



MEMORANDUM

TO: The Honorable Richard Neal, Chairman, House Ways and Means Committee
The Honorable Kevin Brady, Ranking Member, House Ways and Means Committee
FROM: The National Association of Community Health Centers
DATE: November 29, 2019
RE: RURAL AND UNDERSERVED COMMUNITIES HEALTH TASK FORCE

On behalf of the National Association of Community Health Centers, we are pleased to respond to your request for information on 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?

Two key factors that influence patient outcomes in underserved areas are:

- Whether patients have access to high-quality, adaptable primary care, such as that provided by Community Health Centers (also known as Federally Qualified Health Centers, or FQHCs) and
- Whether FQHCs and other safety net providers can recruit adequate staff to care for these patients.

Primary care is a cost-effective way to detect and treat health issues before they become more acute and expensive,¹ and FQHCs are the backbone of the primary care system in underserved areas. Not only do FQHCs address patients' clinical needs, but they also address non-clinical factors that impact patients' health (e.g., food instability, transportation barriers). Also, FQHCs are highly responsive to their communities' needs. For example, over the past decade, rural FQHCs nearly tripled their behavioral health staff in response to the opioid epidemic and rapidly expanded services

¹ Petterson, S., McNellis, R., Klink, K., Meyers, D., Bazemore, A. The State of Primary Care in the United States: A Chartbook of Facts and Statistics. January 2018.

that assist patients in accessing and utilizing care more effectively.² However, uncertainty about on-going Federal funding makes it difficult for FQHCs to make long-term plans.

Unfortunately, most FQHCs and other safety net providers cannot recruit enough clinicians to meet their patients' needs. While the National Health Service Corps (NHSC) helps some FQHCs recruit clinicians, this program is dramatically underfunded, and recent changes will make it even harder for rural providers to recruit NHSC clinicians. Given that each NHSC clinician can care for over 1,000 patients a year, at a cost of only \$25,000 in annual Federal funding, increasing NHSC funding is one of the most effective ways that Congress can address provider shortages in rural and underserved areas.

2. What successful models show a demonstrable, positive impact on health outcomes within rural or underserved communities, for example initiatives that address: a) social determinants of health (particularly transportation, housing instability, food insecurity); b) multiple chronic conditions; c) broadband access; or d) the use of telehealth/telemedicine/telemonitoring?

Numerous studies demonstrate that the FQHC model itself leads to positive impacts, through approaches such as:

- **Directly Addressing Social Determinants of Health:** FQHCs provide services that directly address disparate health outcomes for socially and economically disadvantaged groups. These include education about nutrition and healthy behaviors; job-search assistance; and support to address housing and food insecurity. This approach enables FQHCs to successfully reduce health disparities. For example, nationally 13.4% of Black babies born in 2017 were low birth weight; while among FQHCs this figure was only 11.7%.³
- **Using Innovative Telehealth Technologies:** FQHCs have adopted telehealth at a much faster pace than other primary care physicians. Nationally, 13% of primary care physicians used telehealth to provide remote services for patients and 8% used telehealth to consult with other providers in 2018.⁴ That same year, these figures were 23% and 26% respectively for FQHCs. Overall, 43% of FQHCs use telehealth in some form, including nearly half

² National Association of Community Health Centers. Community Health Centers Meeting Rural Health Needs. August 2019.

³ National Association of Community Health Centers. Community Health Center Chartbook. January 2019.

⁴ Kane, C. K. & Gillis, K. The Use of Telemedicine by Physicians: Still the Exception Rather than the Rule. Health Affairs 37(12). December 2018.

(48%) of rural FQHCs. While more research is needed, initial evidence suggests that it increases access to and the timeliness of care.⁵

In addition, the National Health Service Corps has a long track record of helping rural FQHCs to recruit and retain clinicians. Unfortunately, due to low funding and recent programmatic changes, a growing number of rural FQHCs are unable to recruit NHSC clinicians.

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

Low patient volume in rural areas generally leads to higher per-capita costs and lower revenue from patient services. These financial realities, combined with geographic barriers, create significant challenges for rural organizations to recruit and retain clinicians. While rural FQHCs leverage federal, state, and private programs for recruitment and retention, these programs are generally inadequate to meet their needs. For example, in 2016 over 95% of FQHCs nationally had at least one full-time clinical vacancy, and rural FQHCs were disproportionately affected. The growing need for substance use disorder treatment in rural areas has exacerbated these shortfalls.

