the Institutes of Medicine, and the GAO. Our success and the success of health centers nationally is due to the four statutory requirements of the health centers programs: openness to all regardless of the ability to pay; location in medically underserved areas; provision of comprehensive, preventive and primary care services; and lastly and importantly, the governance of patient majority boards.

We are making a difference in rural north Georgia. H.R. 1343 will ensure continued access to quality care for residents of our area and for millions nationwide.

Thank you once again, and I would be happy to answer your questions.

[The prepared statement of Mr. Miracle follows:]

Testimony of

Steven Miracle

Chief Executive Officer

Georgia Mountains Health Services

Before the

House Energy and Commerce Subcommittee on Health

December 4, 2007

Mr. Chairman and Members of the Subcommittee, my name is Steven Miracle and I am Chief Executive Officer of Georgia Mountains Health Services, Inc., (GMHS), a community health center in Morganton, Georgia. Thank you for the opportunity to speak with the Subcommittee about the federal Health Centers program and its role in expanding and enhancing access to health care services for medically-underserved individuals and families. My health center and centers across the United States appreciate the unwavering support that this Subcommittee has offered to health centers in carrying out their mission and we look forward to continuing to work with you to further strengthen the program to serve additional medically underserved communities.

Mr. Chairman, I know the power of health centers to lift the health and the lives of individuals and families in our most underserved communities because I see it every day at my health center. The community empowerment and patient-directed care model that began in the rural South and the urban Northeast thrives today in every health center in America and I am honored to be here to share with you our success story.

First, I want to share the story of my health center, Georgia Mountains Health Services. Georgia Mountains Health Services began in 1984 as a result of a public-private initiative to provide primary care services to residents of the Appalachian area in the northern part of the state, close to both the Tennessee and North Carolina borders. Every health center has its own unique history, and the path forward for us was never paved with gold. In our case, the roads of our surrounding communities were not even paved, creating tremendous access challenges. Indeed at that time, a trip to Atlanta to obtain health care services would take over 5 hours one way, versus under 2 hours on the four lane road that opened in the 1990s.

The mayor of Morganton and other key city leaders and members of our community determined that health care services were needed in our part of Fannin County, out of great concern about the lack of accessible and affordable care. After extensive work, our community board was formed, our application for federal Health Centers Section 330 grant money was submitted and we received our first grant.

The first provider at Georgia Mountains was a nurse-practitioner who worked in a trailer located on land made available by the City of Morganton. The trailer, incidentally, also doubled as her home as well as the medical office. I'm proud to say that since those early days in the 1980s, we have come along way. That very first trailer has been replaced with a building with five exam rooms and our corporate office. We have also expanded to five additional sites, including one site that provides dental services. We've grown from one nurse practitioner to an organization employing 30 full-time staff, including 11 health care providers, and several bilingual staff to address to growing needs of our Spanish-speaking patients.

During the most recent reporting period, Georgia Mountains provided services to over 6,500 individuals, more than 16,000 total patient visits. Almost 20 percent of our patients are uninsured and nearly 27 percent are Medicaid recipients. The Latino population is growing the most rapidly in our area and accounts for nearly 15 percent of our patients today.

The services available at GMHS are those one would and should expect from a comprehensive primary care facility. We offer our patients basic family medical care and geriatric care in an outpatient setting. Other services include immunizations, basic radiology and full laboratory services. Our physician providers have admitting privileges at hospitals located in Gilmer and Fannin Counties. Services provided at the dental office include preventive screening for children, adolescents and adults; basic restorative services, and specific screening of all diabetics managed by the health center.

Consistent with the statutory requirements of the federal Health Centers program, our patients are seen, at all locations, regardless of their payment source and ability to pay. Georgia Mountains Health Services is included in most insurance plans and on the workers compensation panel for several businesses. If eligible, depending on household size and income, services are

provided at discounted rates based on a sliding fee scale. May I say that we are fortunate that Congress established the program as a community and patient driven, locally-controlled program. It is because of this vision that my board, my staff, and I are able to create tailored health care solutions that work for our community and that are high-quality and cost-effective.

In fact, Georgia Mountains Health Services is active in promoting health and wellness within Georgia's Fannin and Gilmer Counties. Our efforts were recognized with the 2005 Community Service Award from the Fannin County Chamber of Commerce.

Current Statistics

I am also pleased to provide the Subcommittee with a national snapshot of America's health centers. Health centers serve over 16 million people in every state and territory. Health centers provide care to more than 16 million people, including 10 million people of color, 6 million uninsured individuals, at least 807,000 seasonal and migrant farmworkers, and at least 828,000 homeless individuals. Over 1,100 health centers are located in 6,000 rural, frontier, and urban sites across the country. The communities served by health centers are in dire need of improved access to care, and in many cases the centers serve as the sole provider of health services in the area, including medical, oral health, mental health, and substance abuse services.

Patients can walk through the doors of their local health center and receive one-stop health care delivery that offers a broad range of preventive and primary care services, including prenatal and well-child care, immunizations, disease screenings, treatment for chronic diseases such as diabetes, asthma, and hypertension, HIV testing, counseling and treatment, and access to mental health and substance abuse treatment. Health centers also offer critically important enabling services designed to remove unique barriers to care for our patients, such as family and community outreach, case management, translation and interpretation, and transportation services.

As a result of health centers' focus on the provision of preventive and primary care services and management of chronic diseases, low-income, uninsured health center patients are more likely to have a usual source of care than the uninsured nationally. 99% of surveyed patients report that they were satisfied with the care they receive at health centers. Communities served by health centers have infant mortality rates from 10 to 40% lower than communities not served by health

centers, and the latest studies have shown a continued decrease in infant mortality at health centers while the nationwide rate has increased. Health centers are also linked to improvements in accessing early prenatal care and reductions in low birth weight.

This one-stop, patient-centered approach works. The Health Centers program has been recognized by the Office of Management and Budget as one of the most effective and efficiently run programs in the Department of Health and Human Services (HHS). In fact, the Institute of Medicine and the Government Accountability Office have recognized health centers as models for screening, diagnosing, and managing chronic conditions such as cardiovascular disease, diabetes, asthma, depression, cancer, and HIV/AIDS. A major report by the George Washington University found that high levels of health center penetration among low-income populations results in the narrowing or elimination of health disparities in communities of color.

The Health Centers program was last reauthorized in 2002, as a part of the Health Care Safety Net Amendments Act. As you know, the program's authorization expired in October of 2006. I am grateful to the Subcommittee for its leadership role in strengthening and improving the Section 330 statute in 2002, further modernizing it to serve millions of new patients. During the 2002 reauthorization, this Committee and Congress importantly reaffirmed the program's four core elements, and have done so consistently over the entire life of the program. These core elements, which have proved critical to its continued success, require that health centers: 1) be governed by community boards - a majority of whose members are current health center patients - to assure responsiveness to local needs; 2) be open to everyone in the communities they serve, regardless of health status, insurance coverage, or ability to pay; 3) be located in high-need medically-underserved areas; and 4) provide comprehensive preventive and primary health care services.

Reauthorization Key to Historic Expansion of Access to All America

I would like to extend a very special note of gratitude to Rep. Green and Rep. Pickering for introducing H.R. 1343, the "Health Centers Renewal Act," legislation that would provide for a straight reauthorization of the program through FY 2012 at an initial funding level of $2.188 billion in FY 2007. The bill, supported by a majority of the Members of this Subcommittee and the full Committee as well as 230 Members of the House, also continues intact the key program requirements that enable health centers to provide high quality, cost–effective care that is tailored

to the specific health care needs of the communities they serve. Health centers strongly believe that H.R. 1343 represents the best opportunity for the successful renewal of the Health Centers program.

While the Health Centers program has made historic gains in providing increased access to health care services in medically-underserved communities and to medically-underserved populations, major challenges still persist. Lack of access to affordable and readily available primary and preventive care remains a pervasive problem throughout the United States. A recent study by NACHC and the Robert Graham Center found that nearly half of those individuals are "medically-disenfranchised", that is they have some form of insurance but do not have ready access to care and live in areas with insufficient numbers of primary care physicians to provide important primary and preventative care. These individuals are often forced to turn to hospital emergency rooms for basic primary care needs, driving up costs and overburdening already crowded facilities.

With the support of this Subcommittee, health centers stand ready to become an even larger national network of health care delivery in the years ahead. By the year 2015, an estimated 30 million Americans could have access to high-quality primary and preventive care services. This expansion, as supported by this legislation, is an important part of improving and enhancing access to primary care for the growing number of uninsured, underinsured, and publicly insured persons experiencing increasing barriers to care. Eventually, this program growth has the potential to reach all Americans who are without a health care home today, with health centers serving as models and innovation leaders for what the practice and delivery of primary care could become.

Health centers and the National Association of Community Health Centers are deeply grateful to Congress for its support of the Health Centers program. The increases since 2001 have enabled over 1200 additional communities to participate in the Health Centers program and to deliver community-based care to more than 6 million additional patients. We are also very grateful that Congress has provided additional funding for base grant adjustments for existing health centers, which have seen unexpected increases in the number of uninsured patients coming through their doors at the very same time they continue to battle the continuously rising cost of delivering health care in their communities. These base grant adjustments have allowed health centers

across the country to stabilize their operations and continue to provide care to their existing patients, while also looking for ways to expand access to necessary care.

Health centers applaud the leadership of Chairman Pallone and Ranking Member Deal for authoring a successful letter to the House Appropriations Committee in support of $2.188 billion in overall FY 2008 funding for the Health Centers program – equal to the initial year funding in H.R. 1343, which will help fuel the next phase of growth of the program. This expansion, as supported by funding levels in H.R. 1343, will put health centers on a path to eventually serve 30 million patients by 2015. We were also pleased that the full House passed this funding level of $2.188 billion for the Health Centers program as part of FY 2008 appropriations legislation.

Despite the success of the President's recent expansion initiative , less than half of all approvable applications for new or expanded health center sites received funding from 2002-2006, demonstrating a high demand for continued expansion. Indeed the application process is rigorous, and it should be. Health Center program funds are awarded on a nationally competitive basis, ensuring that the highest quality projects receive approval. Despite the overwhelming number of communities that compete for funding under the new and expanded access process, many underserved communities continue to lack adequate resources even to submit a competitive application, and in some cases, to even coordinate and complete the current application. I would point out that this legislation clearly reauthorizes planning grants, which are important tools to help lay the foundation for successful health center organizations in communities currently without them, helping to identify the target communities and populations, and outline strategies for serving those in need.

Health centers recognize the relationship between timely program reauthorization and continued funding and believe that reauthorization will make it possible for even greater expansion of access to affordable, high-quality health services to underserved communities. Additionally, preserving the core elements of the Health Centers statute will ensure that health centers funded by Congress will be held to the highest possible standards and will be accountable to the patients and communities they propose to serve.

In Congress's previous reauthorizations of these statutory requirements, it sent a clear message that it sees patient involvement in health care service delivery as key to health centers' success in

providing access and knocking down barriers to health care. In this reauthorization, nothing is more important than retaining the requirement for patient-majority board governance of health centers and ensuring the enactment of the funding authorization levels in H.R. 1343. Active patient management of health centers assures responsiveness to local needs. This begins with community empowerment, through the patient-majority governing board that manages health center operations and makes decisions on services provided, and leads to the fulfillment of the other core elements of the program. Additional funding for the program will ensure access to high-quality cost-effective care for millions more individuals.

First, I cannot over-stress the importance of the patient-majority board of directors. Through the direction and input of community boards, health centers can identify their communities' most pressing health concerns and work with their patients, providers, and other key stakeholders to address these issues. With unique and direct community connections, board members determine the best approach for removing barriers to health care, helping health centers to meet their patients where they are, not where someone might want them to be. The critical, distinguishing feature of the health center model of community empowerment is that the community has been directly involved in virtually every aspect of the centers' operations, and, in turn, each health center has become an integral part of its community, identifying the most pressing community needs and either developing or advocating for the most effective local solutions.

At Georgia Mountains Health Services, our patient-majority board is a good reflection of both our service area and our patient population. In our small, rural community, we have a mix of retired people, executives, small business owners, and Latinos and Caucasians, all of whom are committed to ensuring that the care we provide is laser-focused on our patients and our community. Our board has been centrally involved in developing our strategic plan and in identifying new service areas needing access to medical services. In addition, individuals on our board are active volunteers in support of the various outreach efforts in which our organization is engaged.

