

**THE CRITICAL ROLE OF
COMMUNITY HEALTH CENTERS IN
ENSURING ACCESS TO CARE**

HEARING
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON ENERGY AND
COMMERCE
HOUSE OF REPRESENTATIVES

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THE CRITICAL ROLE OF COMMUNITY HEALTH CENTERS IN ENSURING ACCESS TO CARE

THURSDAY, MAY 4, 2006

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
SUBCOMMITTEE ON HEALTH,

Washington, DC.

The subcommittee met, pursuant to notice, at 2:42 p.m., in Room 2123 of the Rayburn House Office Building, Hon. Nathan Deal (chairman) presiding.

Members present: Representatives Deal, Bilirakis, Gillmor, Shimkus, Ferguson, Burgess, Pallone, Rush and Green.

Staff present: Ryan Long, Counsel; Katherine Martin, Professional Staff Member; Brandon Clark, Policy Coordinator; Chad Grant, Legislative Clerk; John Ford, Minority Counsel; and Jessica McNiece, Minority Research Assistant.

MR. DEAL. The committee will come to order and the Chair recognizes himself for an opening statement. I am proud to say that we have four expert witnesses appearing before us this afternoon that will help us examine the issues relating to the reauthorization of enabling legislation for community health centers.

Without question, community health centers are an integral part of our country's healthcare delivery system, providing healthcare services to people in communities that would not otherwise have access to such care.

As many of you know, this subcommittee has exclusive jurisdiction over legislation regarding community health centers and we are committed to being good stewards of this program. We join the President in strong support of community health centers and we applaud the thousands of community health centers, employees and volunteers that contribute so much to the success of the program.

Again, I want to welcome our witnesses and I will introduce the panels as they appear and I thank them for their participation. As you have probably determined, the House has now completed its work on the floor and this gets to be a little bit of a hairy time for us at this point. So I am going to cut my opening statement short in hopes that my fellow committee members might follow suit. But we do welcome you here.

[The prepared statement of Hon. Nathan Deal follows:]

PREPARED STATEMENT OF THE HON. NATHAN DEAL, CHAIRMAN, SUBCOMMITTEE ON
HEALTH

The Committee will come to order, and the Chair recognizes himself for an opening statement.

I am proud to say that we have four expert witnesses appearing before us this afternoon that will help us examine the issues related to the reauthorization of enabling legislation for Community Health Centers.

Without question, Community Health Centers are an integral part of our country's health care delivery system, providing health care services to people and communities that would not otherwise have access to such care.

As many of you know, this Subcommittee has exclusive jurisdiction over legislation regarding Community Health Centers, and we are committed to being good stewards of this program. We join with the President in our strong support of Community Health Centers, and we applaud the thousands of Community Health Center employees and volunteers that contribute so much to the success of this program.

Again, I welcome our witnesses and thank them for their participation.

In the interest of time, I would ask my fellow Committee Members to waive their opening statements or keep them as brief as possible so that we can allow our witnesses to leave at decent hour. I would also like to ask for Unanimous Consent that all Committee Members be able to submit statements and questions for the record.

I now recognize the Ranking Member of the Subcommittee, Mr. Brown from Ohio, for five minutes for his opening statement.

MR. DEAL. And at this time I would recognize my good friend from Texas, Mr. Green, for an opening statement.

MR. GREEN. Thank you, Mr. Chairman, and I would like to ask unanimous consent for the statement from our Ranking Member, John Dingell, be placed into the record.

MR. DEAL. Well, I would ask unanimous consent that all committee members have the right to submit their statements and their questions for the record. Without objection, so ordered.

[Additional statements submitted for the record follow:]

PREPARED STATEMENT OF THE HON. JOHN D. DINGELL, A REPRESENTATIVE IN CONGRESS
FROM THE STATE OF MICHIGAN

Mr. Chairman, thank you for calling this hearing today to highlight the critical role that Community Health Centers play in ensuring access to care for millions of Americans nationwide.

Community Health Centers are local, non-profit, community-owned healthcare providers that serve low-income and medically under-served communities. They provide healthcare services to more than 15 million people annually, 6 million of whom have no health insurance coverage. They are located in more than 3,400 communities in every single State, including my home State of Michigan where we have approximately 30 health centers. Community Health Centers are vital to the health and well-being of our country's most vulnerable citizens.

Currently, there are over 41 million uninsured Americans and untold numbers of under-insured persons. Due to the slowing economy, this number is increasing at a rapid

pace. As a result, demand for healthcare services has increased drastically, forcing risky delays for important primary and preventive healthcare services.

For almost 40 years, America's Health Centers have helped communities meet escalating health needs and address costly and devastating health problems, from infant health development to chronic illness, to mental health, substance addiction, homelessness, domestic violence, and HIV/AIDS. Community Health Centers span urban and rural communities across the Nation and their remarkable success has earned them broad bipartisan support among Federal, State, and local policy-makers. We should continue to do everything within our power to support these Health Centers and provide them with the resources they need so that they can continue to do their jobs as successfully and effectively as they have for the past four decades.

Legislation reauthorizing Community Health Centers should be considered soon by this Committee. But I note that we should also not forget the valuable contribution school-based health centers also make to communities across our Nation. I hope that we can consider developing some program enhancements for school-based health centers either during the consideration of the Community Health Centers reauthorization or at some time in the near future.

PREPARED STATEMENT OF THE HON. JOE BARTON, CHAIRMAN, COMMITTEE ON ENERGY
AND COMMERCE

Good morning. Mr. Chairman, I commend you for holding this hearing. I look forward to working with you and the rest of the Subcommittee as we consider the role played by community health centers in the health care delivery system.

At the end of this year the authorization of community health centers will expire and this Committee needs to examine how we can ensure that this program continues to provide affordable and quality care to those who need it most. Community health centers have received widespread support not only at the federal level but more importantly, at the local level where the care is being administered. It is important to note that these centers are great sources of preventative health care, which helps to control ever-increasing health care costs. It is our responsibility as federal representatives to ensure that taxpayer's money is being spent efficiently and community health centers have demonstrated that they are effective in achieving this goal.

The statistics are impressive. There are over 900 community health centers providing a broad spectrum of health services to 3600 localities, both urban and rural, located in every state and territory in the nation. Of the total number of community health center patients, 90% live below 200% of the federal poverty line. The list of primary health care services administered by community health centers is long—mammograms, dental services, immunizations, prenatal care, mental health services, chronic disease management, and cholesterol checks.

Community health centers are at the heart of our nation's health care safety net. They work to provide care to the medically underserved and are able to identify services unique to each community, constantly focusing on building on their successes. Most importantly, these centers provide a favorable alternative to patients who would otherwise utilize emergency rooms for non-emergency services, which results in alarmingly high costs. By providing preventative care, we keep people in the community healthier. Healthy people use fewer services and this decreases the burden on our health care delivery system, including the Medicare and Medicaid programs.

Certainly, as with any program, there is room for improvement. However, we should continue to keep in mind that community health centers are highly successful both in containing costs but more importantly, serving the health care needs of local communities. I am interested to hear from our witnesses how they believe the program can be strengthened.

I look forward to hearing from our witness from the Health Resources Service Administration about how this program is administered and what the goals are for the final year of the President's Expansion Initiative. I also look forward to hearing from our three witnesses on the second panel. Mr. Hawkins, from the National Association of Health Centers, for the perspective he can provide in examining the program through the numerous centers across the nation. Likewise, I want to thank Ms. Grant-Davis for testifying as to how the various community health centers in the state of New Jersey serve their patients. And finally, I especially want to thank Tarrant County Commissioner Roy Brooks for coming in all the way from Texas to share how his community was able to create and new community health center and how the community is benefiting from this achievement. Thank you Chairman Deal for calling this hearing today and I welcome the witnesses.

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

Mr. Chairman, thank you for holding this hearing today to examine the important role of Federally Qualified Community Health Centers in providing access to health care for Americans living in medically underserved communities.

President Bush and I agree about the importance of federal investment in Community Health Centers (CHCs). I am pleased that the President's budget includes a request for an additional \$181 million for CHS, which would bring the overall federal investment in CHCs to almost \$2 billion in FY07. This federal investment will go a long way to fulfill the President's commitment to create 1,200 new or expanded health center sites by the end of next year.

CHCs have a unique place in our health system, abiding by four key principles: serving all citizens regardless of their ability to pay; targeting resources to high need areas; providing access to comprehensive primary care services; and governance and direction by the community being served.

CHCs are a particularly important component of Maine's health care infrastructure. We have twenty-nine centers operating in federally designated Health Professions Shortage Areas (HPSAs) throughout the State. Twenty percent of Maine residents live in HPSAs for primary care, 18 percent in mental health HPSAs; and 65 percent in dental HPSAs. One in ten Maine residents receives care at a CHC during a given year. Approximately fifteen percent of Maine Medicare (MaineCare) beneficiaries statewide are CHC patients.

CHCs are a model of efficient, cost-effective primary care delivery which save health system dollars. For example, CHCs save the MaineCare program more than thirty percent in annual spending per beneficiary due to lower emergency department utilization, reduced specialty care referrals, and fewer hospital admissions.

I look forward to working with my colleagues to reauthorize the Community Health Centers program. CHCs are a shining example of how federal investment in health care can improve access across this nation for citizens in underserved communities, many of whom have no other means of health care coverage.

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

Thank you Mr. Chairman and thank you to the witnesses who are joining us today.

I cannot say enough good things about the amazing work that Community Health Centers do. The Community Health Centers in my district—in Madison and Beloit, WI—are incredibly vital parts of their communities and I am continually amazed at the variety of critical services that they offer.

For some people, the Community Health Center is the only place where they can access dental care. For others, it's the only place that provides affordable care. And for yet others, it's the only place where they can easily communicate with their health care providers without the interference of language barriers.

The tie between Community Health Centers and the communities they serve is invaluable and is something that must be preserved through continuing the majority-patient requirement for governance boards. The requirement that 51% of board directors be patients provides Community Health Centers with an incredible tool to ensure that they are, indeed, meeting the needs of the community.

I think it's important to note that we are currently in the middle of Cover the Uninsured Week. As we know, there are currently 45.8 million Americans without health insurance, and millions more are underinsured.

We all know that Community Health Centers play a vital part in providing the uninsured and underinsured with access to affordable care, but I think it's important for us to take one moment to reflect that while this access is fantastic and greatly appreciated, it is still not health insurance. Community Health Centers cannot—and should not—bear the burden of providing care for all of our nation's uninsured, and I look forward to this Subcommittee addressing the need for systematic change of our crumbling health care system.

Lastly, I'd like to voice my support for H.R. 5201, the reauthorization bill that my colleagues Mr. Bilirakis and Mr. Green (of Texas) have introduced and of which I was proud to be an original cosponsor. I look forward to working with members of this Committee to move forward a reauthorization that preserves the current structure of Community Health Centers and ensures their continued ability to be vital parts of our communities.

Thank you Mr. Chairman.

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

Thank you, Mr. Chairman, for holding this important hearing on Community Health Centers (CHCs). I believe the witnesses today will highlight the crucial role that CHCs play in providing quality health care to underserved communities across America.

For over 40 years, CHCs have provided high-quality, affordable primary care and preventive services to the nation's most vulnerable populations. Today, there are over 900 CHCs operating in 3,600 urban and rural sites in every U.S. state and territory. In 2003, CHCs treated over 12 million people in underserved areas, including 4.8 million uninsured patients. They performed mammograms on over 200,000 women, gave check-ups and preventive services to 1.6 million children, and administered 2.2 million immunizations.

CHCs also offer services that many other providers do not, such as transportation, translation, and culturally sensitive health care that helps overcome common barriers to health care.

In my home state of California, over 1.8 million Californians were served at CHCs in 2004. In California's 14th Congressional District, which I'm proud to represent, there are 14 CHCs. I cannot emphasize enough what an important part of the health care safety net CHCs are, providing care to the uninsured and underinsured who would otherwise lack access to health care. Community Health Centers are essential, efficient, and effective and I'm proud to support efforts to enhance their important mission.

The Health Centers Program, set forth in Section 330 of the *Public Health Service Act*, was renewed in 2002 and is set to expire on September 30, 2006. I thank my colleagues, Representatives Michael Bilirakis and Gene Green, for introducing H.R. 5201, the *Health Centers Renewal Act of 2006* and I'm proud to be an original cosponsor

of this important bipartisan legislation which reauthorizes the Community Health Centers Program through 2011.

I urge my colleagues on this Subcommittee and in Congress to support H.R. 5201 and reauthorize the Community Health Centers Program so we can continue to provide health care services to those who need them most.

PREPARED STATEMENT OF THE HON. PAUL E. GILLMOR, A REPRESENTATIVE IN CONGRESS
FROM THE STATE OF OHIO

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

Earlier this week, I visited Fremont Community Health Services, a Community Health Center located in my district. As some of you may know, shortly after Hurricane Katrina hit last summer, Fremont Community Health Services raised \$20,000 to send two doctors, three nurses, and a mobile health unit to assist a sister Community Health Center in Biloxi, Mississippi. However, the medical team was soon hit in the form of government red tape, delaying their departure – The Health Resources and Services Administration (HRSA) advised Fremont that they would not be covered in terms of malpractice insurance under the Federal Tort Claims Act (FTCA) should they choose to provide medical services in temporary locations, across state lines. While the Fremont mobile unit was eventually granted temporary FTCA coverage from HHS by allowing permanent federal employees onsite to swear-in the group as “temporary federal employees,” the same temporary federal liability coverage was not extended to Fremont Community Health Services last January when they attempted to assist the Biloxi Health Center yet again - because there would not be a permanent federal employee on-site this time around to temporarily “federalize” the medical team.

The Community Health Center in my district is not alone. In fact, as a result of Hurricane Katrina, many Community Health Center sites were either totally destroyed or closed due to damage, or damaged but still operating. Although these Health Centers were calling for the help of sister facilities throughout the country, Health Centers ready and willing to provide that help simply could not, due to a lack of FTCA coverage. It took so long for a team of Iowa Health Center volunteers to get the “federal green light” that after a week in New Orleans waiting, and not working, they went back home. A group of Texas Health Centers looked to by-pass the federal review process by purchasing private liability coverage for health care providers coming in from out of state, but were unsuccessful – it turned out that the insurance market would not support new coverage for such a high-risk hurricane relief effort.

After raising this issue several times with HHS, and encouraging them to exhaust all avenues of administrative authority to provide FTCA coverage for such instances of natural disaster and public health emergency, HRSA has indicated that a legislative change will be needed to address this issue. And H.R. 3962, introduced last fall by Mr. Schwarz of Michigan would do just that – extend FTCA liability coverage for Health Center employees who travel offsite, or across state lines to provide care at health centers affected by President-declared natural disasters and public health emergencies.

I encourage my colleagues on this panel to join me in need to bring further awareness to this issue and debate the merits of H.R. 3962, with the hopes of enacting it soon. By doing so, we can do our part to ensure access to care, and not deny it when people need it the most. We cannot wait for another natural disaster or potential public health emergency.

Without objection, I would like to insert an Associated Press article into the public hearing record reporting on this matter in further detail. With that, I welcome the panel of witnesses today, look forward to their testimony, and yield back by time.

PREPARED STATEMENT OF THE HON. CHARLIE NORWOOD, A REPRESENTATIVE IN CONGRESS
FROM THE STATE OF GEORGIA

Thank you Mr. Chairman.

We are approaching 1,000 community health centers with 3,600 sites serving over 13 million Americans.

There are over 80 in Northeast Georgia alone. They operate in rural communities where health services are either scarce or non-existent. They provide care for the poor, so they don't use the emergency room.

I don't think I can say it any simpler -- health centers are working and should be reauthorized. While I'd be open to modest changes, I think the current program is a success.

While 25% of our population lives in rural areas, only 10% of physicians practice there.

Rural Americans, like many folks in my district are more likely to live below the poverty level and be uninsured.

