

State of Maine

Primary Care Safety Net Environmental Scan

FINAL REPORT

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Strategic solutions for Maine's health care needs

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EXECUTIVE SUMMARY

Purpose of the Project and Approach

The Maine Health Access Foundation (MeHAF) contracted with John Snow Inc. (JSI) to assist the Foundation in conducting an environmental scan of the primary health care safety net in Maine. The goal of the environmental scan was to provide MeHAF with additional information about the range of health care providers that make up Maine's primary care safety net and help the Foundation target its resources to strengthen and expand the safety net.

The environmental scan addressed the following major questions:

1. What is the safety net system in Maine? What are the major components or the safety net including, primary medical care, oral health and mental health and substance abuse providers. What is the role of private-practice physicians providing uncompensated care?
2. Based on the following definition of a "medical home" (a "medical home" provides primary care and collaborates with patients and other providers to ensure that care is accessible, continuous, comprehensive, high quality, coordinated, compassionate, and delivered. Care is available 24 hours a day, seven days a week), which types of providers form the core of Maine's safety net system in terms of providing medical homes for the greatest numbers of the uninsured, underinsured, and underserved compared to other components of the safety net system? In addressing this question, the scan recognizes that the "medical home" concept is an ideal that may not be easily achieved when providing services to underserved, hard to reach populations, especially when safety net providers have limited and categorically constrained funding streams.
3. What services, if any, are not or generally not provided by existing safety net providers? Identify these gaps in terms of relevant characteristics, such as type of service, population affected, and geography?
4. Where are the Foundation's best opportunities to strengthen and expand the service capabilities and reach of existing Maine health care safety net providers?

JSI used a range of qualitative and quantitative approaches in conducting the environmental scan including: key informant interviews with nearly 50 people across the State; secondary data analysis utilizing existing reports and data available; primary data collection of components of the safety net focusing on describing the various component parts of the safety net and estimating the volume of service where not available from existing data sources; geo-mapping displaying the locations of the various types of safety net providers throughout the State; and a literature review on other safety net models

Project Limitations

The environmental scan was intended to provide MeHAF with a primer on the primary care safety net in Maine. In order to complete the study quickly and within a limited budget, the project was intentionally confined to describing the primary care safety net. MeHAF understands that the safety net must include the full scope of health care services including emergency, specialty, diagnostic and inpatient services as well as primary care, but these were outside the scope of this scan. Additionally, the scan did not include a detailed assessment of the need for safety net services in various parts of the State nor a comparison of need to available services. Looking further at other components of the safety net and quantifying the gap between need and current services are potential issues for further study.

Overview of the Primary Care Safety Net in Maine

As in most states, a major purpose of the safety net in Maine is to provide care to low income, uninsured and underinsured groups who have difficulty paying for services in the private sector. However, in many rural areas of the State, so-called safety net providers are essential to provide access for the entire population. Also safety net providers in Maine tend to serve Maine's non-English speaking and minority populations, because much of the private sector has not developed the linguistic and cultural capacity to serve these groups. Thus, the safety net in Maine has the role of filling all types of access gaps and in many rural parts of the State is the only system of care.

The environmental scan focused on primary health care services. For purposes of this project, primary care is broadly defined to include primary medical care, oral health, mental health and substance abuse. Based on this broad definition of primary care as well as the role of Maine's safety net in addressing geographic, language and financial barriers to care, many different types of provider groups make up Maine's safety net.

Primary Medical Care Providers

Many different primary medical care providers contribute to the safety net. Most of these serve as "medical homes" while others provide specific services or serve specific population groups. Key provider groups include: critical access hospitals (CAH) and other hospitals, Health Care Access Programs, Federally Qualified Health Centers (FQHC), Indian Health Service clinics, Rural Health Clinics (RHC), primary care residency programs, School Based Health Centers (SBHC), family planning clinics, public health department clinics, and free clinics. Furthermore, independent, privately practicing primary care physicians provide services to people who would otherwise access the safety net, although the extent of their contribution remains unquantified.

While the range of primary medical care providers contributing to Maine's health care safety net is extensive, considerable variation exists on how providers participate and the extent to they serve low income uninsured populations. Considerable variation also exists in the perceptions of policy-makers and different types of providers about which organizations form the core of the safety net.

Oral Health Providers

The safety net for oral health services is much more limited than the primary care safety net. It includes FQHCs (several new FQHC dental sites have been added in recent years), and a handful of non-profit organizations. Also, hygienists contribute to the safety net both through the hygienist education program and private hygienists providing direct service. Private hygienist services are limited in scope and not well understood or quantified yet. Due to the limited safety net for oral health services, low income people often turn to hospital emergency departments. However, hospitals are generally not equipped or staffed to provide oral health services so are not included as part of the safety net.

Mental Health and Substance Abuse Providers

Mental health and substance abuse services in Maine are provided by hundreds of providers that provide services across a spectrum of educational, diagnostic, crisis intervention, outpatient, inpatient, home-based and residential services. For purposes of this scan of the primary care safety net, we have focused on outpatient mental health and substance abuse counseling as the services most closely aligned to the primary care safety net. Although private practitioners and agencies clearly contribute to providing services to low-income uninsured clients, two main groups of providers comprise the safety net for outpatient mental health and substance abuse counseling services in the State: 1. FQHCs and 2. State-contracted agencies. State-contracts are issued separately for adult mental health services, children's mental health services and substance abuse services. For the most part, contracted agencies are private, not-for-profit mental health and/or substance abuse organizations, although some are multi-purpose agencies that also provide other health and human services. A few FQHCs are also among the State-contracted agencies.

Opportunities to Expand and Strengthen The Safety Net

In addition to describing the primary care safety net in Maine, the environmental scan is intended to help MeHAF target its resources to strengthen and even transform the safety net. Based on the scan, some major areas for MeHAF to consider in its future programming and grants-making activities include:

- Work to achieve greater integration among components of the safety net. Stimulating more and better collaboration among the component parts of the safety net is one place MeHAF can potentially help truly transform the safety net to make best use of the services currently available, improve quality, achieve efficiencies and ultimately lead to a true system of care both at the local level and Statewide. Opportunities for enhanced collaboration exist among all provider groups but are particularly urgent among mental health and substance abuse providers and between mental health, substance abuse and primary care.
- Support capacity development both through new safety net providers and enhanced capabilities within current providers. Greater collaboration is critical to strengthening Maine's safety net, but can not alone address all the gaps in services or unmet needs.

Some of the most critical needs noted in the scan include mental health counseling for adults and adolescents who are not diagnosed as seriously and persistently mentally ill, mental health and substance abuse services specifically focused for older adults, substance abuse counseling for people who have not come through the criminal justice system, psychiatry for children in the northern part of the State, and oral health services, particularly for adults, Statewide.

Providers need operating funds to support safety net services either to cover the costs of serving additional uninsured patients and/or providing non-reimbursable supportive services that are essential to effective access. MeHAF should continue to help programs obtain operational funding to enhance capacity; by supporting demonstration projects that position providers for more substantial funding, assisting in grant writing through educational forums or one-on-one assistance, or providing start-up funding for programs that can become self-sustaining.

MeHAF can also support activities that expand capacity without funding for new programs or services. For example, sharing “best practice” approaches and providing training to assist general medical providers provide some mental health and substance abuse services within the primary medical care setting (or conversely helping mental health and substance abuse providers identify primary medical care issues) can help extend capacity in key areas.

- Increase involvement of providers who may not normally be considered part of the safety net. Many providers are involved in providing safety net services, but are not always identified as being part of the safety net. These include hospitals and their physician practices, RHCs, primary care residency programs and independent private practitioners. Involving more diverse provider groups in discussions and initiatives related to the safety net could be accomplished by convening meetings including these groups or for these groups, as well as encouraging funding applications from places that have not historically applied for Foundation funding.

Involving independent private practitioners including physicians, licensed mental health and substance abuse professionals, dentists and hygienists represent a special challenge because they are so disperse and their practices are so variable. MeHAF could help involve more private practitioners in organized and coordinated care systems by building on the approach taken and lessons learned by the exiting Health Care Access Programs. These programs have been successful in organizing volunteer providers into care systems for the uninsured and are one important way to bring committed individuals into the system and support them.

- Move the Dialogue beyond Primary Care to Encompass all Safety Net Providers.

Additional efforts to integrate primary care components of the safety net are important to transforming the safety net system. However, until all components of the system (primary care, specialty care, hospital services, residential/long term care, home care etc) are strong and work together, the system will remain extremely fragile. Critically, recruiting and retaining the health professionals that sustain the safety net depends on having resources across the spectrum of care. While systemic change is inevitably a long-term, complex process, MeHAF has an opportunity to provide leadership in strengthening the full safety net system by better portraying the complete story of the safety net and taking a role in facilitating dialogue, joint planning and strategy development at community and State level.

I. PROJECT PURPOSE APPROACH AND ACTIVITIES

A. Purpose of the Project

The Maine Health Access Foundation (MeHAF) contracted with John Snow Inc. (JSI) to assist the Foundation in conducting an environmental scan of the primary health care safety net in Maine. The goal of the environmental scan was to provide MeHAF with additional information about the range of health care providers that make up Maine's primary care safety net and help the Foundation target its resources to strengthen and expand the safety net.

The environmental scan addressed the following major questions:

1. What is the safety net system in Maine? What are the major components or the safety net including, primary medical care, oral health and mental health and substance abuse providers. What is the role of private-practice physicians providing uncompensated care?
2. Based on the following definition of a "medical home" (a "medical home" provides primary care and collaborates with patients and other providers to ensure that care is accessible, continuous, comprehensive, high quality, coordinated, compassionate, and delivered. Care is available 24 hours a day, seven days a week), which types of providers form the core of Maine's safety net system in terms of providing medical homes for the greatest numbers of the uninsured, underinsured, and underserved compared to other components of the safety net system? This definition of "medical home" was developed by the American Academy of Pediatrics (AAP) and has been adopted by the American Academy of Family Physicians (AAFP) and the federal Maternal and Child Health Bureau (MCHB) of the Health Resources and Services Administration (HRSA). The study recognizes that the "medical home" concept is an ideal that may not be easily achieved when providing services to underserved, hard to reach populations especially when safety net providers have limited and categorically constrained funding streams.
3. What services, if any, are not or generally not provided by existing safety net providers? Identify these gaps in terms of relevant characteristics, such as type of service, population affected, and geography?
4. Where are the Foundation's best opportunities to strengthen and expand the service capabilities and reach of existing Maine health care safety net providers?

B. Approach

JSI used a range of qualitative and quantitative approaches in conducting the environmental scan. Specifically our approach included:

- **Key Informant Interviews:** At the outset of the project JSI conducted a series of key informant interviews among key stakeholders in the State. These initial interviews were intended to provide JSI with an overview of the various components of the safety net as well as perceived gaps in safety net services. Additional interviews were conducted throughout the project to gain information about specific provider groups. A list of people

interviewed is included in Appendix 1. Most of the initial interviews were conducted in-person, although some were conducted by telephone based on the interviewees schedule and preference. The interviews were conducted using a structured interview guide, but allowed for open discussion. Issues addressed included: expectations/goals for the project; the interviewees role in the safety net; components of the safety net known to the interviewee; perceived strengths of the safety net; perceived gaps in the safety net; and perceived challenges in the development and maintenance of a strong safety net system.