Another critical component of the Health Centers law is that in order to ensure that services are not duplicated, health centers are required under the statute to be located in high-need, federally-designated, medically-underserved areas. This requirement establishes health centers in identified underserved communities where there are well-documented gaps in care. Health

centers are also distinctive in the broad range of required and optional primary and preventive health and related services they provide under Section 330. This also includes a range of enabling services that ensure optimal access to care.

Georgia Mountains believes that these core statutory requirements provide the crucial framework for success of the Health Centers program. Our center and the entire program simply would not be where they are today without these critical elements. I commend Congress for safeguarding these requirements in every previous reauthorization of the Section 330 program since its inception and urge you to renew these core elements in this reauthorization today.

Preparing Health Centers for the Future

In their four-decade history, health centers have faced down and overcome many challenges and today this is no different for Georgia Mountains. One of these challenges is the looming primary care workforce shortage in underserved communities and the other is the struggle to provide health care services in the wake of natural disasters.

Even though our health center has expanded access to services in the Morganton area over the past seven years, we are always working to ensure that we will have an adequate number of physicians and other providers to deliver care to our patients. The looming workforce shortage is often the number one topic of discussion among my fellow health center directors across the country, as we all cope with a dramatic decline in both the number of graduating medical students choosing the n primary care field and those that choose to serve in a medically-underserved community. The same is true for dental students.

It shouldn't be surprising that a study from the Journal of the American Medical Association (JAMA) found significant vacancies in physician and other health professions positions at health centers across the country. The greatest vacancy rates were in rural and inner-city health centers, ranging from 19% to 29% of their current workforce. By discipline, there were vacancies for more than 760 primary care physicians, 290 nurse practitioners, physician assistants, and nurse midwives, and 310 dentists.

Health Centers Rely on Other Key Programs to Address Challenges

One solution that would help Georgia Mountains Health Services and other centers address workforce shortages is the reauthorization and expansion of the National Health Service Corps (NHSC). I am grateful that the Committee reauthorized this program in 2002 at the same time as it reauthorized the Health Centers program, and I urge the Committee to do so this year. Health centers hold the NHSC program in very high regard because the program is critical to ensuring that there are adequate numbers of health care providers to deliver care to their patients. Approximately 54 percent of NHSC clinicians serve in health center sites. As a health center CEO, I recognize the great value of the NHSC. My health center is in need of three additional providers: a family practitioner, a pediatrician, and a dentist. While our center is located in a Health Professional Shortage Area, I have been unable to obtain a Corps clinician. I recognize the value of the Corps, and I urge Congress to reauthorize the program at increased funding authorization levels that would allow our center to take advantage of the Corps.

The threat of a public health emergency is a second critical challenge for health centers in the 21st century. The experience of many health centers who mobilized to help their sister health centers in the wake of Hurricane Katrina and Rita points to the need to update the Federal Tort Claims Act (FTCA) statute to ensure liability coverage for other health centers and their employees who travel offsite to provide care at health centers affected by a public health emergency. While our health center did not have an opportunity to participate in the response to Katrina or Rita, a natural disaster or public health emergency can strike anywhere and at anytime. In reflecting on the area in which we are located, it is possible that we could be the nearest source of primary care should an emergency occur in another state, Tennessee for example. I understand that there is legislation that would help health centers address this issue, H.R. 870, sponsored by the late Rep. Paul Gillmor and Rep. Diana DeGette, which we support.

Additionally, the FTCA must also be modernized to allow health centers to better address the physician shortage facing my health center and others across the country. In several instances over the years, I have been approached by physicians and other providers in our community who wanted to volunteer at our health center. If the liability protection afforded to health center physicians under the FTCA could be clarified to cover doctors who wish to volunteer their time – this would open up volunteer opportunities for physicians wishing to donate their services at our sites. There is legislation, H.R.1626, sponsored by Rep. Tim Murphy and Rep. Susan Davis that would clarify FTCA coverage to include physicians who volunteer to provide care to health center patients. We believe that H.R. 1626 will provide immediate assistance to health centers to

address workforce shortages and, most importantly, give doctors a chance to make a real difference in communities.

I also wanted to briefly express my support for H.R. 4205, the "School-Based Health Clinic Establishment Act," legislation to improve the health of America's school children through the development and operation of school health clinics to provide comprehensive primary care health services to underinsured and at-risk children and adolescents. While Georgia Mountains Health Services does not operate a school-based clinic, we are well aware that these clinics provide high-quality comprehensive primary, preventive, and mental health care services to approximately 2 million students in 46 states.

Conclusion

Health centers appreciate the unwavering support of Congress for the program over the past four decades. Over that period, health centers have produced a return on the federal investment in the program, by providing access to care and a health care home to millions of patients in medically-underserved communities across the country. Because Congress has continued to reaffirm the core elements of the program; that health centers are open to all, run and controlled by the community, located in high need medically-underserved areas, and provide comprehensive primary and preventive services, the program has successfully responded to the challenges posed by our ever-changing health care system. On behalf of health centers across the country, their staffs, and the patients they serve, we stand ready to work with you to ensure that the Health Centers program is reauthorized this year in order continue to providing a health care home for everyone who needs their care. Thank you once again and I would be happy to entertain questions from the Committee.

Mr. PALLONE. Thank you. Mr. Guzman.

STATEMENT OF RICARDO GUZMAN, CHIEF EXECUTIVE OFFICER, COMMUNITY HEALTH AND SOCIAL SERVICES CENTER, INC., DETROIT, MI

Mr. GUZMAN. Good afternoon, Mr. Chairman, ranking member and members of the subcommittee. Before I go into my little speech, I wanted to again thank the committee for being able to make this presentation.

It was interesting, listening to Dr. Williams and the members of the committee. We don't always get kudos in terms of the work that we do in the community. So thank you very much.

The second item, though, is Mr. Jones, Mr. Miracle and myself represent 81 years of providing services in community health centers to the citizens and the residents of the United States.

My name is Ricardo Guzman, and I am chief executive officer of the Community Health and Social Services Center, a comprehensive, federally qualified health center with two community health centers and one school-based health clinic in Detroit, Michigan. I want to thank you for the opportunity to speak today on behalf of the Nation's health care safety and our providers and to emphasize the importance of your support of school-based health clinics, which we refer to as SBHCs. The National Assembly of School Health Care, which I represent today, supports the continued growth of the consolidated health center program.

As Congress moves towards reaffirming its support for a health care safety net system, it is incumbent upon each of you not to leave children and youth behind in this process. As a manager of health centers, I am here today to tell you that SBHCs are an important health care safety net provider for children and adolescents, and it is time for Congress to support the life-altering work that they do every day.

Therefore, I want to thank Representatives Hooley and Capito for their leadership in introducing H.R. 4230, the School-Based Health Center Act of 2007, which authorizes a grant program to support and expand SBHCs nationwide, the only medical model solely dedicated to meet the health needs of children and adolescents in schools.

For members who are here today who might not be as familiar with this model of health care, let me tell you more about SBHCs and the comprehensive care and mental health support they offer.

These programs are like doctors' offices in schools. There are 1,700 school-based health centers in 44 States and the District of Columbia and Puerto Rico. These programs provide services ranging from acute medical care, chronic disease management, preventive medical care, health education, mental health and, in some programs, oral health services. They serve as a medical home and as a secondary access point for the students they see. When a medical home already exists, the relationships between the two has been documented as complementary, not duplicative.

The daily educational experience of children and adolescents can be optimized by reducing obstacles to learning created by poor health. Providers have the advantage of proximity and time with

students to create substantive relationships with high-risk youth throughout their academic career.

A nationwide poll found that voters looked to the Federal Government to set aside specific funds for SBHCs, yet only 36 percent of programs are eligible to receive funds from the Federal Government to support their efforts.

In fact, in my SBHC we do not receive section 330 funds. The mental health of students, particularly the need for assistance with grief, peer pressure, bullying and suicide prevention is of special concern to voters and SBHCs are responding to this need.

As an example, in our center, a young girl came to our SBHC requesting aspirin because of a headache. As the nurse practitioner spoke with the student, it became apparent that the student really came because she needed to talk with someone. She was thinking of killing herself. In our SBHC, we were lucky to have our social worker on staff who was able to see her immediately.

In spite of the tremendous advantages afforded by SBHCs, significant policy and financial barriers threaten the sustainability of the model and prevent widespread replication. While we are fortunate in Detroit to sponsor and fund our program through our community health center, only 22 percent of the current programs nationwide are eligible for this funding.

You heard from the government witness, funding exists for this segment of the school-based health center population. However, three-quarters of the field can't receive these funds. Access to these funds is severely limited. Therefore, the vast majority of SBHCs operating throughout the country do not have access to the same sources of funding that we have.

There is no specific Federal funding program for SBHCs. Because of inadequate funding forpreventive and mental health care services in primary care settings, SBHCs experience great difficulty in integrating and sustaining their comprehensive scope of services.

SBHCs have had great difficulty being recognized as Medicaid service providers. Even when the clinics are recognized as providers, services outside of the traditional doctor-patient visit that are central to the success of the model are not reimbursed by Medicaid.

Therefore, as the committee enters into discussions regarding the various models of health care currently administering to populations in need, I urge you to include H.R. 4230 in this discussion. The authorization of a grant program to support and expand SBHCs nationwide is an urgent need if we are to allow all students an opportunity to grow up healthy, strong, and achieving their educational potential.

Our Nation is hungry for change. Americans are no longer willing to accept their ineffective health care system, the kind of system where a child can die from something as treatable as a dental abscess. School-based health clinics must be front and center as we transform our Nation's health care system to gain equity, access, and opportunity for all children.

Thank you very much.

[The prepared statement of Mr. Guzman follows:]

STATEMENT OF J. RICARDO GUZMAN

Good afternoon Mr. Chairman and Members of the Subcommittee,

I am Ricardo Guzman, the chief executive officer of the Community Health and Social Services Center, a comprehensive federally Qualified Health Center with two community health centers and one school-based health clinic in Detroit, Michigan. I want to thank you for the opportunity to speak today on behalf of our Nation's health care safety net providers and to emphasize the importance of your support of school-based health clinics. The National Assembly on School-Based Health Care, which I represent today, supports the continued growth of the consolidated health center program. As this committee begins its consideration of H.R. 4230, The School-Based Health Clinic Establishment Act of 2007 and the Health Centers Renewal Act of 2007, I urge you to consider the needs of underserved populations throughout the country.

As Congress moves toward reaffirming its support for a health care safety net system, it is incumbent upon each of you, not to leave children and youth behind in this process. As a manager of health centers, I am here today to tell you that school-based health clinics are an important health care safety net provider for children and adolescents and it is time for Congress to support the life altering work they do every day. I want to thank Congresswoman Hooley for her leadership in introducing, H.R. 4230, The School-Based Health Clinic Establishment Act of 2007, which authorizes a grant program to support and expand school-based health clinics nationwide.

For Members here today who might not be as familiar with this model of health care, let me tell more about school-based health clinics and the comprehensive care and mental health support they offer. These programs are like doctors offices in the schools. There are 1,700 school-based health clinics in 44 states, DC and Puerto Rico. These programs provide services ranging from acute medical care, chronic disease management, preventive medical care, health education, mental health and in some programs, oral health services. They serve as a medical home and as a secondary access point for the students they see. When a medical home already exists the relationship between the two has been documented as complementary not duplicative.

The daily educational experience of children and adolescents can be optimized by reducing obstacles to learning created by poor health. In our school-based health clinics, we work closely with teachers, parents, and school administrators to serve students in the best possible manner.

A nationwide poll found that:

Voters look to the Federal Government to set aside specific funds for the clinics. Yet only 36 percent of programs report receiving any funds from the Federal Government to support their efforts.

Voters also believe that school-based health clinics should provide a wide range of services including prevention and treatment of chronic diseases such as asthma and diabetes. They are also supportive of providing students in school with health education on eating right and exercising, treatment of acute illness and sudden trauma. The great majority of existing programs provide these services.

The mental health of students particularly the need for assistance with grief, peer pressure, bullying and suicide prevention is of special concern to voters, and school-based health clinics are responding to this need as well.

School-based health care is vital to my community—and many like mine—because it provides unprecedented access to health, mental health and oral health services. The programs are designed with input from the community and school. Providers have the advantage of proximity and time with students, creating substantive relationships with high risk youth throughout their academic career.