Health centers address their needs, including treatment, preventive, and emergency care. They treat anyone from the area regardless of their ability to pay. They are also Medicare and Medicaid providers -- guaranteeing access for our poor and elderly.

While healthcare costs have risen, health centers have kept theirs well under those of other providers. Patients of health centers **are healthier, use emergency rooms less and save money. In Georgia they save the state \$13.4 million each year in Medicaid costs alone! They are a good deal for poor Americans and taxpayers.**

I have been an enthusiastic supporter of this program and am glad the President has supported the expansion of centers in 200 new communities.

However, they cannot meet the demand for their services without the right funding and staffing.

I have worked with Mr. Bilirakis to increase funding and more people will be served and centers will open as a result.

As for staffing I'd like to point out that Title 7 funding, which I have defended with Congresswoman DeGette for years, exists to recruit health professionals to serve in rural areas.

I hope the appropriators are listening --We preserve Title 7 and we alleviate the health professions shortages described by the *Journal of the American Medical Association* that exist in rural health centers.

Recognizing and reauthorizing this program is critical to ensuring our nation's uninsured and rural populations have access to affordable, quality preventative and primary care services.

Thank you and I yield back

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

Mr. Chairman, thank you for having this hearing on the nation's community health centers. The panels today will testify to the great importance of the work of these centers in providing care for those most at risk in our communities. Our goals here today should not be to change the structure of what has already been successful. Rather we should be talking about enhancing and expanding what has already worked.

The cost effective services provided by health centers contribute to the social and physical well-being of millions of Americans from school children and the elderly to adults who have NOWHERE else to go for health care. That is why I am in favor of a substantial increase in funding for community health centers.

Mr. Chairman, in Brooklyn, New York, Twelve Community Health Centers serve almost 200,000 people a year, an increase of nine percent over three years. They provide cost effective health services for our low-income residents, including immunizations, mammograms, prenatal and perinatal services, cancer screenings, child health services and a host of other critical services. We should expand these services so that thousands of other low income residents can have access to critical care.

Thank you.

PREPARED STATEMENT OF THE HON. FRED UPTON, A REPRESENTATIVE IN CONGRESS FROM
THE STATE OF MICHIGAN

Mr. Chairman, I am a strong supporter of the Community Health Center program and look forward to working with you on reauthorizing this vital health care safety net program. We are very fortunate that the poor, uninsured or underinsured, homeless and migrant populations in urban and rural communities in my Southwest Michigan Congressional district are well-served by three networks of community and federally qualified health centers, with a total of ten clinic sites providing accessible, high-quality primary and dental care services. I have great respect for the commitment and dedication to our most vulnerable citizens that I have witnessed in the administrators and health professionals at these health centers. They are a special breed fulfilling a challenging mission.

MR. GREEN. Mr. Chairman, I wish I could tell you I am going to keep mine short but I think this is such an important issue. I want to thank you for holding the hearing as Democratic co-sponsor on this with Congressman Bilirakis from Florida. I think it is fitting our subcommittee is holding this hearing on Cover the Uninsured Week, since health centers are a critical part of our country's safety net.

In 2005, health centers provided care to six million uninsured individuals who represented 40 percent of the patient population at health centers. Ninety-one percent of the health center patients are low-income and 36 percent are Medicaid beneficiaries. Without a doubt, health centers are meeting their vision of providing much needed healthcare to medically underserved in our country. Much of this success can be attributed to core elements of the section 330 statute Congress put in place to authorize the health center program.

To be eligible for Federal funding, health centers must be located in medically underserved communities, the majority governed by community members utilizing the centers for healthcare. And they must provide comprehensive primary and preventative healthcare with services available to all community residents regardless of the patient's ability to pay. This focus on primary and preventative healthcare has yielded a tremendous savings for our healthcare systems as health centers provide the uninsured and underinsured with access to care that they would otherwise seek from a hospital emergency room.

Access to affordable primary care health centers has reduced the need for inpatient and specialty care because medical problems in health

center patients are treated earlier before they reach emergency proportions that require a trip to the emergency room or inpatient hospital care. In fact, studies suggest that health centers save Medicaid approximately 30 percent in annual spending on beneficiaries receiving care at our Nation's health centers.

The successful result is these health centers have become the medical home for more than 15 million Americans. Health centers also represent the Nation's largest primary care system with one in nine Medicaid beneficiaries and one in five low-income individuals receiving care at these centers.

I have a personal interest in this issue, as we have been working for years in the Houston area to establish additional community health centers to serve our growing uninsured and underinsured population. My State of Texas unfortunately ranks number one in the level of uninsured with 25 percent of Texans living without health insurance. The statistics for the Houston area are just as troubling, more than 30 percent of Harris County residents living without health insurance.

Despite the obvious need for additional community centers in the Houston area, we have been playing catch up for quite a while. Last year, our area was awarded five additional FQHCs, bringing our total to nine, including look-alike centers. When you consider nine sites, more than one million uninsured however in the Houston area will still have fewer than ten FQHCs while other cities, such as Chicago, have more than 70 sites.

In the Houston area we know that our work is not done. As a Nation, we have a long way to go before we meet the President's goal of locating a health center in every low-income county in this country. In fact, studies suggest that there are still more than 904 counties in the U.S. in need of a health center. To ensure these goals are met, it is crucial we reauthorize the health center program, whose reauthorization expires this year.

Mr. Bilirakis and I have introduced H.R. 5201 to do just that. In our legislation, we authorize a program until 2011, keeping intact the core elements of the program that has been critical to its success. I would like to thank the majority of the subcommittee for co-sponsoring the legislation and hope our committee leadership will put the reauthorization at the top--at the important part of the top of our agenda.

And again, I want to thank our Chairman, the Ranking Member, and our witnesses who are appearing today and I look forward to the testimony. And I will give thoughts toward the next step we need to take to ensure continued success of health center programs. Thank you, Mr. Chairman.

MR. DEAL. I thank the gentleman. I now recognize my friend, Dr. Burgess, for an opening statement.

MR. BURGESS. Thank you, Mr. Chairman. And I, too, will not use all of the time. But I do want to thank you for calling the committee today, a subject that is important to me and the community that I represent.

Community health centers comprise an important component of our healthcare system. By providing comprehensive primary health, mental health, oral screenings and substance abuse to low-income and underinsured patients, health centers fill an important gap in the healthcare safety net. As Mr. Green just pointed out, more than 60 percent of federally qualified health centers patients have no other health insurance and many others are underinsured. It is essential that the health clinic exist in every community where need exists. Unfortunately, this is not the case in every community, especially the area of Texas that I represent.

President Bush has made a serious commitment to expand community health centers to more underserved communities. I have been working over the last several months with my county commissioner, Roy Brooks, who is here today, to establish another federally qualified health center in Tarrant County, Texas. Over that time, there have been difficulties, but the stakeholders involved understand the importance of establishing a clinic in the southeast part of the city of Fort Worth. Diseases, chronic diseases, such as congestive heart failure, hypertension, diabetes and some of the highest rates of infant mortality anywhere in the country persist in this corner of Texas and the need for a health center is indeed critical.

After the devastation of Hurricane Katrina with so many Louisiana residents taking flight to Texas and especially North Texas, the need has only been compounded. So I look forward to working with Commissioner Brooks and our friends at HRSA and the National Association of Community Health Centers to make this goal a reality.

And Mr. Chairman, just a point of personal privilege, I do want to thank Commissioner Brooks. He readjusted his schedule, came all the way up here today to be with us. As often pointed out back home during--we just had our primary a few months ago in Texas and Mr. Brooks and I are not on the same ballot but we are frequently on the same page, especially when it comes to issues like a community health center. And I believe, if I am not mistaken, Mr. Brooks is here with his daughter and we are very happy to welcome you to the committee today. Thank you, Mr. Chairman. I will yield back.

MR. DEAL. I thank the gentleman and I recognize Mr. Ferguson, the Vice Chairman of this subcommittee, for his opening statement.

MR. FERGUSON. Thank you, Mr. Chairman. Thank you for holding this important hearing on community health centers. I want to begin by welcoming Ms. Kathy Grant Davis, who is Executive Director of the New Jersey Primary Care Association, which is in Princeton, New Jersey. Our community health centers in New Jersey provide critical care and services to many underserved populations in my home State, including migrant and homeless health centers. Ms. Davis' organization and community health centers throughout our Nation are a valuable resource for taking care of people in our communities.

For more than 40 years, health centers have provided high quality, affordable primary care and prevention services. The people served by these organizations are from underserved populations, as I say, and are often isolated from other forms of care used by the community. They may be isolated by language and economic factors, and community health centers are there to serve them.

I look forward to Kathy's testimony today and testimony from our other panelists, and I look forward to working with the committee and you, Mr. Chairman, to reauthorize these valuable community healthcare partners and I yield back.

MR. DEAL. I thank the gentleman. Well, we made good progress there. I am pleased to introduce our first panel, which consists of Ms. Elisabeth Handley, who is the Division Director for Policy and Development of the Bureau of Primary Healthcare at U.S. Health and Human Services, commonly referred to as HRSA. And the subject of today's hearing is The Critical Role of Community Health Centers in Ensuring Access to Care. Ms. Handley, you are certainly in a unique position to comment on that and we would welcome your opening statement. I would say to all of those who will testify that your written statements have been made a part of the record and you may feel free to elaborate on anything that you would like to. But we are pleased to have you and will recognize you at this time.

**STATEMENT OF ELISABETH HANDLEY, DIVISION
DIRECTOR FOR POLICY AND DEVELOPMENT, BUREAU
OF PRIMARY HEALTH CARE, HEALTH RESOURCES
AND SERVICES ADMINISTRATION, U.S. DEPARTMENT
OF HEALTH AND HUMAN SERVICES**

MS. HANDLEY. Thank you, Mr. Chairman, and members of the subcommittee for the opportunity to meet with you today on behalf of the Health Resources and Services Administration to discuss the critical role of health centers and access to care. I have this oral statement and I

believe you have just given me permission to submit my entire written statement for the record. Thank you.

For more than 40 years, the health centers program has helped build high quality and cost-effective primary care delivery systems that serve low-income residents in inner cities and in rural and isolated areas. I am proud today to update you on the success and growth of the health centers program.

The President's Health Center Initiative, which began in fiscal year 2002, complements the President's proposals to increase health insurance coverage in private and public insurance programs and to help all Americans gain access to affordable, high-quality healthcare. By any measure, we have been enormously successful implementing the President's Health Center Expansion Initiative.

In 2005, the health center system served an estimated 14 million people. That is over 3.5 million more than in 2001 at more than 3,740 delivery sites. This represents an increase of more than 770 new and expanded sites since 2001. The fiscal year 2007 budget will continue the President's commitment to create 1,200 new or expanded sites to serve over 15.8 million people in fiscal year 2007.

The President proposes an additional \$181 million for the sixth year of the President's expansion plan to significantly expand the health center safety net by increasing the number of access points and the people served. The requested increase would fund the development of 182 new access points. That is new starts administered by a new grantee organization and satellites of existing grantees, 120 expanded existing sites and serve 1.2 million new patients.

New access points will be competitively established through health centers targeting the neediest populations and communities by replicating existing models of success. Expanded access points will be targeted in communities where an existing health center's ability to provide care falls short of meeting documented service delivery needs of the uninsured and underserved populations. By significantly expanding the number of existing access points, increased penetration into these populations will be achieved.

In addition, the President has established a new goal to help every poor county in America that lacks a health center by establishing a new health center or a rural health center. Within the total request, \$52 million will be directed for a new initiative to fund health centers in poor counties around the Nation. With the fiscal year 2007 requested increase, the President's Health Center Initiative is on track to establish or expand 1,200 sites and to serve an additional 3.5 million patients over the 2001 level.

However, there is a likelihood that without special attention some high-poverty counties throughout the country may not successfully secure a health center site. So this new initiative will target 80 high poverty counties without a health center site. The goal of the new initiative is to carry the success of the current initiative further to ensure that every poor county that can support one healthcare center site has one.

Access to primary and preventative health services is critical, especially in poor counties that are medically underserved. Health centers are unique among primary care providers for the array of enabling services they offer, including care management, translation, transportation, outreach, health education. They commit significant resources to managing chronic conditions, too, diabetes, asthma and cardiovascular disease, for example. In 2004, health centers provided over 52 million encounters, over 250,000 mammograms, 1.5 million PAP tests and nearly 2.4 million encounters for immunizations, as well as over 425,000 HIV tests and counseling and prenatal and delivery care for 364,000 women. Over 95.7 percent of the grantees also provided translation services.

The overall effectiveness of the health center program has been proven in numerous studies and evaluations. Under the Administration's ratings of Federal programs, the health center program receives the highest possible ranking, effective. Programs rated effective, according to OMB, set ambitious goals, achieve results, are well managed and improve efficiency. The program achieved this rating based on the fact that it's designed to have a unique and significant impact and that evaluations indicate that the program is effective at extending high-quality healthcare to underserved populations.

Mr. Chairman, in conclusion, I would like to note that health centers offer high-quality, prevention-oriented, case-managed, family-focused primary care services that result in appropriate and cost-effective use of ambulatory, specialty, and inpatient services. Primary care is delivered for all life cycles and includes a full range of health services. In administering grants for the health centers program, we take great pride in the high evaluation given the program and in the bipartisan support of the Congress for the program. And we fully recognize that the program works only as a partnership with those extraordinary local primary care providers who provide indispensable quality clinical services to underserved Americans with few healthcare alternatives. Thank you.

[The prepared statement of Elisabeth Handley follows:]

PREPARED STATEMENT OF ELISABETH HANDLEY, DIVISION DIRECTOR FOR POLICY AND DEVELOPMENT, BUREAU OF PRIMARY HEALTH CARE, HEALTH RESOURCES AND SERVICES ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

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 Centers Program.

We testified before the Subcommittee on August 1, 2001, to discuss the most recent reauthorization of the Health Centers Program. At that time, the funding for the program was approximately \$1.2 billion. We thank you for both your efforts in reauthorizing the program and ensuring funding to expand this worthwhile program to accomplish the President's Initiative, with a requested FY2007 funding level of approximately \$2 billion.

Today, 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—an effort designed to establish or expand 1,200 health center sites and serve over 15.8 million patients in FY 2007. This continues to be a priority because we know that these funds go to provide direct health care services for our neighbors who are most in need.

In 2005, the health center system served an estimated 14 million people—almost 3.5 million more than in 2001—at more than 3,740 service delivery sites that represents an increase of more than 770 new and expanded sites since 2001. Health Centers are located in all 50 States, the District of Columbia, and the territories.

The President's 2007 budget proposes an additional \$181 million for the sixth year of the President's expansion plan to significantly expand the Health Center safety net by increasing the number of access points and people served. Approximately \$181 million would fund the development of 182 new access points (new starts administered by new grantee organizations and satellites of existing grantees), 120 expanded existing sites, and serve 1.2 million new patients. New access points will be competitively established through Health Centers targeting the neediest populations and communities by replicating existing models of success. Expanded access points will be targeted in communities where an existing Health Center's ability to provide care falls short of meeting the documented services delivery needs of the uninsured and underserved populations. By significantly expanding the number of existing access points, increased penetration into these populations will be achieved.

With the FY 2007 requested increase, the President's Health Center Initiative is on track to establish or expand 1,200 sites over the 2001 level. However, there is the likelihood that without special attention, some high poverty counties throughout the country may not successfully secure a Health Center site. Included in the President's commitment is the goal to create a Health Center site in every poor county that lacks a Health Center site and can support one. Within the total request, \$52 million will be directed to fund 80 new Health Centers sites in poor counties around the Nation. Access to primary and preventive health care services is critical, especially in poor communities that are medically underserved.

Health Centers Program

The distinguishing mission of the Health Centers Program is to empower communities to solve their own local access problems and to improve the health status of their under served and vulnerable populations by building community-based primary care capacity and by offering case management, home visiting, outreach, and other enabling services. The program also addresses significant challenges facing communities by targeting public housing, homeless, and migrant health center development as well. Health Centers provide access to high quality, family oriented, comprehensive primary and preventive health care, regardless of ability to pay.