- **Secondary Data Analysis:** JSI reviewed existing reports and data available in the State related to the safety net and uninsured, under-insured and underserved populations. Data sources and reports reviewed are listed in Appendix 2: data on population demographics; relevant State surveys and research reports; the Bureau of Primary Health Care’s Uniform Data Set (UDS) consolidated reports for FQHCs and NHSC sites in Maine and comparable health centers; reports from other federal programs such as the Title X family planning programs; and, epidemiological information.
- **Primary Data Collection of Components of the Safety Net:** Primary data collection focused on describing the various component parts of the safety net and estimating the volume of service where not available from existing data sources. This information was collected through interviews with a sample of providers. The information collected helped to give a comprehensive picture of the safety net, by describing the extent to which various components of the safety net serve as “medical homes”, identifying gaps in services and defining current service levels for providers serving as “medical homes”. Descriptive data for each group of providers contributing to the safety net includes: organization type, services offered, service locations and geographic area covered, population served, and any policies that impact on services to the uninsured. The description of providers serving as “medical homes” also includes estimates of the volume of services, where the information was possible to collect.
- **Geo-mapping:** JSI developed maps that display the locations of the various types of safety net providers throughout the State. Although many maps of different provider groups existed prior to this project, JSI developed a comprehensive set that can be used interactively to further understand the safety net. These are included in Appendix 3. Appendix 4 lists providers by group with addresses.
- **Literature Review/Information on Other Models:** A literature review was conducted at the outset of the project and consulted for answering all the questions. The literature review provided many of the documents used in the secondary data analysis.

C. Project Limitations

The environmental scan was intended to provide MeHAF with a primer on the primary care safety net in Maine. In order to complete the study quickly and within a limited budget, the project was intentionally confined to describing the primary care safety net. MeHAF understands that the safety net must include the full scope of health care services including emergency, specialty, diagnostic and inpatient services, as well as primary care, but these were outside the

scope of this scan. Additionally, the scan did not include a detailed assessment of the need for safety net services in various parts of the State, nor a comparison of need to available services. Looking further at other components of the safety net and quantifying the gap between need and current services are potential issues for further study.

II. OVERVIEW OF PRIMARY CARE SAFETY NET IN MAINE

A. The Need for a Primary Care Safety Net in Maine

The primary health care safety net in Maine has the role of providing access for people who have difficulty accessing or using health services. As in most states, a major purpose of the safety net in Maine is to provide care to low income, uninsured and underinsured groups who have difficulty paying for services in the private sector. However, in many rural areas of the State, so-called safety net providers are essential to provide access for the entire population. Also safety net providers in Maine tend to serve Maine's non-English speaking and minority populations, because much of the private sector has not developed the linguistic and cultural capacity to serve these groups. Thus, the safety net in Maine has the role of filling all types of access gaps and in many rural parts of the State is the only system of care.

Low-income uninsured and underinsured populations often face the most serious barriers to accessing health care. For the 2000 census, Maine had a total population of 1,274,923. Just under 11% of the population (about 138,967 people) live in poverty as defined by having annual incomes less than 100% of the Federal Poverty Level (FPL). Approximately 29.5% (about 376,102 people) have incomes below 200% FPL, which is the income level typically used to define low income for purposes of the health care safety net. These percentages range by county with the lowest percentages mostly in the southern parts of the State (Cumberland County has the lowest percentages in both categories) and the highest percents in the north (Washington County has the highest percentages in both categories). Appendix 5 contains an analysis of population demographics and poverty levels by county. Predictably, people with low incomes are much more likely to be uninsured than the population overall. Based on the 2004 data from the Kaiser Family Foundation, overall, 10% of Maine's population is uninsured. The rate is 12% among the non-elderly population (about 131,430 people). Of non-elderly people who are uninsured 51% (about 67,029 people) have incomes below 200% FPL. Nineteen percent (19%) of Maine residents (about 249,710 people) receive Medicaid benefits.

Maine's 2000 Behavioral Risk Factor Surveillance System (BRFSS) shows that other characteristics of Maine's uninsured population are similar to national averages. Men are slightly more likely to be uninsured than women (15.6% of men and 10.1% of women on the 2000 BRFSS were uninsured). Also younger adults are more likely to be uninsured than older adults. For Maine, approximately 25% of people age 18-24 are uninsured. This decreases to about 15% in the 35-54 age group and to less than 2% in people over 65. Maine's 2000 BRFSS does not report uninsurance rates by race but nationally, Hispanics have the highest rates of uninsurance (45%), Blacks and other minorities have uninsurance rates of about 25% and Whites are least likely to be uninsured with national rates of 12%. Among non-citizens, uninsurance rates are

typically also very high, in the 40-50% range. As Maine's minority population grows, it is likely the State will experience similar rates among these population groups.

The BRFSS also documents one of the effects that lack of health insurance has on access to care. The survey asks "was there a time in the last 12 months that you needed to see a doctor but could not because of cost?" Not surprisingly, people responding "yes" to this question are disproportionately uninsured. Overall about 11% of the surveyed population in Maine responded "yes" to this question (compared to 9% nationally). People who were most likely to respond "yes" to this question were low income (27% of those with incomes less than 15,000 responded "yes" compared with only 3% with incomes over \$50,000) and young (about 15.5% of those under 34 responded "yes" while the rates were 5%-11% in those over age 45). Although the numbers are small, Hispanics are also much more likely to respond "yes" than other racial categories (about 31% of Hispanics responded "yes" compared to about 10% for all other groups). The recent series of reports by the Institute of Medicine on the Consequences of Uninsurance, Kaiser Family Foundation reports and others further and indisputably document the devastating impact lack of health insurance has on people's health. These reports conclude that people without health insurance are less likely to receive timely preventive care, receive less timely and comprehensive treatment for chronic illnesses, experience higher mortality rates, and are more likely to be hospitalized for avoidable health problems and when hospitalized are more likely to die than their insured counterparts.

Maine has recognized the devastating impact lack of health insurance has on individuals and communities and has made universal coverage of all Maine residents a State priority. The Dirigo Health Reform Act (Dirigo) is making health insurance more affordable for more people. The full impact of Dirigo is still in the future and the ultimate success it will have in reducing uninsurance rates is unknown. It is probable that Maine will continue to need a safety net for people without health insurance for many years to come. In any event, building a strong safety net system benefits the health care system overall and everyone who uses it.

B. Safety Net Provider Types

The environmental scan focused on primary health care services. For purposes of this project, primary care is broadly defined to include primary medical care, oral health, mental health and substance abuse. As noted under "limitations" above, the study did not specifically address emergency, specialty, diagnostic or inpatient services, although these are recognized as critical components of any health care safety net. Because there are unique and complex issues related to obstetric and gynecological (OB/GYN) services, and because the services are often provided by people with specialized training, OB services were not specifically addressed in the project. However, where information was provided related to prenatal or OB services for a specific type of provider, this information is presented.

Based on this broad definition of primary care as well as the role of Maine's safety net in addressing geographic, language and financial barriers to care, many different types of provider groups make up Maine's safety net.

B1. Primary Medical Care Providers

Many different primary medical care providers contribute to the safety net. Most of these serve as “medical homes” while others provide specific services or serve specific population groups. Key provider groups include: critical access hospitals (CAH) and other hospitals, health care “access” programs, Federally Qualified Health Centers (FQHC), Indian Health Service clinics, Rural Health Clinics (RHC), primary care residency programs, School Based Health Centers (SBHC), public health department clinics, family planning clinics and free clinics. Furthermore, independent, privately practicing primary care physicians provide services to people who would otherwise access the safety net, although the extent of their contribution remains unquantified.

While the range of primary medical care providers contributing to Maine’s health care safety net is extensive, considerable variation exists on how providers participate and the extent to they serve low income uninsured populations. Considerable variation also exists in the perceptions of policy-makers and different types of providers about which organizations form the core of the safety net. There is general agreement that certain types of provider organizations are definitely part of the safety net in Maine. These are places that are required to serve uninsured or under insured patients in return for receiving grant funding, loan forgiveness and/or special designation status. Among primary care providers, such organizations include: FQHCs (Federally-funded and Look-Alike); “Automatically Designated” Rural Health Clinics (RHCs), also know as “safety net” RHCs; J-1 or National Health Service Corps (NHSC) providers; School-Based Health Centers and family planning clinics. There is also general agreement that a second group of organizations are part of the safety net based on explicit missions to serve the uninsured. These include free clinics and “access” programs that bring together networks of private providers.

Other organizations and providers are also definitely part of the safety net, but there is less consensus within the State on the role these providers play. First, the State’s primary care residency programs and particularly the family practice residencies are seen by many as an important part of the safety net based on a history of serving a significant number of uninsured and Medicaid (MaineCare) patients. There is also debate about the extent to which hospitals (CAH and others) are part of the primary care safety net. By law, Maine hospitals must provide medically necessary hospital services free of charge to individuals at 100% of the Federal Poverty Level (FPL) or below. However, the majority of hospitals go well beyond this requirement. The hospitals’ free and reduced care policies typically extend to all aspects of the hospital system including employed primary care and physician services. Hospitals also provide laboratory and diagnostic services for other safety net providers such as FQHCs, free clinics and access programs.

Hospitals in Maine are clearly involved providing primary care for low income patients through their employed physician practices. In addition to employing many primary care physicians and operating primary care practices, there are 34 Emergency Departments and 3 Trauma Centers maintained by Maine Hospitals. *The National Report Card on the State of Emergency Medicine*, released in 2006 by the American College of Emergency Physicians, ranked Maine 8th among states for support of its emergency care system. The State scored highest (“Grade A”) in the category of *Access to Emergency Care*. While Emergency Departments are not intended to be

part of the primary care safety net, often they may be the provider of last resort. Maine's State Health Plan issued by the Governor's Office of Health Policy & Finance in 2004 states the following:

In 2000, Maine's rate of emergency room use was 43 percent higher than the national average and substantially higher than either New Hampshire's or Vermont's. This statistic suggests that many Mainers are using the emergency room to obtain primary care services, which is neither the most cost-effective nor the highest quality source of primary health care services. It is also a form of primary health care delivery that Maine is unlikely to be able to sustain.

The State Health Plan specifically cites as an area of concern the use of hospital emergency departments as a resource for mental health crisis intervention. The first objective contained in the State Health Plan is to *Develop strategies to reduce the use of emergency departments for Mainers experiencing a psychiatric crisis.*

The Maine Health Information Center also issued a report in 2004 on Emergency Department use by the MaineCare population. The study found that among 143,299 MaineCare-only members, 55,860 members (39 percent) had at least one ED visit and 25,930 members (18 percent) had multiple ED visits during FY2003. The report also cites comparative national data for the adult Medicaid population from *Health, United States, 2003*. Among U.S. adults age 18-64 covered by Medicaid, the percent using the hospital emergency department at least once during the year (39.7 percent) was more than double the rate for the uninsured (19.9 percent) or private-insured (17.2 percent). Adults covered by Medicaid were also more likely to have two or more ED visits (21.7 percent) during the year compared to the uninsured (6.6 percent) or private-insured (4.7 percent). The Maine study found significant regional variation in use rates of ED use. Health Service Areas (HSAs) with the highest rates included Caribou, Pittsfield, Fort Fairfield, Houlton, Belfast, Calais, Rumford, and Skowhegan HSAs while lowest rate areas included Biddeford, Augusta, Machias, Portland, Brunswick, Bridgton, Fort Kent, and York HSAs. The study further found that:

MaineCare members used the ED for a wide variety of reasons including, ear infections, respiratory and viral infections, minor sprains and strains, back problems, dental problems, asthma, gastrointestinal disorders, neuroses and depression. Many of these problems can be treated by a visit to a physician office or mental health specialist instead of the hospital ED.

Finally, there is debate within the State about the extent Rural Health Clinics (RHCs) contribute to the safety net. RHCs are not legally mandated to offer access to services to patient's regardless of their ability to pay, unless they receive "Automatic Designation" (refer to PL 107-251, S. 1533), . Of the approximately 45 RHCs, according to the Federal designation office, 10 have Automatic Designation status. However, the majority of all RHCs maintain formal or informal policies for free or reduced health care services. Many RHCs are operated by hospitals and the hospital reduced fee policies are typically extended to the RHCs.

B2. Oral Health Providers

The safety net for oral health services is much more limited than the primary care safety net. It includes FQHCs (several new FQHC dental sites have been added in recent years), and a handful of non-profit organizations. Also, hygienists contribute to the safety net both through the hygienist education program and private hygienists providing direct service. Private hygienist services are limited in scope and not well understood or quantified yet. Most people do not view private dentists as part of primary care safety net, as they provide only limited services to the Medicaid population and almost none to the uninsured. Similarly, hospital emergency departments are not generally viewed as part of the safety net. Due to the limited safety net for oral health services, low income people often turn to hospital emergency departments. However, hospitals are generally not equipped or staffed to provide oral health services so are not included as part of the safety net.