In spite of the tremendous advantages afforded by school-based health clinics, significant policy and financial barriers threaten the sustainability of the model and prevent widespread replication. While we are fortunate in Detroit to sponsor and fund our program through our community health center, only 22% of programs nationwide are eligible for this funding. Therefore the vast majority of clinics operating throughout the country do not have access to the same sources of funding that we have. There is no specific Federal funding program for school-based health clinics. Because of inadequate funding for preventive and mental health care services in primary care settings, school-based health clinics experience great difficulty in integrating and sustaining their comprehensive scope of services. For example since the proliferation of Medicaid managed care, school-based health clinics have had greater difficulty being recognized as Medicaid service providers. Even when the clinics are recognized as providers, services outside of the traditional doctor patient visit are not reimbursed by the Medicaid program. These services are central to the success

of the model and are identified by sponsors and insurers alike as the model's added value.

Therefore, as the committee enters into discussions regarding the various models of health care currently administering to populations in need, I urge you to include H.R. 4230, The School-Based Health Clinic Establishment Act of 2007 in this discussion. The authorization of a grant program to support and expand school-based health clinics nationwide is an urgent need if we are to allow all students an opportunity to grow up healthy, strong and achieving their educational potential.

Our Nation is hungry for change. Americans are no longer willing to accept their ineffective health care system—the kind of system where a child can die from something as treatable a dental abscess. Momentum is building around improving children's health access and quality in states across the country and in the halls of Congress. School-based health clinics must be front and center as we transform our Nation's health care system to gain equity, access, and opportunity for all children.

Thank you.

Mr. PALLONE. Thank you. Dr. Ehlert.

STATEMENT OF MICHAEL EHLERT, M.D., PRESIDENT, AMERICAN MEDICAL STUDENT ASSOCIATION, RESTON, VA

Dr. EHLERT. I think we are still on.

Mr. Chairman, members of the committee, my name is Dr. Mike Ehlert. I am president of the American Medical Student Association and a recent graduate of Case Western School of Medicine in Cleveland, Ohio.

I have taken a year off from my clinical training, and I am proud to represent my members and offer the following testimony on the shortage of primary care physicians in the United States and on H.R. 2915 to reauthorize the National Service Corps.

As background, AMSA is the Nation's oldest and largest independent, student-governed organization of physicians-in-training. With a membership of more than 68,000 medical students, premedical students, interns, and residents, AMSA continues its commitment to improving medical training and the Nation's health.

We have proudly testified for each of the National Service Corps reauthorizations since our 1970 championing of the Emergency Health Personnel Act, the origin of the Corps. In academic medical centers, urban hospitals, and community based clinics, physicians-in-training are at the forefront of providing care to a wide range of patients, including the Nation's most vulnerable.

Through our rotations in emergency rooms, we see the impact of inadequate access to primary care daily. Our Nation is in a crisis of reliable primary and preventive care for all Americans. The absence of primary care physicians endangers not only the individual health of our patients but the community as well.

For individual patients, primary care doctors can see a wide range of health problems, provide a place where patients can expect to have their problems resolved, as well as coordination of care where necessary. This teamwork allows patients to rely on a consistent and informed provider to take a greater role in decisions about their health.

Primary care also allows appropriate attention to be given to health promotion and creates opportunities for early prevention of disease. The majority of health costs in America are incurred by preventable and reversible health risks, as well as easily detectable and treatable conditions.

According to a report by the Institute of Medicine, Primary Care: America's Health in a New Era, primary care reduces the cost and increases access to appropriate medical services. Health outcomes improve because primary care enables individuals to obtain services before the illnesses become severe, to better control their chronic conditions, and ultimately reduce the inefficient use of emergency rooms. This all decreases the cost of care in America.

The shortage of primary care physicians is, however, a problem that is not distributed evenly. Over 50 million Americans reside in areas designated as HPSAs, health professional shortage areas, by the Bureau of Health Professions. In 2000, HRSA estimated that an additional 26,000 physicians were needed to meet the desired clinician-to-population ratio in these shortage areas.

There are currently over 4,000 professionals participating in the National Service Corps, and throughout its history over 27,000 professionals were placed in underserved areas. As you have heard, retention rates usually hover around or greater than 50 percent. Those eligible for Corps funding include primary care physicians, which by definition include pediatricians, internists, OB/GYNs, psychiatrists and family physicians and the other members of the primary care team, including nurse practitioners, physician assistants, midwives, dentists, dental hygienists, and mental/behavioral health professionals.

The premise of the National Service Corps is a financial incentive for those clinicians who practice in locations not as rewarding as others. It is no secret that our financing system for health care does not reward those who prevent or coordinate care but rather those who perform procedures or provide hospital-based critical interventions. Further, student debt is at an all-time high. According to the most recent report by the Association of American Medical Colleges, the average medical student graduates with $120,000 in educational debt. My fiancee and I will have over $300,000—$300,000—to repay.

Primary care is the lowest-paying physician profession. It is no wonder that the number of U.S. graduates entering primary care fields has steadily decreased over the last decade.

The Corps provides a crucial incentive to care for Americans who are most vulnerable and least likely to have access to care. Both the scholarships and loan repayments are a much-needed investment in our health care workforce and the health of these communities. The Corps allows committed and driven and compassionate physicians to follow their interests to provide care to the Nation's neediest, instead of being forced to make career decisions based on high debt loads. Central to this service are the Nation's federally qualified health centers; and, as you have heard, over 54 percent of Corps recipients work in community health centers.

In a recent article published by JAMA, and as statistics quoted today, the average health center has a family physician staff vacancy of more than 13 percent. In rural areas, the rate approaches 16 percent.

As a physician-in-training and as the AMSA president, I strongly believe that continued support and increased funding for the Corps is crucial to improve the Nation's health. There are a number of bills before this committee that would reauthorize the Corps. We

emphasize, however, the importance to authorize increased funding for the program. The Corps turned away half of the 1,800 physicians who applied last year, an even lower acceptance rate for students who apply for scholarships, with over 11 applicants for each available scholarship.

As my time is up, I will just summarize to say that an immediate increase in funding for the Corps is crucial for an already proven vacancy rate, a paucity of primary care physicians, and a ballooning of student debt that push young physicians away from primary care and away from underserved areas. This would recognize the crucial role physicians play in coordinating and managing the health of their patients.

Thank you, and I look forward to answering any questions.

[The prepared statement of Dr. Ehlert follows:]

Testimony for the
Committee on Energy and Commerce
Subcommittee on Health

US House of Representatives

December 4th, 2pm

Michael J. Ehlert M.D.
President, The American Medical Student Association

Mr. Chairman, Members of the Committee,

My name is Dr. Michael Ehlert. I am President of the American Medical Student Association, and a graduate of Case Western School of Medicine in Cleveland, Ohio. On behalf of our members, I am pleased to offer the following testimony on the Reauthorization of the National Health Service Corps and on the shortage of primary care physicians in the United States.

As Background, AMSA is the nation's largest, independent, student-governed organization of physicians-in-training. With a membership of more than 68,000 medical students, premedical students, interns, and residents from across the country, AMSA continues its commitment to improving medical training and the nation's health.

In academic medical centers, urban hospitals, and community-based clinics, physicians-in-training are at the forefront of providing care to a wide range of patients, including the nation's most vulnerable. Through our rotations in Emergency Rooms we see the impact of inadequate access to primary care daily. While rotating through outpatient settings and in our student-run clinics, we experience the burden placed on these physicians by growing patient loads and inadequate staffing levels. Our nation is in a crisis of reliable primary and preventive care for all Americans.

The absence of primary care physicians endangers not only the individual health of patients, but that of the community as well. For the individual patient, primary care doctors can see a wide range of health problems and provide a place where patients can expect to have their problems resolved without additional referrals or coordination of care when necessary. Physicians help patients navigate our complicated healthcare system and manage the different recommendations by specialists. They provide continuous, longitudinal care and overtime develop relationships with patients and families – acting as a medical *home*. This team-work allows patients to rely on a consistent and informed provider and take a greater role in decisions about their health. Primary care also allows appropriate attention to be given to health promotion and creates opportunities for early prevention of disease. The majority of health care costs in America are incurred by preventable and reversible risks as well as easily detectable and treatable conditions. In developing these deeper, longitudinal relationships with patients, primary care doctors

can come to know patients' families and communities and provide care appropriate to the context of their patients' lives, culture and environment.

I remember a patient I was seeing in the clinic who was complaining of fatigue and headache. Already blind from uncontrolled diabetes, testing revealed dangerous dehydration and blood sugars 5 times normal. After admitting her to the hospital, giving her fluids and correcting her blood sugar I asked her about the course of her illness. While she could recount all the specialists she has seen – vascular surgeons, nephrologists, ophthalmologists, neurologists – she could not name a singular primary care physician who has diagnosed her diabetes, followed her disease or followed up after her specialist care. It is my belief that if she had a physician planning and coordinating her care, she would still have her sight and not be facing imminent kidney failure in the coming year.

According to a report by the Institute of Medicine, *Primary Care: America's Health in a New Era*, primary care reduces costs and increases access to appropriate medical services. Health outcomes improve because primary care enables individuals to obtain services before illnesses become severe, to better control their chronic conditions, and ultimately to reduce preventable hospitalizations and inefficient use of emergency rooms. In examining specific health outcomes, the famous Rand Health Insurance Study from the 1980's demonstrated that access to primary care services among low-income individuals resulted in improved vision, more complete immunization, better blood pressure control, and reduced mortality when compared with other low-income individuals that had reduced access to primary care services. Other evidence demonstrates that preventable hospitalization rates are lower in areas where there is a higher ratio of family and general practice physicians.

When we look abroad to other industrialized countries, countries whose health systems are oriented toward primary care realize better population outcomes. They achieve better health status (based on 14 WHO indicators such as low birth weight ratio, neonatal mortality, age-adjusted life expectancy, and years of potential life lost), higher satisfaction with health services among their populations, lower expenditures per capita, and lower prescription medication use. Ultimately, both for individuals and larger populations, primary care is a corner stone of successful health systems and good health outcomes.

The shortage of primary care physicians is, however, a problem that is not distributed evenly across the population. Over 50 million Americans reside in areas designated as primary medical care health professional shortage areas by the Bureau of Health Professions. In 2000, HRSA estimated that an additional 26,657 physicians were needed to meet desired clinician to population ratios in these shortage areas.

This situation is not new. It was for these same reasons that in 1970, shortly after our independence from the American Medical Association, AMSA, then, as in now, supported the passage of the Emergency Health Personnel Act.

Today, the National Health Services Corps, administered through the Health Resources and Services Administration at DHHS, maintains programs that provide service-obligated scholarships and loan-repayment to health professional students in health professional shortage areas (HPSAs). These two NHSC programs are authorized under title III of the Public Health Service Act. They were last reauthorized in the 2002 and expired at the end of the 2006 fiscal year. There are currently 4,333 professionals participating in the Corps and in its history, 27,000 professionals were place in underserved areas. Eligible for Corps funding are primary care physicians—pediatricians, internists, obstetricians/gynecologists, psychiatrists, and family physicians—and other members of the primary care team, including nurse practitioners, physician assistants, midwives, dentists, dental hygienists, and mental/behavioral health professionals.

The premise of the NHSC is one of financial incentive for those clinicians who practice in locations not as rewarding as others. It is no secret that our financing system for health care does not reward those who prevent or coordinate care, but rather those who perform procedures or provide hospital based, critical intervention care. Further, student debt has hit an all-time high. According to the most recent report from the Association of American Medical Colleges, the average medical students graduates with $120,000 in educational debt, up to $300,000 in some cases. It is no wonder that the number of US graduates entering primary care fields has steadily decreased in the past decade. The Corps provides a crucial incentive to care for Americans who are most vulnerable and least likely to have regular access to care. Both the scholarships and the loan repayments are a much needed investment in our health care workforce as in the health of those communities.

The scholarships have also been cited as providing support for those who are underrepresented in medicine. These minority students face increased barriers to becoming health care professionals. Tuition at US medical schools has increased an astounding 11.1 percent which is even more daunting if you are not from the top quintile in US income – where over 60% of students' families are. Keep in mind that African Americans, Hispanics and Native Americans make up over 25% of the population, and less that 6% of physicians. Any program which provides relief from these costs is an improvement and an investment in the health care workforce.