Historically, the National Health Service Corps (NHSC) has been the most effective national program for helping rural FQHCs recruit and retain providers. However, this program is dramatically underfunded relative to the need, and recent programmatic changes indicate that rural FQHCs will have an even harder time recruiting through the NHSC starting in 2020.

Also, the Committee should consider that “target” provider-to-population ratios should be lower in rural areas than urban ones, for two reasons:

- Geographic barriers mean that rural providers cannot reasonably serve the same number of patients as providers whose patients are located more closely.
- Many rural areas have low patient volume but relatively a relatively high number of primary care visits due to opioid addictions and other challenges.

4. What lessons can we glean from service line reduction or elimination in hospitals that serve underserved communities where —

- a. **Patients have the option to transition to alternative care sites, including community health centers and federally qualified health centers?**
- b. **There is broader investment in primary care or public health?**
- c. **The cause is related to a lack of flexibility in health care delivery or payment?**

⁵ Uniform Data System. Bureau of Primary Health Care, HRSA, DHHS.

FQHCs want to be part of any solution to address disruptions in care and closures in rural and underserved areas. However, it is important to note some limitations on FQHCs' ability to fill the gap created by the partial or complete closure of a hospital:

- As FQHCs' core mission is primary care, they generally are not equipped to assume the responsibilities of other community providers, such as emergency, skilled nursing, and inpatient care.
- FQHCs must be governed by a Board of Directors, a majority of whose members are patients of the health center. This Board must approve the FQHC adding any new roles, and must assume responsibility for overseeing any new functions that it adds.
- Some of the benefits generally associated with FQHCs – such as Federally-supported malpractice insurance and a unique payment system under Medicaid and Medicare – do not legally extend beyond primary care and outpatient dental and behavioral health services.

With these limitations in mind, FQHCs are keenly interested in being part of any solution to address disruptions in care and closures in rural and underserved areas.

5. If states or health systems have formed regional networks of care, leveraging for example systems of transport or the use of telehealth/telemedicine, what states or entities are these, what approaches did they use to form these networks, what challenges did they overcome, and what challenges persist?

Many FQHCs are members of Health Center Controlled Networks (HCCNs.) Through HCCNs, FQHCs work together to improve access to and quality of care, including through the use of data analytics to support quality measurement and improvement. In addition, HCCNs achieve cost efficiencies through the provision of management, financial, administrative, technological, training and clinical support services, and by leveraging their group purchasing power. As a result, FQHCs that participate in an HCCN are more likely than non-participants to achieve Patient-Centered Medical Home (PCMH) recognition and to use health IT for patient engagement.

Also, some rural FQHCs have formed consortia with urban providers to expand access to telecommunications and broadband service. All members of such consortia are eligible to receive funding from the FCC's Rural Healthcare Connect Fund, which provides a 65 percent discount on internet access and related services. While these consortia have been beneficial in expanding broadband access to rural FQHCs, not all urban consortia members provide clinical support to their rural counterparts. NACHC would support requiring all urban consortia members to provide remote clinical support (e.g., telehealth consults) to their rural partners as a condition of their receiving Rural Healthcare Connect Funds.

Finally, while FQHCs have adopted telehealth at a faster pace than other primary care physicians, challenges remain. The most common barrier cited by of FQHCs is the lack of insurance reimbursement. Other barriers include the lack of funding for telehealth equipment, lack of training for telehealth, and inadequate broadband service.⁵

6. What successful models show a demonstrable, positive impact on addressing workforce shortages in rural and underserved areas? What makes these models successful?

The National Health Service Corps is a highly effective program for placing and retaining clinicians in federally-designated Health Professional Shortage Areas (HPSAs). Currently, more than 13,000 NHSC providers serve 13.7 million patients residing in HPSAs, with another 1,480 medical students preparing to enter the program. Roughly 60% of NHSC clinicians serve in an FQHC, with the remainder serving many other types of safety net providers, such as Indian Health Service facilities, Critical Access Hospitals, correctional facilities, and Substance Use Disorder Treatment Facilities.⁶

The NHSC has a strong track record of attracting providers who are willing to stay in the HPSA long-term. A recent evaluation program found that 79% of NHSC providers in a primary care HPSA were still working in a HPSAs one year after completing their service requirement, and 68% stayed in a primary care HPSA after 10 years. Notably, NHSC providers serving in FQHCs have slightly higher retention rates, with 80% staying in a HPSA after one year and 72% after 10 years.⁷

Unfortunately, the NHSC is dramatically underfunded. At present, over 95% of FQHCs report at least one full-time clinical vacancy, and all FQHCs meet the eligibility criteria to recruit multiple NHSC clinicians. However, due to current limitations on NHSC funding, only a fraction of FQHCs can recruit any NHSC clinicians, and due to recent changes to the program, rural providers will face increasing difficulty in doing so.