B3. Mental Health and Substance Abuse Providers

Mental health and substance abuse services in Maine are provided by hundreds of providers that provide services across a spectrum of educational, diagnostic, crisis intervention, outpatient, inpatient, home-based and residential services. For purposes of this scan of the primary care safety net, we have focused on outpatient mental health and substance abuse counseling as the services most closely aligned to the primary care safety net. Although private practitioners and agencies clearly contribute to providing services to low-income uninsured clients, two main groups of providers comprise the safety net for outpatient mental health and substance abuse counseling services in the State: 1. FQHCs and 2. State-contracted agencies. State-contracts are issued separately for adult mental health services, children's mental health services and substance abuse services. Considerable overlap exists among agencies receiving State funding for adult and children's mental health outpatient counseling services; there is less overlap between mental health and substance abuse providers. For the most part, contracted agencies are private, not-for-profit mental health and/or substance abuse organizations, although some are multi-purpose agencies that also provide other health and human services. A few FQHCs are also among the State-contracted agencies.

III. SAFETY NET PROVIDERS

As discussed above, the environmental scan separates providers into three broad categories: primary medical care providers, oral health providers and mental health and substance abuse providers. Furthermore, among primary medical providers, some function as "medical homes", while others provide specific services. Within each category a number of provider types contribute to the safety net. This section describes each of the provider types in more detail. In addition, two matrices summarize key provider characteristics: one matrix summarizes primary care safety net providers that also serve as "medical homes"; the second summarizes safety net providers that do not serve as "medical homes". The discussion of medical home attributes in each provider group, recognizes that the full definition of a "medical home" as defined by the American Academy of Pediatrics and HRSA, is an ideal that can rarely be achieved given characteristics of the population served and/or limitations on services due to financial

constraints. The discussion is intended to help identify where the system could be strengthened rather than judge the current operations of a particular provider group.

The provider overviews and matrices summarize:

- Services The specific services each provides. This helps define which groups are or have the potential to serve as “medical homes”.
- Components of Medical Home: The degree to which primary medical provider groups address the key elements of a “medical home” including accessibility, comprehensiveness, continuity and cultural competence. Provider groups that do not provide general primary care medical services are not included in the “medical home” analysis because, by definition, they cannot be considered a “medical home”. This distinction does not make them any less important to the safety net.
- Obligation to Participate: The basis on which providers participate in the safety net: e.g. are they obligated to provide services to low income uninsured patients due to Federal or State laws and/or terms in the grant or contract; does their mission explicitly state their intention to serve underserved populations; or, are they voluntarily providing care without the mandate of funding requirements or mission? While the basis on which providers participate in the safety net does not in itself determine the extent of their participation, it does effect the public’s perception of their role in the safety net. It may also impact the degree to which policies facilitating access are publicized and actively implemented.
- Population: The target population served.
- Service Volume: For providers serving as “medical homes” the volume of services provided by a provider group on an annual basis. Actual data is used when possible, estimates when actual data is not available.
- Gaps: Geographic coverage of a given provider group. Geographic gaps in coverage are identified. Gaps for particular population groups are also identified.

A. Safety Net Organizations Serving As Medical Homes

Descriptions by Provider Group

A1. Federally Qualified Health Centers

Provider Group Overview:

A Federally Qualified Health Center (FQHC) is a federal designation assigned by the US Department of Health and Human Service’s (DHHS). Most FQHCs receive grant funds under Section 330 of the Public Health Service (PHS) Act to support the provision of comprehensive primary health care services. Depending on the population served by the FQHC, an FQHC may receive 330 funding as a Community Health Center (CHC), Migrant Health Center (MHC),

Health Care for the Homeless Center (HCH), School-Based Health Center (SBHC), or Public Housing Primary Care Center (PHPC). FQHCs that do not receive Section 330 grants are known as “Look-Alikes” in that they meet all of the same eligibility requirements as funded grantees. Look-Alikes are eligible for many of the benefits conferred by FQHC status.

FQHC status provides an array of benefits to health care organizations that operate in underserved, high need areas and/or serve high need, underserved populations in order to expand access to quality, comprehensive primary care services. Health care organizations that have FQHC status receive enhanced reimbursement from Medicare and Medicaid. FQHCs that receive 330 funds can also be covered under the Federal Tort Claims Act (FTCA), which allows certain health center employees to be deemed as federal employees and thus have malpractice coverage. Finally, FQHCs may participate as covered entities in the drug pricing program established by Section 340(b) of the PHS Act, which insures that eligible organizations have access to drugs at the lowest available prices. FQHC Look-Alikes are eligible for enhanced Medicare and Medicaid reimbursement and 340(b) drug pricing, but not FTCA coverage.

In order to qualify as an FQHC, an organization must meet several essential elements that distinguish it from other types of providers. FQHCs are required to:

- Be located in or serve a high need community, (i.e., “medically underserved areas (MUA)” or “medically underserved populations (MUP)”);
- Provide, either directly or through contracts or cooperative arrangements, a broad range of primary care services inclusive of medical, dental, mental health and substance abuse services, as well as supportive services, such as case management, translation and transportation services, that promote access to health care;
- Make services available to all residents of its service or “catchment” area, with fees adjusted based upon a individual’s ability to pay; sliding fee scales must be offered for people with incomes up to 200% of the Federal Poverty Level (FPL);
- Operate under the direction of a governing board with a majority of directors who are users of the center and who represent the diversity of individuals being served by the center; and
- Meet other performance and accountability standards regarding its administrative, clinical, and financial operations.
- Health centers operated by a tribe or tribal organization pursuant to the Indian Self-Determination Act or urban Indian organizations that receive funding under Title V of the Indian Health Care Improvement Act are also designated as FQHCs. (See discussion of Indian Health Service sites).

FQHCs provide health services to underserved populations. This includes all people who face barriers in accessing services because they have difficulty paying for services, because they have language or cultural differences, or because there is an insufficient number of health

professionals or health resources available in their community. Underserved populations also include people who have disparities in their health status. Some health centers may focus on specific special populations such as homeless people, migratory and seasonal farmworkers, residents of public housing, or at-risk school children, while most serve a cross-section of the population in their communities. The specific population groups to be served by a health center are defined by that health center through a process of assessing the needs, resources and priorities in their community and determines the type of Section 330 funding they receive.

As of 2004, there were 19 Federally-funded FQHC organizations and one FQHC Look-Alike that collectively operate more than 60 distinct community based clinical sites in Maine.¹ Seventeen (17) of the 19 FQHCs that receive Federal funding receive Section 330 funds. The remaining two organizations serve Native American populations and receive funds under Title V of the Indian Health Care Improvement Act. Of those organizations that receive 330 funds, 15 serve the general population. One of the organizations, Health Care for the Homeless in Portland, serves exclusively the homeless population, and another, Migrant Health Program, Inc., serves exclusively the migrant population. The FQHC Look-Alike organization provides services in more than a dozen clinic sites.

In 2004, the 14 FQHCs organizations that received 330 funds employed roughly 210 FTE providers who provided primary care medical services. FQHCs employed only 1.35 OB/GYN physicians but six health centers provide prenatal care utilizing family practitioners or nurse midwives in addition to the OBs. In 2004, the funded FQHCs provided prenatal care to a total of 447 patients and delivered 266 babies.

These organizations also employed approximately 20 FTE oral health providers and 20 FTE providers that provided behavioral health services. Over the past few years FQHCs in Maine have made significant efforts to increase behavioral health and oral health capacity, but despite the success of these efforts capacity is still extremely limited.

In 2004, Maine's FQHCs had patient care expenditures (not including costs of facilities and administrative overhead) totaling \$22.9 million. \$19.2 million were for primary care medical services, \$1.9 million were for oral health services, \$1.2 million were for mental health services, and \$600,000 were for substance abuse services.

“Medical home” Characteristics:

- **Accessible.** FQHCs are required to develop services and systems that help to ensure access to quality health services to underserved populations who face barriers in accessing services because they have difficulty paying for services, have language or cultural differences, or because there is an insufficient number of health professionals or health resources available in their community. FQHCs are also expected to develop services that address and reduce the health disparities that exist between segments of the population.

¹ Information is based on the clinics cited in the organizations annual Uniform Data System (UDS) Report, 2004.

FQHCs must provide access to services without regard for a person's ability to pay. FQHCs are required to have a sliding fee scale for those who are uninsured and who have incomes below 200% FPL. FQHCs must also offer interpretation services for people with limited English-speaking ability and provide assistance with transportation, if necessary.

- **Continuous.** Although specific arrangements vary by community, FQHCs are expected to ensure that their patients have access to emergency services 24 hours a day, 7 days a week and to provide coverage for their hospitalized patients.
- **Comprehensive.** FQHCs are expected to provide directly or through contracts a comprehensive array of basic health services including: primary care, laboratory and radiologic services, emergency services, oral health services, mental health/substance abuse services, and a full array of preventive services. All health centers are also expected to provide appropriate case management, health education, outreach, transportation and interpretive services which help to ensure access to these basic health services.
- **Coordinated.** All health centers are expected to develop systems and provide services which help ensure quality and access to comprehensive health services. FQHCs are expected to have ongoing referral arrangements with specialty providers and with one or more hospitals and to develop systems that facilitate access to these services and all appropriate social services. Health centers are required to provide case management services to help coordinate care.
- **Culturally effective.** Health centers are expected to ensure that services, programs, and systems are developed that ensure full and equal participation of the diverse cultures in their community, including participation of persons with limited English-speaking ability.

Obligation to serve the Uninsured/Underinsured:

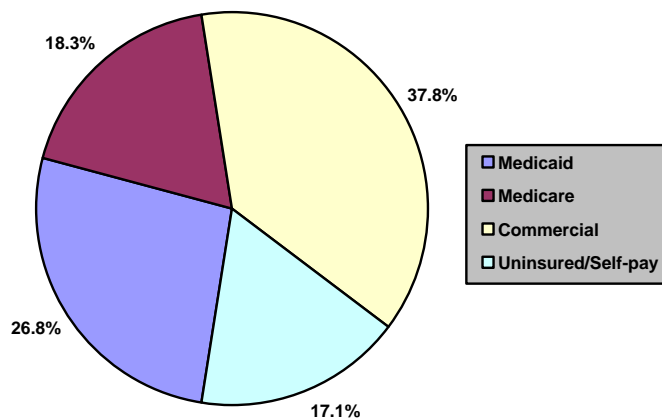
FQHCs have a regulatory and contractual responsibility to provide access to quality, comprehensive, coordinated, and culturally appropriate services to uninsured, low income populations without regard for a person's ability to pay.

Population Served:

FQHCs serve a broad population of insured and uninsured individuals but their target are the low income, uninsured populations, as well as those who are insured by Medicaid. The following is the distribution of insurance status of those throughout Maine who are served by the network of FQHCs for the 2004 reporting year.

In 2004, FQHCs in Maine provided primary care medical services to 83,208 individuals through 312,113 distinct medical service encounters. These same organizations also provided mental health, substance abuse and oral health services. See the table below for an account of the number of distinct patients and the number of visits in each of these service categories.

Federally Qualified Health Centers
Distribution by Insurance Status and Insurance Type
2004



	Medical Services	Oral Health Services	Mental Health Services	Substance Abuse Services
Unduplicated Patients	83,208	10,879	3,098	684
Visits	312,113	22,768	14,543	6,167

Geographic Coverage and Service Gaps:

19 FQHC entities and 1 FQHC Look-Alike operate more than 60 clinic sites in 14 of Maine’s 16 counties. Clinic sites are well distributed through out the State, particularly in the South and Central areas of the State, and particularly outside of the State’s primary population centers. Most of the sites are full service clinics and provide a broad array of primary care services. A number of the sites serve specific populations or are specialty clinics such as women’s health, dental, substance abuse or foot clinics. In many areas FQHC sites make up the core of the primary care safety net. These organizations often play a significant role in planning and local policy and are supported by the areas hospitals. Seven of the 20 FQHC organizations operate small networks of 2 or 3 clinic sites and 4 of the organizations operate large networks, ranging from 5 to 16 clinic sites. The remaining nine FQHC organizations are smaller organizations that operate out of single clinic locations.