The National Health Service Corps allows committed, driven, and compassionate physicians to follow their interests and provide primary care to the nation's neediest instead of being forced to make career decisions based on high debt loads. Central to this is the presence of the nation's Federally Qualified Community Health Centers—the NHSC provides the staffing backbone to the nation's CHCs. These centers, numbering more than 3,800 today, provide comprehensive care to 15 million people regardless of ability to pay. CHC patients are evenly split between urban and rural settings, and about 70 percent live at or below the poverty line. Three-quarters have no insurance or are enrolled in Medicaid.

Unfortunately, despite generous and much-needed funding increases recently given to health centers, staffing levels are not keeping up with patient demand. The Institute of Medicine found that access to appropriate care is influence by the number and distribution of primary care clinicians. In a recent article published in JAMA, the average health center in 2004 had a family physician staff vacancy rate of more than 13 percent. In rural areas, the rate approaches 16 percent. Even while health centers provide care in the trenches of America's health disparities, help is urgently needed to bring more primary care physicians to provide sufficient staffing at health centers.

As a physician-in-training and as AMSA President, I strongly believe that continued support and increased funding for the National Health Service Corps is critical to improve the nation's health and ultimate provide everyone with affordable, quality healthcare. There are a number of bills before this committee that would reauthorize the National Health Service Corps, we emphasize however, the importance to authorize increased funding for the program. The Corps turned away about half of the 1,800 physicians who applied last year. There is an even lower acceptance rate for students who apply for scholarships with over 11 applicants for each available scholarship in 2006. In the bill introduced by congressman Braley, HR 2915, authorized funding for the Corps would double to $300 million. Furthermore, $30 million would be reserved for allopathic and osteopathic medical students who apply for the scholarship program. An immediate increase in funding for the Corps and carving-out funds for scholarships are crucial for the already proven vacancy rate, paucity of primary care physicians, and ballooning student debt that push young physicians away from primary care and away from underserved areas. This would recognize the crucial role physicians play in coordinating and managing the health of their patients.

Submitted in solidarity,

Michael J. Ehlert MD

AMSA National President

Mr. PALLONE. Thank you all, and we will start with questions. We will start with me. I will recognize myself for 5 minutes.

I wanted to ask Mr. Guzman, we heard Ranking Member Barton raise concerns about creating a new pot of money for school-based clinics when other pots already exist. And you touched on this in your testimony, but I was going to ask you to comment further on why authorizing a new grant program is necessary and why relying on existing or other revenue streams is not adequate.

And I, just from my own experience in New Jersey, I believe that most of the school-based clinics in my district or in our State are primarily State-funded. But I don't know—knowing the situation in the State, I am sure that that money is not—there is not a lot to go around. So if you would talk about that.

Mr. GUZMAN. Yeah. We are in the same boat in Michigan.

I think there are two questions here. The first one is the funding. We need dedicated dollars to that. There are different models. This model of school-based health centers works, and it allows us to have different models that would include health departments, that would include hospitals. But I think that if you look at—if you accept the concept that there are no real dedicated dollars with the exception of FQHC dollars, which are very, very limited——

In our particular case, we did not get any encouragement by the Bureau to submit for a school-based clinic. There was several issues related to whether or not we had to provide the array of services required, have certain hours of operation that would have been contrary to—not contrary, but counter to the school and the local school district's wishes in our particular case.

Mr. PALLONE. Again, I don't know if it was Mr. Murphy or one of my colleagues on the Republican side pointed out that everything we are talking about here is preventative; and, unfortunately, we don't get it scored. But, I mean, we all believe that all these things save money in the long run; and it is unfortunate that we can't score them.

The other question I wanted to ask, I guess I could ask of Mr. Jones and Mr. Miracle, obviously, as was mentioned earlier with Dr. Williams, the authorization levels provide for increased—higher authorization, more funding in Mr. Green's bill that is before us and if you wanted to indicate whether you are supportive of the authorized funding levels included in the bill. Do you think they are adequate to sustain the community health centers program over the authorization period, and is there sufficient increased demand to justify the increased authorization levels? Obviously, I think so, but I would like to hear from you.

Mr. JONES. On two parts. The demand is definitely—at our health center, located in the State of Mississippi, not only are we dealing with the patients, our current patients, but continued growth in patients and relocation because of Katrina. We are still receiving patients, new patients in our clinic. The demand—because of the downturn of the economy, we have many of our patients that are not able to afford health insurance that are seeking the health center and seeking the availability of health center services. We are—in our most rural counties, we are seeing more and more patients that are not able to travel a long distance to work. They are again seeking our services.

So, yes, there is a demand. To meet that demand, we must have increased funding to not only sustain our existing base, our existing patients' care and facilities but also to expand to meet the demand, the new demand.

Mr. PALLONE. Mr. Miracle?

Mr. MIRACLE. I would concur with that. In our community in rural north Georgia, we are a very tourist economy; and we also are a second-home-construction economy. We are having problems, and I foresee in the next 6 months that the unemployment rate in our area will skyrocket. Those folks that are employed because of the tourist economy are employed by small businesses who don't typically provide insurance, and so we have a 20-plus uninsured rate in our community, and I envision that that will continue.

We need the dollars to help us take care of the greater demand that I foresee in our community. We also need dollars to expand our services. We don't currently provide mental health services at our center. There is a serious need in our community for that, and I see increased funding levels being able to help us to provide those additional services.

And, lastly, there is just a general increase in the cost of supplies our organization faces as well as other providers. And with the large percentage of uninsured that we see, it would be very helpful to have additional funding to help us just keep up with the health care inflation.

Mr. PALLONE. Thank you.

Mr. Murphy?

Mr. MURPHY. Thank you; and thank you, panelists. This is very enlightening to have you all here. But I know your jobs require a great deal of services above and beyond the call of duty, so I thank you for that.

I should first relay a message, Mr. Miracle, from Ranking Member Deal. He is on the floor managing part of the debate on the Norwood organ donor bill, so he sends his apologies. He wishes he could be here. He may be back.

But a question for Mr. Jones and Mr. Miracle on the issue I mentioned before about the medical malpractice costs for people under the Federal Torts Claim Act versus volunteers. Mr. Jones, you made specific reference to that. Do you have any idea what it costs your clinic to pay some of these medical malpractice costs under the Federal Torts Claim Act versus physicians who volunteer in clinics? Do you have any direct knowledge of what those difference in costs would be?

Mr. JONES. Per physician I really would need to do some research on that, but I can tell you that prior to FTCA coverage our cost per physician, which was more than 5 years ago, exceeded $5,000 annually per provider. With 20-plus providers, you can see that is a substantial amount of money. OB/GYN and other services considerably higher in providing costs. In today's market I would say it would be considerably higher per provider.

Mr. MURPHY. And in some other States those numbers might even be——

Mr. JONES. Much higher. Much higher.

Mr. MURPHY. Do you agree with that, Mr. Miracle, too?

Mr. MIRACLE. I don't have any direct knowledge of professional liability insurance outside of our organization. But I know that it would be substantial, and it would be a burden to Georgia Mountain Health.

Mr. MURPHY. And among the three of you involved with these clinics, too, your overall administrative costs, have you done any analysis of what the administrative costs would be compared to if you—other kinds of clinics or hospitals that would not be based upon this sort of like the clinic model that you use?

Mr. JONES. At the current time, I don't have those numbers for you, but I can tell you that, from observation, our administrative costs are much lower than what you would find in the private sector.

Mr. MURPHY. That is helpful.

Mr. JONES. But I would be glad to get those figures for you.

Mr. MURPHY. Thank you. I appreciate it.

Mr. Guzman, in your testimony, you said you are fortunate in Detroit to have other funding, but you said only 22 percent of programs nationwide are eligible for some specific funding. What kind of funding were you talking about and why is only 22 percent eligible for that?

You need the microphone.

Mr. GUZMAN. I am sorry. I think the mike is on.

What I know about that is, of the FQHCs, only 22 percent is my understanding are eligible for funding for school-based health centers. The balance of that, which is over three-quarters of the 1,700 school-based health centers, do not receive any Federal dollars.

Mr. MURPHY. Is that something that you see there is some legislative corrections in some of the bills we are dealing with here?

Mr. GUZMAN. Well, that would be the hope.

When we were talking just a moment ago, when you were talking about malpractice insurance, because the school-based health center that our organization runs at the local high school, which is out of our scope, our Section 330 scope, we have to pay malpractice insurance. Even though we have FTCA coverage within the clinic physicians and medical providers as well as the other staff, we have to pay her malpractice insurance because she is not deemed—I guess she is out of system.

Mr. MURPHY. Thank you.

And, Doctor, thank you for not only your testimony but giving your time. Can I ask what it pays to be a family—or a primary practitioner under this program?

Dr. EHLERT. Under the National Service Corps or in general?

Mr. MURPHY. Under National Service Corps.

Dr. EHLERT. It depends on the individual clinics, actually, but the Corps provides for each year, depending on the scholarship that it covers, but the loan repayment is $25,000 per year. And then there has been a focus—as Dr. Williams mentioned, there is actually—HRSA has decided to also increase that $35,000 for people that meet requirements and stay on past.

Mr. MURPHY. But there is a salary, too. You get paid, correct?

Dr. EHLERT. Correct. The payers, I think, are here. They would be better to comment on how much they are able to pay their physicians.

Mr. MURPHY. You are doing it now?

Dr. EHLERT. No, I have graduated from medical school, but——

Mr. MURPHY. Can someone tell us how much they get paid?

Mr. GUZMAN. Sure. Primary care docs, and again depending upon the region of the country, but in the Midwest primary care docs are averaging somewhere in the area of between $175,000 and probably 225.

Mr. MURPHY. To the ones at the clinic or ones in private practice?

Mr. GUZMAN. The ones in the clinics.

Mr. MURPHY. And in private practice what would they make?

Mr. GUZMAN. Private practice they are probably averaging a little bit more than that.

Mr. MURPHY. Mr. Jones? You are not paying that?

Mr. JONES. Pretty much depending upon experience and specialists, the range in our clinic is from $125,000 to $140,000.

Mr. MURPHY. So quite a dramatic difference between what the private sector would be——

Mr. JONES. That is still much lower than the private sector.

Mr. MURPHY. And people who, as you mentioned, Doctor, may have several hundred thousand dollars of debt in the family to deal with.

Well, thank you so much for your testimony. I appreciate that.

Mr. PALLONE. Costs more in the urban areas. Cost of living.

Mr. GUZMAN. That is what we say, yeah.

Mr. PALLONE. Sure.

Mr. Green.

Mr. GREEN. Thank you, Mr. Chairman.

My staff just told me that in our clinics in Texas we have never heard the numbers, but, knowing doctors' costs, I would say that is probably a little higher than what would be paid in urban Houston. But it is a benefit because you have the the loans payback.

Mr. Miracle and Mr. Jones, I read several studies that point to the role of health centers in reduction of health care disparities. Specifically, it has been shown that these disparities don't exist among health center patients even after controlling for socioeconomic factors. These are impressive health outcomes, especially given that health care center population is 23 percent African American, 36 percent Hispanic, much higher proportions of minority representation than the Nation at large.

Can you speak to how health centers have achieved such success at eliminating these health disparities? And what role, if any, does the community board play in helping health centers to tailor their preventative and primary health care services to address the most pressing health needs of the minority populations within these communities? Like I said, I think some of these numbers are very good compared to the numbers we normally hear about health care disparities.

Mr. JONES. One of the things that is part of our planning, our board participates in our planning. It begins from the board, the clinical staff, and the office of the corporation. We plan yearly, annually, and have strategic plans.

But the main thing is making sure that we are very sensitive to the population group that we serve, making sure that we have in-

terpreters when needed but also making sure that we listen to our consumer board. They are there, they are patients of the clinic, they see the need of the clinic, and they report to us and make sure that we listen.

And we try to respond. We are located in areas where our population is located, and we make sure that our facilities' doors are open to everyone, and that is a part of our staff training, from our housekeeping staff to our doctors. We make sure that every patient is respected, and after 20 years of service, the community knows this. They know that they can come there.

And it was evident of Katrina. The community health centers, all six of my community health centers were avenues for care; and from the mayor to the sheriff, they knew they could refer patients to our clinic because we were accustomed to dealing with patients that were homeless, patients that were disenfranchised. We have the experience to deal with those patients. And all of a sudden, when Katrina hit, everybody was homeless. So we became a site, an open-door site for the patients.

Mr. GREEN. OK. Mr. Miracle?

