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

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

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

I. Introduction

As other witnesses will testify, there has been consistent data over time that community health centers perform exceptionally well and do so at a lower cost than other providers and other primary care settings. Across the board, being connected to primary care services leads to better outcomes and lower costs. Recent research has shown that, for every $1 invested in primary care, $13 is saved in downstream costs.[1] Of the 4.3 trillion dollars in health spending in the U.S. every year, the nation only spends 5% on primary care. However, research has shown that if the U.S. spent closer to 12 percent,[2] it would cut per-patient costs and lead to a decrease in overall health care expenditures. And the most effective way to achieve a return on investment from primary care is to invest in community health centers, which are the gold standard of primary care–comprehensive, patient-centered, patient-governed, accountable, competitively funded, and tailored to the needs of local communities. As my colleagues at the National Association of Community Health Centers (NACHC) found in a recent survey, **without community health centers, 15 million more patients would be at risk for not having a usual source of primary care**.[3]

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

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

[3] "Closing the Primary Care Gap: How Community Health Centers Can Address the Nation's Primary Care Crisis", (National Association of Community Health Centers, February 2023), https://www.hcadvocacy.org/wp-content/uploads/2023/02/Closing-the-Primary-Care-Gap_Full-Report_2023_digital-final.pdf .

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

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

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

II. Community Health Center Expansion of Services

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

It is important to note that these accomplishments exemplify the unique ability of community health centers to respond quickly to local community needs. Even in the face of nationwide trends, each

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

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

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

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

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

[9] "Health Centers Provide Cost Effective Care" (National Association of Community Health Centers, July 2015), http://nachc.org/wp-content/uploads/2015/06/Cost-Effectiveness_FS_2015.pdf.

community health center can address the particular impact on its local community based on the input of their consumer majority boards, which are run by community health center patients as required by statute.

1. Confronting the COVID-19 Pandemic

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. Providing Behavioral Health Care

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

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

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

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

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

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

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

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

Third, community health centers have leveraged telehealth to reach more patients in need. A 5-year Patient-Centered Outcomes Research Institute study highlighted how several rural community health centers successfully use telehealth for mental health services. The study looked at two models of care: linking patients to specialists via telehealth or integrating telehealth into primary care services. Both groups "reported substantially and statistically significant improvements in perceived access to care, decreases in their mental health symptoms and medication side effects, and improvements in their quality of life."[20]

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

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

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

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

4. Addressing the Social Determinants of Health

Community health centers are uniquely positioned to address SDOH and improve population health outcomes. According to Healthy People 2030, SDOH are "the conditions in the environments where people are born, live, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks."[23] 6 in 10 of adults have one chronic disease and 4 in 10 adults have

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

[21] "Camarena Health 2021 Annual Report" (Camarena Health, 2021), https://www.camarenahealth.org/wp-content/uploads/2022/09/CAM_2021AnnualReport_Web_AZ.pdf.

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

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

multiple chronic diseases.[24] Evidence shows that social and behavioral factors are significantly associated with the development of chronic diseases such as hypertension and diabetes, and often these SDOH are manageable or treatable.[25] Even worse, disparities in SDOH exacerbate chronic diseases, especially in certain communities, and limit ways for people to live a healthy, fulfilled life.[26] The COVID-19 pandemic exacerbated SDOH challenges; compared to before the pandemic, over half of the community health centers said they saw an increase in the number of patients seeking housing services (69%), food and nutrition services (63%), and transportation services (53%).[27]

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

Food Insecurity:

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

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

Housing Instability:

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

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

[26] Paula Braveman and Laura Gottlieb, "The Social Determinants of Health: It's Time to Consider the Causes of the Causes," *Public Health Reports* 129, no. 1_suppl2 (January 1, 2014): 19–31, https://doi.org/10.1177/00333549141291S206.

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

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

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

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

Without stable housing, it is near impossible for a patient to care for basic health and human needs. A person without stable housing lives, on average, 27.3 fewer years than the average housed person.[31] With nearly 1.3 million patients at community health centers nationwide experiencing homelessness, housing instability and homelessness are key issues that community health centers must tackle.[32]

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

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

Linguistic Access

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

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

- North East Medical Services (NEMS) in San Francisco, California provides many languages and dialects as a standard part of their culturally competent care, including English, Cantonese, Mandarin, Toishan, Vietnamese, Burmese, Korean, Spanish, and Hindi.[37] The NEMS health center also helps improve health literacy by providing health education resources in other

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

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

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

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

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

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

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

languages.[38] Resources are available for asthma, high blood pressure, childhood immunization schedules, diabetes, mental health, and nutrition.

Community health centers of all sizes provide language services, and centers use different modalities to fit the needs of their patients. Centers often have bilingual health providers and nonclinical staff, provide interpreters, and/or use video services to assist in providing care.[39] During the pandemic, language often was a barrier for telemedicine. However, a recent qualitative study showed that audio-only visits with bilingual staff improved patient experience and access to care at community health centers.[40] The audio-only visits also removed barriers to broadband and connectivity issues.