FQHCs are major referral sources for social service providers in their areas and may also be a referral source for private health care providers who are unable to meet the needs of all of the low income, uninsured populations in their areas, given the fact that they do not receive grant subsidy or the benefits related to reimbursement that FQHCs are provided.

FQHCs play a major role in the State but by no means are they located in every community and in many areas they are not necessarily the dominant provider. This is particularly true in Maine’s most populated areas as well as Maine’s least populated areas. In Maine’s southern most counties (York and Cumberland), where more than one-third of the State’s population

resides, the safety net tends to be dominated by a network of privately funded providers, anchored by large hospitals and their affiliated primary care clinics, including a number of free clinics. In the least populated, extremely rural areas of the State, the safety net tends to be dominated by rural health clinics that are often affiliated with the State's Critical Access Hospitals. Capacity in many of the State's least populated areas is often reinforced by a network of National Health Service Corps (NHSC) placements and J-1 Visa physicians who receive certain benefits for serving in underserved areas.

A2. Indian Health Service Sites

Provider Group Overview:

The Indian Health Service (IHS) is an agency within the Department of Health and Human Services and is responsible for providing health services to American Indian and Alaskan Native (AI/AN) people. The IHS is the federal health provider and health advocate for the AI/AN people and its goal is to assure that that comprehensive, culturally acceptable, personal, and public health services are available and accessible to AI/AN people. The mission of the IHS, in partnership with the AI/AN people, is to raise the physical, mental, social, and spiritual health of AI/AN populations to the highest level.

As of 2002, the IHS funds 49 hospitals and 545 ambulatory facilities, including health centers, school-based centers, health stations, and Alaska village clinics. 36 of the hospital and 110 of the health centers are operated directly by IHS, while the remaining are funded by IHS but are operated by tribes or independent organizations in urban areas.

There are five sites in Maine that are funded by the Indian Health Service (IHS). These sites are not operated by IHS but rather by four federally recognized Tribal groups in the State; the Maliseet, the Micmac, the Passamaquoddy, and the Penobscot. As mentioned above, all five of these sites receive funds from the IHS. All are also designated as FQHCs pursuant to the Indian Self-Determination Act, but none of the sites currently receive any 330 Funds. One of the sites is a National Health Service Corps (NHSC) site and has hired a provider who is in the Loan Repayment Program.

With respect to Medicaid reimbursement, American Indian and Alaskan Native (AI/AN) populations are entitled to equal access to services covered by state Medicaid programs for all persons found eligible under the states' Medicaid plans. These services are reimbursed at the standard Medicare all-inclusive rate, which is set to ensure that providers are able to cover 100% of their cost of providing services. This rate is typically higher than the FQHC cost-based rate. IHS sites could, if they wanted, be reimbursed at the FQHC rate but since most sites are reimbursed at a higher rate using the all-inclusive rate they rarely, if ever, do. All of the organizations operate out of single clinic sites. All of the clinics provide comprehensive primary care services to their Tribal members and most also serve members of other federally recognized Tribes who reside in the area. Sites funded by the IHS are expected to have full referral networks for specialty and in-patient services. Sites also provide broad case management services and most also have public health programming that provides education regarding clean water, sanitation, and other environmental and public health issues.

According to the US 2000 Decennial Census, there are 13,156 American Indians residing in Maine, including those that report as AI/AN and one or more other races. 7,316 people report as AI/AN alone. Most reside on tribal reservations in very rural areas of Northern Maine and in the Downeast region. Following is a listing of the programs, along with their tribal affiliation and the location of their clinics. The project team was not able to get data describing the number of patients served or the payer mix for these sites.

- Pleasant Point Health Center, Passamaquoddy Indians, (Perry)
- Indian Township Health Center, Passamaquoddy Indian Tribe (Princeton)
- Penobscot Indian Nation Health Department, Penobscot Indian Tribe (Old Town)
- Houlton Band of Maliseet Indians Ambulatory Care Clinic (Houlton)
- Aroostook Band of Micmac Indians Ambulatory Care Clinic (Presque Isle)

“Medical home” Characteristics:

- **Accessible.** All of the IHS sites are operated by tribal groups and serve all members of their Tribe. A number of the sites also serve members of other federally recognized Tribes who reside in the area.
- **Continuous.** Specific arrangements vary by site, however, IHS funded sites are expected to ensure that their patients have access to emergency services 24 hours a day, 7 days a week and to provide coverage for their hospitalized patients.
- **Comprehensive/Coordinated.** IHS sites expected to provide a comprehensive array of primary care services including: preventive services, acute care, laboratory, and radiologic services. In addition, they are expected to ensure through contracts or referral arrangements a full continuum of specialty care and in-patient services. IHS sites are also expected to provide appropriate case management, health education, outreach, and transportation services as well as other environmental and public health services such as education related to sanitation and clean water.

Obligation to serve the Uninsured/Underinsured:

IHS tribal sites are obligated to serve members of their Tribe. Most sites also provide services to members of other federally recognized Tribes that reside in their areas.

Population Served:

The IHS sites serve predominantly members of the Tribe that operate the site. A number of the sites also serve members of other federally recognized Tribal groups. According to the US 2000 Decennial Census, there are 13,156 American Indians residing in Maine, including those American Indian populations that report as being two or more races. IHS sites serve a large portion of this population in but significant proportions of the AI/AN population are also served by other facets of Maine’s healthcare system.

Geographic Coverage and Service Gaps:

As mentioned above, most AI/AN people in the State reside on tribal reservations in very rural areas of Northern Maine (Aroostook County) and in the Downeast region (Penobscot County). Statewide, in 2000 only 6/10ths of 1% of the population was AI/AN alone. In Aroostook, 1.4% of the population is AI/AN and in Penobscot 1% of the population is AI/AN. In all other counties the proportion is on average ½ of 1%.

A3. Primary Care Residency Clinics

Provider Group Overview:

There are seven primary care residency programs operated by five academic hospitals. Collectively, the residency programs provide comprehensive primary care services in more than a dozen primary care clinics in six of Maine's communities. The residency programs are located predominantly in the south and south central portions of the State in Maine's most populated areas. Most of the programs operate out of single clinic sites. One of the programs has two clinic locations, and one has multiple locations. The following is a listing of the programs, along with their hospital affiliation and the location of their clinic(s).

- Central Maine Medical Center, Family Medicine Residency (Lewiston)
- Eastern Maine Medical Center, Family Practice Residency Program (Bangor)
- Maine-Dartmouth Family Practice Residency (Maine General) (Augusta and Waterville)
- Maine Medical Center Residency Program (Maine Health) (Portland)
 - Family Medicine
 - Internal Medicine/Pediatrics
 - Internal Medicine
 - Obstetrics and Gynecology as well as many sub-specialties
- University of New England College of Osteopathic Medicine (UNECOM) Family Practice Residency Program (Biddeford)

A comprehensive array of primary care medical services are provided by both residents in training as well as fully licensed providers. Many of the family practice residency programs as well as Maine Medical's OB residency are also significant providers of safety net OB services. Maine's residency programs serve a disproportionate number of uninsured, those insured by Medicaid and non-English speaking patients and are important players in the State's safety net both for the services they provide and because many of their graduates remain in Maine to practice. While data was not available from all the residency programs, those that did supply data estimated that at least 50% of the patients they serve are MaineCare patients with estimates over 90% for pediatric patients. Between 10% and 40% of patients are uninsured depending on the residency program and whether a specific clinic serves adults and/or children. The largest residency program (Maine Medical) also estimates that 33% of their patients are non-English speaking.

Patients seen at residency clinics have full access to the specialty care services, labs, diagnostic services, and in-patient care that is available in the parent hospital's service network. Most of

the programs are Family Practice residencies. Most of the programs focus is on training providers who will be prepared to practice in rural settings and significant efforts are made to encourage residents to stay in Maine when their training is complete. In fact, Maine residencies have been very successful in placing physicians in Maine, including in underserved rural areas. For example, Eastern Maine Medical Center estimates that 75% of its Family Practice residents remain in Maine. Similarly, between 1997 and 2003 the Maine-Dartmouth Family Practice Residency placed 46 of its 61 graduates (75%) of its graduates in rural areas (mostly in Maine).

“Medical home” Characteristics:

- **Accessible.** All of the residency programs are operated by hospitals and as such are required by law to provide free care to patients living at or below the Federal Poverty Level (FPL). Most hospitals provide care on a sliding fee scale that range up to 200% of FPL (some even go beyond 200%) and this policy is also transferred to the residency clinic.
- **Continuous.** Because the residency programs are operated by hospitals, patients seen at the residency program clinics have access to emergency on-call services 24 hours a day, 7 days a week through a network of providers who are on-call.
- **Comprehensive/Coordinated.** Residency programs are operated by hospitals and are integrated into the hospital’s operations. As a result, all of the residency programs have access to their affiliated hospital’s full network of health care services including specialty care, labs, diagnostic services, in-patient services, and other supportive services.

Obligation to serve the Uninsured/Underinsured:

As stated above, hospitals in Maine are required by law to provide free care to patients who live at 100% of FPL or below. Most hospitals in Maine offer free care or care at reduced rates to patients who are above the poverty line ranging from 125% of the FPL on up to 300% of FPL. Most of the hospital’s free care policies go up to 200% of the FPL. The residency programs are operated directly by hospitals and patients at these clinics are afforded the same free care and rate policies as those served in other hospital departments.

Population Served:

The primary care residency programs in Maine are well known for their policies related to low income, uninsured populations and serve a disproportionate number of those on Medicaid, those without insurance, those who have limited means to pay the full customary fees and people who do not speak English. Social service agencies and other agencies that serve low income populations are aware of the residency programs in the State and regularly refer their clients to the residency programs for services.

Geographic Coverage and Service Gaps:

The residency programs are located in Southern and South Central Maine in the State's largest population centers. The northern most program is in Bangor.

A4. Health Care Access Programs

Provider Group Overview:

Health Care Access Programs (HCAP) in Maine provide primary care medical services and a limited array of specialty care services to uninsured individuals through a network of volunteer providers who agree to serve uninsured patients at no cost or for a significantly discounted rate. In addition to primary care and specialty care services, the programs also provide access to lab and diagnostic services through formal or informal service networks free of charge or at highly discounted rates.

All of the programs are back-stopped by hospitals in their area's that provide services that the programs are not able to provide based on the hospital's existing policies related to the uninsured. The hospitals that are affiliated with these programs also provide substantial financial and operational support. In some cases, the partnering hospital may provide various services free of charge, as well as expand or enhance their free care policies for those enrolled in the health care access programs. In one case, the hospital serves as the financial intermediary and donates equipment and supplies to the health care access program. In another case, the affiliated hospital provides direct financial support to pay for a portion of the administration and facility costs.

Three of the programs, CarePartners, Maine Health Alliance, and Franklin Health Access, also receive or have received federal support from the Healthy Communities Access Program (HCAP) and/or its predecessor the Community Access Program (CAP). CAP/HCAP is a program operated by the Federal DHHS, Health Resources Services Administration's (HRSA) that provides funds to community-based organizations to coordinate and strengthen health services for uninsured and underinsured populations. CarePartners was established by a CAP grant and has continued with major support from MaineHealth. The Maine Health Alliance has expanded and enhanced its program with the support of an HCAP grant. Franklin Health Access was recently awarded HCAP funding for an IT project to link medical and pharmaceutical records between Franklin hospital, private practices, and retail pharmacies.

Program enrollees are typically identified through existing community-based health, social service, and educational agencies and are screened for eligibility. If they are deemed eligible then they are enrolled in the program and are referred to a primary care provider in the network for care. The primary care providers have a list of specialty care providers that are in the program's network, and are trained on how to access program lab and other diagnostic services.