Health Center grantees, as a result of their receiving from HRSA a grant under section 330 of the Public Health Service (PHS) Act, are eligible for enhanced benefits including Medicaid/Medicare reimbursement, access to the Federal Tort Claims Act (FTCA) program for health center malpractice coverage, and access to the program for discount drugs for patients under section 340B of the PHS Act.

Under section 330, Health Centers are required to provide primary health services, including those related to family medicine, internal medicine, pediatrics, obstetrics, or gynecology that are furnished by physicians and where appropriate, physician assistants, nurse practitioners, and nurse midwives. Additional required basic health services include diagnostic laboratory and radiological services and a series of preventive health services, including prenatal and perinatal services; appropriate cancer screening; well-child services; immunizations against vaccine-preventable diseases; screenings for elevated blood lead levels; communicable diseases and cholesterol; pediatric eye, ear, and dental screenings; and preventive dental services.

Health Centers Requirements

To receive section 330 grant funds, a clinic must meet a number of statutory requirements. The Health Center must: be located in a federally designated medically underserved area (MUA) or serve a federally designated medically underserved population (MUP); be a public or private nonprofit health center; provide comprehensive primary health services, referrals, and other services needed to facilitate access to care, such as case management, translation, and transportation; have a governing board, the majority of whose members are patients of the Health Center; provide services to all in the service area regardless of ability to pay; and offer a sliding fee schedule that adjusts according to individual family income.

The requirement that a majority of board members be Health Center patients makes these clinics unique among safety net providers and is designed to ensure that the centers remain responsive to community needs. Under section 330, a Health Center applicant needs to demonstrate the establishment of a governing board that has a 51 percent consumer majority, meets monthly, selects the Health Center's services and hours, approves the Health Center's annual budget, selects the Health Center's director, and establishes the Health Center's general policies.

Health Centers Awards Process

HRSA accepts, on a competitive basis, applications from eligible organizations seeking a grant for operational support for new and existing Health Centers. Eligible organizations are public or nonprofit entities including tribal, faith-based and community-based organizations.

The largest category of grant awards includes new access points encompassing both new clinic starts and satellites of existing clinics. Other categories include grants to expand medical capacity at existing locations.

All eligible and responsive grant applications are referred to an Objective Review Committee (ORC), comprised of experts in the delivery of community health care services, for their independent review and recommendations. When funding decisions are made, each applicant receives a notification letter listing strengths and weaknesses of each section of their application as noted by the ORC. This review approach provides valuable technical assistance for improving future applications for both awardees and those we were not able to approve during a particular cycle.

Technical Assistance

HRSA works directly with communities to develop needed resources through the primary care associations in each State. These primary care associations, funded by HRSA, provide ongoing technical assistance involving guidance and options for

organizations interested in applying for Health Center grants and to existing Health Center grantees interested in expanding their comprehensive primary care services.

In addition, HRSA assists applicants through grant-writing workshops and other technical assistance activities that are provided through a cooperative agreement with the National Association of Community Health Centers. Such activities assist applicants to: demonstrate a high level of need in the community; present a sound proposal to meet this need; show that the organization is ready to rapidly implement the proposal; display responsiveness to the health care environment in the service area; and demonstrate collaborative and coordinated delivery systems for the provision of health care to the underserved in their communities.

Federally-funded health centers are similar to other health care businesses. Like most businesses, at any point in time, approximately 4 percent of health centers are experiencing significant challenges to their viability. HRSA, with assistance from interdisciplinary teams that may include contractors, grantees and staff, provides intensive technical assistance to grantees to address problems. At all times, continuity of service for the affected population is the first priority under consideration in addressing such challenges.

Health Centers Services

Health Centers offer ambulatory services that reflect the diverse needs of the populations they serve. Because of the combination of low incomes, linguistic barriers, and frequently poor health status, Health Center patients require access to enabling services as well as comprehensive primary care services.

Health Centers are unique among primary care providers for the array of enabling services they offer, including case management, translation, transportation, outreach, eligibility assistance, and health education. Health Centers commit significant resources to managing chronic conditions including diabetes, asthma, and cardiovascular disease.

In 2004, Health Centers provided more than 52 million encounters, over 250,000 mammograms, over 1.5 million pap tests, and nearly 2.4 million encounters for immunizations, as well as over 425,000 HIV tests and counseling, perinatal and delivery care for 364,000 women. Over 95.7 percent of grantees provided translation services either directly or by referral.

Health Centers are staffed by a combination of clinical, enabling, and administrative personnel. They are typically managed by a chief executive officer and a clinical director. Depending on the size of the patient population, the clinical staff consists of a mixture of primary care physicians, nurse practitioners, physician assistants, substance abuse and mental health specialists, dentists, hygienists, and other health professionals.

Health Centers Financing

Health Centers receive funding from a variety of sources. A majority of Health Centers revenue comes from Federal resources including Medicaid, Medicare, the section 330 grant, SCHIP and other Federal programs. On average nationwide, HRSA grants comprise 23 percent of Health Center revenue, but as little as 15 percent depending on the individual community and grant application. At 35 percent, Medicaid is the largest source of revenue for Health Centers, followed by Federal grants. Health Centers serve about 10 percent of all Medicaid enrollees nationally.

For Health Centers' revenues, in addition to Medicaid and the section 330 Federal grant funding, Medicare accounts for 6 percent, self-pay for 6 percent, other third-party payers 7 percent, other State/local government or foundations account for 18 percent and the remaining 5 percent from other sources.

Health Centers Background

The development of the Consolidated Health Centers Program began over 40 years ago with the creation of the migrant health center program and followed by the neighborhood health center demonstration projects initiated in 1965 and first funded by Congress as part of the War on Poverty. By the early 1970s, about 100 neighborhood health centers had been established under the Economic Opportunity Act. 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 features of the Health Center model. With the phase-out of the Office of Economic Opportunity in the early 1970s, the centers supported under this authority were transferred to the Public Health Service. The mandate of the centers was broadened so that comprehensive primary and preventive services were provided to all who came through the doors. The Community Health Center program, as authorized under section 330 of the Public Health Service Act, was established in 1975. A reauthorization that consolidated the separate authorities of the Community, Migrant, Homeless and Public Housing Health Centers under section 330 took place in 1996. Most recently, the Health Care Safety Net Amendments of 2002 reauthorized the Consolidated Health Centers Program through 2006. The 2002 Health Center reauthorization requires that grants be awarded for FY 2002 and beyond in such a way that maintains the proportion of the total appropriation awarded to migrant, homeless and public housing applicants in FY 2001. In general, about 81 percent of funding is awarded to community health centers, with the remaining 19 percent divided across migrant, public housing, and homeless health centers.

Health Centers' Effectiveness

The overall effectiveness of the Health Center program has been proven in numerous studies and evaluations. Under the Administration's rating of Federal programs, the Health Center program receives the highest possible ranking – "Effective." Programs rated "Effective," according to the Office of Management and Budget, "set ambitious goals, achieve results, are well-managed and improve efficiency." The program achieved this rating based the fact that it "is designed to have a unique and significant impact," and that "evaluations indicate the program is effective at extending high-quality health care to underserved populations."

Conclusion

Health Centers offer high quality, prevention-oriented, case-managed, family-focused primary care services that result in appropriate and cost-effective use of ambulatory, specialty and in-patient services. Primary care is delivered for all life cycles, and includes a full range of health services. In administering grants for the Health Centers Program, we take great pride in the high evaluation given the program, and the bipartisan support of Congress, and fully realize that the program works only as a partnership with those extraordinary local primary care providers providing indispensable quality clinical services to underserved Americans with few health care alternatives.

We look forward to working with the Committee and the Congress in reauthorizing the Health Center program. I would be happy to answer any questions at this time.

MR. DEAL. Thank you. I will begin the questioning. First of all, we understand that the President's Initiative is designed to try to help the, as we would call them, poor counties. Would you explain the criteria that are used to determine who gets priority in the grant process? I have a rural district by and large, but it is on the fringe of the Atlanta metropolitan area. And some of my counties that do not have a hospital

and in some cases do not have a doctor, do not qualify based on income, because we have some of those commuters who are commuting into Atlanta that have rather high incomes that skew the average income for the county. But it is still a medically underserved area in terms of personnel available in the community. Does the issue of medically underserved, is that a criteria that you consider, as well?

MS. HANDLEY. Let me describe a little bit about the way the program might look or the concepts behind the program. First of all, let me give you a sense of the way the money part of it would work.

We anticipate HRSA awarding \$48 million to 80 new access points with the fiscal year 2007 budget and \$4 million for 50 planning grants. And the conceptual framework for the program is to have a health center in high poverty counties where there is no existing health center and there is high poverty but where there is also an ability to support a health center. We haven't determined all of the program parameters at this point in time.

MR. DEAL. One of the issues that Dr. Burgess has raised with us privately, and he may get back to ask the question in greater detail, is the requirement as I understand it, that 51 percent or a majority of the makeup of the board must be patients themselves. And in new startup centers I would think that would be a difficult situation. There has been some suggestion that perhaps we should look at some alteration on startup centers in order to be able to satisfy that. Have you found that to be a deterrent and a problem in new startup centers?

MS. HANDLEY. Mr. Chairman, what you are referring to, the governance requirement is that a majority, which is generally speaking about 51 percent of the board, be comprised of consumers. And we believe that it is sort of a cornerstone of the program in that it provides a consumer input to the leadership and decision making that takes place in the organization. We do understand that new starts will need to have time to come into compliance with the requirements. How they will come into compliance is a part of their application but we give them additional time after they have actually become a new start and been funded, to come into compliance with our requirements. We have not found this to be an issue with a great number of health centers, even with--it hasn't been an issue in the program.

MR. DEAL. One of the things that we have struggled with in this committee dealing with the cost of healthcare, is an effort to try to decrease the number of emergency room presentations, especially for non-emergency reasons. Do you have any evidence that community health centers help to deal with that number of emergency room presentations?

MS. HANDLEY. I have not come prepared with any data today but we would be happy to provide data later. What I can say is that the primary healthcare provision that the health centers do is really essential to providing a medical home for millions of Americans. And the fact that they have a medical home where they can get primary and very comprehensive primary care services means that they are going to have less of a need for using an emergency room or going to other kinds of providers.

MR. DEAL. Well, I think you have hit on the term that I have heard repeatedly and that is medical home. When I ask in my local community some of the people who are conducting the questioning of various individuals who had repeat performances or repeat appearances at the ER, they were asked who their medical home doctor was and they gave the name of the ER doctor. We would like to change that pattern and obviously, I do think that community health centers do a good job of providing that alternative medical home, which has the effect I think of reducing those ER visits, especially the non-emergency presentations. Thank you very much. I am going to recognize Mr. Green for his questions.

MR. GREEN. Thank you, Mr. Chairman. And we have some stats, at least for Harris County because we have a small number but because we are partnering with creating these current hospital systems in the area, that will show in their participation based on their belief, and these are both for-profit and non-profit, their belief that they will lower the number of visits if there is a community health center close that will take them. But we will get that information at least. And again, ours is small in Harris County compared to the number of centers, but I am sure we can get that information nationwide. Ms. Handley, the President stated as a goal having a community health center in every poor county in the country. And the National Association of Community Health Centers teamed with George Washington University estimated that 929 poor counties in our country are without a health center. The Administration's budget proposed a \$181 million increase in health center funding for fiscal year 2007, which would bring the total funding to nearly \$2 billion next year. As we consider the authorization through 2011, what authorization levels does HRSA believe we need in the out years, the 2010 or 2011, to keep us on the path to achieve the President's goal?

MS. HANDLEY. I am not in a position, sir, to respond to what we need in additional out years to meet the goal.

MR. GREEN. Okay. Coming from--

MS. HANDLEY. We can get that for the--

MR. GREEN. Coming from our side, of course, we would like to have no cap on it and get whatever we can get through the appropriations

process, but sometimes that is not always possible. I appreciate that information you shared with the committee. Last summer the GAO issued findings from a study of the Health Center Program. Under the Health Center Program, centers are required to provide referrals for specialty care that are not deliverable at the center. And about only one of the beauties of it is that you do have full gamut of access--dental, psychiatric. The GAO found that many health centers are having difficulties finding specialty care for patients, especially for the uninsured. Many of the difficulties are due to a shortage of available specialists. The result, according to the GAO, was long waiting lists for health center patients to see specialty care. Can you comment on the actions HRSA has taken to remove the barrier to care and what was posed as a threat to the patient's health and in my view works against the success of our centers to achieve reducing health disparities? Has that been an issue with some of our health centers in other parts of the country?

MS. HANDLEY. I am not aware of whether it has been an issue in other parts of the country, sir. I think I would have to get back to you with an answer for that.

MR. GREEN. Okay. If you could just get back to me whenever you can.

MS. HANDLEY. Sure.

MR. GREEN. Mr. Chairman, that is all the questions I have. Thank you.

MR. DEAL. I thank the gentleman. Dr. Burgess, I haven't stolen all of your questions but I did steal the one about the makeup of the board. But you are recognized for questions.

MR. BURGESS. Thank you, Mr. Chairman. You can steal my questions all you like. Did you get a satisfactory answer?

MR. DEAL. I expected you to explore it further.

MR. BURGESS. Well I guess, Ms. Handley, that remains a concern of mine. I heard part of your answer to the Chairman and I will admit I haven't been here very long. I've only been in Congress three years, but my observation of the startup time for the only clinic in Tarrant County was years. One of the stumbling blocks of setting that up was having to constitute the board. And the education of board members to be able to run what is realistically--I mean, I have run a clinic before. I have run a medical practice and it is a difficult financial venture that if you make the wrong decisions can all come apart at the seams. What would be wrong with relaxing some of those requirements for a short period of time, particularly in an area like Tarrant County or maybe down in Houston where we have had people displaced by Hurricane Katrina and so the ranks of the uninsured have swelled in those areas? What would be

wrong with relaxing those board requirements for a short period of time to allow the clinic to become up and functional and then identify people who are served by the clinic to become additional board members and ultimately make up the 51 percent?

MS. HANDLEY. Well sir, currently the way the process works is if they want to become a new access point they don't actually have to have the 51 percent. They have to have a plan to getting to the majority on the governance board. So in essence, there is a time period during which they can get the board and accumulate the board.

MR. BURGESS. How long a time period is that, if I may?

MS. HANDLEY. I think the period is a reasonably long period that might extend to as long as a--

MR. BURGESS. Could you get that information to the committee?

MS. HANDLEY. Yes.

MR. BURGESS. And perhaps the precise language that a group would need to follow if they were to do that? You know, one of the problems I have is I look at that map of where the Federally qualified health centers are in this country and I see a bunch in the east, I see a bunch paralleling the Mississippi River. I see a bunch in California. I don't see many in north Texas. What are they doing right that we are doing wrong that allows them to have the clinics and us not?

MS. HANDLEY. I think there has been a lot of interest and activity in your State. As you pointed out in the beginning, really, health centers are a small business and it takes time to get a small business up and running. And I think there has been a lot of activity in the Primary Care Association and the Primary Care Office in the State of Texas to grow the health center program. And we have in fact worked closely with them so that there have been some new look-alikes, which provide the organizations, the health centers, with increased revenue from Medicare and Medicaid and decreased costs for pharmaceuticals. So the State and us through our funding of the Primary Care Association and the PCO actually have been working together to grow these organizations.

MR. BURGESS. But let me interrupt you because Tarrant County, I am not sure of the precise population but about a million. Just North Denton County, population 480,000. Tarrant County has one Federally qualified health center that opened this year and I don't remember the trajectory for the number of years that it took to get there but I have heard five, six, seven, even eight years length of time to get that started up. Denton County has zero Federally qualified health centers. What do we need to be doing in North Texas to make these facilities available to our patients who are just as much in need as patients in states that border the Mississippi or in the Northeast or out west? How do we develop the program so that we can get the facilities where they are needed?

