



November 29, 2019

The Honorable Richard Neal
Chairman
Committee on Ways and Means
United States House
1102 Longworth
Washington, D.C. 20515

The Honorable Kevin Brady
Ranking Member
Committee on Ways and Means
United States House
1102 Longworth
Washington, D.C. 20515

Dear Chairman Neal and Ranking Member Brady:

On behalf of the Maine Primary Care Association (MPCA), a membership association representing the collective voices of Maine's 20 Community Health Centers, which provide high quality, affordable and integrated primary and preventive care services to over 210,000 individuals, or 1 in every 6 Maine people, I want to thank you for the opportunity to respond to your request for information on Rural and Underserved Communities.

Nearly 60% of Maine's 1.3 million people live in rural areas, making it the second most rural state in the country. Our 35,380 square miles is comprised of small cities and towns, villages, islands and rural wilderness. While the service industry has become the top economic sector, fishing, forestry, mining and agriculture comprise the second most important sector and those jobs are rural. Maine people work hard for long hours, and between work and family there is precious little time, even for necessary health care.

(Source: <https://www.britannica.com/place/Maine-state>).

The 2017 American Community Survey by the U.S. Census Bureau confirms Maine's status as the oldest in the country. In 2017, 252,634 people under 18 lived in Maine – 22,000 fewer than seven years ago. The number of people 65 and grew by more than 55,000 to 266,214. (Source: *Maine Public*, September 14, 2018).

According to [U.S. NEWS & World Report](#), Maine ranks 42nd in utilizing public transportation. As a result of these—and my other factors—Maine experiences the perfect storm of being extremely rural, having an ageing population, hazardous employment and limited transportation, not to mention long and very cold winters. Due to these inherent factors and others, it is vital to health and well-being of all Maine people that national health policy supports improved care delivery and health outcomes in rural and underserved communities.

1. What are the main health care-related factors that influence patient outcomes in rural and/or urban underserved areas? Are there additional, systems or factors outside of the health care industry that influence health outcomes within these communities?

Given challenges facing rural Mainers, the most significant impact on patient outcomes and quality of life is access to affordable, high quality, and local health care. The creation, continuation and support of Federally Qualified Health Centers (FQHCs/CHCs) is a lifeline for rural Mainers. In the most recent round of New Access Point funds through HRSA, 5 applications were submitted to expand access, yet not a single site was funded across Region 1; instead, those investments went predominantly to urban areas.

FQHCs provide care regardless of insurance status/ability to pay and are crucial to areas experiencing economic upheaval. When paper mills close or Maine's natural resource industry downturns, people who have had health care often lose it, delaying critical treatment needs. CHCs help to fill that void. However, a FQHC system unable to hire and retain adequate staffing will fall short of program goals; services will not be available without staff. As such, National Health Service Corps (NHSC) clinicians are essential to care delivery FQHCs. These are skilled providers who offer a great return on investment. In Maine, the CHCs' ability to leverage NHSC is about to be undermined by efforts to "modernize" the scoring rubric, inherently disadvantaging rural areas.

A NHSC primary care provider can serve over 1,000 underserved patients a year, at a cost of only \$25,000. The demand for NHSC clinicians is greater than the number of clinicians that the program can support at current funding levels. ***For these reasons, we encourage Congress to expand funding for NHSC.***

3. What should the Committee consider w/respect to patient volume adequacy in rural areas?

The inherent urban bias in public policy creates challenges for rural programs that find themselves gauged by an urban measuring stick. Rural service programs, including health care, will not always meet goals based on urban modeling. As such, we suggest that the question of "patient volume adequacy" should not be viewed in a vacuum. Developing a rural measurement model to better understand not just volume, but impact on individuals and communities, would be a more nuanced way to understand the importance and impact of services provided.