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?

Nearly half of all FQHCs are in rural and frontier areas, and the vast majority of FQHCs offer behavioral health, substance use disorder, and dental services alongside primary care, especially in rural areas. As of 2017, 90% of health center offer behavioral health and/or substance use disorder services onsite and more than 80% offer dental. The proportion of behavioral health providers is especially high in rural states; for example, 100% of West Virginia's, South Dakota's, and New Mexico's health center organizations offer behavioral health onsite. Moreover, 61% of rural FQHCs with a telehealth program used it for behavioral health services in 2017.⁸

⁶ Health Resources and Services Administration. NHSC Builds Healthy Communities: 2019. 2019.

⁷ Negrusa, S., Hogan, P., Ghosh, P. & Watkins, L. National Health Service Corps – An Extended Analysis. Prepared by The Lewin Group, Inc. for the Assistant Secretary for Planning and Evaluation. September 2016.

⁸ National Association of Community Health Centers. Community Health Center Chartbook. January 2019.

When needed services are not offered onsite or through telehealth, FQHCs are required to provide support services that assist patients in accessing care and using it more effectively. These services often take the form of case management, education, referral to specialists, and transportation. Almost 80% of all FQHCs have case managers onsite to help patients navigate the health care system and access care.⁹

In FY18, Congress created the NHSC Substance Use Disorder (SUD) Workforce Loan Repayment Program, which offers clinicians up to \$75,000 in loan repayment in exchange for a three-year commitment to provide SUD treatment services. While this program has been very helpful to those FQHCs and other organizations who are able to recruit a clinician, as with other parts of the NHSC program, the need for clinicians far exceeds the number that can be funded under current funding levels.

8. The availability of post-acute care and long-term services and supports is limited across the nation, but can be particularly challenging in rural and underserved areas facing disproportionately large burdens of chronic and disabling conditions. What approaches have communities taken to address these gaps in care delivery and the associated challenges of social isolation?

As providers of primary and preventative care, FQHCs pride themselves on providing high-quality comprehensive care. In some instances, particularly in rural areas, FQHC providers often serve roles outside of their health center, such as care in nursing homes or long-term care facilities. In response to a growing aging population at their FQHCs, several FQHCs operate a Program for the All-Inclusive Care for the Elderly (PACE) program. With the health center focus on community-based care, PACE is a logical connection for FQHCs. However, starting a PACE program can be an undertaking for providers, especially FQHCs who often operate on narrow margins and there are often barriers to a health center starting a PACE program. NACHC would welcome the opportunity to further discuss programs such as PACE and investments in post-acute and long-term services in rural areas and the appropriate role that FQHCs might be able to provide.

9. There are known, longstanding issues with the availability and integrity of data related to rural and urban community health. What data definitions or data elements are needed to help researchers better identify the causes of health disparities in rural and underserved areas, but are unavailable or lack uniformity?

While there are issues with data in community health settings, these are not different from those of larger communities, although FQHCs have fewer resources to address them. Existing data standards are not adequate to facilitate interoperability or data liquidity because they are not harmonized across programs and agencies, which puts unnecessary burden on centers. A single

federal data dictionary should contain all the federal requirements for FQHCs to ensure alignment and to greatly reduce the burden of implementation and discover of requirements. It must include social determinants of health and a process to engage and respond to feedback by clinical users. Mappings to this dictionary would add immense value to centers as it would eliminate the need for the expertise and resources to do this locally.

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?

Efforts to strengthen safety and quality in underserved areas should begin by ensuring that there are enough clinicians in these areas. When an underserved community lacks an adequate number of clinicians to meet patients' needs, existing clinicians are stretched thin and patients cannot always access care in a timely manner.

As discussed above, a single NHSC primary care provider can serve over 1,000 underserved patients a year, at a cost of only \$25,000 to the Federal government. The demand for NHSC clinicians -- from FQHCs and other eligible providers -- far outpaces the number of clinicians that the program can support at current funding levels. For these reasons, we strongly encourage Congress to expand funding for the NHSC.

Finally, improving reimbursement for support services, home and community-based care, and care provided by alternative care team members -- e.g., peer counselors, translators, and care coordinators -- could significantly reduce higher-cost services currently performed in the clinic.

In closing, we appreciate this opportunity to share our perspective on policy options that can improve care delivery and health outcomes in rural and underserved communities. If you have any questions, please contact Steve Carey, Chief Strategy Officer, at scarey@nachc.org or 703-395-1241.