Something has been missing from North Texas and I would like you to help me identify what that is and how to correct that problem because I have got zip codes in my district that have infant mortality rates that should not be in this country. They simply should not be. I have got healthcare disparities in zip codes in my county that just should not be. And I think part of the problem is the lack of this type of facility in those communities has not just hurt access but it hurts utilization. People have to go so far to a county health facility that they just simply don't bother or they don't bother to get the blood pressure checked or the routine checks that are going to hold the costs down. Help me with what those other places are doing right that we are not doing.

MS. HANDLEY. Well, I think part of--two responses. One is that it is, again, it is a small business that does take time to grow and is a partnership within a local community. I think the second part of the answer is that in addition to the Primary Care Association within the State and the Primary Care Office, which is a part of the State Department of Health, we are certainly willing to talk with you further about how it might be possible.

MR. BURGESS. Well, I hope so because I have got the CEOs of every hospital in Tarrant County sitting down in boardrooms with me. They get it. They understand. They are ready to be good partners in this but we can't move off dead center. And I guess because I am new and I don't understand how bureaucracy works or doesn't work, I am having a lot of difficulty understanding why I can't get these services for my constituents. Mr. Chairman, thank you. I will yield back.

MR. GREEN. If I could ask you to yield? I know your time has run out but since I am the only one on our side I am going to take the phantom time, I guess. But one of the things we identified years ago was before we get to a healthcare center is that the CAP Program that we had for the early '90s--I know Congressman Bilirakis--

MR. BURGESS. Mr. Green, I am reclaiming my time. With all due respect, we have been working at this. This is not just something that has started in the last few months.

MR. GREEN. I know but--

MR. BURGESS. And I will be happy to visit with you after.

MR. GREEN. Okay.

MR. BURGESS. But I will save the committee's time. I don't think I need that lecture today.

MR. DEAL. Well, the next person for questioning is Mr. Bilirakis from Florida.

MR. BILIRAKIS. Thank you, Mr. Chairman. I have an opening statement and I ask unanimous consent that it might be made part of the record. I am sorry I wasn't here when you started out.

MR. DEAL. They have already been approved for admission in the record.

MR. BILIRAKIS. Oh, okay. It is my understanding that over the past four years HRSA has funded over 700 new community health center sites with the increased funding that Congress has provided and for which I really strongly feel the Administration should be commended. I know that the President feels very, very strongly about this subject and I have been pleased to lead, along with my colleagues Mr. Brown and Mr. Green and others, the bipartisan effort to secure those increases.

Can you tell me over the past four years--well, let me back up first. Can you tell us with certainty whether Section 330, grant funds in general and expansion funds in particular, are being targeted to communities with the greatest need? In other words, there is a strong feeling for additional funding and whatnot and it has been there, it isn't being used the way that we intend that it be used. That is the general question.

MS. HANDLEY. Yes, sir, I do believe it is. We have need built into the application process in a couple of ways and we are working on strengthening the process for the future. The way it works now is that we look at need in the application process. It is an eligibility sort of review criteria. If you don't have a high enough need, you don't even go through the objective review process that all competitive applications go through if you don't meet that threshold score of need. In addition, within the application itself there is a score that is assigned for need so we are looking in two ways in the current process. In the future, we have added more weight to need so for future funding cycles we anticipate that need will become even a larger part of the process. It won't be a screening factor. It will be built into the actual application score so that it is 35 points out of 100. And we believe that this will make sure that we are targeting our scarce Federal dollars to the places of greatest need and we are providing flexibility for the applicants in that we are going to have standardized data. But not that they have to provide every--they get to pick from among the data items. So we think what we have for the future will even move towards exhibiting greater need. And we published in the Federal Register, April 26, our response to the proposed revised need process and now have this available for the future.

MR. BILIRAKIS. Do we have many applications for a center that basically would be approved or even have been approved but that we don't have construction because there is inadequate funding?

MS. HANDLEY. I don't think I could really comment on that because the statute does not make construction money available. So it is not a part of the grant that we make with the 330 dollars.

MR. BILIRAKIS. Well, you know, I guess there is a criteria and something about how the dollars have to be used for construction, buying property, things of that nature. There are already a lot of storefront type of community health centers, which are county centers and whatnot. I mean, shouldn't we be flexible? I had just raised this question. I hadn't really given much thought to it. But shouldn't we be flexible enough to feel that maybe that can be done or some of our Federal dollars can be used in that way, rather than say hey, it has got to be used this way? Or it has to be used to purchase property. It has got to be used for a new construction. Any opinion on that?

MS. HANDLEY. Well, our dollars are not used for construction. They are really used for direct services for patients to get care. And having the program requirements that we do in place assures that people are protected. They get the full range of services that are required under the law, as well as the organization is going to be there and be able to continue to provide care. That it will be fiscally solvent and around for the long-term so there is continuity of care.

MR. BILIRAKIS. Well, getting off of that a moment, I know for instance I have visited some of these centers. Now granted, some would be county centers, state supported, county supported. But I find that they are 8:00 to 5:00 centers and no Saturdays and Sundays. Now, is that the best use of that center, the best use of that money? We are talking about people who--hopefully they work--need, but they are not going to be able to get there during the day and not be able to get there on a Saturday or Sunday or particularly on a Sunday. Any opinion about that? Are there any criteria there that in terms of enabling these centers to open other hours, even mandating that they work other hours?

MS. HANDLEY. What we require of them is that they provide care that will meet the needs of their target population. So there is flexibility built into our requirements. We would expect that they could provide care at different times. That they would have some evening hours, for example, or that they would--some of them are sometimes open on weekends to meet the needs. And obviously if you have a migrant community health center they are going to have a definitely different way of delivering care and a different number of hours.

MR. BILIRAKIS. Well, it isn't just the migrant community. We are talking about most people, particularly low-income people working 8:00 to 5:00 hours, also and not being able to--

MS. HANDLEY. Right.

MR. BILIRAKIS. It is something that I think we should explore, Mr. Chairman. We talk about the money and we talk about this and that and I don't know, I have got to go into this construction and purchase of property thing with my staff on that because maybe I didn't understand it

well enough. But I am also concerned that it is there and it is not really being utilized as well as it should be, to the fullest extent because of these hours that they keep. Well thank you, Mr. Chairman. I am sorry I took up lots of time.

MR. DEAL. I thank the gentleman. Mr. Rush from Illinois is recognized for questions.

MR. RUSH. Mr. Chairman, I ask do you think that we would have maybe time for a second round of questioning if we don't get through our questions?

MR. DEAL. Well, let us wait until we see how many people stick around for the second panel, okay?

MR. RUSH. Okay. All right. Real good. Thank you. Ms. Handley, I appreciate you coming in before the committee. And let me just tell you that I also appreciate the Administration's proposal to increase funding for community health clinics. I know that they are on the front line of providing basic healthcare to constituents such as mine. And I also believe that they could also be and hopefully it won't get to this point but I believe that it will also ultimately be a part of the overall defense against a terrorist attack against urban areas in our nation. I think that this country or this Congress really has not paid attention to the role that community-based health clinics will play in regard to some kind of outbreak or some kind of terrorist attack, especially chemical terrorist attack, in our urban centers. I think the potential for them to be on the front line in terms of the defense of our Nation hasn't been paid close attention to. I am an advocate, a strong advocate for community based health clinics. In my other life as a civil rights activist I played a role in having free health clinics. There was a free health clinic movement back in the Sixties and I think that was a forerunner of the Government's participation.

I am excited about the fact that there are new access points. I think it is 80 new access points that we are going to be providing for under the President's budget. And let me just ask you, in my city in the Inglewood community, which is one of the poorest communities in my city, one of the poorest communities in the Nation, there is a scarcity of health clinics. And I am working with a number of individuals trying to help get that situation resolved. What is the role that your organization, your agency, play in regards to student-based health clinics? And how do you see student-based health clinics lining up with health clinics that are FQHCs, okay? Do you see a role for student-based health clinics and what is the role?

MS. HANDLEY. There are a number of student-based clinics that are really part of other FQHCs that are already existing and operating successfully around the country. There is no separate program

specifically for school-based programs but again, many of the existing grantees that we have that are FQHCs have a component as a part of them that is school-based and they are doing this successfully now.

MR. RUSH. In my experiences with this organization and with others, it seems to me that there is not enough advance notice given to new applicants that will give them enough time to apply for FQHCs. Is there anything that your agency is doing to try to help remedy that problem in terms of making sure that they know when there is going to be applications accepted at HRSA for new clinics? You know, at one time I understand it was, there might possibly be an application process in December. Then maybe May. You know, these organizations are never really given any information they can really work with that will give them enough time to prepare for the application and to prepare an adequate application, a competitive application. Do you have any remedies for that type of problem?

MS. HANDLEY. You raise an important point, which is that these small businesses need time to prepare applications. We generally publish a preview once a year that lists what the opportunities will be and what the timeframes will be for applications. Sometimes the challenge with the dates that are listed in what we call the preview that has the funding opportunities is that we don't yet have a budget. And so we don't want to have organizations spend time and resources preparing an application if there isn't going to be funding for that opportunity. So it is definitely a challenging situation in terms of not wanting them to prepare applications and the preview is our mechanism for advertising what we believe, based on the information we have, will be the dates for the opportunities.

MR. DEAL. The gentleman's time has expired. I recognize Mr. Shimkus from Illinois for questioning.

MR. SHIMKUS. Great. Thank you, Mr. Chairman and I appreciate you being here, Ms. Handley, and thanks for your time.

When I first got elected in '96, of course my district was a little different. I didn't have a single community health clinic in my district. Since then and my lines have been redrawn a little bit, I have 13 and they have really proved a great benefit to the underserved or unserved. And so I want to echo some of the other comments about the great work that they are doing. Illinois has had a history of medical liability issues because of litigation and the fact that they have the Centers for Federal Tort Claims Program, it really helps our State meet those needs. And we continue to have other type of providers wanting the same type of protection or help or assistance but those are all kudos.

I do have some questions on the President's Health Center Initiative, in which his desire to place new community health centers in every poor

county and I have quite a few of those myself and some very, very rural. I have one county that has got 5,000 citizens in it, and so have you all discussed or debated or come up with the criteria you are going to use to determine the eligible counties? And how will you all or OMB determine the top poorest counties? So how are you going to define a poor county and then how are you going to rank them?

MS. HANDLEY. What I mentioned before is that we are looking to make \$48 million worth of awards in fiscal year 2007, based on the President's budget and that will be 80 new access points. Another \$4 million would provide for 50 planning grants. And we haven't worked out all of the program parameters but generally speaking, the eligibility would be limited. We would have a limited competition with all the rest of the requirements applying, except for it would be a limited competition for the counties that were the poorest or that could support a health center. So we haven't gotten to the point of determining--

MR. SHIMKUS. So you don't know the answer right now?

MS. HANDLEY. We haven't gotten to the point of determining which counties and all of the details of the program.

MR. SHIMKUS. I think a lot of us would be interested in understanding what that criteria was. And if that is going to be the role by which the Administration wants to present it then they are going to-- and I am a great supporter of the Administration and believe they are well intentioned. But I mean, there is going to be competition for these and if there is going to be criteria, that criteria needs to be known and fully vetted. So that when awards are given, that if we are going to make that determination, this is the standard we are going to use. Then we in essence comply with those and people know it and we feel good that the money that is being spent is being directed in the intent that you all and we would support.

As I mentioned, my one county is 5,000 residents. I don't know how you are going to define in this proposal sparsely populated. Is that another term that we are going to have to decide on how we are going to define before we move forward?

MS. HANDLEY. Well, I understand your concern about wanting to know the details of the program. And what I would say is that when we do have a funding opportunity that is available, those kinds of details will have to go into what is advertised so that people will understand the eligibility criteria. We are just not yet at that point.

MR. SHIMKUS. Mr. Chairman, if I could just ask for the committee's attention, to just follow this process through? And as the agency moves forward, that we are fully apprised and given some notice on how the Administration would prepare to move in this direction. And that is all the questions I have on this, Mr. Chairman. I yield back.

MR. DEAL. I thank the gentleman. And we would appreciate that kind of follow-up with the committee, if you would.

MS. HANDLEY. Sure.

MR. DEAL. I'm pleased to recognize the gentleman from Ohio, Mr. Gillmor, for questions.

MR. GILLMOR. Thank you, Mr. Chairman. And we are happy to have you here, Ms. Handley. I have got to say I think that the community health centers are just a wonderful asset in this country and they are doing a great job. I have an outstanding one in my district in Fremont, Ohio. In fact, I visited there once again on this past Monday.

But there is one matter that concerns me and it came up as a result of that health center. And we are talking about access to care and this is a situation which is a great impediment to access to care that shouldn't be. After Hurricane Katrina the Fremont Health Center sent a lot of people down to help and we found out that once they crossed the State border they weren't covered by the Federal Tort Claims Act. Now, that situation got handled in a convoluted way because there were some Federal workers down there and they were made Federal temporary employees so then they were covered. But they wanted to go down later and that could not be done. And there have been other members who have had the same problem. My colleague, Joe Schwartz, had a group in his district that wanted to do the same thing.

The bottom line is, you had qualified people that are willing to help in a situation of great need and couldn't because of the Federal law. Representative Schwartz and I introduced a bill which would modify that so they could get Federal Tort Claims coverage and that bill is H.R. 3962.

Now, we did bring this to the attention of your agency. I wrote a letter back in January referencing the situation and that bill and asking specifically whether you thought it was a good idea and if not, did you have another idea to deal with this situation? That was in January. In April I did get a response from Administrator Duke. The only problem was, it didn't answer the question, so we have absolutely nothing. So I guess my question to you is, do you think we ought to be doing something to remove that barrier to access the care in a way that we could let qualified people go in situations like that and still have protection of the Federal Tort Claims Act? And I would appreciate if you could take a look at H.R. 3962 and see if that is a good approach or if you have some other suggestions to make. Because I think as we go through this process, this is something we certainly ought to correct and correct it fairly soon.

MS. HANDLEY. Well, the Administration doesn't yet have a position on the legislation that you are talking about. As you know only too well,

our Department's Office of General Counsel determined that the Federal law as it is currently written does not allow the healthcare providers in one community health center to take their health center Federal Tort Claims Act coverage with them to the other area, the other community. So we are not in a position that--

MR. GILLMOR. Well, I know that because that is what I told you and I know that. My question is, because you are the agency responsible, is that the way it ought to be? And if not, how do we correct it? And I am not directing this at you personally but it appears from your answer and the inner workings of your agency, which I am not blaming you for, we might wait until next year for an answer. So let me ask you, do you have any objection if we move forward to solve the problem, with or without you?

MS. HANDLEY. I can't speak on behalf of the Administration. I am sorry.

MR. GILLMOR. Okay. I understand the constraints you are under so I appreciate that. Thank you.

MR. DEAL. I have had a request from Mr. Rush that we have additional time for questions. I would propose that any Member who wishes to ask additional questions would have an additional three minutes. I would ask unanimous consent, and without objection, we will proceed, and I will not exercise my time. Mr. Green, I would recognize you next.

MR. GREEN. Mr. Chairman, I will defer to my colleague.

MR. DEAL. All right. Mr. Rush is recognized.

MR. RUSH. Mr. Chairman, thank you so much. I want you all to know you all are spoiling me. You are setting a precedent here involving all these deferments.

MR. DEAL. You just remember that.

MR. RUSH. Ms. Handley, look-alikes, can you tell me the purposes of look-alikes and how they fit into your overall game plan as it relates to community-based health clinics, FQHCs?

MS. HANDLEY. Yes, I would be happy to do that. The look-alike program is one where the organizations, the community health center don't actually get health grant funds from the Federal government. But what they do get is the designation as an FQHC, which is important to them for several different reasons, actually three reasons. The first reason is it makes them eligible to get Medicare and Medicaid-enhanced reimbursements, so they get increased revenue sources, in essence. The second reason is with that eligibility they can also get access to the 340-B Program, which is a program for discounted pharmaceutical prices. And then finally, they are also eligible for HPSA designation, Health Professional Shortage Area designation. So it is a good program for

organizations. As you know from your area there is a lot of competition for the grant dollars that are made available each year for each opportunity.