In addition, the FQHCs' very existence in rural communities drives economic viability within those communities as well as the whole state. In 2017, Maine FQHCs had a total economic impact of more than \$428 million. In this light, it becomes all the more important for the federal government to assess ways to support a stable workforce in rural communities. Maine rural economic health and viability is dependent upon robust small businesses and natural resource-based industries; without the necessary infrastructure to support communities—education, transportation, health care and broadband—there is a much lesser chance of success. When the rural economy struggles or fails the rest of the economy suffers. The 2017 USDA Task Force on Rural Prosperity identified services necessary to expand economic opportunities and create jobs in rural areas. A focus on infrastructure improvements, business development, housing, community services such as schools, public safety and **health care**, as well as high-speed internet access in rural areas, helps to create a vibrant economic environment.

7. Access to providers that address oral, behavioral, and substance use needs in rural and underserved communities can be particularly limited. What approaches have communities or states taken to address such gaps in care delivery?

Services for oral health, behavioral health/substance use disorder are all part of comprehensive primary care and are at the heart of the integrated and patient-centered care model that FQHCs must deliver. Each need in its own way challenges the mind, body and spirit and impacts quality of life for individuals, families, and communities. Maine's FQHCs recognize this and have worked diligently to incorporate a vast array of services into their delivery model based on community need.

Seventeen of Maine's FQHCs operate in rural and frontier areas, and yet over 85% offer some form of behavioral health and oral health services. Far too many Maine families have been impacted by the opioid crisis. In 2018, Maine had 354 overdose deaths. Communities continue to look for help and FQHCs have responded by providing access to naloxone, Medication Assisted Treatment (MAT), advocating for low barrier treatment options, and addressing stigma through public education. Behavioral health in primary care settings is crucial in rural areas where people remain hesitant to access behavioral health services due to stigma and cost. As reported in *Health Affairs*, [a study by Alexander Blount](#), Professor of Clinical Family Medicine at University of Massachusetts, found that 75% of patients would not accept a referral to see a behavioral health specialist: "They're going to get treatment in primary care or nowhere," Blount said. If people cannot access appropriate services locally and in a timely manner, the situation does not resolve itself and becomes a crisis, as higher cost interventions are required.

10. Are there two or three institutional, policy, or programmatic efforts needed to further strengthen patient safety and care quality in health systems that provide care to rural and underserved populations?

With more than 70 service sites spread across Maine, FQHCs constitute a critical care delivery network. However, with ongoing operational uncertainty caused by lack of long-term federal funding for CHCs, National Health Service Corps and Teaching Health Center programs, Maine's FQHCs may have to cut services, lay off staff and put expansion plans on hold unless and until Washington is able to pass a permanent funding fix. *As such, we encourage Congress fund these programs long-term, and to increase funding levels to support access to health care services for some of this country's most rural residents.*

Further, we recommend that the Auto-HPSA modernization project be evaluated thoroughly to determine unintended consequences for rural areas. Under the re-scoring, Maine is one of the most negatively impacted states in the country. As a result, our CHCs will lose access to programs vital to recruitment and retention efforts. As one CHC CEO recently said, *"Without scholar and loan repayment opportunities, not even natives of our isolated, remote region are willing to return home."* To illustrate the impact: at this FQHC, the significance of HPSA scores and Loan Repayment (LRP/Scholar)* is monumental; loss of these positions would obliterate the center's ability to serve their small rural communities:

3 of 3 LCSWs are Active HRSA LRP (Loan Repayment Program)
2 of 3 Family Physicians are Active HRSA Scholar & LRP
2 of 3 Family Dentists are Active HRSA LRP
2 of 5 Registered Dental Hygienists are HRSA LRP
1 of 2 FNP are Active LRP

In closing, we appreciate the work you are doing on this important issue and would welcome the opportunity to be of additional assistance as needed. For more information, I can be reached at (207) 621-0677, ext. 2160 or dshargo@mepca.org.

Sincerely,
Darcy Shargo
Chief Executive Officer
Maine Primary Care Association

*FMI on Loan Repayment and Scholar programming within the National Health Service Corps, please see <https://nhsc.hrsa.gov>