

Statement of C. Dean Germano

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

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

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

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

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

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

#### Shasta Community Health Center

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

We care for over 40,000 unduplicated patients, or about one quarter of the total population of our county. Ten percent are uninsured, 70 percent are covered by Medicaid, and 16 percent are covered by Medicare. Over 94 percent live below federal poverty lines. We employ over 440 people, including nearly 100 different providers. We also utilize a wide range of sub-specialists from our community and make extensive use of telemedicine. Over 25 Shasta

providers have utilized the NHSC loan repayment option as a crucial incentive in overcoming the salary constraints for physicians working in a non-profit setting. Without the NHSC, it is almost impossible to recruit physicians who face average education debts of around \$200,000, and even as high as \$500,000.

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

At this time, my health center is already short 4-5 primary care physicians and while we use and depend on NPs and PAs, the severity of many of our patients' chronic diseases makes dependency on physicians a necessity. Overall, local planning shows that our community is

short 20 primary care physicians. In the area of dental and mental health, our HPSA shortage scores in those categories are among the highest in the nation. In summary, “growing our own” through training programs like the THCGME program is not only a good idea, it is a survival imperative for my center in Redding and for centers throughout the country that utilize the THCGME program or want the program to expand to include them.

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

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

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

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

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

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

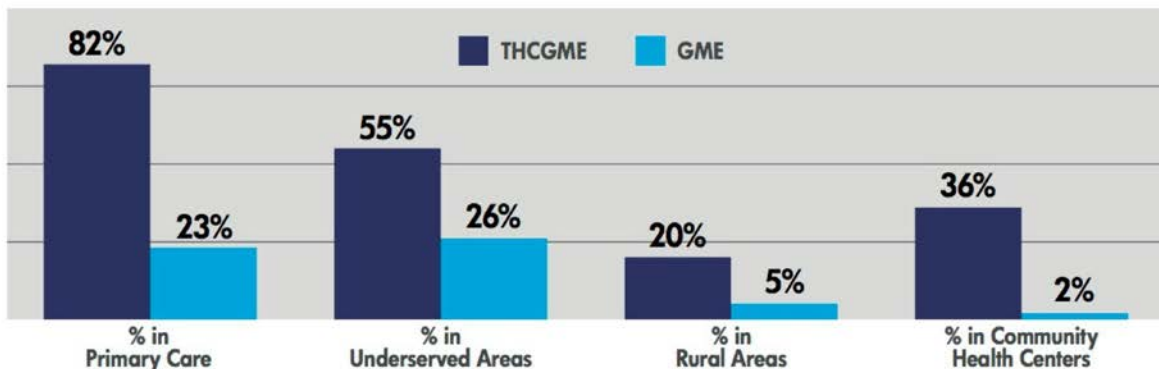
Evidence has shown that resident physicians who train in health center settings are nearly three times as likely to practice in underserved settings after graduation. They are also 3.4 times more likely to work in a health center, compared to those who did not train in health centers. The difficulties in recruiting community-based primary care physicians are also well-

documented; only investment in the community health care workforce pipeline will help meet the workforce demands.

Analysis of the THCGME programs continue to show promising results:

### > TEACHING HEALTH CENTER SUCCESSES

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



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

H.R. 2815 will also help THCs restore some resident slots that were authorized by HRSA but not filled during the last couple years of uncertainty. Within the \$126.5 million, there should be enough funding for a THC like ours to recruit and fill some residency slots that we need to

meet all national accreditation requirements and to grow from our current class of two residents to four residents in each entering class. H.R. 2815 also includes funding for a very modest increase in the per resident allocation (PRA) to help offset inflation over the next five years. While Congress was very generous in restoring the \$150,000 PRA in last year's law, our clinics and residency programs facing rising costs and we are hopeful that Congress can help us preserve our purchasing power during this five-year reauthorization period.

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

### **Community Health Centers Reauthorization Legislation**

None of the work that I have already described today would be possible without the foundation provided to every health center through Section 330 federal grant funding. Especially in times of change and transition, sustaining and boosting health center funding provides continuity for the patients and communities we serve. Federal grant dollars allow health centers

to expand their facilities, open new sites, and broaden their services to meet unmet need in areas with limited access to care. These dollars are invested in services that grant patients easier access to primary care, including transportation, care coordination, and translation and interpretation services. And, leveraging of federal resources occurs because the federal Section 330 grant remains the unofficial stamp of approval that our other sources of funding and support look for as a representation of a high quality health care provider.

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

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

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

Over the last several years, Shasta Community Health Center and health centers in California and across the nation have experienced serious uncertainty due to the challenges we have faced due to recent funding disruptions. By design, health centers are hubs for easier access



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

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

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

and at every CHC, is the essential role of the federal Section 330 grant that supports our ability to provide care to uninsured and underinsured patients.

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

#### **National Health Service Corps (NHSC) Reauthorization Legislation**

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

placements in the last year alone.

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

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

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

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

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

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

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

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

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

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