Some organizations make a business decision that is still worthwhile for them if they aren't, for whatever business reasons, either ready to or maybe not interested in applying for the grant money, to apply for the look-alike program. And we have worked with a lot of different organizations around the country to get them look-alike status. The number of look-alike organizations has been growing over time and we continue to work to make the program available and provide technical assistance to potential applicants.

MR. RUSH. So the look-alike program is like a developmental league for the FQHCs? What is the percentage of look-alikes that graduate into FQHCs?

MS. HANDLEY. I don't remember the number off the top of my head. I can supply it for the record but I know it is exactly as you suggest, though not everybody who is a look-alike necessarily wants to become a new access point. In fact, I remember speaking with a woman at a large health center who for many years had a board that was just not interested in getting any Federal funds. So it can be a really great way for organizations to understand what the requirements are under the 330 grant program because basically a look-alike is just that. It meets all of the requirements. But it can also be something that organizations continue to do on their own.

MR. RUSH. Finally, for the advocates for community-based health clinics in the Congress and on this committee, what are some of the suggestions that you might have where we might be more helpful to your program? And to programs that really address a need, particularly in the poor and underserved areas? What assistance do you need? What can we do to help you?

MS. HANDLEY. Well, the current statute has really been very helpful in being able to make healthcare available to 14 million Americans so we are very pleased with the program that currently exists.

MR. RUSH. Thank you, Mr. Chairman. I yield back the balance of my time.

MR. DEAL. I thank the gentleman. Dr. Burgess, you have additional questions?

MR. BURGESS. Yes, Mr. Chairman. I have two to ask. This is such an important hearing that if we could be allowed to submit written questions for the record and can we--

MR. DEAL. Yes. We have already had a UC to that effect.

MR. BURGESS. Well, Ms. Handley, going back to the issue of the board and formation of the board and you said there are some relaxations

on time. What happens if a clinic is up and running and you all give the go-ahead, and that board isn't ready to go when you say start the clinic?

MS. HANDLEY. I guess what I was trying to convey before was that when you have a new organization that has not been in existence before, we can provide grant funding for before the organization actually is started and there is--

MR. BURGESS. But what then happens if they are not ready to go when the clinic is started though? Is there a penalty?

MS. HANDLEY. I am not aware of a penalty, per se, in that I am not aware of a penalty. But I do know that we have worked with organizations to help them come into compliance, and that most organizations are able to come into compliance, all organizations.

MR. BURGESS. Is HRSA able to waive certain requirements for starting up a federally qualified health center?

MS. HANDLEY. We do have the capacity to waive requirements for certain kinds of health centers.

MR. BURGESS. Can you give us examples of what you can waive?

MS. HANDLEY. I believe we can waive the governance requirements for the migrant and homeless health centers. For example, with the homeless population, it is going to be difficult to get 51 percent of your members to be serving on the board.

MR. BURGESS. And what is the procedure that the clinic follows to seek those waivers?

MS. HANDLEY. They make the request when they are applying for their grant.

MR. BURGESS. Am I understanding when a clinic applies there are certain windows every year that are open where the applications can be taken and this occurs twice a year? Is that correct?

MS. HANDLEY. Generally speaking, it has been once a year. It depends. There are different funding opportunities. The new access points are probably the ones you are thinking about where a new organization gets funded to operate. There is also another opportunity that has been offered for the last 5 years and that is expanded medical capacity. So for an existing new access point, like the one in your county for example, in a future year might decide we would like to ask for additional money to expand the hours of service that we have or the number of providers we have because there is enough need that isn't being met. So those are basically the kinds of two opportunities you are talking about.

MR. BURGESS. It is my understanding that has been started in Tarrant County, they would make application in June, learn in November that they weren't accepted and the next application point would be a month later. So the timing of that proved to be very, very awkward to try

to correct the deficiencies and have a new application in within a month's period of time. For that reason, it took three cycles to get the funding approved because obviously on that second cycle it was difficult to get everything arranged to have it in order to make a successful application. If they are only once a year, then of course that brings up the other problem. If you miss the grant then you have got to wait all that time. And again, we are talking about a community that is in health despair, if I can use that term, and if I seem anxious about it, it is these timelines become so tragic in people's lives because they are definitely negatively impacted. So I do have some written questions I will submit, Mr. Chairman, but my plea would be that we reauthorize this program, we have got to look at ways of streamlining. Yes, we want to be good stewards with the taxpayers' dollars but we want to look at ways of streamlining this process so that we serve those people that the program was intended to serve.

Mr. Chairman, you have been very generous. I will yield back.

MR. DEAL. I thank the gentleman. Mr. Bilirakis, do you have additional questions?

MR. BILIRAKIS. I am going to probably pose the questions and then let them respond in writing. One would be reviews. HRSA undertakes periodic reviews in a way that assesses community need and the relative weight that it gives in the award process, right?

MS. HANDLEY. Yes.

MR. BILIRAKIS. Can you share with the committee the results of those reviews? I mean, the process that you take and the results of those? I mean, this goes to John's questions, Mr. Shimkus' questions and whatnot. You can do that for us, would you?

MS. HANDLEY. Yes.

MR. BILIRAKIS. All right. And you know, these are all questions that will be asked of us by our colleagues in the process of trying to move forward this legislation. So it is critical that we get this sort of information.

And also as a follow-up to Dr. Burgess, I wonder if you could provide the committee the total number of applications submitted each year, beginning in fiscal year 2001 and the number that were scored as fully acceptable or higher and the number that were actually funded. That will give us the answer to I think an awful lot of questions. Will you do that?

MS. HANDLEY. Yes, we can do that.

MR. BILIRAKIS. All right. What are we talking about here as far as a timeline is concerned, intending to be fair? You set the timeline rather than we. But you know, we want to move this legislation. This is a tough year. It is going to be a tough year for legislation. I think that

there is a feeling here that we want to get it moved this year, which means you know, two or three weeks?

MS. HANDLEY. We will move hopefully quicker than that.

MR. BILIRAKIS. Okay, great. Thank you. Thank you, Mr. Chairman.

MR. DEAL. I thank the gentleman. Ms. Handley, we thank you for being here today and if you would follow up on the issues that have been raised for further response, we would appreciate it. Thank you very much for being here.

MS. HANDLEY. Thank you very much. Thanks.

MR. DEAL. We will now ask the second panel if they would take their seats? I am pleased to introduce the three members of the second panel. First of all, Mr. Roy C. Brooks, Commissioner of Tarrant County in Texas, who has already been referred to and introduced I think by Dr. Burgess previously. Ms. Kathy Grant-Davis, Executive Director of the New Jersey Primary Care Association, and Mr. Dan Hawkins, who is Vice President for Federal, State, and Public Affairs of the National Association of Community Health Centers, Incorporated. Gentleman and lady, we are pleased to have you here. And I know Mr. Brooks is under a time constraint about a flight so we are going to begin with you and hopefully you will be able to stay until we get a few questions, as well. You are recognized and we thank you for being here.

STATEMENTS OF ROY C. BROOKS, COMMISSIONER, TARRANT COUNTY, TEXAS; KATHY GRANT-DAVIS, EXECUTIVE DIRECTOR, NEW JERSEY PRIMARY CARE ASSOCIATION; AND DAN HAWKINS, VICE PRESIDENT FOR FEDERAL, STATE, AND PUBLIC AFFAIRS, NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS, INC.

MR. BROOKS. Thank you, Mr. Chairman and members of the subcommittee. I am honored to come before you today not only to advocate on behalf of community health centers but to urge you to take a hard look at increasing the number of these centers in shortage areas, such as Tarrant County, Texas.

The network of health centers in rural and urban portions of the United States is vital to this Nation's system for providing compassionate, culturally and linguistically sensitive comprehensive primary care services to indigent populations. Community-based health centers promote a continuum of high-quality, family-oriented, comprehensive primary and preventive healthcare regardless of ability to pay.

These patients receive a wide range of primary and preventive care services, including adult medicine, infectious diseases, obstetrics/gynecology, pediatrics, dentistry, pharmacy, mental health, substance abuse treatment, school health programs, as well as disease prevention and healthy lifestyle promotion programs. Health centers overwhelmingly serve clients that are low-income and minority, including targeted efforts to serve migrant and seasonal farm workers, homeless individuals, and families and people living in public assisted housing.

The service population includes individuals living in areas of high crime, large numbers of unemployed and impoverished persons, many individuals with chronic diseases such as diabetes, pregnant teens, and substance abusers. These conditions lead to a variety of acute healthcare problems. Many people in these areas face numerous barriers to accessing healthcare services, including those imposed by geography, language, culture, poverty, housing status, and immigration.

It is tragic that bureaucratic red tape, unreasonable expectations, misguided rules, and the unbelievable administration of Federal funding for community health centers has led to many people being deprived of services essential to their health and well-being. I would like to discuss with you some of my observations from a local perspective regarding problems we have experienced during the process of establishing our first FQHC.

Much of the red tape tangle can be attributed to program information notices, which are known as PINS. Regarding the application process itself, FQHC regulatory guidance is a barrier to more FQHCs being created. Specifically the program information notices are vague and have inherent barriers to collaborative relationships with other community organizations, do not ensure those reviewing FQHC applications have an understanding of community and operations issues, and allow State CHC associations and State primary care offices to impose their own agendas when interacting with organizations wanting to pursue FQHC status.

In terms of affiliation agreements, the current PINS do not afford enough flexibility to allow FQHC applicants to utilize providers affiliated with other organizations. In the Tarrant County instance, these would include the University of North Texas Health Science Center and the county hospital district. These organizations have the capacity to see patients of any other organization. As you might expect, it is hard for a start-up clinic located in a medically underserved area and to recruit and retain an adequate number of providers without the assistance of organizations that are willing to collaborate with the FQHC applicant and see their patients.

FQHC applicants should be able to utilize providers from other community organizations if it can be demonstrated that such individuals will be qualified and able to satisfy the agency's expectations.

Regarding management requirements and specialty services, the PINS contain requirements on the type of executive staffing for FQHCs. While the PINS recognize that some FQHCs may be smaller and may not require a full-time executive director, medical director, and finance director, it has been extremely difficult to obtain the agency's approval to have less than full-time management. As you might expect, it is hard for a clinic with one full-time physician to financially justify a full-time executive director, medical director, and finance director. FQHC applicants should be able to utilize management from other community organizations if it can be demonstrated that such individuals will be qualified and able to satisfy the agency's expectations.

Regarding supplantation, the PINS also prohibit the supplantation of funds. The principle of no supplantation of funds is limiting the willingness of some organizations to assist in the creation of new FQHCs. Organizations that are interested in facilitating the creation of an FQHC have been told that they will be required to commit to maintaining their initial funding amount or risk the application being denied because of perceived supplantation of funds. This interpretation has discouraged some organizations that find themselves with a one-time surplus of funds from assisting in the start-up of an FQHC. Supplantation is a misguided rule and one of the biggest obstacles we have to overcome in getting strong support from the Texas Bureau of Primary Care in the 330 grant application process.

It is essential that proper safeguards be in place to assure that State or local money is not being replaced or supplanted by Federal funds. However, prudent consideration of community interest and support should also be part of the equation. In our case, we spent over 2 years trying to convince the Bureau of Primary Health Care at the Department of Health that a clinic closed by the University of North Texas Health Science Center had no relationship to a new site subsequently obtained by UNT and the John Peter Smith Health Network, which is our county hospital. This new location was offered at no charge to be the prime location for the Fort Worth North Side Health Center in their efforts to gain a 330 grant designation.

This is a perfect example of what all of us at the Federal, State, and county level should be encouraging in efforts to create more access points for healthcare, a partnership of healthcare providers and community leaders working together for the common good. I would encourage each of you to consider ways we can make this process easier, not more difficult.

During the process of working with HRSA on our application, representatives from Senator Cornyn's office and Representative Granger's office were shocked to learn that only ten percent of a 330 grant application was based or weighted on need. The core principle for federally qualified health centers is the requirement that they be located in medically underserved areas or health professional shortage areas. Logic screams at me that need is of paramount importance and should be weighted much higher in the scoring process.

MR. DEAL. Mr. Brooks, could you summarize for us? We are way over your allotted time.

MR. BROOKS. Sure. My last point is about proportionality. There are areas in our country, particularly in North Texas, as Dr. Burgess has indicated, where we have significantly less FQHCs than any other part of the country. In particular until the last funding round, the metropolitan area of Boston had more FQHCs than the entire state of Texas. I would encourage taking into consideration proportionality in the next rounds.

We have already addressed the board composition, the 51 percent requirement. Let me just state that that requirement poses two concerns. One is that there may not be the expertise in the clinic area to mount a start-up business. The second concern is that requiring 51 percent before the clinic is funded puts us in a position where we have got a problem with the relationship of our chickens and our eggs. We are required to have consumers on a board when there is no clinic for them to be consumers at.

In conclusion, community health centers are often the only care option for those who need it most. And these centers have become adept at breaking down barriers to access and providing continuity and preventive care.

A very sad example of why we need these is in my own county in Texas. While the infant mortality rate in Texas is just slightly lower than the national average of 6.9 per 1,000 births, Tarrant County's rate is 7.5. The city of Fort Worth is 8.7, and in three targeted zip codes it exceeds 12 per 1,000, which is a rate approaching that in many third world countries. We need more FQHCs in Tarrant County to address that concern.

Finally, I want to thank Dr. Burgess for his willingness to be a strategic partner with me in addressing the issues of health disparities and infant mortality for our joint constituents. And I appreciate the opportunity to share my views with the committee.

MR. DEAL. Thank you.

MR. BROOKS. Thank you, Mr. Chairman.

[The prepared statement of Roy C. Books follows:]

PREPARED STATEMENT OF ROY C. BROOKS, COMMISSIONER, TARRANT COUNTY, TEXAS

Federally Qualified Health Centers: Benefits and Challenges

- **Supplantation** - One of the biggest obstacles we had to overcome in getting strong support from the Texas Bureau of Primary Care in the 330 grant application process was the supplantation issue. It is essential that proper safeguards be in place to assure that state or local money is not being replaced or supplanted by federal funds. However, prudent consideration of community interest and support should also be part of the equation. In our case, we spent over two years trying to convince the BPC at the Department of Health that a clinic closed by the University of North Texas Health Science Center had no relationship to a new site subsequently obtained by UNT and JPS Health Network, our county hospital district. It was offered at no charge to be the prime location for the Fort Worth Northside Community Health Center in their efforts to gain 330 Grant designation.

This is a perfect example of what all of us at the federal, state, and county level should be encouraging in efforts to create more access points for health care, and that is a partnership of health care providers and community leaders working together for the common good. I would encourage each of you to consider ways we can make this process easier, not more difficult.

- **Need** – During the process of working with HRSA (Health Resources and Services Administration) on our application, representatives from Sen. Cornyn's office and Rep. Granger's office were shocked to learn that only 10 per cent of a 330 grant application was based, or weighted, on need. The core principle for Federally Qualified Health Centers is the requirement that they be located in Medically Underserved Areas (MUA's) or Health Professional Shortage Areas (HPSA's). Logic screams at me that Need is of paramount importance and should be weighted much higher in the scoring process. It is my understanding that HRSA representatives assured the congressional staffers that this part of the scoring process would be reviewed. I strongly encourage you to insure that HRSA address this glaring deficiency in the scoring process.
- **Board Composition** – Another core requirement of the application process is that at least 51 per cent board of directors be composed of patients to the clinic. This requirement is needed to assure that the board adequately represents the community it serves. However, starting a new business requires special skills and expertise sometimes not readily found in the population base of the CHC. In order to maximize the efficiency and financial soundness of a new business start-up, HRSA should relax the 51 per cent rule for the first two years of a board's existence to allow business expertise on the board. This two year window would allow the board to more fully exercise its fiduciary responsibility to the community and the federal government in the spending of federal funds.
- **Proportionality** – For a whole host of reasons, some clear and others not so clear, FQHC's are not distributed proportionate to population throughout the country. For example, it is my understanding that, until the last funding cycle, there are more FQHC's in the Boston Metropolitan area than in the entire state of Texas. Further, in the third most populous county in Texas, my own Tarrant County, we only have the one CHC referred to earlier. With a population in excess of 1.7 million people, we should easily have three or more community health centers. We are actively working on an additional location at the present time. I would hope that HRSA will

take proportionality in mind in the next round of applications and perhaps give added weight to those applications from underserved areas such as our county.

