



November 29, 2019

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

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

RE: Rural and Underserved Communities Task Force Request for Information  
Submitted electronically via *Rural\_Urban@mail.house.gov*

Dear Chairman Neal and Ranking Member Brady:

On behalf of the Wisconsin Primary Health Care Association, I am pleased to respond to your request for information on Rural and Underserved Communities. We appreciate your interest in this topic as it is a critically important aspect of health care delivery and transformation.

**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 health care-related 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.

FQHCs provide medical, dental, behavioral health, and increasingly, substance abuse services. Integrated primary care is a cost-effective way to detect and treat health issues before they become more acute and expensive,<sup>1</sup> 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 that assist patients in accessing and utilizing care more effectively.<sup>2</sup> However, uncertainty about on-going Federal funding

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<sup>1</sup> 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.

<sup>2</sup> National Association of Community Health Centers. Community Health Centers Meeting Rural Health Needs. August 2019.



makes it difficult for FQHCs to make long-term plans. Ensuring that FQHCs have long-term stable funding would provide greater stability to these important organizations.

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.

Finally, there are a host of other factors that influence health outcomes within rural and underserved communities, including limited access to jobs that pay family-supporting wages, safe and affordable housing, reliable transportation, and in some cases, access to healthy, nutritious food. Better integration across federal agencies and programs that address these social factors would be helpful to local communities as they work to address systemic and complex issues.

**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:

- Addressing social determinants of health, directly and in partnership with other organizations
- Providing comprehensive, integrated care for people with multiple chronic conditions
- Providing jobs with upward mobility within the rural or underserved communities that they serve
- Creating local economic impact that directly and indirectly impacts the vitality of rural and underserved communities
- Contributing to community coalitions that are working to address interrelated and complex community problems, like addiction, lack of childcare/early childhood education, and job training.

The National Health Service Corps has a long track record of helping FQHCs in rural and underserved areas 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.

Some of the best models for innovative approaches are hatched in local communities, by engaging people from multiple sectors and mobilizing the community itself towards creative community-based solutions. As an example, in Richland Center, Wisconsin, a group called Southwest Partners<sup>3</sup> has created a Career-Education Cooperative that links high school students to local businesses for internships and school credit, is engaging in local economic development, and is now launching a community aquatic center. While none of these projects address health care directly, the projects are addressing some of the social

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<sup>3</sup> <http://www.southwestpartners.org/>



conditions needed to achieve health outcomes, reduce health disparities, and attract the health care workforce of the future.

Another example is an effort led by Milwaukee Health Services, Inc., an FQHC on the north side of Milwaukee, Wisconsin, where 40% of the county population have incomes below 200% of the Federal Poverty Guideline. The FQHC is addressing workforce challenges by partnering with the Area Health Education Center for engaging the future workforce, is providing family supports to students seeking higher education in partnership with the Social Development Corporation (local Community Action Program) and providing internships to students of employees to boost family income stability and promote job readiness. Often, there are few resources to support this kind of cross-agency partnership, but when it happens it is often very successful.

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

It is critically important that we retain access to health care 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 remain financially viable and recruit and retain clinicians. Expansion of broadband access and telehealth capabilities should enable rural providers to serve broader and more sparsely populated areas, but there are sometimes no substitutes for in-person care. One of the primary definitions of value in rural areas ought to be geographical access. As such, 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?**

As mentioned above, it is important that we retain access to care for rural and underserved communities. FQHCs can play a role in addressing ongoing needs. 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.

It would be helpful for cross-agency collaboration to ensure that creative and flexible alternatives exist. As an example, if one entity had an arm that could be supported as a Critical Access Hospital and another arm that could be supported as an FQHC, would that model have an operational, regulatory, and reimbursement pathway to operate?

**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?**

N/A

**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.<sup>4</sup>

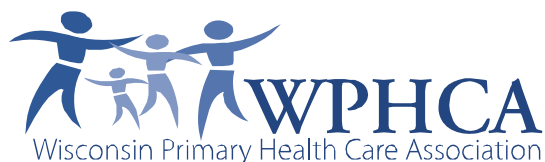
The NHSC has a strong track record of attracting providers who are willing to stay in the HPSA long-term. A recent evaluation program found that 79% of NHSC providers in a primary care HPSA were still working in a HPSAs one year after completing their service requirement, and 68% stayed in a primary 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.<sup>5</sup>

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.

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<sup>4</sup> Health Resources and Services Administration. NHSC Builds Healthy Communities: 2019. 2019.

<sup>5</sup> 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.



**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.

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.<sup>9</sup>

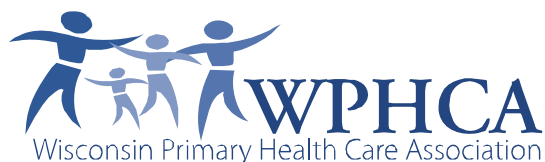
In FY18, Congress created the [NHSC Substance Use Disorder \(SUD\) Workforce Loan Repayment Program](#), which offers clinicians up to \$75,000 in loan repayment in exchange for a three-year commitment to provide SUD treatment services. While this program has been very helpful to those FQHCs and other 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 mentioned above, many FQHCs are actively engaged with community partners, such as Community Action Programs, nursing homes, schools, law enforcement, shelters, and food pantries. Despite limited resources to support such collaboration, these community coalitions are often able to begin to address community needs. Several FQHCs in Wisconsin are actively engaged in meeting the needs of community members who suffer from addiction. They have formed peer recovery groups, sober social/activity groups, and other avenues to foster better social cohesion. Social isolation is a key contributing factor in the opioid/substance use epidemic – and our long-term success in addressing this issue is tied to our creativity and ability to create social connectedness in rural and underserved communities.

**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?**

NA



**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 FQHCs and other safety net providers have long-term, stable funding in order to provide core access in rural and underserved communities. Currently 100% of federal FQHC funding is set to expire on December 20, 2019. FQHCs need the assurance that funding is secure as a way to remain operational in rural and underserved communities.

Efforts to support and grow health care workforce is also equally important. Ensuring that the National Health Service Corps has the funding to support at least one provider in every FQHC in the country would be a significant step in the right direction, even if it doesn't fully address the gaps. Equally important, we need federal partners to help us develop the workforce of the future to include new midlevel providers (e.g., dental therapists) as well as alternative care team members (peer counselors, translators, and care coordinators) could go a long way in stretching the capacity of limited numbers of physicians, advanced practice nurse practitioners, physicians assistants, certified nurse midwives, psychiatrists, and dentists.

Alignment across federal agencies designed to meet the non-health care needs (e.g., housing, employment, food, transportation) would be helpful to communities as they aim to work across sectors to meet community needs. Something relatively simple, like a common screening and intake form for all social programs, may go a long way in helping communities better coordinate needs among people living in rural or underserved areas.

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 Stephanie Harrison, CEO, at [sharrison@wphca.org](mailto:sharrison@wphca.org) or 608-277-7477.

Sincerely,

Stephanie Harrison, CEO  
Wisconsin Primary Health Care Association