Five of the programs serve in distinct service areas and enroll clients within roughly a 45 minute drive of the partnered hospital site. One of the programs is less centralized and provides services through a broader Statewide network. In this instance, case managers refer clients to primary

care providers in the network based on where the client lives. After they are referred, the programs case managers provides ongoing support and work with the volunteer provider to ensure appropriate health and social service referrals as well as to provide overall care coordination.

While there are great similarities between the programs with respect to their mission and how they are operated, there is also significant variation. The following are brief descriptions of the programs.

- **CarePartners (Portland, Damariscotta, and Augusta Areas)** CarePartner's sites are all based on the same model and are implemented in three Maine counties in collaboration with MaineHealth, a large, integrated health system in Southern Maine. The Portland site is affiliated with Maine Medical Center. The Augusta site is affiliated with Maine General Medical Center, and the Lincoln County site in Damariscotta is affiliated with Miles Memorial hospital and St. Andrews Hospital. At the core of each of the programs is a recruited network of primary care and specialty care providers who agree to provide services to a certain number of uninsured patients for free or for a nominal patient contribution. The primary care providers in the network provide comprehensive primary care services and work with CarePartner's staff to manage other aspects of the patient's care. Patient's have access to a network of specialty care providers who, like the primary care providers, agree to serve CarePartner's enrollees on a limited basis. Patient's also have access to services at the partnering hospital free of charge or on a discounted basis. Providers in the network along with patients work in collaboration with CarePartner's case managers who coordinate/integrate services and provide health education. CarePartner's care managers also work with enrollees and physicians to facilitate access to free or low cost pharmaceuticals through the pharmaceutical companies' Patient Assistance Programs (PAPs) and/or through a specific CarePartners pharmaceutical program that provides prescription drugs at extremely discounted rates in partnership with Anthem Blue Cross Blue Shield. The current enrollment in the program is about 1,047 and approximately 2,000 people have been assisted since the program's inception in 2000.
- **Franklin Health Access. (Greater Franklin Area).** Franklin Health Access (FHA) is located in Farmington, Maine and serves people throughout the Greater Franklin area. FHA is a collaborative initiative supported by the Franklin Community Health Network, comprised of multiple entities including Franklin Memorial Hospital, PineTree Medical Associates, and Evergreen Behavioral Health Services. The initiative also includes a large network of primary care and specialty care providers that includes providers from the HealthReach network of community health centers, private providers, dentists and pharmacists. The mission of Franklin Health Access Network is to improve the health and well being of uninsured, financially disadvantaged people through advocacy, education, treatment, and access to services. Franklin Health Access welcomes people of all ages that are: 1) uninsured or have health insurance deductibles of \$5,000 or more, 2) low income with household incomes that are 200% of the federal poverty level or below, and 3) Franklin County, Livermore, Livermore Falls, or Vienna residents of three months or more. Those enrolled in the program receive a comprehensive array of basic primary

care services and have access to specialty care services on a referral basis. Enrollees also have access to a full range of services at Franklin Memorial Hospital and prescription drugs on a discounted basis. Patient fees are nominal and are based on a sliding fee scale. The current enrollment in the program is about 700.

- **Community Health Connections (Greater York Area).** Community Health Connections is a non-profit organization located in York, ME that has recruited a network of primary care providers and specialists who work in conjunction with York Hospital to provide health care services to uninsured, low income populations in the Greater York area. Those enrolled in the program are placed with a primary care provider and have access to a full array of primary care services as well as a limited array of specialty care services. Services that can not be covered by the provider network are referred to York Hospital and are covered on a discounted basis based on the hospital's existing policies towards the uninsured. The program also has a pharmacy assistance program that helps patients access free prescription drugs through the pharmaceutical companies' Patient Assistance Programs. York Hospital serves as the financial intermediary and supports the project in other significant ways. The current enrollment in the program is about 120 patients.

- **Maine Health Alliance (Northern Maine).** The Maine Health Alliance (MHA), located in Bangor, is a broad health care provider organization with a membership of 11 community hospitals and 350 medical practices. MHA promotes the ability of its member providers to deliver accessible, quality, and cost effective services through a variety of initiatives aimed at improving communication, care coordination, and chronic disease management. One such initiative is MHA's, health care access initiative, funded by HRSA's, Health Communities Access Program. The MHA program provides intensive case management and care coordination services to uninsured and underinsured patients that are served by primary care providers in their network. In essence, the program provides MHA's providers with access to a cadre of case managers who work with providers to coordinate the care for those who are uninsured. The focus of the program is on serving patients with chronic conditions, which are often complex, time consuming, and problematic for sites to handle, particularly if patients are uninsured. The program does not ensure a medical home but does assist patients and primary care providers to ensure that care is well coordinated the that patients have access to all of the services that are available in their area.

“Medical home” Characteristics:

- **Accessible.** Health Care Access Programs provide services free of charge or at greatly discounted rates to those who are uninsured and meet various financial eligibility requirements. A number of the programs are closed to enrollment or have a waiting list.

- **Continuous.** Once a patient is enrolled and assigned a primary care provider (PCP), the patient is afforded all of the same policies and services that are afforded to their assigned PCP's other patients. These policies vary considerably across providers but all have

some form of coverage, 24/7, even if it is merely a referral to an affiliated hospital emergency room.

- **Comprehensive.** All of the programs provide basic primary care services through physicians, nurse practitioners, or physician assistants. The programs do their best to provide a comprehensive array of medical specialty, mental health, and substance abuse services but the program's networks are volunteer-based and the referral networks are incomplete. All of the programs in Maine are directly or loosely affiliated with large hospitals. These hospitals provide services that can not be covered directly by the program.
- **Coordination.** All of the programs provide basic case management services and do what they can to assist patients to coordinate their care.

Obligation to serve the Uninsured/Underinsured:

All Health Care Access Programs have a mission-driven obligation to serve the uninsured and some are also contractually bound to serve the uninsured based on receiving HRSA funding and/or local funding agreements.

Population Served:

The target populations for these programs are the uninsured with an emphasis on the low and middle income working poor. Often their clients are employed by small businesses who do not offer health insurance or who are self-employed. These clients commonly are not eligible for Medicaid but do not earn enough to pay for health insurance.

The size of these programs varies considerably across the program offices. The largest of the programs has more than 800 physicians in their network and an enrollment of more than 1,200 uninsured clients. The smallest of the programs provides services to about 120 clients at any given time.

Geographic Coverage and Service Gaps:

There are four Health Care Access organizations in the State. Three of the programs operate in 5 distinct service areas and a fourth organization is based in Bangor but serves more broadly in the other parts of the State.

- Bangor and Northern Maine (Maine Health Alliance)
- Greater Franklin Area and Franklin County (Franklin Health Access)
- Kennebec County (Care Partners)
- Lincoln County (Care Partners)
- Greater Portland Area (Care Partners)
- York County (Community Health Connections)

A5. Free Clinics

Provider Group Overview:

Free clinics are private, non-profit, community based organizations that provide primary care medical services as well as a limited array of medical specialty care services and behavioral health services to those who are uninsured. We identified seven free clinics in Maine. Each of these clinics provides free services to those who are uninsured through a volunteer network of providers, but there is significant variation across the clinics with respect to the services they provide and the days and hours that they operate.

All of the clinics are made possible through the donation of goods and services, volunteerism, and community donations. Funding is generally raised on the local level and there is little if any government funding or support. Many of the programs are heavily supported by their local hospitals.

“Medical home” Characteristics:

- **Accessible.** Free clinics provide care free of charge to those who are uninsured, most have minimal to no guidelines or requirements related to income or proof of insurance status.
- **Continuous.** None of the free clinics in Maine are open on a full-time basis. Most are only open 1 or 2 days per week. One of the clinics is open 4 or 5 days per week but all services are not available on all of the days. Some clinic sessions will be dedicated to primary care, while others will be reserved for specialty care such as mental health counseling or cardiac care. On-call coverage varies from organization to organization. In most cases there is no call coverage and clients are referred to the local hospital emergency room. In one case there are volunteer providers who are not able to volunteer for specific clinics but have volunteered to take emergency call coverage during certain periods. In another case, emergency calls are taken by a nurse who provides triage services, making referrals to a local emergency room, if necessary.
- **Comprehensive.** There is a great deal of variation across the clinics with respect to the services that are offered to their patients. All of the clinics provide basic primary care medical services and have contractual arrangements in place to facilitate lab services and diagnostic services. In most cases, labs and diagnostic services are provided free of charge by an affiliated hospital. In one case they are provided by an outside vendor and are paid for by the program. Some of the clinics provide primarily acute care services and have very limited ability to provide a medical home or on-going services to those with chronic conditions. A number of the clinics, however, do make great efforts to provide routine preventive care and do serve as medical home for many of their clients. All of the clinics work to recruit specialty providers based on the needs of the community but in most cases the referral networks are very limited and the clinics most refer their patients to local hospitals. A number of the clinics have extensive volunteer specialty care networks and are able to respond to the needs of most of their clients, although capacity

is often limited. None of the free medical clinics provide oral health services. Many of the clinic sites provide behavioral health services but there are major capacity gaps.

- **Coordinated.** Similarly to the Health Care Access Programs, all of the free clinics are formally or loosely affiliated with one or more of the hospitals that operate in their areas. These hospitals inevitably serve as a back-stop for clinics, providing services to free clinic patients that can not be accessed by volunteer providers. In some cases, the hospital offer expanded payment terms and benefits to those who receive services at the free clinic sites. All of the clinics provide basic case management services and do what they can to assist patients to coordinate their care.

Obligation to serve the Uninsured/Underinsured:

Free clinics have a mission-driven obligation to serve the uninsured. In some cases, the organization also has a contractual obligation based on the requirements of its local funders.

Population Served:

The free clinics in Maine serve uninsured populations regardless of income or employment status. In 2004, the free clinics collectively served roughly 3,000 uninsured patients and provided care through an estimated 6,200 visits. The largest of the clinics served roughly 600 patients in 2004 and the smallest served roughly 100 patients.

Geographic Coverage and Service Gaps:

The clinics we identified are located in Biddeford, Brunswick, Buxton, Ellsworth, Portland (2), and Rockland. We were unable to contact a clinic that was thought to exist in Lewiston and one of the clinics (Spruce Street) recently was designated as an FQHC organization. Similarly to the Health Care Access Programs, free clinics play important roles in their communities, particularly for the uninsured but they do not make up the core of the safety net in any community. They are an important part of broader networks for those in need, but currently provide services to a limited number of people.

A6. Hospital Employed Primary Care Providers

Provider Group Overview:

There are 36 acute care and 3 specialty hospital corporations in Maine. Of approximately 2800 total physicians in Maine, including approximately 1200 primary care physicians, it is estimated that more than a third are employed by hospital corporations and their affiliates. The proportion of employed physicians is highest in rural communities where in some cases nearly all physicians in a community are employed by a hospital-based corporation. Consistent with national trends, Maine's hospitals increasingly serve as the foundation of a continuum of health services in a region including community-based health promotion, primary and specialty medical care, emergency and acute care, as well as in some cases home health, long term care, and

psychiatric care. Maine hospitals participate in the primary care safety net through multiple mechanisms including the following.

Charity Care – Maine law requires hospitals to provide medically necessary hospital services free of charge to individuals at 100% of the Federal Poverty Level (FPL) or below. However, the majority of hospitals go well beyond with this requirement. The average percentage of FPL for determining free care is 177% and the median is 200%. Approximately two-thirds of Maine hospitals also have sliding fee scale policies that may extend in some cases up to as much as 300% of the FPL. With some variation, the free and reduced care policies typically extend to all aspects of the hospital system including employed primary care and physician services.

Health Access Programs and Free Clinics – Maine Hospitals are the primary supporters, both financially and logistically, of the Health Access Programs and Free Clinics that operate in various areas of the State. These types of programs are addressed in separate sections of the report.