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

5. Building and Retaining the Health Care Workforce

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

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

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

In total, in 2021-2022, there were over half a million participants nationwide and over 368,000 graduates across these programs.[44] Among these, over 42,000 participants reported being from an underrepresented minority, disadvantaged, or rural background. Over 25,000 participants focused on the Department of Health and Human Services (HHS) priority of health equity and SDOH. 69% of recent graduates now practice in a medically underserved community, primary care setting, or rural area. NHSC

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

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

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

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

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

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

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

providers represent a diverse group of clinicians. 33% of the nation's total population identifies as Black or Hispanic/Latino. This same population only represents 11% of physicians in the U.S. However, roughly 25% of physicians serving through the NHSC identify as Black or Hispanic/Latino, a key indication that the NHSC is successfully driving clinician diversity.[45]

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

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

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

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

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

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

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

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

[47] "Camarena Health 2021 Annual Report" (Camarena Health, 2021), https://www.camarenahealth.org/wp-content/uploads/2022/09/CAM_2021AnnualReport_Web_AZ.pdf.

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

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

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

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

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

Also notable, the quality of care provided by community health centers has not altered or been sacrificed in the face of growth. 1,058 community health centers (77%) have achieved Patient-Centered Medical Home (PCMH) recognition, and community health centers have an eight times greater odds of attaining PCMH certification compared to other types of health care practices.[54] The PCMH model of care enables community health centers to have strong patient outcomes at lower costs despite treating patients who are often sicker, with more complex health care needs, and those who come from a poorer population than in other health care settings. 79% of community health centers met or exceeded one or more national clinical benchmarks in 2020, with more than half (55%) reporting improvements in 5 or more

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

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

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

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

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

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

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

clinical quality measures (CQMs) and 1 in 6 community health centers nationwide (16%) reporting improvements in 8 or more CQMs.[55]

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

IV. Community Health Center Financial Crisis

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

Medicaid Unwinding

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

Community health centers expect that the end of the Public Health Emergency and continuous Medicaid coverage will pose a significant risk to community health centers, as Medicaid provides health care coverage to over 48% of community health center patients[59] - or about 15 million patients - and made up 41% of community health center revenue in 2021.[60] A new report from the Geiger Gibson/RCHN Community Health Foundation Research Collaborative at the George Washington University Milken Institute School of Public Health puts the facts into a stark reality**: up to 2.5 million community health center patients could lose their Medicaid coverage once continuous enrollment ceases.**[61] HHS estimates that 56% of those losing coverage will be due to loss of eligibility and will need to transition to another source of coverage. 44% will lose Medicaid coverage despite still being eligible ("administrative churning"), although HHS is taking steps to reduce this outcome. Community health centers will continue to care for these patients regardless of their status. **But without additional resources, they will face**

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

[56] "Report to Our Communities 2021" (Yakima Valley Farm Workers Clinic, 2021), https://www.yvfwc.com/wp-content/uploads/2022/07/119_220711_RTOC_Web_Single_8.5x11_Pages.pdf.

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

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

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

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

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

enormous financial challenges to sustain everything from workforce recruitment and retention, to continued programming to address SDOH, to community outreach to keep patients healthy.

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

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

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

- At Cumberland Family Medical Center (CFMC) in Kentucky, one patient eloquently captures the expertise and understanding community health center staff provide. "I am a widow and am on a fixed income. I cannot afford insurance if it was not for the ACA. I tried signing myself up, but was unable to get the application completed, but with the help of CFMC's KyNectors, I now have insurance and can afford to go to the doctor when I need to. The KyNectors were so helpful and any time I have a question I still call her. She even called after I was enrolled to make sure I had

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

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

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

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

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

received my insurance card. Thank you CFMC for caring about your patients and going above and beyond to make sure they have the best care possible."[67]

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

Expiration of Supplemental COVID Funding

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

Erosion of the 340B Program

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

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

Workforce Shortages

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[67] "Outreach Stories & Patient Testimonials," Cumberland Family Medical Centers, n.d., https://www.cumberlandfamilymedical.com/media/outreach_stories_patient_testimonials.aspx.

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

[69] Internal ACH survey data available upon request.

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

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

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

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

V. Conclusion: The Case for Investment

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

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

We urge Congress to scale investment in community health center funding, including infrastructure, workforce, and innovation. We request a five-year extension of the Community Health Center Trust Fund, with the following annual funding amounts: FY24: $6.2 billion; FY25: $6.98 billion; FY26: $7.87 billion; FY27: $8.87 billion; and FY28, $10 billion.

We realize these are large amounts of funding in a difficult fiscal time for our country. But I hope my testimony today made the case that community health centers are the best place to invest scarce federal

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

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

resources. As has been documented over and over again, the savings yielded by the community health center program are immense.

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

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

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

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

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