In conclusion, I urge you to reauthorize funding of Community Health Centers, for I believe they represent the highest and best use of federal funds in improving health care delivery to those citizens who have the greatest need. Properly established and maintained, an FQHC can have a critical impact in the community it serves.

MR. DEAL. Thank you. Ms. Grant-Davis, you are recognized.

MS. GRANT-DAVIS. Thank you. I want to thank you for this opportunity to speak--

MR. DEAL. Pull that microphone a little closer, please.

MS. GRANT-DAVIS. Okay, how is that? I want to thank you for the opportunity to speak with you today and for the unwavering support the subcommittee has given to America's health centers. I want you to know that your steadfast commitment to the health center program and its expansion has made a real difference in the lives of many underserved Americans across the country, including my State of New Jersey.

Earlier this year I received a letter from a grandmother, which actually really made my day, who wrote to thank our Primary Care Association for its work in opening a new health center in Glassborough, a very rural community where she lives. She wrote that her daughter, a young, uninsured mother of two children who suffers from severe asthma now has medical care and access to medications and I just want to read part of it. She wrote, "I cannot thank your program enough for opening the Community Health Center of Glassborough, where my daughter saw a doctor today and received prescriptions for her asthma and for a bronchial infection. She will be able to get well and breathe comfortably thanks to you. Because of you she will be able to take her son for a bike ride and run and be outside. Do you realize what a gift you have given her."

Chairman Deal, Representative Green, and members of the committee, I want you to realize the gift that you have given to this mother and the 15 million people currently served by health centers: the gift of a medical home where they can obtain high quality healthcare, regardless of insurance status or ability to pay. Indeed, access to care at health centers allows individuals to be productive members of their families and their communities. I would like to ask permission to have the letter from this New Jersey grandmother inserted into the record.

MR. DEAL. Without objection.

[The information follows:]

213 Overbrook Avenue
Glassboro, NJ 08028
February 15, 2006

New Jersey Primary Care Association
14 Washington Road
Princeton Junction, NJ 08550

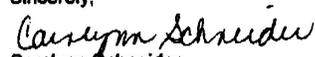
Dear Staff:

Today, for the first time in many years, my adult daughter received medical care. She is a young woman who takes both of her children to the doctor whenever they need medical care, but neglects her own health. You see, her children have health insurance and she does not.

Christina has severe asthma but has not had her asthma drugs since she lost her insurance. She has borrowed her sister's medicines at times and cobbled together treatment for infections hoping that they did not develop into something serious.

I cannot thank your program enough for opening the Community Health Center of Glassboro where Christina saw a doctor today and received prescriptions for her asthma and for a bronchial infection. She will be able to get well and breathe comfortably thanks to you. Because of you, she will be able to take her son for a ride on her bike! and run! and be outside when it is cold or very hot without wheezing! and no longer have pain with each breath! She will be normal. Do you realize what a gift you have given her?

Sincerely,


Carolynn Schneider
856-881-2431
chc10@comcast.net

MS. GRANT-DAVIS. Thank you. New Jersey's health centers deliver comprehensive primary care in 90 sites to more than 322,000 patients. Eighty-eight percent of our patients are people of color. Seventy-eight percent have incomes at or below 100 percent of the Federal poverty level and nearly 45 percent are uninsured. New Jersey's 21 health centers form an essential component of the State safety net and we are committed to providing high quality and comprehensive care.

MR. GREEN. Mr. Chairman?

MR. DEAL. Yes.

MR. GREEN. Could I ask because I know that time is late and we don't have many members? We have read your statements. In fact, both the Commissioner and yours. If you could summarize and then we could get the questions and that would make it better I think for everyone, if possible.

MS. GRANT-DAVIS. Then there are really just three points that I would like to make.

MR. GREEN. Okay. Thank you.

MS. GRANT-DAVIS. And this actually is in response to some things that I have heard before. But I think one of the benefits of having community health centers is that they can develop many partnerships. And one of the things I think is important to realize that we do work very

closely with hospitals to triage people out of the emergency rooms. That is critically important. In New Jersey we are working with the Medical Society of New Jersey to make sure that we have specialty care. We are working with Susan G. Coleman Foundation. So there are many partnerships and by having a health center it allows you to bring more parties to the table so that you have comprehensive care.

And the last point that I would like to make is that we urge you to provide a straightforward reauthorization of the Health Center Program through the fiscal year 2011. And the community board, nothing succeeds more than this because the patients have direct control of the care that they actually are receiving. So we urge you to reaffirm these core principles as you consider the reauthorization of the Health Center Program and I thank you for the opportunity to talk today.

[The prepared statement of Kathy Grant-Davis follows:]

PREPARED STATEMENT OF KATHY GRANT-DAVIS, EXECUTIVE DIRECTOR, NEW JERSEY
PRIMARY CARE ASSOCIATION

Good Afternoon. My name is Katherine Grant Davis and I am here representing New Jersey's health centers, which include community, migrant, and homeless health centers. I am the Executive Director of the New Jersey Primary Care Association, a membership organization of health centers dedicated for advocating on behalf of the medically underserved.

I want to thank you for this opportunity to speak with you today and for the unwavering support the Subcommittee has given to America's health centers. I want you to know that your steadfast commitment to the Health Centers program and its expansion has made a real difference in the lives of millions of medically underserved Americans across the country including my state. Earlier this year, I received a letter from a grandmother, who wrote to thank our PCA for its work in opening the Community Health Center of Glassboro, NJ where she lives. She wrote that her daughter, a young uninsured mother of two children, who suffers from severe asthma, now has medical care and access to medications through the new health center. She wrote:

"I cannot thank your program enough for opening the Community Health Center of Glassboro where [my daughter] saw a doctor today and received prescriptions for her asthma and for a bronchial infection. She will be able to get well and breathe comfortably thanks to you. Because of you, she will be able to take her son for a bike ride on her bike and run and be outside when it is cold or very hot without wheezing, and no longer have pain with each breath. Do you realize what a gift you have given her?"

Chairman Deal, Ranking Member Green and Members of the Committee, I want you to realize the gift you have given to this Glassboro, NJ mother and the 15 million people currently served by health centers – the gift of a medical home where they can obtain high-quality health care regardless of her insurance status or her ability to pay. Indeed, access to care at health centers allows individuals to be productive members of their families and their communities. I would like to ask permission to have the letter from this New Jersey grandmother inserted in the Record.

New Jersey's health centers deliver comprehensive primary care in 90 sites to more than 322,000 persons. 88% of our patients are people of color, 78% have incomes at or

below 100% of the Federal Poverty Level, and nearly 45% are uninsured. New Jersey's 21 health centers form an essential component of the state's safety net for health care services. We are committed to providing high quality, comprehensive health care services in federally designated medically underserved areas and underserved populations.

New Jersey health centers provide a comprehensive set of primary care services and enabling services to all people, regardless of their ability to pay. Our centers not only provide care to families, they also provide care to high risk and special populations including people with changing insurance coverage and those with chronic conditions and disabilities. Research has repeatedly shown that these groups cost the system a disproportionate share of available resources and we are committed to providing them with the best service in a cost-effective manner. And our record of success is hard to ignore. 1 out of every 15 poor persons in New Jersey is served by a health center. Since 2000 we have increased capacity in every county in New Jersey except for two. Dental, medical, and mental health capacity have been increased in over 80% of our existing centers. We have doubled the number of uninsured they we see in just 5 years. However, in communities across our state, the need to expand health centers is still growing steadily.

Our PCA is committed to the expansion of the health center model of care in New Jersey. Toward that goal and with the support of HRSA's Bureau of Primary Health Care and NACHC, the NJPCA provides training and technical assistance to the health centers in our state in order to assist our centers in carrying out the requirements of the statute and program requirements. NJPCA also conducts extensive planning and implementation activities to ensure the success of the health center expansion effort in the highest need areas of New Jersey.

I am also happy to report that the NJPCA are our health centers are major forces for community-wide collaborative efforts to expand access to underserved individuals and families. We have rolled up our sleeves and have joined together to form partnerships with other safety net providers that truly bring people into care and improve the health of entire communities. As an example, we are working hand in hand with the New Jersey Hospital Association to ensure that patients are triaged to our centers since we are a more appropriate setting for non emergent patients. In addition, we are working with the Susan G. Komen Foundation to ensure that all women, regardless of insurance status, are screened for breast cancer and that they have a medical home. Lastly, we were one of the original partners of the RX for New Jersey program, which is a company started by the drug manufacturers in New Jersey. This program is designed to ensure that patients, who can not afford their medication, have access to free prescriptions. We stand ready to continue our activities in all of these areas to ensure that the health centers in our state can build on their record of success over the years and in this current expansion effort.

Health centers are doing the job expected of them and they need the continued support of this Subcommittee, and indeed of the entire Congress, in order to continue fulfilling the long-range plan endorsed by the President and the Congress to expand the reach of the Health Centers program in underserved communities. That is why we urge the Subcommittee to provide a straightforward reauthorization of the Health Centers program through FY 2011 at an initial funding level of \$1.963 billion for FY 2007. Our New Jersey health centers believe that a straightforward reauthorization of the program is the best path forward to the continued success of the Health Centers program in expanding access to cost-effective, high-quality health care services to underserved communities.

Reauthorization of the program would renew the most important requirements of the Health Centers program, including governance by a patient-majority board, health centers' openness to all regardless of ability to pay, location in medically-underserved areas, and the provision of comprehensive preventive and primary care services. In particular, our centers would not be able to help change the health status of their patients

without patient-majority boards. Nothing succeeds like community control and health centers know that better than anyone else. Our health center boards are stewards of the health of fellow neighbors. Health centers are truly consumer-driven – they put patients in the driver’s seat to tailor services to best meet the needs of their local communities. NJPCA and New Jersey health centers urge the Subcommittee to reaffirm these core principles as you consider the reauthorization of the Health Centers program.

Thank you for this opportunity to talk with you. If there are any questions, I would be pleased to answer them at this time.

MR. DEAL. I thank the gentlelady. Mr. Hawkins, you are recognized for your statement.

MR. HAWKINS. Thank you, Mr. Chairman, and members of the subcommittee and I appreciate the opportunity to be with you this afternoon to talk about the Health Center Program. I want to ask with Dr. Burgess here, is there a doctor in the house? A little hoarse but we are going to get through this and I will do it in much less than the allotted time. You have a written statement so I don’t need to repeat those things.

I would say I actually began my career in a health center. I actually helped start one in south Texas. Not Tarrant County but we did it with a community group. Got it together, got funded. That center serves 40,000 people today and it has a community board, functions like a dream. In fact, it is the regional ambulatory health center for UTSA and San Antonio Medical School. So it can be done.

In this reauthorization, Mr. Chairman, on behalf of the Association, the health centers and the 15 million people they serve today, we do count the look-alikes that Mr. Rush mentioned in our patient counts. Nothing is more important than retaining the patient majority governing board requirements at these health centers. It is the one small place in America’s healthcare system, the only place where healthcare is of the people, by the people, for the people, patient democracies. We believe the Health Center Program is already a well-proven model of care and we fully support its reauthorization without change.

I want to extend this very special note to a long-time friend and supporter of health centers, Mr. Bilirakis and Mr. Green for introducing H.R. 5201, with now better than 80 cosponsors to provide a straightforward five-year reauthorization of this program. We think it is the best starting point and hope it will serve as a marker for the successful renewal of this program, Mr. Chairman, as you move legislation to make that happen.

The second thing we would like to point out, it was already pointed out earlier by Mr. Gillmor, is that there are some things we do need. One is that the FTCA, the Federal Tort Claims Act statute does need to be updated to take care of the problems that occurred along the Gulf Coast following Katrina to ensure that health center clinical staff can go where

they are needed most. And so we urge you to move legislation, H.R. 3962, Mr. Schwartz and Mr. Gillmor's bill, to do that.

We also want to thank Dr. Burgess for his support in sponsoring H.R. 1313 with Mr. Murphy. The Act that would--and to answer a question provided earlier by a member of the subcommittee--what can we do to help with the problem of specialty care for uninsured people? H.R. 1313 would extend Federal Tort Claims Act coverage to physicians who volunteer to work at health centers or to serve health center patients. We think it is a perfect example of something that would both provide immediate assistance and give local doctors the opportunity to make a real, real difference.

For all of these things we thank you. We thank you, Mr. Chairman, for your steadfast and longstanding support for the Health Center Program over time and in particular last year. We thank you for that and we look forward to working with you as this program is reauthorized to reach that day when health centers are truly able to offer a healthcare home. Medical yes but really healthcare. Medical, dental, mental health, et cetera, to everyone who needs it in America. Thank you and we would be happy to answer your questions.

[The prepared statement of Dan Hawkins follows:]

PREPARED STATEMENT OF DAN HAWKINS, VICE PRESIDENT FOR FEDERAL, STATE, AND PUBLIC AFFAIRS, NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS, INC.

Mr. Chairman and Members of the Subcommittee, my name is Dan Hawkins and I am Vice President for Federal, State, and Public Affairs for the National Association of Community Health Centers. On behalf of America's Health Centers and the 15 million patients they serve, I want to express my gratitude for the opportunity to speak to you today about the federal Health Centers program and its role in expanding and enhancing access to health care services for medically-underserved individuals and families. NACHC and health centers 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 have personally seen the power of health centers to lift the health and the lives of individuals and families in our most underserved communities during my time as a health center director in south Texas from 1971 to 1977. The health center is still in operation today, and has expanded to serve over 40,000 patients annually. The community empowerment and patient-directed care model thrives today in every health center in America and I am honored to be here to share with you their success story.

Background and History of the Health Centers Program

Conceived in 1965 as a bold, new experiment in the delivery of health care services to our nation's most vulnerable populations, the Health Centers program has a 41-year record of success that serves as an enduring model of primary care delivery for the country. Congress established the program as a unique public-private partnership, and has continued to provide direct funding to community organizations for the development and operation of health care systems that both address pressing local health needs and

meet national performance standards. This federal commitment has had a lasting and profound effect on health centers and the communities and patients they serve in every corner of the country. Now, as in 1965, health centers are designed to empower communities to create locally-tailored solutions that improve access to care and the health of the patients they serve.

Current Statistics

Today, America's health centers serve almost 16 million people in every state and territory. Health centers provide care to 10 million people of color, 6 million uninsured individuals, 725,000 seasonal and migrant farmworkers, and 700,000 homeless individuals. Over 1,000 health centers are located in 3,600 rural, frontier, and urban communities 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, dental, 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 ensure that health center patients can truly access care, 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.

From Demonstration Program to Formal Authorization

The legislative history of the Health Centers program is one of continued reaffirmation of the patients' voice in the ownership and operation of their health care system. The Health Centers program began in rural Mississippi, and in inner-city Boston in the mid- 1960s, to serve rural, migrant, and urban individuals who had little access to health care and no voice in the delivery of health services. In 1975, Congress permanently established the Community Health Centers program at Section 330 of the Public Health Service Act and the Migrant Health Center program at Section 329, as part of the Community Health Extension Amendments Act. The 1975 authorization was also notable because it also formally established the patient-majority governing board, location of centers in high-need areas, and minimum service requirements for service in

statute for the first time. In the 1980s and 1990s, the Health Care for the Homeless and Public Housing Health Centers Programs were created. In 1996, the Community, Migrant, Public Housing and Health Care for the Homeless programs were consolidated into a single statutory authority within the Public Health Service Act (PHSA).