Mr. MIRACLE. I think from the health disparity standpoint, two things to make comment about.

Number one is, where it relates to our Latino population, we deliver culturally competent care. I mean, we have a bilingual staff, and we have gone through separate training to help those folks, our staff communicate with our patient population. And I think that is very important to be able to talk to folks in a way, or—to talk to folks where they are, as opposed to from some other standpoint. So that has helped a lot. In fact, our organization was recognized recently, one of four health centers in Georgia to be recognized as a culturally competent health center.

The other thing is, as a participant in HRSA's disease collaborative program, we monitor, track, and communicate outcomes to our providers, and we hold ourselves accountable to specific outcome measurements. By identifying how well we are doing on A1C levels, for example, is very important, and that helps to make sure that we are providing the care that we need for those chronic disease cases.

Mr. GREEN. OK.

Mr. GUZMAN. If I could just add one other point, we are also required as FQHCs to provide a wide array of other services, wraparound services that encompass social work, nutrition, health education, et cetera. And I think that if you encompass that in the role in how we do things, that is why you see much of the differences along with all of the other things that have taken place.

One of the things that in school-based health centers we have been trying to do is mirror that concept of not just a physician and/or provider being in a location but the provider being there along with social workers and the availability of nutrition and health education programs.

Mr. GREEN. Mr. Chairman, I know I am out of time. I had one more question for Mr. Miracle about the dental services he offers for adults and children, and our bill that Mr. Pickering and I have would authorize the funding for expanding those services, including

mental health, dental, and pharmacy services at every health center.

And with that I won't take up any more time, particularly since you said we would have the markup in early January when we come back.

Mr. PALLONE. We don't come back in early January.

Mr. GREEN. Well, late January. Well, early and late January when we come back.

Mr. PALLONE. We will do it as quickly as we can. I don't think we come back until after the 15th of January, actually, but—OK.

Mr. Burgess?

Mr. BURGESS. Thank you, Mr. Chairman.

Mr. Jones, I guess I was a little startled to hear your story about Katrina and individuals across the border in Alabama who could not come and help because they wouldn't be covered under the Federal Tort Claims Act. Is that correct?

Mr. JONES. Yes. We received an opinion, clarification from HRSA once we began to explore the idea. Which once they crossed—although they were deemed in their health facility, if they crossed State lines or if they moved from another health center you are only deemed at the health center that you are contracted to work for.

Mr. BURGESS. So that was strictly encompassing that population of individuals who were covered at a health center under the Federal Tort Claims Act?

Mr. JONES. That is right.

Mr. BURGESS. Because the information was exactly different than I was given near Dallas. I am licensed but not insured; and, obviously, when we started taking in large numbers of displaced persons, they said—I called the Texas Medical Association for clarification. They said, well, you can't go to Reunion Arena or you will be exposed to liability, but you could go to Louisiana and you wouldn't.

So it is just an odd situation where we find you got one set of information and I got a completely different set. But I guess it only encompassed that universe of people who are employed by the federally qualified health center and had their coverage as an employee, is that correct?

Mr. JONES. Correct. Again, we are asking for clarification.

Mr. BURGESS. It seems—we are the Federal Government. We don't pay any attention to State boundaries anyway in so many things, so I am just surprised that we do in this one.

Mr. JONES. Right. We were surprised, too.

Mr. BURGESS. Maybe an educational program needs to be undertaken before our next end-of-the-world occurs.

Dr. Ehlert, you testified very eloquently about the reauthorization of the National Health Service Corps scholarship and loan forgiveness. Is the scholarship and loan forgiveness under the National Health Service Corps, is that the only avenue that a medical student would have available to them for this type of help or are there other entities that might provide assistance?

Dr. EHLERT. I don't have a detailed list but certainly I know that there are regions, counties, and States that have designed repayment programs, as well as certain centers that do provide similar

incentives for people to go and work there. And certainly scholarships, there is a myriad of scholarships for student.

Mr. BURGESS. When I started medical school in 1974, and they had just phased out at that time what was called the Berry Plan, which the Armed Services would pay for your education, books, and a stipend on which to live. Do the Armed Services provide any type of stipend or loan forgiveness program that you are aware of?

Dr. EHLERT. There is a tremendous opportunity for people that includes both scholarship and stipend. However, your commitment through that is to serve in the military and at military health centers, not at community health centers.

Mr. BURGESS. But it is a similar one-for-one trade, 1 year in for training and 1 year in repayment?

Dr. EHLERT. I am not a scholar, but that is my understanding through my colleagues that have done it.

Mr. BURGESS. And is that the type of help that is available, is it comparable?

Dr. EHLERT. I feel it is more robust.

Mr. BURGESS. Which is more robust?

Dr. EHLERT. The military one, because they encompass more long-term benefits of having been in the military.

Mr. BURGESS. I see.

Dr. EHLERT. That is the same as anyone who served in the military.

Mr. BURGESS. OK. But that is still a trajectory that is available to a medical student.

Dr. EHLERT. Certainly. And my association supports those opportunities for students as well.

Mr. BURGESS. Well, now, have you done the math as to if the funding increase—and do bear in mind—and this is something I did not know before I got here—we have got authorizers, and we have got appropriators, and we are talking about an authorization limit here that is extremely—then there is another hurdle to cross to actually get the appropriations.

I found this out at the National Institutes of Health when I went out there—I have been out there for several field trips—and every building is named after an appropriator. There is none named after an authorizer. But if we authorize it at the level that is in the Braley bill, how many new scholarships will be created as a result of that?

Dr. EHLERT. Again, there is discretion in HRSA. I don't know how many.

But I would just like to point out what I said in my testimony of 11 applicants for each scholarship recipient and about half of the physicians who apply for the stipend while they work in the centers has been turned down.

Mr. BURGESS. But from the standpoint from the government side that is good because then we are getting the most qualified and highly motivated individuals. A lot of competition to get those scholarships?

Dr. EHLERT. Certainly. And some of the greatest leaders I know that have come out of medical school have been denied these scholarships, which is ironic. So, true, it does drive quality, but there is still that need.

Mr. BURGESS. Are they awarded on a competitive basis?

Dr. EHLERT. Yes.

Mr. BURGESS. Grade point average and national boards and—they still do all that stuff?

Dr. EHLERT. The last people I talked to who applied, there is a formula. I don't know the details of the formula, but, yeah, there is a formula involved.

Mr. BURGESS. So your opinion that the National Health Service Corps scholarships and loan forgiveness programs are a good deal for medical students or is it like the court of last resort?

Dr. EHLERT. No, I think it is a tremendously good deal.

Mr. BURGESS. And do you think that us increasing the authorization limit, you think that need, that pressure is still going to be there, still going to remain there?

Dr. EHLERT. Absolutely. I didn't include it in my oral testimony but in my written testimony. Medical tuition went up 11.1 percent last year. So there is actually less and less—if funding stays the same, it becomes less and less incentive.

Mr. BURGESS. Yeah, but you have so much more to learn now.

I just want to thank you for taking the time to come up here today. I know it is time you could have given to something else.

And, Mr. Chairman, I yield back.

Mr. PALLONE. Thank you.

Mr. Deal.

Mr. DEAL. Thank you, Mr. Chairman; and I think you have been told where I went. I was handling the Charlie Norwood organ transplant bill on the floor. As all of you know, that is an important piece of legislation honoring my good friend from Georgia, the late Congressman Charlie Norwood. I do apologize for missing your testimony.

Let me be quick. Mr. Miracle, how long did it take for your center to qualify for the Section 330 funds and how difficult a process was that?

Mr. MIRACLE. I don't know how long it took because it happened before I got there. I can tell you that we applied in 2003 for an expansion for a new start-over in Union County, and we were denied. I can tell you that we tried again in this most recent round with the high poverty counties for Murray County, and we were successful.

What happened between then and now partly was my maturity as a manager of an FQHC but also the help that was provided by the State PCA, the organization that community health centers in Georgia belong to. And the technical support that they provided, with help from HRSA, to our organization to put together a quality grant was tremendously helpful.

Mr. DEAL. OK. What part of the process was the most onerous, do you think?

Mr. MIRACLE. Writing 200 pages of—I think the most onerous part was understanding the community. It was onerous, but it was important. I mean, we, in putting that grant together, required not just sitting in the office in Morgantown and saying, oh, let's do a community health center grant for Chatsworth, but I and my staff actually went to the community several times, met with the hospital there, with community leaders.

We understood from resources that were available the need in the community in terms of the underserved population, and I ended up where I felt that I know that community as well as I know the community where our home center is. And although it was onerous and difficult, it was the most important part of the process, as far as I was concerned.

Mr. DEAL. OK. Do you know offhand how many community health centers we have in the State of Georgia?

Mr. MIRACLE. I can give you an estimate. I think there are some 22 organizations. My guess is that there is some 35 or 40 service sites. But I will have to get back to you with the exact number.

Mr. DEAL. OK. Obviously, since the one in Union County was denied I assume you think there is still a need for some more in our State?

Mr. MIRACLE. Well, I do; and some of that is—as we talked about earlier, there are pockets of needs. And Union County is one of those areas where on the surface it may look like there is no need but there are certainly—as you know, there are certainly some serious pockets of underserved areas in that county. We have 159 counties in Georgia. There are many that would be deserving of a community health center.

Mr. DEAL. Is there any kind of geographical bias in the process, in your opinion?

Mr. MIRACLE. Well, not that I can tell. We serve—we are in north Georgia. We see patients from Tennessee and North Carolina. When we were denied the grant for Union County, my opinion was, well, we needed to just go back and do a better job next time.

Mr. DEAL. OK. Anybody disagree with any of those assessments? Mr. Guzman?

Mr. GUZMAN. Yes, Congressman, I would disagree with that.

I think there appears to be some type of bias. In Michigan, as an example, and specifically in Detroit, we have a significant population. You only have four community health center organizations that represent probably another 10 clinics, points of access for a population of almost 900,000 people. In our particular center, as an example, we see about 78 percent of the folks are uninsured. So that is clearly a need, and we are not quite sure what the status is at the Bureau, but we don't think we got our fair share.

Mr. DEAL. Yours is a metropolitan area.

Mr. GUZMAN. Correct.

Mr. DEAL. Mr. Jones, yours is a rural area.

Mr. JONES. Very rural.

Mr. DEAL. What do you see?

Mr. JONES. I would not say there is a bias. I am concerned about the formula. I am concerned about a county not looking at the—looking at the county as being a county of economic growth when in fact there are pockets in that county that the—there is created a situation where there is a few with a tremendous amount of wealth, but the majority of the county is poor. Unfortunately, that county is not a high priority. The majority of the population in that county has tremendous need, but it is not rated because of the formula.

Mr. DEAL. In a rural area, that percentage of wealth tends to distort it even more than it would in a metropolitan area.

Mr. JONES. Very much so.

Mr. DEAL. OK. My time is up. Thank you all very much, and I apologize again for not hearing your testimony. Thank you.

Mr. PALLONE. Well, let me thank all of you for participating. This is obviously a very important issue with all three of these bills; and I know, as I said before, Mr. Green is pushing us to move quickly on trying to markup the legislation and move it. We are certainly cognizant of the fact that we need to get moving because of the need, and your testimony has helped us a great deal in that respect. So thank you all.

Let me mention that members may submit additional questions to you to be answered in writing. Those should be submitted to the clerk within the next 10 days, and then we will notify you if we have some additional questions.

But thank you again; and, without objection, this meeting of the subcommittee is adjourned.

[Whereupon, at 4:37 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

February 13, 2008

Ricardo Guzman, M.S.W, M.P.H.
Chief Executive Officer
Community Health and Social Services Center Inc.
5635 W. Ford St.
Detroit, MI 48209

Dear Mr. Guzman:

Thank you for appearing before the Subcommittee on Health on Tuesday, December 4, 2007, at the hearing entitled "H.R. 1343, Health Centers Renewal Act of 2007; H.R. 2915, National Health Service Corps Scholarship and Loan Repayment Programs Reauthorization Act of 2007; and H.R. 4230, School-Based Health Clinic Act of 2007." We appreciate the time and effort you gave as a witness before the Subcommittee on Health.

Under the Rules of the Committee on Energy and Commerce, the hearing record remains open to permit Members to submit additional questions to the witnesses. Attached are questions directed to you from a certain Member of the Committee. In preparing your answers to these questions, please address your responses to the Member who has submitted the questions and include the text of the Member's questions along with your responses.