Critical Access Hospitals – Thirteen of Maine’s hospitals are designated as Critical Access Hospitals (CAH) eligible to receive cost-based reimbursement. There is no additional requirement placed on a Critical Access Hospital to provide services to low income individuals regardless of ability to pay. However, participation in the Critical Access Hospital program also entails activities to encourage the development of rural health networks, to assist with quality improvement efforts, and improve rural emergency medical services – all intended to sustain access to adequate health care services in rural communities.

Rural Health Clinics – The majority of Rural Health Clinics (RHC) in Maine are based in hospital corporations which employ the primary and specialty care professional staff of the clinics. The role of RHC’s in the safety net is discussed in another section.

Hospital-Operated Primary Care Centers – In addition, to primary care offices with RHC designation, the majority of Maine hospitals own or manage primary care centers. In addition to providing the employment base for many primary care physicians and midlevel providers in communities across Maine, the charity care policies of the hospital are typically extended to the hospital-operated primary care centers.

Primary Care Residency Programs – As described in a separate section, five Maine hospitals participate in hosting primary care residency programs that collectively serve as an important component of the primary care safety net.

Hospital-Based Specialists and Diagnostic Services – Maine hospitals employ a variety of specialists including general surgeons, orthopedic surgeons, oncologists, psychiatrists, obstetricians and hospitalists. The importance of this to the primary care safety net is that by being within one integrated system, low income primary care patients have improved access to diagnostic and specialty services and communication between primary care and specialists is enhanced.

“Medical home” Characteristics:

Maine hospitals have increasingly incorporated a broader continuum of services within their mission and operation including provision of primary care services. The “medical home” characteristics for hospital-based primary care services typically includes:

- **Accessible** – Hospitals are required to provide medically necessary services free of charge to individuals at the poverty level or below. Hospitals provide free services well above that level on average and typically extend free and reduced fee policies to their primary care operations.
- **Continuous** – Hospital-based primary care physicians typically participate in a call rotation as a condition of their employment with the hospital. Hospitals increasingly employ hospitalists that provide inpatient coverage as part of the clinical care team. Family physicians in particular reportedly utilize the services of hospitalists, while pediatricians and internists may continue to manage inpatient care of their own patients.
- **Comprehensive** – Hospital-based primary care programs have a varying array of services available on-site in addition to primary medical care. Staff may include social workers and counselors. The hospital-affiliation facilitates on-site specialty services such as psychiatry and in some cases practices are co-located with mental health or dental services.
- **Coordinated** – Coordination of services is facilitated for hospital-based primary care programs by virtue of their affiliation with a larger network of services. A number of primary care offices also have social workers on staff to assist with care coordination.
- **Culturally effective** – Hospital-based primary care programs attempt to provide culturally effective services consistent with their overall hospital’s mission to provide high quality services. Practices contacted as part of this study indicated having arrangements for interpretation services or having bilingual individuals on staff. One hospital (Mercy) is beginning a pilot program to have city outreach workers stationed in its primary care offices to assist refugee populations.

Obligation to serve the Uninsured/Underinsured:

Hospitals are required to provide medically necessary hospitals services free of charge to individuals at 100% of the federal poverty level or below. Hospitals provide free services well above that level on average and typically extent free and reduced fee policies to their primary care operations.

Population Served:

Hospital-based primary care practices serve a broad population in their target communities. All hospital-based primary care practices contacted during this study indicated taking new patients regardless of ability to pay except in cases where individual provider panels were full and therefore closed to all new patients.

Geographic Coverage and Service Gaps:

Hospital-based primary care services are found associated with hospitals in all areas of the State, although the proportion of hospital employed primary care clinicians is greatest in rural areas.

The Maine Recruitment Center, part of the Maine Hospital Association, listed 61 primary care physician vacancies at the end of 2005 with the majority of openings in the Coastal and Northern regions of the State (the other regional categories used by the Maine Recruitment Center for reporting in the Maine Hospital Association newsletter are Western and Southern). By comparison, the current number of primary care physician vacancies in New Hampshire is 34.

A7. Rural Health Clinics

Provider Group Overview:

A Rural Health Clinic (RHC) is a clinic certified to receive Medicare and Medicaid reimbursement based on allowable costs in place of a fee schedule. The purpose of the RHC program is to improve access to primary care in underserved rural areas. Thus, RHC's must be located in rural areas with current health care shortage designations (HPSA or MUA). RHC's are required to use a team approach of physicians and midlevel practitioners (nurse practitioners, physician assistants, and certified nurse midwives) to provide services. RHC's may also provide other health care services, such as mental health, but they may not be reimbursed for those services based on their allowable costs. Rural Health Clinic's must also have a Quality Assessment and Performance Improvement program that is appropriate for the complexity of its organization and services and focuses on maximizing outcomes by improving patient safety, quality of care, and patient satisfaction.

Rural Health Clinics may be "provider-based" or independent. A provider-based RHC is operated as a component of an existing Medicare certified provider such as a hospital, nursing home or home health agency. The provider organization with which the RHC is associated handles its reimbursement. RHC's that are provider-based to a hospital with less than 50 beds are exempt from the per-visit reimbursement cap. Independent RHC's are subject to a per-visit reimbursement cap and go through an RHC fiscal intermediary (e.g. Blue Cross) for reimbursement. Factors influencing the decision to be an independent or provider-based RHC include physician employment preferences and the visit/procedure profile of the practice. RHC's can be for-profit or not-for-profit, public or private.

Rural Health Clinics are not legally mandated to offer access to services to patient's regardless of their ability to pay. However, the Health Care Safety Net Amendments of 2002 (PL 107-251, S. 1533) contain optional provisions for Automatically Designating Rural Health Clinics as meeting the requirement for location in a Primary Care Health Professional Shortage Area (HPSA) for a period of six years. Automatic Designation establishes site eligibility for the National Health Service Corps and J1-Visa programs. Clinics requesting Automatic Designation must guarantee in writing that they will meet the following additional requirements:

- The Rural Health Clinic will not discriminate in providing health care services to someone who is uninsured or insured through Medicare or Medicaid.
- The Rural Health Clinic will prepare a schedule of fees or payment of services for those at various income levels and will display a notice regarding the availability of discounted fees for the uninsured and willingness to accept patients from Medicare and Medicaid.

It is also important to note that the majority of all Rural Health Clinics do maintain formal or informal policies for free or reduced health care services. Provider-based Rural Health Clinics in particular have such policies as an extension of their corporate structure and institutional mission of the parent organization.

According to the Federal designation office, in 2005, there were 45 Rural Health Clinics in Maine. Included among these were 10 RHC's with Automatic Designation status.

“Medical home” Characteristics:

The core rural health clinic services for which practices receive cost-based reimbursement are primary health services including physicians, midlevel providers, clinical psychologists and clinical social workers; basic laboratory tests, emergency care services as a first response, x-ray services (which can be provided through arrangements with other facilities); and hospital specialty care through demonstrated arrangements with specialty providers. Thus, the “medical home” characteristics for RHC sites include:

- **Accessible** – RHC sites in general are not required to have a sliding fee scale for persons with low income with the exception of Automatic Designation RHC's (10 in Maine). However, the majority of RHC's do so anyway as a matter of practice. In addition, RHC's are by definition intended to sustain access to care in underserved rural areas.
- **Continuous** - RHC sites are expected to follow usual and customary practice for quality medical care and are required to have a Quality Assessment and Improvement Program. As such, the majority of RHC physicians participate in the local medical care system through call rotations, hospital coverage and specialty referrals as appropriate.
- **Comprehensive** - RHC sites are expected to provide or arrange for a “continuum of services”. Many RHC's have social workers on-staff or contract and have co-location arrangement services for mental health services and in some cases dental care.
- **Coordinated** – RHC sites are expected to function as part of a system of care that assures access including making provision for appropriate referrals for specialty care and inpatient care.
- **Culturally effective** - RHC sites are required to have a Quality Assessment and Improvement Program which includes assessment of patient satisfaction.

Obligation to serve the Uninsured/Underinsured:

Only practices seeking Automatic Designation are mandated to provide access to service regardless of ability to pay and to maintain a sliding fee schedule. Other RHC's commonly do so as part of their mission or the mission of their parent organization (e.g. hospital) to sustain access to care in rural communities.

Population Served:

Rural Health Clinics serve a broad population in their target communities including a higher proportion of elderly and low income patients compared to the general population due to their rural location. The characteristics of the communities served range from coastal islands with a year round population in the hundreds to broad regions served by networks of Rural Health Clinics affiliated with hospitals. The volume of services for rural health clinic organizations in Maine ranges correspondingly from a few thousand primary care visits to more than 75,000 visits per year. While no specific data source is currently available describing the payer mix for Maine RHC's overall, a rough estimate based on a sample of RHC's contacted for this study suggests that approximately 10% of RHC patients are uninsured, 21% have MaineCare, 45% have Medicare, and the balance are covered by private insurance. Although these are rough averages, payer mix varies considerably among RHCs with some, for example, serving significant elderly (Medicare) populations and others serving more of a cross section of the population.

Geographic Coverage and Service Gaps:

RHC's are well distributed in rural communities across western, central, coastal and northern Maine. Not surprisingly, the pattern of distribution mirrors the distribution of hospitals as most RHC's, whether provider-based or independent, are established as part of the network of care around a hospital service area.

RHC's in Maine are a part of the broader efforts to build and sustain a vertical network of health care through coordination, collaboration and integration of services that is notable in many Maine communities. Service gaps relating to RHC services are thus generally considered within the overall context of strategic planning for the local health care system.

A8. National Health Service Corp Providers

Provider Group Overview:

The National Health Service Corps (NHSC) is a program of the United States Department of Health and Human Services (DHHS) that seeks to improve the health of underserved populations by bringing together primary care health professionals and communities with health professional shortages. In 2005, NHSC professionals were practicing in 24 community sites in Maine.

An eligible NHSC community site is a public, nonprofit, or private health facility that provides a continuum of services, including comprehensive primary health care and appropriate referrals or

arrangements for specialty and inpatient care to individuals in a health professional shortage area (HPSA). NHSC community sites must agree to treat all patients regardless of the method or ability of the patient to pay for services – defined as accepting Medicare/Medicaid assignments and having provisions for a sliding-fee scale for those who are at or below 200 percent of the federally designated poverty level. The NHSC strives to establish an interdisciplinary health care team at each community site.

The two primary mechanisms for the NHSC to encourage health professionals to locate in underserved communities are scholarship and loan repayment. The **NHSC Scholarship Program** offers payment of tuition, fees and a monthly stipend for up to 4 years in return for service in a high need community upon completion of training. To be eligible for the NHSC Scholarship Program, individuals must be a U.S. citizen enrolled, or accepted for enrollment, in a fully accredited U.S.:

- Allopathic or osteopathic medical school
- Family nurse practitioner program (master's degree in nursing, post-master's or post-baccalaureate certificate)
- Nurse-midwifery program (master's degree in nursing, post-master's or post-baccalaureate certificate)
- Physician assistant program (certificate, associate, baccalaureate, or master's program)
- Dental school

Scholars attending medical school are expected to complete residency programs in one of the following specialties:

- Family medicine
- General pediatrics
- General internal medicine
- Obstetrics/gynecology
- Psychiatry

The Scholarship Program is highly competitive with approximately 3,000 applicants annually for 400 scholarships awards.

The table below shows a comparison between Maine and several other states for the number of NHSC listed vacancies. Comparison states include neighboring states (including Vermont), 2 states with similar total populations (Idaho and Hawaii), and 2 states with similar population densities (Colorado and Oregon). As the table displays, the vacancy rate as proportion of the total state population is highest in Maine compared to the 7 other states. It is possible that the higher rate is due in part to more proactive use of the NHSC listing service by Maine facilities, but also may be an accurate reflection of a higher rate of provider shortages in Maine.