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 is scheduled for reauthorization this year. Health centers are 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, as it has consistently over the entire life of the program. These core elements, which have greatly contributed 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.

2006 Reauthorization of the Health Centers program

As we look forward in the life of this 41-year experiment in community health empowerment, the National Association of Community Health Centers believes that the Health Centers program is already a well-proven model of care, with core elements that have stood the test of time. It is for that reason that NACHC fully supports the reauthorization of the program without changes; in other words, a "straight reauthorization." We believe that this is the best way to ensure that health centers can continue in their critical role in providing access to health care services in underserved communities.

I would like to extend a very special note of gratitude to Mr. Bilirakis and Mr. Green for introducing H.R. 5201, the "Health Centers Renewal Act," legislation that would provide for a straight reauthorization of the program through FY 2011 at an initial funding level of \$1.963 billion in FY 2007. The bill, supported by many Members of the Subcommittee and full Committee, 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 where they are located. We believe that H.R. 5201 provides the best starting point for this reauthorization and we hope that the legislation can serve as a marker for the successful renewal of the Health Centers program.

In Congress's previous reauthorizations of these bedrock requirements, it has 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 patient-majority board governance of health centers in our view. 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.

Through the direction and input of these 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. This has been particularly valuable as health centers address and work to eliminate health disparities in their patient population. Board members with unique and direct community connections 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.

I also want to expand on the other core features of the Health Centers program, each of which has played a key role in the continued success of the program. First, health centers are unique among health providers and systems in the federal statutory requirement that they be open to all in the community regardless of ability to pay. Like the community board requirement, this element is what links health centers to the local neighborhoods they serve. There is no cherry picking at health centers; everyone – the uninsured, underinsured, those on Medicaid and Medicare, and those who have private coverage can receive quality health care at health centers. Health centers are interested in addressing health needs on a community-wide basis, and the requirement that they be open to all in the areas they serve allows them to do just that.

Second, health centers are required under the statute to be located in high-need, medically-underserved areas. In reauthorizing the provision in 2002, Congress sought to ensure that much-needed, precious resources were allocated to the communities most in need of health center services. Location of health centers in federally-designated MUAs prevents the duplication of services, and establishes health centers in identified underserved communities where there are well-documented gaps in care.

Third, health centers are 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. In 2002, Congress not only reauthorized this requirement, but added to the list by including appropriate cancer screenings and specialty referrals as required services and behavioral health, mental health, substance abuse, and recuperative care treatment as optional services that health centers may provide.

We believe that these core statutory requirements provide the crucial framework for success of the Health Centers program. The program simply would not be where it is today without these critical elements. We 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.

Health Centers Meeting New Challenges

In their four-decade history, health centers have faced down and overcome many challenges. Health centers in the 21st century are now facing two particularly tough challenges: first, the struggle to provide health care services in the wake of natural disasters, and second, the uphill battle against the growing shortage of health care providers in underserved communities.

Even as access to health care services has expanded through the growth of the Health Center program, center administrators and community boards are coping with a dramatic decline in both the number of graduating medical students choosing a primary care field and in the number of dental students. This reality led the American College of Physicians (ACP), in a recent report, to warn that the nation's primary care workforce – which it called “the backbone of our health care system” – is, in its own words, “on the verge of collapse.”

The ACP report noted that too few young physicians are going into primary care, while 35% of all currently practicing physicians are already over the age of 55 and will soon retire. Indeed, over the past 8 years alone, the number of Family Practice residents has fallen 22%, while the overall number of medical residents has risen 10%.

There is a very direct connection between the findings of that report and those in a more recent article in the Journal of the American Medical Association (JAMA), which

found significant vacancies in physician and other health professions positions at health centers across the country. Not surprisingly, 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 center vacancy rates nationwide varied from 13% for primary care physicians to 7% for non-physician providers and 18% for dentists. While health centers, as they have always done, continue to make lemonade out of lemons, they could use some additional assistance from Congress in this endeavor.

Health Center Rely on Other Key Programs to Address Challenges

Health centers believe that one key solution to addressing workforce challenges is the reauthorization of the National Health Service Corps (NHSC) program, as its authority also expires this year. Health centers thank the Committee for reauthorizing the program in 2002 and for designating health centers as Health Professional Shortage Areas for NHSC placements. Renewal of the NHSC is critical to ensure that there are adequate numbers of health care providers to deliver care to health center patients. As many of you know, the Health Centers and National Health Service Corps programs have grown up together, and have weathered innumerable storms over the years. In that time, the one constant in the relationship between health centers and the Corps has been the decades-old connection to local communities and a commitment to fill the gaps in our health care safety net. This foundation in the community spurred the establishment of both programs, guides their current operations, and will fuel their growth and expansion to more underserved communities in the years to come. Nearly 4,000 NHSC clinicians, including physicians, dentists, nurse practitioners, physician assistants, nurse midwives, and behavioral health professionals, currently provide health care services to millions of medically underserved Americans. Approximately 50% of NHSC clinicians serve in health center sites.

Indeed, the JAMA study mentioned above also found a high degree of reliance among health centers on providers fulfilling a service obligation under the NHSC program, state loan repayment programs, and the J-1 visa waiver program. Overall, 30% of health center physicians and 26% of dentists are fulfilling a service obligation under one of those programs. Again, the highest such reliance was among rural and inner-city health centers, where up to 45% of the current workforce consists of either NHSC, state loan repayment and J-1 visa waiver obligors.

The threat of a public health emergency is a second critical challenge for health centers in the 21st century. Health centers in Mississippi, Alabama, and Louisiana were hard hit by Hurricane Katrina. In these Gulf Coast states, approximately 54 health center grantees in 302 communities serve nearly 750,000 patients. For many communities, the health center is the first place people turn in the event of a public health emergency. Indeed, health centers worked with other responders to provide services to those affected by the disaster and HHS expedited funding to open new centers in areas most directly impacted by Katrina in order to expand access to health care services. Health centers from California to Maine have treated tens of thousands of hurricane evacuees, and many centers nationwide sent medical teams and mobile health vans to the Gulf Coast to help their fellow health centers besieged by people in need of medical treatment. However, their current Federal Tort Claims Act (FTCA) medical liability coverage did not cover them once they crossed state lines because of a ruling by HHS limiting such coverage.

The experience of many health centers who mobilized to help their sister health centers in the wake of Hurricane Katrina points to the need to update the 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. HHS has indicated that FTCA coverage is only available within a state, therefore limiting health center

medical staff that could travel to help serve displaced individuals. A center in one state may be the nearest source of primary care should an emergency occur in another state. Texas is bearing a heavy burden of support for victims from Louisiana. Many centers across the country stand ready to help our Texas centers, but under HRSA's interpretation, they cannot do so. We can see no reason for limiting this to state lines in emergencies and we strongly urge the Committee to enact H.R. 3962, legislation sponsored by Rep. Joe Schwarz, and cosponsored by several members of the Committee, which would address this issue before the start of the 2006 hurricane season.

Additionally, the FTCA must also be modernized to allow health centers to better address these looming physician shortages I outlined earlier. Health centers would like to better utilize volunteer physicians to help meet this need; however, the confusion surrounding medical liability coverage often makes this prohibitive. Unfortunately, the liability protection afforded to health center physicians under the FTCA does not currently cover doctors who wish to volunteer their time – causing undue difficulty at health centers. In turn, health centers have been reluctant to recruit volunteer physicians for fear that their current malpractice coverage may be inadequate or insufficient. NACHC and health centers support H.R. 1313, legislation sponsored by Rep. Tim Murphy that would extend FTCA coverage to physicians who volunteer to provide care to health center patients. We believe that H.R. 1313 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. NACHC and health centers look forward to working with the Committee to address these challenges as health centers continue their mission and work to deliver health care services to underserved individuals and families.

Reauthorization Key to Historic Expansion of Access Through Program

Health centers recognize the relationship between timely program reauthorization and continued funding and believe that expedited reauthorization will make it possible for even greater expansion of access to affordable, high-quality health services to underserved communities. Additionally, the core elements of the Health Centers statute 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.

I want to briefly expand on our vision for the expansion of the Health Centers program in order to provide further guidance to the Subcommittee on the funding authorization level beyond FY 2007. In 1999, bipartisan Congressional Resolutions introduced in the House and Senate recognized the importance of continued growth in the federal investment in health centers. The resolution endorsed the doubling of Health Center appropriations over five years. Combined with President Bush's expansion initiatives, this goal has nearly been achieved, and as a result, millions more Americans have access to the affordable, effective primary and preventive care available at our nation's health centers.

NACHC and health centers are deeply grateful to Congress for its support of the Health Centers program. In Fiscal Year (FY) 2006, Congress appropriated \$1.78 billion in overall funding for the Health Centers program. The increases since 2001 have enabled hundreds of additional communities to participate in the Health Centers program and to deliver community-based care to more than 4 million people in the past 4 years. 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.

We also appreciate the President's strong support for the program and his request for a \$181 million increase in FY 2007, which would bring overall health center funding to \$ 1.963 billion. This year we expect health centers to serve 16 million people in every state across the country.

Despite the expansion of the program, the demand for health centers is at record highs – in 2004, we estimate that there were over 430 applications for new access points, only 91 of which received funding – a 21 percent success rate. 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 possible quality projects receive approval.

Yet the need for these services is still largely unmet. 36 million Americans remain underserved today – individuals and families with little or no access to medical care. With continued growth in the program and in the federal investment, health centers can continue the successful expansion effort in order to meet that need.

NACHC believes that a growth rate of 15% over the next five years in the program authorization level will enable health centers to serve over 20 million Americans by 2010. Indeed, at this rate, health centers will meet the need in America and rise to the challenge of their charter – to serve all of the underserved within fifteen years.

Given the increasing need for health centers, we are extremely grateful that the President has committed to continue the growth of the program by announcing the continuation of his Health Center Expansion Initiative into the future. This new announcement will focus on placing new health centers in poor counties that currently lack a health center site, a very ambitious goal. Our own analysis indicates there are more than 920 poor counties without a center today. Through this continued expansion, we believe that millions of additional patients will have access to care at a health centers in the foreseeable future. We commend the President for his continued support of the Health Centers program and we look forward to working with Congress to ensure that it soon reaches every community in need.

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. DEAL. Well, thank you and let me say to Mr. Hawkins and to your membership that we appreciate what your members do across the country. They provide a very vital service and please relay that on behalf of our committee today.

MR. HAWKINS. I certainly will do, Mr. Chairman. Thank you.

MR. DEAL. Let me touch on just a few and I will be brief. And we do have people, including myself, who have got airplanes to catch and I am going to be mindful of that.

You have mentioned several things, one being the bill that Mr. Gillmor is the cosponsor of, on the portability and effect of Federal Tort Claims Act coverage. Mr. Green and I were recounting some of the incidents that came out of the Katrina situation where that was a real concern. I suppose that you would say that your organization would support that portability and also the issue of volunteers being covered by it. I think that is a separate bill that has been proposed so that volunteers who come into an environment could have that degree of liability protection. Do you support that?

MR. HAWKINS. That is correct, Mr. Chairman. There is not a health center in the country who hasn't reported to me that there are many, many local doctors who would gladly, gladly volunteer to provide care, including specialists. Orthopedists, cardiovascular surgeons who would provide that care in the health center or even in their office, pro bono, no charge, if only their malpractice, their liability were covered and that is crucially important.

And yes, to answer your other question, the ability of health centers, the outpouring of support and response for all of the health centers and communities in the Gulf Coast following Katrina and Rita and even Wilma was just, it was heartening. As much as the devastation was heart-rending; heart-uplifting it was to see the response of America in general and health centers were no different. It is only a matter of time. It is only a question of when, not if, we are going to have the next disaster, the next public health emergency. We need to fix this problem so that health centers can move to where their help is needed most before that happens.

MR. DEAL. I think we heard during testimony at a previous hearing, even a health center that was dislodged by Katrina was told that if the same people moved to a different location, that they might not have this coverage.

MR. HAWKINS. That is correct and they nevertheless did it.

MR. DEAL. They just do.

MR. HAWKINS. They moved to a shelter area in a tent and provided the care.

MR. DEAL. That just doesn't seem very logical to me so we are hopeful that we might be able to make some progress on that front.

The other issue I would ask you to address very quickly and that is the makeup of the board itself, majority patients served members makeup. I recognize that you and Ms. Grant-Davis both subscribe to the idea that that is a good principle. But we heard in the previous HRSA

testimony that in the start-up situation where Mr. Brooks says that was a concern that HRSA perhaps would give some flexibility in that. Do you have any knowledge as to whether or not in start-up situations HRSA has been a little more lenient on that issue at the beginning?

MR. HAWKINS. Well, they should be because in the statute today is a two-year waiver of the governing board requirement. So as long as--and this is a key factor--the entity is committed to meet that 51 percent patient majority governance expectation by the end of the 2 year period, there is language in the law itself. This subcommittee wrote it some years ago, that allows for a waiver of not only that. It says the Secretary may make a grant with respect to which he or she is unable to make all of the determinations required in Section 330. So not only the governing board but other requirements, as well. In fact, there is great flexibility in this statute on location and the designation of medically underserved areas. There is a provision that allows Governors to request the designation of an area that doesn't meet the MUA requirements. On the delivery of services, Commissioner Brooks indicated and I am rather surprised to hear that affiliation agreements were not allowed or that there were bureaucratic barriers. I am here to say on behalf of the National Association that we strongly encourage affiliation agreements. It is the only way to maximize care to those folks. Now, there has to be a core staff. This can't be a sham, virtual health center. But once there is that core staff there should be affiliation agreements with good partners, like the hospitals and the other--the medical community, et cetera, to really have a collaborative process that can work.

MR. DEAL. All right. I am sure, Mr. Brooks, that you will have a chance to elaborate on your point. And I agree with your point of view that it is pretty hard when you have got only one doctor to have a requirement that is sort of inflexible in some regards about having three other permanent folks. That to me sort of flies in the face of common sense. But I am going to let someone else explore that with you since my time is up. Mr. Green?

MR. GREEN. Thank you, Mr. Chairman. And I think all three of these witnesses brought up things that we can deal with and one is the 51 percent. I am glad to know that there is a 2 year, in the statute, that is not something that I have seen and that gives the flexibility. I do think 51 percent after you are up and running is very important because that way you have the community managing their own facility. And practically on the ones we have worked with, you have to be in business for six months anyway and by then you have a patient base and you know who may be willing to take the time to be on the board. And also your patients who may have leadership ability or who want to do it and keep it in their communities. So I think if we have to, the 2 years, I am glad it is in the

statute. I want to make sure it is in the reauthorization so we will utilize that because we have had some concern about that with the board makeup.

But the proportionality, I agree. You know, in Texas for many years we haven't felt like we wanted these FQHCs. My colleague, Bobby Rush, I think Chicago has 70, but they started in 1960's doing it each year, so we have a lot of catch-up to make, and I know that same case with HRSA for Houston area, and I didn't even make it for Texas and Tarrant County and that is where you need to look where the need is not being met right now and have centers that are there and you can put them together as local collaboratives.

Mr. Hawkins, let me ask a question because I like the idea of patient referral efforts, and one of my goals in my areas is to have medical schools brought in to be a referral. We will have family physicians, we will have them do their residency, but also get substantially better care if we have a teaching facility there. Do you know of any problem any of our medical centers or community centers had in affiliating with medical schools that would be providing some of that specialty care?

MR. HAWKINS. To the contrary, Mr. Green. And matter of fact, I tell you within the first year that my health center down in Brownsville, Texas operated, our friends and colleagues at UTMB in Galveston were flying down all of the family practice residents to rotate through our health center for a 3 month family practice rotation. Because they said on Galveston Island they could not find need like there was in south Texas. And as I mentioned, my old health center, I can take no credit for its great success today, is today--

MR. GREEN. I am glad to know it is in Cameron County. My son lives there.