To facilitate the printing of the hearing record, your responses to these questions should be received no later than the close of business **Wednesday, February 27, 2008**. Your written responses should be delivered to **316 Ford House Office Building** and faxed to **202-225-5288** to the attention of Melissa Sidman, Legislative Clerk/Public Health. An electronic version of your responses should also be sent by e-mail to Ms. Melissa Sidman at **melissa.sidman@mail.house.gov** in a single Word formatted document.

Thank you for your prompt attention to this request. If you need additional information or have other questions, please contact Melissa Sidman at (202) 226-2424.

Sincerely,

JOHN D. DINGELL
CHAIRMAN

Attachment

cc: The Honorable Joe Barton, Ranking Member
Committee on Energy and Commerce

The Honorable Frank Pallone, Jr., Chairman
Subcommittee on Health

The Honorable Nathan Deal, Ranking Member
Subcommittee on Health

The Honorable Edolphus Towns, Member
Subcommittee on Health

C · H · A · S · S
Community Health & Social Services Center, Inc.
5635 W. Fort • Detroit, MI 48209 • (313) 849-3920 • Fax (313) 849-0824

February 26, 2008

The Honorable Edolphus Towns:

Thank you for submitting questions in response to my testimony before the Subcommittee on Health on December 4, 2007 at the hearing entitled "H.R. 1343, Health Centers Renewal Act of 2007; H.R. 2915, National Health Services Corps Scholarship and Loan Repayment Programs Reauthorization Act of 2007; and H.R. 4230, School-Based Health Clinic Act of 2007." My responses to your inquiries are documented below. Please feel free to contact me should you have any further questions on the subject.

1. Isn't there already federal funding available for school-based health clinics?

There are no **direct** sources of federal funding available for the school-based health care model. However, 36% of school-based health clinics report receiving some funds from the federal government. Federal funding comes from three primary sources:

- School-based health clinics may compete for federal dollars from the community health center (330) program. However, eligibility for funding is restricted to federally qualified health centers, which excludes nearly eight in ten school-based health clinic sponsors.

- Maternal and Child Health Block (MCHB) grant is used by states and localities to establish grant programs. However, not all states offer MCHB dollars to their school-based health care programs and community need has significantly outpaced the block grant's diminishing appropriation.

- School-based health clinics can also bill Medicaid for care provided to those students they serve who have Medicaid. As I mentioned in my testimony, it has limited availability and the reimbursement rate is rarely satisfactory. 72% of clinics reported billing Medicaid for some services.

2. How is a school-based health clinic different than the school nurse?

The school nurse is responsible for the day-to-day management of the health of all students to ensure their ability to participate in the classroom setting and to learn to their greatest potential. The school nurse routinely assesses students' needs, utilizing and valuing the additional easily accessible and user-friendly resource of the school-based health clinic for students who need health, mental health, and social services. A school based health center is like a doctor's office in the school. The staff of the clinics either directly provides or makes available age-appropriate services such as medical care, oral heath, mental health, social services, and health education. Services are available with parental permission to eligible students who enroll to receive care in the clinic. While school-based health clinics do exist in schools that have limited or no nursing services, they do not take the place of nursing services.

3. Do school-based health clinics only offer services to uninsured children and youth?

School-based health clinics offer services to all children – both uninsured and insured. However school-based health clinics are most often located in medically underserved areas where uninsured children and adolescents are likely to live.

4. Are all school-based health clinics located in cities/ urban areas?

While 59% of clinics are in urban communities, there has been growing interest in establishing clinics in rural areas. Currently 27% of school-based health clinics nationwide are located in rural communities.

6. What can you tell us about the cost and cost savings of these programs?

In many cases the presence of a school-based health clinic in a community results in savings of expenditures for Medicaid, SCHIP and private insurance. For example: (1) Adolescents with Medicaid in Denver were four times less likely to access urgent and emergent care if they used school-based health clinics and (2) New York's school-based health clinics saved approximately $3 million in hospitalization inpatient costs for children with asthma in 2004.

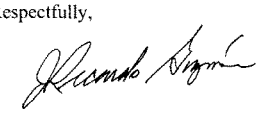
7. Have school-based health clinics played a role in the school for crisis intervention and emergency relief?

Sure – one of the best examples is the role school-based health programs played in the wake of Hurricanes Katrina and Rita in Louisiana and Mississippi. They provided desperately needed services to students including comprehensive physicals, immunizations and refilling of prescriptions for chronic ailments like asthma. Clinic staff secured temporary food, clothing, shelter, rescue and relocation for the evacuees. Essentially, the basic health care needs of students and their families were met, when they would have gone unmet. Furthermore, social workers in the clinics began the desperate and arduous task of dealing with the severe mental health issues faced by the students; anxiety, depression and, of course, post-traumatic stress. School-based health clinics continue today to help these individuals improve the quality of their lives by providing needed mental health care.

8. How are parents involved in the health care delivered by school-based health clinics?

Every school-based health clinic provider values parent/guardian engagement in the health of their child and makes every reasonable effort to encourage the involvement of parents. Programs are committed to informing students and families of the scope of services provided in the clinic and the extent and limitations of confidentiality, within the dictates of federal, state, and local laws and regulations. Moreover, in the 2004 census, published by the National Assembly on School-Based Health Care, over 40% of clinics indicated they involve parents in overseeing the work of the clinics, designing health related events and advocating on behalf of the school-based health clinic.

Respectfully,



J. Ricardo Guzman, LMSW, MPH

January 4, 2008

Dennis P. Williams, Ph.D.
Deputy Administrator
Health Resources and Services Administration
5600 Fishers Lane
Rockville, MD 20857

Dear Dr. Williams:

Thank you for appearing before the Subcommittee on Health on Tuesday, December 4, 2007, at the hearing entitled "H.R. 1343, Health Centers Renewal Act of 2007; H.R. 2915, National Health Service Corps Scholarship and Loan Repayment Programs Reauthorization Act of 2007; and H.R. 4230, School-Based Health Clinic Act of 2007." We appreciate the time and effort you gave as a witness before the Subcommittee on Health.

Under the Rules of the Committee on Energy and Commerce, the hearing record remains open to permit Members to submit additional questions to the witnesses. Attached are questions directed to you from certain Members of the Committee. In preparing your answers to these questions, please address your responses to the Member who has submitted the questions and include the text of the Member's questions along with your responses. Please also begin the responses to each Member on a new page.

To facilitate the printing of the hearing record, your responses to these questions should be received no later than the close of business **Friday, January 18, 2007**. Your written responses should be delivered to **316 Ford House Office Building** and faxed to **202-225-5288** to the attention of Melissa Sidman, Legislative Clerk/Public Health. An electronic version of your responses should also be sent by e-mail to Ms. Melissa Sidman at **melissa.sidman@mail.house.gov** in a single Word formatted document.

Thank you for your prompt attention to this request. If you need additional information or have other questions, please contact Melissa Sidman at (202) 226-2424.

Sincerely,

JOHN D. DINGELL
CHAIRMAN

Attachment

cc: The Honorable Joe Barton, Ranking Member
Committee on Energy and Commerce

The Honorable Frank Pallone, Jr., Chairman
Subcommittee on Health

The Honorable Nathan Deal, Ranking Member
Subcommittee on Health

The Honorable Joseph R. Pitts, Member
Subcommittee on Health

The Honorable Tom Allen, Member
Subcommittee on Health

Response to Follow-Up Questions from the Health Subcommittee of the House Energy and Commerce Committee's December 4, 2007 Hearing on Pending Legislation

The Honorable Frank Pallone:

1) Please provide a map of health center locations.

Response:

A map of health center locations across the U.S. is included in Attachment B of this document.

The Honorable Gene Green:

1) Provide the number of applications submitted for each year beginning in FY 2002 and the number that were scored as fully acceptable or higher, and the number that were actually funded. The table below provides the information, except for the number of applications that were scored as fully acceptable. That information is not available.

Response:

New Access Point Awards (FY '02-'07) Funding Summary and Success Rates

New Access Point Award Success Rate Summary	Applications received	Applications funded	National Success Rate
	(U.S.)	(U.S.)	(U.S.)
FY 2002	390	171	44%
FY 2003	468	100	21%
FY 2004	488	63	13%
FY 2005	181	94	52%
FY 2006	NA	86	NA
FY 2007*	267	127	48%
Total FY 2002-2007	1794	641	36%
* Does not include 75 High Poverty NAPs funded out of 119 total High Poverty NAPs Applications (63% success rate)			

The Honorable Tim Murphy

1) Provide information to the chairman of the committee on extending Federal Tort Claims Act (FTCA) medical malpractice coverage to health center volunteers.

Response:

The extension FTCA to health center volunteers has significant legal and financial implications. The Department of Health and Human Services (HHS) is reviewing the medical malpractice issues related to health center volunteers and other volunteers across the various HHS agencies that are affected by FTCA.

In the aftermath of Hurricane Katrina, HHS's Office of Public Health Emergency Preparedness sought civilian relief workers to assist in areas devastated by Hurricane Katrina. Certain workers providing medical care in the impacted areas were sworn in as temporary, Federal employees serving under a FEMA Mission Assignment. As temporary Federal employees, these providers qualified for FTCA coverage under the general FTCA authority. Although HHS is no longer deploying civilian relief workers under the Hurricane Katrina FEMA Mission Assignment, it is possible that in a future Federally-declared emergency, FEMA will again provide an opportunity for civilians to volunteer and serve as intermittent Federal employees.

In addition, it is possible that in emergency situations, volunteers would qualify for immunity or limited liability. This immunity or limited liability may be available under State or Federal charitable immunity/limited liability statutes (such as the Federal Volunteer Protection Act of 1997, PL 105-19), or under Federal provisions related to the National Disaster Medical System (NDMS) (section 2811 of the PHS Act). In "Overcoming Barriers to Physician Volunteerism," Hattis (2005) reports that 43 States and the District of Columbia have laws that provide varying levels of protection to health professional volunteers. Volunteers may receive FTCA coverage under NDMS. NDMS response team members are required to maintain appropriate certifications and licensure within their discipline, where applicable. Members are activated as Federal employees, and then their licensure and certification is recognized by all States. Additionally, NDMS response team members are paid while serving as part-time federal employees and have the protection of the Federal Tort Claims Act in which the Federal Government becomes the defendant to provide interstate aid in the event of a malpractice claim.

The Honorable Tammy Baldwin:

1) Has HRSA evaluated the data from community health centers of late to measure the impact that increased Medicaid cost-sharing provisions in the Deficit Reduction Act of 2005 have had on utilization of community health centers and the people they serve?

Response:

HRSA has not conducted evaluations measuring the impact of increased Medicaid cost-sharing provisions on health centers.

2) Are there any states that have provided a model for others to look at in terms of collaboration with the Health Center program and are there cost savings generated from that?

Response:

Texas has implemented a FQHC Incubator Program to provide state funding to help strategically position clinics to apply for and receive federal FQHC funding and/or to receive designation as an FQHC Look-Alike. The Texas Department of State Health Services launched the incubator program in fiscal year 2004. Approximately $5 million was available for awards in 2007. Attached is some information from Texas Association of Community Health Centers on the program (Attachment A). HRSA does not have information on cost savings from the Texas FQHC Incubator Program.

Requests from The Honorable Michael Burgess:

1) Provide details in writing of the steps HRSA has taken to address health care needs in Louisiana in the aftermath of the September 2005 hurricanes.

Response:

In the wake of the hurricanes of September 2005, HRSA assisted grantee organizations to return to operations providing medical and enabling services (e.g. transportation, translation) to their patients. The Agency assisted grantees to meet the surge in health care needs in areas affected by the hurricanes. The following actions are among the key steps HRSA undertook:

- expedited the Health Professions Shortage Area "whole county" primary care designation for 21 parishes in Louisiana. HRSA worked closely with Louisiana's State Primary Care Offices and State Primary Care Associations to develop the expedited procedures. In addition, HRSA streamlined its data collection requirements when new HPSA areas were requested, and responded to such requests within 48-hours.
- expedited the process of National Health Service Corps Loan Repayment applications for clinicians willing to serve in high need areas in the states covered by the Public Health Emergency Declaration.
- deployed over 250 HRSA staff including Public Health Service Corps Commissioned Officers, Ready Responders and civilian employees who served in emergency response and recovery efforts for Hurricanes Katrina and Rita.
- coordinated the deployment of Public Health Service Inactive Reserve Corps Officers to support HRSA grantees.
- awarded grants to establish 26 new health center sites in areas affected by the hurricanes. HRSA also sped up the delivery of $2.3 million in grant funding by three months to nine sites in Texas, five in Louisiana, four each in Florida and Oklahoma, two in Georgia, and one each in Mississippi and Tennessee.
- expedited the start date of 180 sites under the 340B Drug Pricing Program from October 1, 2005 to September 9, 2005 to allow them to immediately begin purchasing drugs for patients at the deeply discounted 340B prices.