	NHSC Vacancies January 2006	State Population	Vacancies per 100,000 pop
Maine New	67	1,321,505	5.1
Hampshire	17	1,309,940	1.3
Vermont	5	623,050	0.8
Massachusetts	100	6,398,743	1.6
Colorado	75	4,665,177	1.6
Oregon	63	3,641,056	1.7
Hawaii	9	1,275,194	0.7
Idaho	46	1,429,096	3.2

The **NHSC Loan Repayment Program** identifies and contracts with fully trained and licensed primary health care clinicians for service at eligible community sites. In exchange for this service, National Health Service Corps Loan Repayment Program participants receive funds for the repayment of their qualifying educational loans that are still owed, plus tax assistance. Historically, applications have exceeded available funding. Therefore, the National Health Service Corps Loan Repayment Program is also a highly competitive program. To be eligible for loan repayment, health professionals must be fully-trained in one of the following disciplines:

- Allopathic (MD) or osteopathic (DO) primary care physicians
- Primary care certified nurse practitioners (ARNP)
- Certified nurse-midwives (CNM)
- Primary care physician assistants (PA)
- General practice dentists (DDS/DMD)
- Registered clinical dental hygienists (DH)
- Psychiatrists (MD/DO)
- Clinical or counseling psychologists (CP)
- Clinical social workers (SW)
- Psychiatric nurse specialists (PNS)
- Marriage and family therapists (MFT)
- Licensed professional counselors (LPC)

“Medical home” Characteristics:

The NHSC program expectation for a placement site is that it provides a continuum of services, including comprehensive primary health care and appropriate referrals or arrangements for specialty and inpatient care. In Maine, NHSC providers are all based in organizations that contribute to the primary care safety net including FQHCs, RHCs and mental health agencies. In 2005 six providers were with FQHCs while the remainder were in RHCs or mental health/substance abuse agencies. The “medical home” characteristics for NHSC sites include:

- **Accessible** - NHSC provider sites are required to have a sliding fee scale for persons with income at or below 200% of the federal poverty level.

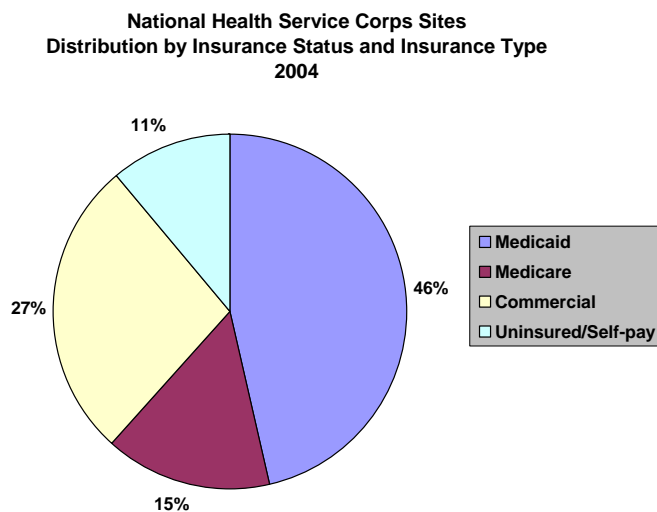
- **Continuous** - NHSC provider sites are expected to ensure that their patients have access to emergency services 24 hours a day, 7 days a week.
- **Comprehensive** - NHSC sites are expected to provide or arrange for a “continuum of services”.
- **Coordinated** – NHSC sites are expected to “Function as part of a system of care that assures access” including making provision for appropriate referrals for specialty care and inpatient care.
- **Culturally effective** - NHSC sites are expected to provide services in ways that “bridge cultural and language barriers”.

Obligation to serve the Uninsured/Underinsured:

By definition, NHSC professionals practice in rural or urban communities with shortages of health professionals. Further, sites are required to “maintain a discounted fee schedule that assures there is no financial barrier to care.”

Population Served:

NHSC professionals serve a broad population of insured and uninsured individuals in their target



communities. As previously mentioned, the majority of NHSC professionals in Maine are located in facilities serving low income, uninsured populations. For providers placed in FQHCs, volume and payer mix information is included with the information reported for FQHCs. While data is not available for all other NHSC providers, the information displayed below describes the population characteristics for 10 NHSC sites not

included with the FQHC information. In 2004, the payer mix for these 10 sites was as follows:

In 2004, the 10 NHSC-supported (non-FQHC) sites for which data is available provided primary care medical services to 20,105 individuals, oral health services to 9,937 individuals, and mental health or substance abuse services to 717 individuals. See the table below for an account of the number of distinct patients and the number of visits in each of these service categories.

	Medical Services	Oral Health Services	Mental Health & Substance Services
Unduplicated Patients	20,105	9,937	717
Visits	52,207	30,686	14,204

Geographic Coverage and Service Gaps:

The 24 total NHSC community sites are distributed throughout Maine with the majority located in rural or non-urban settings. Not surprisingly, this distribution generally mirrors the array of health professional shortage areas across Maine.

Nationally, the NHSC estimates that its program currently meets only 10% of the need for primary care, oral, and mental and behavioral health clinicians in HPSA's. At the end of 2005, there were 65 position vacancies for Maine sites listed with the National Health Service Corps which roughly suggests that approximately 27% of the identified need is being met (24/89). Included among the 65 listed vacancies are 9 with HPSA scores of 14 or higher (where a higher score equals greater need). NHSC scholars are required to locate in communities with HPSA scores of 14 or higher and professionals applying for loan repayment similarly maximize their chances of acceptance by locating in such communities. The 9 high priority position listings include 4 for clinical psychologists, 1 psychiatrist, 2 dentists, 1 family physician and 1 internist.

A9. J-1 Visa Waiver (Conrad State 30) Program

Provider Group Overview:

Federal law requires that international medical graduates, who are not United States citizens but are accepted to pursue graduate medical education or residency training in the U.S., must obtain a J-1 exchange visitor visa. The J-1 visa allows these medical school graduates to remain in the United States until they complete their studies. Upon completion of their studies, the graduates on J-1 visas (the "J-1 Physicians") must return to their home country for at least two years before they can return to the United States. Under certain circumstances, a J-1 Physician may request the Department of Homeland Security to waive the "two-year home country physical presence requirement."

The waiver may be requested under any one of the following four circumstances.

- Extreme hardship to his/her spouse or children who are citizens or permanent residents of the United States.
- Persecution if forced to return to his/her home country.

- A United States government agency makes a request for the waiver on the basis that the J-1 Physician's work is in the national and/or public interest.
- A state department of health makes a request for the waiver on the condition that the physician agrees to practice in an area having a shortage of health care professionals. This provision allows state departments of health to sponsor up to thirty J-1 Physicians per federal fiscal year (October 1 - September 30) under the Conrad State-30 Program.

The purpose of the Conrad 30 J-1 Visa Waiver Program is to improve access by sponsoring J-1 Physicians who agree to serve in medically underserved areas for the waiver of the two year home country physical presence requirement.

In order to meet eligibility and qualifications for visa waivers, J-1 Physicians must have 1) completed at least a 3-year residency in a primary care specialty (Internal Medicine, Family Practice, Pediatrics, OB/Gyn) or General Psychiatry program, and 2) agree to practice for a period of not less than three years in a federally designated shortage area (HPSA, MUA/P, or MHPSA).

Employers who sponsor J-1 physicians must meet the following requirements:

- The practice site must be physically located in a federally designated Health Professional Shortage Area (HPSA), Medically Underserved Area (MUA), or Medically Underserved Population (MUP) for primary care and in a Mental Health Professional Shortage Area (MHPSA) for mental health care. Note: in 2004, this requirement was modified to allow states are to place a portion of their J-1 visa providers in non-shortage designation areas as long as the state or J-1 provider could demonstrate they were serving an underserved population. Maine is able to use 5 of its 30 J-1 slots in this way.
- The practice site must have attempted unsuccessfully to recruit a U.S. citizen or a permanent resident physician for a period of at least six months.
- An employer or owner of the practice site who has previously defaulted on a J-1 visa waiver contract, or who is in default of the National Health Service Corps or any state scholarship or loan repayment program is not eligible to request a waiver.
- The J-1 Physician may not submit an application as an employer on his/her own behalf.
- Compensation offered to the J-1 Physician must be at least equal to the local prevailing wage for the position or the employer's actual wage for similarly employed U.S. workers, whichever is higher.

“Medical home” Characteristics:

The extent to which a J-1 physician provides a medical home for their patients varies considerably and is dependant on their employer’s practice characteristics and policies. Many J-1s practice in hospital outpatient clinics, residency clinics, and rural health centers that offer a

comprehensive array of services, full coverage 24/7, formally coordinate services, and full service medical homes Others practice in small private practices in rural areas and do not provide or coordinate services to the same extent as the other provider groups mentioned above.

- **Accessible.** The aim of the program is to expand access to primary care services in underserved areas but J-1 physicians are under no obligation to serve the uninsured. A majority of those who are on contract do practice in clinics that offer a sliding fee scale to those who are uninsured.
- **Continuous.** The extent to which J-1 physician practices provide continuous care 24/7 varies extensively based on the type of employer. A large proportion of J-1s practice in hospitals, large health clinics, or group practices. These physicians are likely to provide continuous coverage 24/7 through formal on-call providers. Other physicians in smaller practices are less likely to be able to ensure continuous coverage 24/7.
- **Comprehensive/Coordinated.** Likewise, there is variation across the J-1 physician practices with respect to the nature of the services that they offer to their patients. Larger clinics and hospital-based practices are likely to provide and/or closely coordinate a comprehensive array of primary care, specialty care, and supportive services. Those that practice independently are less likely to provide a comprehensive array of services directly and rely on a less well coordinated network of referral providers.

Obligation to serve the Uninsured/Underinsured:

J-1 physicians and their employers have no obligation to serve patients who are uninsured or to provide care at a discounted rate, although most J-1 Physicians in Maine do provide care on a sliding fee scale based on income. The only legal requirement in this regard is that they must not charge patients more than the usual and customary rate prevailing in the federally designated shortage area in which services are provided.

Population Served:

As mentioned above J-1 physicians must agree to practice for a period of not less than three years in a federally designated shortage area (HPSA, MUA/P, or MHPSA).

Geographic Coverage and Service Gaps:

The 35 active J-1 Physicians are distributed throughout Maine with the majority located in Maine's rural and non-urban locations. Similarly to the State's NHSC providers their distribution roughly mirrors the array of HPSA's that exist in the State.

B. Safety Net Organizations Not Serving As Medical homes

Descriptions by Provider Group

B1. Oral Health – Public and Private, Non-Profit Dental Programs

Provider Group Overview:

There are two main types of providers serving as the safety net for oral health services in Maine; public and private non-profit dental programs, and FQHCs. Hospital emergency departments, which are often providers of last resort for the uninsured and low income patients, are not part of the oral health safety net and privately practicing dentists serve very few uninsured and MaineCare patients. Some hygienists provide safety net services but the number and scope of hygienists participating in the safety net is unknown. This section describes the non-FQHC oral health providers. FQHC providers are described in B2. below.

There are roughly 15 public and private, non-profit organizations outside of the FQHCs that collectively operate more than 40 separate clinics or community-based oral health programs through out the State. The programs provide a range of preventive, restorative, and emergency services to those without access to services with an emphasis on low income uninsured and underinsured populations as well as those who are insured by MaineCare. There is great variation across the programs and clinic sites with respect to who the programs serve, when and how often they are open, how many patients they serve, the services that are provided, the payment or billing policies, how the programs are funded, and how the programs are generally operated.

While the number of safety net oral health clinics seems large, the number is misleading and gaps in safety net oral health services in Maine are immense. Many of the programs operate on a part-time basis. Most of the programs are restricted to serving people in specific geographic areas (e.g. specific counties or municipal areas) although there are two programs, the Community Dental Program and the Miles for Smiles Program, that provide services at multiple sites. A number of the clinics serve those who reside outside of their geographic area but can not apply their sliding fee scale or offer discounted rates to this population. Many serve specific segments of the population (e.g., children, adults, older adults, or the severely mentally ill.) For example, there are a set of programs geared specifically to children that provide oral health screenings and other preventive services and there is another set of programs geared to middle-aged and older adults that fits dentures. Most of the programs provide basic preventive and restorative care combined with oral health education and specialty care referrals. These basic services include: dental screenings, x-rays, cleanings, fluoride treatments, dental exams, sealants, fillings, and extractions, as well as oral health education and case management services. Others programs provide more extensive services such as root canals and dentures.