MR. HAWKINS. Home of the brave, yeah. But it is a 40,000 patient center and it is the regional ambulatory health center for the UT San Antonio Medical School. Every third and fourth year medical student, every single one of them and every family practice resident at UTSA and ever pediatric resident, every OB/GYN resident, rotates through that center now for six to twelve months and they are out of their residency period. So that is a perfect example of where the collaboration--I mean, it is synergistic. It is working all the time and that is not the only center in America where that is happening.

MR. GREEN. Mr. Chairman, one of the things I have heard from medical schools, is that there is not a funding base for doing that and it is difficult for the school to be able to fund it. And I know we have a hearing next week on graduate medical education and we might look at, whether it is this bill or something else, to encourage medical schools to provide that through the FQHCs. Because again, I think we raise the

level of the healthcare but we also train the next generation of family practitioners that we need in the community. And also, you know, we have that quality that we get from having a teaching institution.

Let me ask one other question before my time is up, in the 50 seconds. I read several studies that point to the role of health centers in the reduction of healthcare disparities. And Ms. Grant-Davis or Commissioner Brooks, can you speak to the role of health centers that really show that we are eliminating the disparities? That that is the goal originally of the community health centers and I want to make sure it is continued even though 40 years and even though some states were a little behind but we are trying to play catch up.

MS. GRANT-DAVIS. Yes, I would be happy to address that. In our State we know that hypertension, asthma, and diabetes are our top three, and so we have reengineering programs. They are called disease collaboratives where it is a care model that is based on the particular disease. And we have been able to demonstrate, and there are actual national studies that demonstrate, that by using a collaborative care model, that you can decrease the incidences of chronic diseases. Which allows the patient to have a better quality of life and it also reduces the disparities amongst the healthy and those that have these chronic diseases. So there have been some wonderful care models put in place, not only in my State but on a national basis, as well.

MR. BROOKS. In our one community health FQHC in Tarrant County, it is located in a predominantly Hispanic community and the community board has been able to structure a health delivery, a model, that addresses health disparities experienced in that population, particularly diabetes and hypertension. I don't want to leave the impression with this committee that I am opposed to community control of the FQHC boards. I am not. I just want to make sure that there is enough flexibility in the application process to allow us to gear up without penalty to 51 percent control.

From what I understand, the language says that the statute allows and the Secretary may. This is equivocal language and we need something perhaps a little more definite.

MR. GREEN. In what little time or few seconds I have left, I agree and if we have to do something but I think the board makeup, particularly after it is up and running, is important to make sure they continue to serve that particular community.

MR. BROOKS. We agree on that.

MR. GREEN. Thank you.

MR. BROOKS. Thank you.

MR. BURGESS. [Presiding] Thank you for yielding back. I recognize Mr. Bilirakis for five minutes.

MR. BILIRAKIS. Well, thank you. Mr. Chairman. I won't take that time because I think we are all going in danger of missing our airplanes.

I would just ask Ms. Davis, Grant-Davis--I am sorry.

MS. GRANT-DAVIS. Yes.

MR. BILIRAKIS. You in your testimony referred to--basically we refer to it as a clean bill, the legislation to reauthorize. We say a clean bill and we want a clean bill means we discourage any amendments, that sort of thing, that might sort of knock it off track. But you have heard the concern here on the 51 percent during the startup period, whatever that period turns out to be and we have talked here about the liability protection. Would you be against those being offered as amendments and possibly becoming part of the bill? I believe you--well, go ahead.

MS. GRANT-DAVIS. You are asking if I would be opposed to amending the bill to include those?

MR. BILIRAKIS. Yes, right.

MS. GRANT-DAVIS. My experience has been that we in New Jersey have asked for waivers before for the community board and we have had every single one of our health centers able to meet that stipulation. As a primary care association, my role is for technical assistance and training. And even for a health center that has been in existence for 20 years, we still do board training. And so once you become a board we just don't let you out there. There is still continuation of making sure that you keep meeting the board requirement.

MR. BILIRAKIS. Yeah, all right. But I am not sure really what your answer is. You are very eloquent but the trouble is we are all kind of rushed here.

MS. GRANT-DAVIS. Thank you.

MR. BILIRAKIS. And we all want to do the right thing. So would you oppose amending the legislation because you want a clean bill, as you had referred to earlier?

MS. GRANT-DAVIS. Okay. I am going to defer that to Mr. Hawkins.

MR. BILIRAKIS. Well, Mr. Hawkins, you don't find any problem with the idea that the 51 percent maybe should not be applicable to a start-up period, do you?

MR. HAWKINS. No, but Mr. Bilirakis, we absolutely support the notion of flexibility in the start-up.

MR. BILIRAKIS. Okay.

MR. HAWKINS. I heard what Commissioner Brooks said and he may have a very good point. That sometimes bureaucrats read the statute as may but that doesn't mean I have to. But the language, I would strongly recommend that you never change the shell. I don't think you want to mandate that being the most unreasonable but--

MR. BILIRAKIS. To let the local people provide a basis.

MR. HAWKINS. But you can certainly, this committee, can make it imminently clear in report language that may means that upon any reasonable request by an organization asking for that time period, it should be or if you will, must be granted. The committee can make clear the intent. You wrote the language. You can specify that.

MR. BILIRAKIS. Yes, right. Ms. Grant-Davis, as far as the liability protection, whether it be in the form of some sort of Good Samaritan protection or whether it be actual liability protection from the standpoint of subsidizing that protection, you would not have any problems with that?

MS. GRANT-DAVIS. My understanding is that there are separate bills that are moving.

MR. BILIRAKIS. Well, there are.

MS. GRANT-DAVIS. Right. I absolutely support them.

MR. BILIRAKIS. But I am here to tell you that this is the one that in all probability, would have the best opportunity of getting through the process and this is why we talk in terms of amending. You see what I mean? Attaching thereto. So you would be a supporter of that?

MS. GRANT-DAVIS. If I can get volunteer docs under Federal Tort--

MR. BILIRAKIS. Amen to that. Right. And Commissioner Brooks, very quickly. No questions. I just want to say to you that Dr. Burgess has said that he is new here and doesn't understand the bureaucracy. I am here to tell you that is probably his top issue and he has many top issues but probably the top one is community health centers, particularly the one in his district. He and I have already talked about that long before this hearing. So I want you to know that his heart is really with you as far as that is concerned. Thank you very much. Thank you, Mr. Chairman.

MR. BROOKS. As Dr. Burgess indicated, we are on different sides of the political aisle but we find each other to be reliable partners and have gained a great appreciation for each other through working on these particular issues. So I appreciate him as well.

MR. BURGESS. I thank the gentleman for yielding back. We have been joined by the gentleman from New Jersey, Mr. Pallone. He is recognized for 5 minutes for questions.

MR. PALLONE. Thank you, Mr. Chairman, and I apologize that I wasn't here earlier, particularly since--and I am apologizing mainly to Kathy Grant-Davis because she is from New Jersey and she is someone I have known for a few years now. But we had another hearing on Rutgers Undersea Program. Would you believe that? So I had to go to that, too. Anyway, I just wanted to extend a special welcome to Kathy, who serves as Executive Director of New Jersey's Primary Care Association, a non-profit that represents New Jersey's community health

centers. And I can honestly say there are few people who have worked harder than Kathy to ensure New Jersey's uninsured and underinsured have continued access to quality health services. And I want to thank you for being here today and the service you provide to our State. Thank you. Now, I have got four questions here. I am going to have to try to fit them in 4 minutes. I don't know if I can. But I wanted to mention, Kathy, I am always delighted to visit the community health centers in my district and I am impressed with the array of healthcare services they provide to my constituents.

You mentioned the importance of the community board I guess in your statement and I agree with you. Could you give me an example of how a patient majority board at one of the health centers in my district, for example, has contributed to the success of that health center in expanding access to healthcare services?

MS. GRANT-DAVIS. I would be delighted to. We just actually opened a new site in Red Bank in your district.

MR. PALLONE. Oh, great.

MS. GRANT-DAVIS. We opened it last week and that was as a result of many discussions with the board about the need to expand services into that area.

MR. PALLONE. This is separate from the--there is another private one that exists there, right?

MS. GRANT-DAVIS. This is the VNA of Central Jersey has now expanded a new site into Red Bank and it was that board that looked at the demographics. They looked at the financial concerns. They looked at where people had to travel, patient origin. I met with them on many occasions and it was because of that board that they decided that there was a new site that needed to be opened in the Red Bank area.

The same with the Plainfield Health Center. You remember how their old facility looked. It was four or five exam rooms. It was that board that did the capital campaign, the fundraising, everything to get that new state of the art building up and running.

MR. PALLONE. Well, great. Thank you.

MS. GRANT-DAVIS. You are welcome.

MR. PALLONE. I am going to number two now. You mentioned in your testimony, again that I missed, that the centers in New Jersey are working with hospitals to triage more patients out of hospital emergency rooms to the health centers. Can you just expand on that initiative a little?

MS. GRANT-DAVIS. I would be delighted to. After years of discussion with the hospitals about what our role should be, we have decided to do really formal programs to make sure that we were the primary care providers. We share facilities. We share staff. In many

cases, the health center staff is on-site in the emergency room and will set up appointments immediately for the patients so that they have a medical home.

And on the flip side, the hospitals are serving for what we need, which is some specialty, diagnostic, lab. And so there is the primary care piece and now our sister agencies are able to help us with the other piece, as well. And so those are really formal programs and the wonderful thing about that is that we are looking into technology. When a patient presents at the emergency room the hospital can see right away that they are a health center patient and there can be a sharing of records.

And so it is a really formal program and I am delighted to be working with the Hospital Association on that.

MR. PALLONE. Well, great. Now, I am going on to number three. You know the Robert Wood Johnson Foundation in our State recently released a report highlighting the problems of the uninsured on a State-by-State basis. I just wanted to ask you, what trends are you seeing in New Jersey for the uninsured and how has that affected the health centers and their ability to meet the need?

MS. GRANT-DAVIS. I will go back to the year 2000. We were serving approximately 78,000 uninsured amongst all of the health centers. In the year 2005, that number jumped to 142,000 so it almost doubled. So in order to meet the need we have gone from approximately 40 or 50 sites now up to 90 sites in really just about every county. So as that number continues to grow we are trying to open new sites with both the HRSA money, as well as some State money, as well. There is still 1.1 million in New Jersey so we serve about ten percent.

MR. PALLONE. Okay. And then Mr. Chairman, I will ask one more question here. As many of you know, the President has introduced a new plan on how to respond to the outbreak of Avian influenza and I am curious, what role would the health centers play in such a crisis or in a bio-terrorism crisis? And specifically, would the health centers be able to respond to surged capacity and do you have contingency plans in place?

MS. GRANT-DAVIS. Yes. That is a wonderful question. I am glad you asked that. And this is an area where as a primary care association we have spent an inordinate amount of time to make sure that our health centers are ready. We have written policies and procedures but I think the most important thing we have done for them is that we make them do drills. We just did a drill down in Camden. We had some sort of emergency situation so everybody knows their role. We do tabletop drills. We provide all types of training. And we have also made sure that each health center in New Jersey is tied into its county emergency

medical system. Every single health center in New Jersey knows the incident command system.

And so we have put together many different documents, which in fact we have shared with many different health centers to make sure that they are ready. We are now in the process of writing surged capacity plans for each one of them and will be doing a major training for health centers in New York, New Jersey, Puerto Rico, and the Virgin Islands around a pandemic.

MR. PALLONE. Okay, thanks. Mr. Chairman, I could just ask if I could include my opening statement in the record because I didn't--thank you.

MR. BURGESS. Yes.

MR. PALLONE. Thank you, all the panelists.

MR. BURGESS. The gentleman's time has expired and time is critical. I may not use all of my time for questions. I feel like the kid in medical school who was asked a question he couldn't answer so he told the professor, do you want the theory or the application? I feel with Mr. Hawkins we have got the theory. With Commissioner Brooks we have got the application.

Mr. Hawkins, I mean I absolutely agree with Commissioner Brooks. I value and I respect the 51 percent board makeup but I don't know if the theory is matching the application on this. We heard testimony from the HRSA Commissioner that the points where the Secretary may waive are for migrant, homeless, rural, and public housing populations. And I think that Commissioner Brooks is exactly correct where he says the language is not specific enough. And that is where we may wish to address that in the language of the reauthorization bill because clearly, you have got a man here of significant intellect and capability, well respected in his community, and he had to move heaven and Earth in order to get his first clinic started in a community of, if I am correct, now it is 1.7 million in the county, 1.7 million. Just a little ways to the southeast of where that clinic is, we have got a significantly underserved area, the type of area that this clinic was designed for. It is what people had in mind when they said let us have a federally qualified health center. Let us tackle this 12 per 1,000 infant mortality rate. Let us tackle these unconscionable health disparities that we are seeing.

So it is not with any intent to harm anything that is working well but it needs to work well, as Mr. Brooks so eloquently put it, there needs to be proportionality. It needs to work in all areas of the country.

Commissioner Brooks, no question that the hurricane of course, the two hurricanes, didn't affect our area of Texas directly but we certainly felt the aftershock from that. Can you relate to the committee just a little bit of what we went through in Tarrant County after the hurricanes hit?

MR. BROOKS. Thank you for the question, Dr. Burgess. Tarrant County was one of the areas to which evacuees were bussed. Initially, we set up an intake center at one of our public school facilities and staffing that intake facility was a cadre of doctors from our public hospital. And every person who got off of a bus, before they were assigned a pallet was assessed for their medical condition. During the course of the peak of dealing with Katrina evacuees, we dealt with some 7,000 evacuees in Tarrant County. Of those, our public hospital serviced about 2,500 in outpatient visits, 400 or 700 ER visits, almost 7,000 prescriptions were filled.

MR. BURGESS. Now, there is probably no way to know how many of those 7,000 remain in Tarrant County today. Was there any type of a guess as to the number?

MR. BROOKS. The best guess that I have been able to come up with is somewhere between 800 and 1,000 still in Tarrant County, most of which are in my precinct.

MR. BURGESS. In your precinct and this is of course the precinct that has some of the greatest medical need. So in an area of great medical need, we have added 1,000 more lives that would definitely benefit from having this type of facility within easy access for them.

MR. BROOKS. Absolutely correct.

MR. BURGESS. You mentioned and my time is about up, too but just something that struck me. You have got an executive director, a medical director, a finance director, all supported by the revenue generation of one physician? Is that--

MR. BROOKS. That is what the regulations require.

MR. BURGESS. And we haven't even talked about the nurse, the lab technician, or the guy that empties the trash can at the end of the day.

MR. BROOKS. It appears to be a little top heavy in management.

MR. BURGESS. How many patients does that physician see then during the day, during the average clinic cycle? Is there a limit or is it just he can see as many as can walk in the door?

MR. BROOKS. I am afraid that that is a question that I can't answer.

MR. BURGESS. Just doing my calculations, I mean he would almost have to see 70 or 80 folks to pay for the overhead that you are carrying behind you. Mr. Hawkins, do you have--

MR. HAWKINS. I would just like to say that the average health center today has 15,000 patients. That is about the equivalent of about a seven and a half FDE physician or clinician practice. So the one doctor practice--in fact, my understanding, I wish they were here, of HRSA's rules is normally they really require--I mean, when they fund a \$650,000 new start health center, they expect that center to get up to 3,000 or 4,000 patients within two years. That is a one and a half to two FDE doctor

practice and growing from there. So again, you may have anomalies like this, but the average health center is running from seven to ten FDE and that is just physicians. We are not even talking dentists.

MR. BURGESS. Well, my time--we may be able to get HRSA to clarify that for us on the record in writing. But I want to thank our panel for being here today. This has been an informative discussion that we have had. My staff keeps reminding me I have got a three-star General waiting so with that, I am going to adjourn the hearing since there are no other members here to ask questions.

MR. HAWKINS. Ours is not to reason why, right?

MR. BURGESS. The subcommittee is adjourned.

[Whereupon, at 4:36 p.m., the subcommittee was adjourned.]