2) Please provide a map of health center locations.

Response:

A map of health center locations across the U.S. is attached to this document.

The Honorable Tom Allen

1. I understand that nearly 80 percent of NHSC clinicians remain in service to their underserved communities even after their service commitments are completed. While this is a good number, what tools do we have to make sure an even higher percentage is retained?

Response:

The program can only indirectly affect retention of NHSC clinicians. One thing that experience and studies have shown is that the longer a clinician remains at a site under an obligation, the more likely it is that clinician will be retained. The program uses this to its advantage by offering four-year scholarships, and allowing loan repayers to continue to request annual amendments as long as they have qualified loans.

But the major work of retention is done by the employing site, through offering a good working environment and, with the involvement of the greater community, embedding the clinician and his or her family in the economic and social fabric of the community. The NHSC offers technical assistance to sites and communities to help them not only recruit but also to retain clinicians.

2. In this year's Congressional Budget Justification, you show that NHSC field strength increased up until 2004, and then began to decrease. In fact, you project a drop of more than 1,000 clinicians between 2005 and 2008. During that period, the funding requested and provided for the NHSC has also dropped. Shouldn't we be trying to get more NHSC clinicians into our communities?

Response:

Funding for the NHSC Recruitment Line, which supports the Scholarship and Loan Repayment Programs, has remained stable from 2005 through the 2009 President's Budget. The decrease in the Field Strength from its historic peak in 2005 to the estimated 3,434 is due to larger numbers of loan repayers asking for amendments in later years, and less for new contracts as the program has already put more than 1,100 new clinicians into the field, on average from every year from 2003 through 2005. The initial loan repayment contract is for two years, after which the clinician may request additional, annual amendments (more loan repayment funding in return for another year of service). The number of new clinicians cannot equal the number of scholars and

loan repayers who fulfill the service commitment and are no longer counted in the Field Strength.

The Honorable Joseph R. Pitts

1. Under the parental involvement requirements in H.R. 4230, in how many States would school-based clinics be required to provide parental consent prior to providing prescription contraception of the morning-after pill?

2. Under the parental involvement requirements in H.R. 4230, in how many States would school-based clinics be required to provide parental notification prior to providing prescription contraception of the morning-after pill?

Response to Questions 1 and 2:

HRSA does not collect information regarding whether or not school-based clinics adhere to State or local laws regarding parental consent or notification for providing contraceptive or reproductive services.

3. Under H.R. 4230, could school-based clinics refer students to abortion clinics?

Response

School-based health centers may provide a broad array of referrals for health services. State and local laws affect the types of referrals and health services delivered to school-aged children. Because HRSA does not collect information about adherence to state and local laws governing the provision of health services for children, we are unable to respond.

Attachment A

Information From the Texas Association of Community Health Centers on Texas's FQHC Incubator Program

Funding Opportunities

Overview
Section 330 Program Requirements
Benefits of FQHC Designation
Benefits of "Look-Alike" Designation
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Federal Funding Opportunities
Texas Funding for FQHC Development
Planning Grants
Development Grants
Transitional Operating Support
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Texas Funding for FQHC Development

In Texas, to complement the President's New Access Point Initiative and to provide much needed pre-development funding the 78th Texas Legislature created the FQHC Incubator Program, which is administered by the Texas Department of Health. The purpose of the Incubator Program is to strategically position clinics to apply for and receive support as an FQHC and/or to receive designation as an FQHC look-alike. The plan has five components; four that provide direct funding to communities and one that is for a statewide expansion support plan.

Component 1: Planning Grants
Component 2: Development Grants
Component 3: Transitional Operating Support
Component 4: Capital Infrastructure Grant Funds

Incubator grants are true seed funding that will end after August 31, 2004 for awards in the first year of the program and August 31, 2005 for awards in the second year of the program. Due to the seed-funding model, TDH will partner with each grantee to ensure appropriate strategic steps that promote long-term sustainability for the grantees. For more information about the FQHC Incubator Program contact the Texas Primary Care Office at 512.458.7518.

TACHC

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Texas Funding for FQHC Development

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Component 1: Planning Grants

Planning Grants are designed to support specific technical assistance activities that are key to successful applications.

The objectives of this program component are to support:

Unfunded communities in exploring the feasibility of FQHC funding and/or begin the planning process for an application
Currently funded FQHCs in exploring expansion opportunities
Specific technical assistance to both community organizations interested in pursuing FQHC funding and organizations already receiving FQHC funding.

Planning Grant Example Activities

Attending or developing grant development workshops specific to FQHC funding including workshops on general application guidelines, but also specific application component workshops (i.e. business plans, clinical plans, etc.)
Conducting community collaboration and coordination meetings
Evaluating community readiness and need
Identifying special populations to be targeted
Determining viability and sustainability of a clinic in the community

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Texas Funding for FQHC Development

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Component 2: Development Grants

Development Grants provide support for development of the organizational and collaborative capacities required of FQHCs.

The objectives of this program component are to help:

Organizations meet all governance, management, and fiscal requirements of Federally Qualified Health Centers.
Organizations have sufficient capacity to apply for FQHC funds or to apply to be an FQHC look-alike.

FQHC Look-Alike Development Grant Example Activities

Developing non-profit, consumer-based board of directors.
Negotiating formal collaborations and memorandums of understanding (MOUs), including admitting privileges, with hospitals, specialists, and public health offices.
Identifying and developing capital infrastructure such as a facility (does not include purchase of a facility).
Development of, or securing technical assistance for the development of, FQHC application components (i.e. health center budget, clinical plans, management information system development plan, business plan, administrative development plans, and grant narratives).
Workforce development (i.e. physician recruitment)
Leveraging community, state, and federal resources
Technical assistance on any of the above activities

Texas Funding for FQHC Development

Overview
Section 330 Program Requirements

Component 3: Transitional Operating Support

Benefits of FQHC Designation
Benefits of "Look-Alike" Designation
Funding Opportunities
Federal Funding Opportunities
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Development Grants
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Only 2% of awards have gone to clinics that were non-operational at the time of their applications, so the purpose of this component is to provide transitional support for the operations of organizations that meet the definition of a FQHC until organizations can sufficiently diversify revenue streams.

The objectives of this program component are to:

Increase the number of operational clinics applying for FQHC funding.
Provide support to FQHCs in developing operational satellite sites not currently within their scope of services.
Increase sustainability and decrease administrative expenses through participation in the TDH Service Delivery Integration Program.

Transitional Operating Support Grants Example Activities

Administrative expenses of operating safety net site that serves everyone regardless of ability to pay
Off-set expense of instituting sliding fee scale
Support for developing and providing comprehensive services as outline in FQHC look-alike application and program requirements
Organizational development expenses required to diversify funding sources or increase sustainability such as Development Director, Income Analysis, or one-time administrative expenses to reduce operational overhead

TACHC

Texas Funding for FQHC Development

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Federal Funding Opportunities

Component 4: Capital Infrastructure Grant Funds

The goal of Component 4 is to provide communities with grant funds to develop a safety-net infrastructure.

Texas Funding for FQHC Development
Planning Grants
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The objectives of this program component are to:

Increase the ability of FQHCs to open satellite sites in communities with the fewest resources.
Increase the capacity of safety-net sites to provide comprehensive health care services.

Capital Infrastructure Grants Example Activities

Major equipment purchases
Building purchase
Major renovations that are contained within the existing structure shell

I

110TH CONGRESS
1ST SESSION

H. R. 1343

To amend the Public Health Service Act to provide additional authorizations of appropriations for the health centers program under section 330 of such Act.

IN THE HOUSE OF REPRESENTATIVES

MARCH 6, 2007

Mr. GENE GREEN of Texas (for himself and Mr. PICKERING) introduced the following bill; which was referred to the Committee on Energy and Commerce

---

A BILL

To amend the Public Health Service Act to provide additional authorizations of appropriations for the health centers program under section 330 of such Act.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Health Centers Renewal Act of 2007".

SEC. 2. FINDINGS.

The Congress finds as follows:

1 (1) Community, migrant, public housing, and
2 homeless health centers are vital to thousands of
3 communities across the United States.
4 (2) There are more than 1,000 such health cen-
5 ters serving nearly 16,000,000 people at over 5,000
6 health delivery sites, located in all 50 States of the
7 United States, the District of Columbia, and Puerto
8 Rico, Guam, the Virgin Islands, and other territories
9 of the United States.
10 (3) Health centers provide cost-effective, high-
11 quality health care to poor and medically under-
12 served people in the States, the District of Colum-
13 bia, and the territories, including the working poor,
14 the uninsured, and many high-risk and vulnerable
15 populations, and have done so for over 40 years.
16 (4) Health centers provide care to 1 of every 8
17 uninsured Americans, 1 of every 4 Americans in
18 poverty, and 1 of every 9 rural Americans.
19 (5) Health centers provide primary and preven-
20 tive care services to more than 700,000 homeless
21 persons and more than 725,000 farm workers in the
22 United States.
23 (6) Health centers are community-oriented and
24 patient-focused and tailor their services to fit the
25 special needs and priorities of local communities,

1 working together with schools, businesses, churches,
2 community organizations, foundations, and State
3 and local governments.
4 (7) Health centers are built through community
5 initiative.
6 (8) Health centers encourage citizen participa-
7 tion and provide jobs for 50,000 community resi-
8 dents.
9 (9) Health centers make health care responsive
10 and cost-effective through aggressive outreach, pa-
11 tient education, translation, and other enabling sup-
12 port services.
13 (10) Health centers help reduce health dispari-
14 ties, meet escalating health care needs, and provide
15 a vital safety net in the health care delivery system
16 of the United States.
17 (11) Health centers increase the use of preven-
18 tive health services, including immunizations, pap
19 smears, mammograms, and HBa1c tests for diabetes
20 screenings.
21 (12) Expert studies have demonstrated the im-
22 pact that these community-owned and patient-con-
23 trolled primary care delivery systems have achieved
24 both in the reduction of traditional access barriers

1 and the elimination of health disparities among their
2 patients.
3 (13) Congress established the health centers
4 program as a unique public-private partnership, and
5 has continued to provide direct funding to commu-
6 nity organizations for the development and operation
7 of health centers systems that address pressing local
8 health needs and meet national performance stand-
9 ards.
10 (14) Federal grants assist participating commu-
11 nities in finding partners and recruiting doctors and
12 other health professionals.
13 (15) Federal grants constitute, on average, 24
14 percent of the annual budget of such health centers,
15 with the remainder provided by State and local gov-
16 ernments, Medicare, Medicaid, private contributions,
17 private insurance, and patient fees.
18 (16) Reauthorizing the health centers program
19 for 5 years will strengthen and expand health cen-
20 ters in order to put them on a path to become the
21 health care home for nearly 30 million patients
22 served by the year 2015, creating further systemic
23 savings and a healthier Nation.

1 **SEC. 3. ADDITIONAL AUTHORIZATIONS OF APPROPRIA-**
2 **TIONS FOR HEALTH CENTERS PROGRAM.**

3 Section 330(r) of the Public Health Service Act (42
4 U.S.C. 254b(r)) is amended by amending paragraph (1)
5 to read as follows:

6 "(1) IN GENERAL.—For the purpose of car-
7 rying out this section, in addition to the amounts
8 authorized to be appropriated under subsection (d),
9 there are authorized to be appropriated
10 $2,188,745,000 for fiscal year 2008,
11 $2,451,394,400 for fiscal year 2009,
12 $2,757,818,700 for fiscal year 2010,
13 $3,116,335,131 for fiscal year 2011, and
14 $3,537,040,374 for fiscal year 2012.".

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110TH CONGRESS
1ST SESSION

H. R. 2915

To amend the Public Health Service Act to reauthorize the National Health Service Corps Scholarship and Loan Repayment Programs.

IN THE HOUSE OF REPRESENTATIVES

JUNE 28, 2007

Mr. BRALEY of Iowa (for himself, Mr. CONYERS, Mr. EMANUEL, Mr. BOSWELL, and Mr. LOEBSACK) introduced the following bill; which was referred to the Committee on Energy and Commerce

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A BILL

To amend the Public Health Service Act to reauthorize the National Health Service Corps Scholarship and Loan Repayment Programs.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the "National Health Serv-
5 ice Corps Scholarship and Loan Repayment Programs Re-
6 authorization Act of 2007".

1 **SEC. 2. REAUTHORIZATION OF NATIONAL HEALTH SERVICE**
2 **CORPS SCHOLARSHIP AND LOAN REPAY-**
3 **MENT PROGRAMS.**

4 (a) REAUTHORIZATION OF APPROPRIATIONS.—Sec-
5 tion 338H(a) of the Public Health Service Act (42 U.S.C.
6 254q(a)) is amended by striking "$146,250,000" and all
7 that follows through the period and inserting
8 "$300,000,000 for each of fiscal years 2007 through
9 2011.".

10 (b) SCHOLARSHIPS FOR MEDICAL STUDENTS.—Sec-
11 tion 338H of such Act is further amended by adding at
12 the end the following:

13 "(d) SCHOLARSHIPS FOR MEDICAL STUDENTS.—Of
14 the amounts appropriated under subsection (a) for a fiscal
15 year, the Secretary shall obligate $30,000,000 for con-
16 tracts for scholarships under this subpart to individuals
17 who are accepted for enrollment, or enrolled, in a course
18 of study or program described in section 338A(b)(1)(B)
19 that leads to a degree in medicine or osteopathic medi-
20 cine.".

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110TH CONGRESS
1ST SESSION

H. R. 4230

To amend the Public Health Service Act to establish a school-based health clinic program, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

NOVEMBER 15, 2007

Ms. HOOLEY (for herself, Mrs. CAPITO, Mr. ALLEN, Mr. BLUMENAUER, Ms. BORDALLO, Mr. CLEAVER, Mr. COURTNEY, Mr. ENGEL, Mr. HONDA, Mr. MCGOVERN, Mr. MICHAUD, Mr. VAN HOLLEN, Mr. WYNN, Mr. WU, Ms. KILPATRICK, Mr. AL GREEN of Texas, Mr. KILDEE, and Ms. SCHAKOWSKY) introduced the following bill; which was referred to the Committee on Energy and Commerce

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A BILL

To amend the Public Health Service Act to establish a school-based health clinic program, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "School-Based Health Clinic Act of 2007".

SEC. 2. FINDINGS; PURPOSE.

(a) FINDINGS.—The Congress finds as follows:

1 (1) Nearly 8,700,000 children in the United
2 States have no health insurance, including an in-
3 crease of over 600,000 in the past year.
4 (2) The American Medical Association rates
5 adolescents aged 13 to 18 as the group of Americans
6 with the poorest health indicators.
7 (3) More than 70 percent of children who need
8 psychiatric treatment do not receive services.
9 (4) School-based health centers are located in
10 over 1,700 schools in 43 States, the District of Co-
11 lumbia, and Puerto Rico.
12 (5) School-based health centers ensure access to
13 health care by providing care regardless of a child's
14 ability to pay.
15 (6) Forty-five percent of children and adoles-
16 cents treated at school-based health centers have no
17 insurance.
18 (7) Forty-four percent of children and adoles-
19 cents treated at school-based health centers are en-
20 rolled in Medicaid, SCHIP, or other public coverage.
21 (8) School-based health centers promote access
22 to providers for many children and adolescents who
23 otherwise would have difficulty seeing a provider.

1 (9) School-based health centers effectively pro-
2 vide primary, preventative, and mental health serv-
3 ices to children and adolescents.
4 (10) School-based health centers effectively uti-
5 lize resources by often leveraging State and local
6 government funds, private contributions, and Med-
7 icaid, SCHIP, and private insurance payments.
8 (11) For school-based health centers' target de-
9 mographic (students with public insurance or who
10 are uninsured), data show that school-based health
11 centers decrease school absences.
12 (12) School-based health centers identify stu-
13 dents at risk for health and behavioral problems,
14 thus reducing obstacles to the learning process.
15 (13) School-based health centers administer
16 medication to students with chronic illness, which re-
17 duces absences as well as disciplinary action for stu-
18 dents with behavioral health problems.
19 (14) Empirical analyses show that school-based
20 health centers reduce Medicaid costs by providing
21 cost-effective and timely care.
22 (15) School-based health centers encourage pa-
23 rental involvement to increase family participation in
24 school- and education-oriented activities.

1 (b) PURPOSE.—The purpose of this Act is to fund
2 the development and operation of school-based health clin-
3 ics—
4 (1) to provide comprehensive and accessible pri-
5 mary health care services to medically underserved
6 children, youth, and families;
7 (2) to improve the physical health, emotional
8 well-being, and academic performance of medically
9 underserved children, youth, and families; and
10 (3) to work in collaboration with the school to
11 integrate health into the overall school environment.
12 **SEC. 3. SCHOOL-BASED HEALTH CLINICS.**
13 Part Q of title III of the Public Health Service Act
14 (42 U.S.C. 280h et seq.) is amended by adding at the end
15 the following:
16 **"SEC. 399Z–1. SCHOOL-BASED HEALTH CLINICS.**
17 "(a) DEFINITIONS; ESTABLISHMENT OF CRITERIA.—
18 In this section:
19 "(1) COMMUNITY.—The term 'community' in-
20 cludes parents, consumers, local leaders, and organi-
21 zations.
22 "(2) COMPREHENSIVE PRIMARY HEALTH SERV-
23 ICES.—The term 'comprehensive primary health
24 services' means the core services offered by school-
25 based health clinics, which—

1 "(A) shall include physical health services
2 and mental health services; and
3 "(B) may include optional health services
4 such as nutrition, oral health, health education,
5 and case management services.
6 "(3) MENTAL HEALTH SERVICES.—The term
7 'mental health services' means mental health assess-
8 ments, crisis intervention, counseling, treatment, and
9 referral to a continuum of services including emer-
10 gency psychiatric care, community support pro-
11 grams, inpatient care, and outpatient programs.
12 "(4) PHYSICAL HEALTH SERVICES.—The term
13 'physical health services' means comprehensive
14 health assessments; diagnosis and treatment of
15 minor, acute, and chronic medical conditions; and
16 referrals to, and follow-up for, specialty care.
17 "(5) SCHOOL-BASED HEALTH CLINIC.—The
18 term 'school-based health clinic' means a health clin-
19 ic that—
20 "(A) is located on school property;
21 "(B) is organized through school, commu-
22 nity, and health provider relationships;
23 "(C) is administered by a sponsoring facil-
24 ity; and

1 "(D) provides, at a minimum, comprehen-
2 sive primary health services during school hours
3 to children and adolescents by health profes-
4 sionals in accordance with State and local laws
5 and regulations, established standards, and
6 community practice.
7 "(6) SPONSORING FACILITY.—The term 'spon-
8 soring facility' is a community-based organization,
9 which may include—
10 "(A) a hospital;
11 "(B) a public health department;
12 "(C) a community health center;
13 "(D) a nonprofit health care agency;
14 "(E) a school or school system; and
15 "(F) a program administered by the In-
16 dian Health Service or the Bureau of Indian
17 Affairs or operated by an Indian tribe or a trib-
18 al organization under the Indian Self-Deter-
19 mination and Education Assistance Act, a Na-
20 tive Hawaiian entity, or an urban Indian pro-
21 gram under title V of the Indian Health Care
22 Improvement Act.
23 "(b) AUTHORITY TO AWARD GRANTS.—The Sec-
24 retary shall award grants for the costs of the operation

1 of school-based health clinics that meet the requirements
2 of this section.
3 "(c) APPLICATIONS.—To be eligible to receive a grant
4 under this section, an entity shall—
5 "(1) be a school-based health clinic; and
6 "(2) submit to the Secretary an application at
7 such time and in such manner as the Secretary may
8 require containing—
9 "(A) evidence that the applicant meets all
10 criteria necessary to be designated as a school-
11 based health clinic;
12 "(B) evidence of local need for the services
13 to be provided by the clinic;
14 "(C) an assurance that—
15 "(i) school-based health clinic services
16 will be provided to those children and ado-
17 lescents for whom parental or guardian
18 consent has been obtained in cooperation
19 with Federal, State, and local laws gov-
20 erning health care services provision to
21 children and adolescents;
22 "(ii) the clinic has made and will con-
23 tinue to make every reasonable effort to es-
24 tablish and maintain collaborative relation-

1 ships with other health care providers in
2 the catchment area of the clinic;
3 "(iii) the clinic will provide on-site ac-
4 cess during the academic day when school
5 is in session and 24-hour coverage through
6 an on-call system and through its backup
7 health providers to ensure access to serv-
8 ices on a year-round basis when the clinic
9 is closed;
10 "(iv) the clinic will be integrated into
11 the school environment and will coordinate
12 health services with school personnel, such
13 as administrators, teachers, nurses, coun-
14 selors, and support personnel, as well as
15 with other community providers co-located
16 at the school; and
17 "(v) the clinic sponsoring facility as-
18 sumes all responsibility for the clinic's ad-
19 ministration, operations, and oversight;
20 and
21 "(D) such other information as the Sec-
22 retary may require.
23 "(d) PREFERENCES.—In reviewing applications
24 under this section, the Secretary may give preference to

1 applicants who demonstrate an ability to serve the fol-
2 lowing:
3 "(1) Communities with evidence of barriers to
4 primary health care and mental health services for
5 children and adolescents.
6 "(2) Communities that have consistently scored
7 poorly on child and adolescent standardized health
8 indicator reports.
9 "(3) Communities with high percentages of chil-
10 dren and adolescents who are uninsured, under-
11 insured, or enrolled in public health insurance pro-
12 grams.
13 "(4) Populations of children and adolescents
14 that have demonstrated difficulty historically in ac-
15 cessing physical and mental health services.
16 "(e) WAIVER OF REQUIREMENTS.—The Secretary
17 may, under appropriate circumstances, waive the applica-
18 tion of all or part of the requirements of this section with
19 respect to a school-based health clinic for a designated pe-
20 riod of time to be determined by the Secretary.
21 "(f) USE OF FUNDS.—
22 "(1) FUNDS.—Funds awarded under a grant
23 under this section may be used for—
24 "(A) acquiring and leasing buildings and
25 equipment (including the costs of amortizing

1 the principle of, and paying interest on, loans
2 for such buildings and equipment);
3 "(B) providing training related to the pro-
4 vision of comprehensive primary health services
5 and additional health services;
6 "(C) managing a school-based health clin-
7 ic;
8 "(D) paying the salaries of physicians and
9 other personnel; and
10 "(E) purchasing medical supplies, medical
11 equipment, office supplies, and office equip-
12 ment.
13 "(2) AMOUNT.—The amount of any grant made
14 under this section in any fiscal year to a school-
15 based health clinic shall be determined by the Sec-
16 retary, taking into account—
17 "(A) the financial need of the clinic;
18 "(B) State, local, or other operation fund-
19 ing provided to the clinic; and
20 "(C) other factors as determined appro-
21 priate by the Secretary.
22 "(g) TECHNICAL ASSISTANCE.—The Secretary shall
23 establish a program through which the Secretary provides
24 (either through the Department of Health and Human
25 Services or by grant or contract) technical and other as-

1 sistance to school-based health clinics to assist such clinics
2 to meet the requirements of subsection (c)(2)(C). Services
3 provided through the program may include necessary tech-
4 nical and nonfinancial assistance, including fiscal and pro-
5 gram management assistance, training in fiscal and pro-
6 gram management, operational and administrative sup-
7 port, and the provision of information to the entities of
8 the variety of resources available under this title and how
9 those resources can be best used to meet the health needs
10 of the communities served by the entities.

11 "(h) EVALUATION.—The Secretary shall develop and
12 implement a plan for evaluating school-based health clinics
13 receiving funds under this section and monitoring the
14 quality of their performance.

15 "(i) AUTHORIZATION OF APPROPRIATIONS.—For
16 purposes of carrying out this section, there are authorized
17 to be appropriated $50,000,000 for fiscal year 2009,
18 $55,000,000 for fiscal year 2010, $60,500,000 for fiscal
19 year 2011, $66,550,000 for fiscal year 2012, and
20 $73,200,000 for fiscal year 2013.".

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