Nearly all of the programs are operated out of distinct, stationery clinic sites but a small handful of programs are run out of a mobile van or are operated by a traveling team of providers that bring their supplies with them. Sites include primary and secondary schools, community centers, health departments, Universities, health clinics, private dental clinics, hospitals, and mental health centers, as well as other community-based health and social service settings. Some of the programs are staffed by volunteers who are recruited from the community. Other programs hire part-time or full-time dentists that are paid on a salary or on a fee-for-service basis.

A majority of the clinics serve a broad distribution of insured and uninsured patients. Typically the sliding fee scale is based on income as a ratio of the federal poverty level and sliding fee scale ranges up to those who earn 200% of the federal poverty level or below. A number of clinics only serve the uninsured and do not have billing operations, even for those on MaineCare. Most of the clinics request any required payments at the time the service is provided and do limited billing after the fact. One of the clinic sites requires that payments be made in advance and will refund payments if appointments are cancelled 24 hours or more in advance.

Clinics are funded through federal, state, and local government sources, as well as patient revenues, private foundation grants, and corporate/individual contributions. Most sites receive a majority of their funds from State and local municipal sources combined with revenues from patient fees and co-pays. Many sites are also supported by grants or contributions from private organizations or private individuals such as the United Way, Anthem Blue Cross and Blue Shield, catholic charities of Maine, or private hospitals.

Obligation to serve the Uninsured/Underinsured:

The majority of the programs are heavily subsidized by the State and/or municipal governments and are bound to provide services to those with limited financial means and who are unable to pay the full and customary fee for services. Others have a mission-driven obligation and receive private donations and in-kind contributions.

Population Served:

As mentioned above, the clinics serve a spectrum of men, women, and children in Maine, with some focusing on very specific population groups. Overall, the emphasis is on low income, uninsured populations and those on MaineCare who have limited access to services.

Geographic Coverage and Service Gaps:

While services are broadly distributed through out the State, most of the services are provided in the more densely populated southern and central areas of the State. However, there are a number of programs that operate in the Downeast area as well as in the northern parts of the State. As noted above, many programs operate on a part-time basis, some serve only specific populations (e.g. children or elderly) and some provide only certain services so critical gaps in services exist even where safety net programs are operating. Consequently, despite the great efforts of all of these programs capacity is still extremely limited through out most of Maine's communities, particularly in the West and Northern portions of the State.

B2. Oral Health - Federally Qualified Health Center Dental Clinics

Provider Group Overview:

16 of the 20 FQHCs (including the FQHC Look –Alike) provide oral health services within at least one of their clinic locations on at least a part-time basis. These sites provide primarily

preventive, restorative, and emergency services to low income, uninsured populations that are served by their sponsoring organizations.

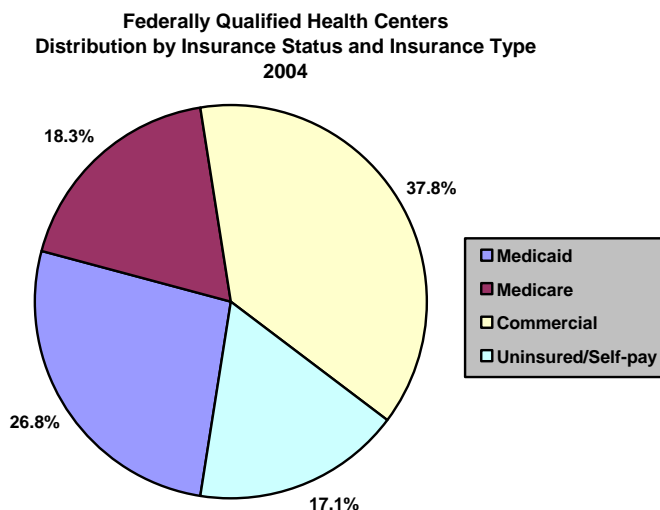
Overall in 2004, Maine's FQHC organizations that receive 330 funds had dental care expenditures (not including costs of facilities and administrative overhead) totaling \$1.9 Million.

Obligation to serve the Uninsured/Underinsured:

FQHCs have a regulatory and contractual responsibility to provide access to quality, comprehensive, coordinated, and culturally appropriate services to uninsured, low income populations without regard for a person's ability to pay. To the extent possible, FQHCs are expected to ensure access to oral health services in their service area to those they serve.

Population Served:

As mentioned above in an earlier section, FQHCs serve a broad cross section of the insured and uninsured populations in the service area but their target populations are low income populations, the uninsured, and those insured by Medicaid. In 2004, the overall distribution of patients served by any and all of the services provided by the FQHCs who received 330 funds was:



In 2004, FQHCs that received 330 funds provided oral health services to 10,879 unduplicated patients through 22,768 patient visits.

Geographic Coverage and Service Gaps:

Given that 80% of the FQHCs provide some level of oral health services, the distribution of oral health services across the State by FQHCs mirrors the distribution of primary care medical services provided by these organizations. What should be made clear, however, is that in many cases services are provided on a very part-time basis. The FQHCs are major sources of oral health care in many of Maine's communities, particularly for those that are uninsured or are on Medicaid, but capacity is still very constrained.

B3. Mental Health and Substance Abuse Services: State Contracted Agencies

Provider Group Overview:

The State-supported safety net for mental health and substance abuse services is formed by about 50 categorical programs and spread across more than 200 agencies/providers. Based on the “Maine Department of Health and Human Services – Annual Report on Service Contracted with Community Based Agencies” for the State’s Fiscal Year (FY) ending June 30, 2005, mental health and substance abuse services are funded through three offices under the Department of Health and Human Services’ (DHHS) Deputy Commissioner for Integrated Services. The three offices are: Children’s Services, Mental Health Services (adults) and Substance Abuse Services. Each of these offices has several categories of programs and contracts with numerous agencies. For the most part, contracted agencies are private, not-for-profit mental health and/or substance abuse organizations, although some are multi-purpose agencies that also provide other health and human services such as FQHCs or hospitals. Mental health and substance abuse services are administered through three regional offices to help coordinate and integrate the services.

The mental health and substance abuse system in Maine is in transition. The recent integration of several programs under the DHHS Deputy Commissioner for Integrated Services is intended to lead to better integration at the regional and community level. In addition, the legislature has mandated managed care for all MaineCare mental health patients (approximately 85,000 people) and it is anticipated this could lead to consolidation of services and more selective contracting. Following is an overview of the current organization of State-supported mental health and substance abuse services.

Adult Mental Health Services

For Maine’s Fiscal Year (FY) ending June 30, 2005, 117 agencies received funding for Adult Mental Health Services. Funding amounts range from less than \$1000 to over \$5,000,000 in 12 program categories including community support programs, residential services, crisis stabilization and outpatient services. The total FY 05 State contract budget was \$65,455,951 of which \$2,607,834 was contributed by Federal funding, \$20,474,008 by the State General Fund (Non-Seed) and an estimated \$42,374,109 by the General fund as MaineCare Seed. The MaineCare Seed is provided as matching funds that enable State contracting agencies to receive Federal Medicaid funds of approximately \$79,000,000.

Among this array of services and funding, the services that are most closely aligned with the primary care safety net are in a category called “Outpatient and Professional Services”. This category includes:

- Day Treatment/day Support. Services are provided in a agency environment and most often in a group setting
- Diagnosis and Evaluation to provide recommendations for treatment and service needs
- Outpatient Services including professional assessment, counseling and therapeutic services. Components of service may include diagnosis and assessment, psychometric evaluation, individual, family or group therapy, medication review and chemotherapy, and other similar professional services that include a direct client encounter.

- Medication services that are directly related to prescription, administration, education and/or monitoring of medications
- Specialized Individual and Group Services including treating caregivers, peer and family support

The FY 05 State budget for all services in this category was \$8,693,082, almost all of which was contributed by the General Fund; only \$204,152 was contributed by Federal funds. A total of 45 agencies received State contracts for these services and 19 of these received substantial funding (i.e. over \$100,000). One FQHC (HealthReach) received funding for adult outpatient mental health services. The remaining agencies were mostly not-for-profit mental health agencies or counseling centers. The ones with the most significant funding are: Community Counseling Center (\$451,705), Counseling Services Inc. (\$501,125), HealthReach Network (\$411,424), Kennebec Valley Mental Health Center (\$977,533), Mid-Coast Mental Health Center (\$399,254), Sweetser (\$528,347), Tri-County Mental Health Services (\$1,052,404), Aroostook Mental Health Services Inc. (\$387,394), Community Health and Counseling Services (\$839,341), NorthEast Occupational Exchange (\$376,269) and Protea Behavioral Health Services Inc. (\$1,172,901). The State's Annual Report does not specify which agencies received funding for which services under the general category of "Outpatient and Professional Services" so the amounts listed include all services included in the category. However, in reviewing the agencies' web sites, all indicate they offer outpatient mental health counseling for individuals groups and families.

Children's Services

For FY ending June 30, 2005, 147 agencies received funding for Children's Mental Health Services. Funding amounts range from less than \$1000 to over \$7,000,000, although only one agency (Sweetser) received over \$2 million. Children's services are categorized in 11 service categories that represent 25 funded programs. The major categories include several community and family support programs, residential services, crisis stabilization and outpatient services. The total FY 05 State contract budget was \$46,890,909 of which \$1,169,672 was contributed by Federal funding, \$9,028,960 by the State General Fund (Non-Seed) and an estimated \$36,692,277 by the General fund as MaineCare Seed. The MaineCare Seed is provided as matching funds that enable State contracting agencies to receive Federal Medicaid funds of approximately \$68,500,000.

Primary care mental health services for children are more difficult to categorize than adults since services are often targeted at the family and home environment rather than outpatient clinical settings. However, for purposes of this analysis we are focusing on "Individual and Group Counseling" within the category of "Outpatient and Professional Services". Total funding for children's individual and group counseling was \$5,435,182 in FY 05, of which the majority (\$4,502,174) was contributed by the General Fund for MaineCare seed. Only \$57,517 was contributed by Federal funds (other than Medicaid).

A total of 36 agencies received State contracts for children's individual and group counseling and 17 of these received substantial funding (i.e. over \$100,000). Mostly, the same agencies received funding for children's outpatient services as for adult services. Some agencies received

significantly more funding for adults or children (showing a focus on one group) while others received more proportional funding. With the exception of HealthReach, all the agencies listed above as receiving significant funds for adult services, also received at least \$100,000 for children's services. Funding for children's outpatient counseling services among these agencies was as follows: Community Counseling Center (\$258,973), Counseling Services Inc. (\$182,057), Kennebec Valley Mental Health Center (\$169,529), Mid-Coast Mental Health Center (\$118,798), Sweetser (\$456,866), Tri-County Mental Health Services (\$574,673), Aroostook Mental Health Services Inc. (\$195,673), Community Health and Counseling Services (\$310,403), NorthEast Occupational Exchange (\$135,949) and Protea Behavioral Health Services Inc. (\$543,999). HealthReach, again the only FQHC to receive funding in this category, received \$72,693 for children's outpatient counseling. Additional agencies received significant funding for children's counseling services, most notably, Spurwink School which received \$916,027. Spurwink also received funding for adult outpatient services but only in the amount \$112,629.

Substance Abuse Services

For FY ending June 30, 2005, 99 agencies received funding for Substance Abuse Services. Funding amounts range from less than \$1000 to just over \$1,500,000, although only one agency (Drug Rehabilitation) received over \$1million and that was for residential services. Funding for substance abuse services is far less than for mental health services and much more reliant on Federal funds. The total FY 05 State contract budget for Substance Abuse Services was \$14,389,254 of which \$5,475,400 was contributed by Federal funding, \$3,306,855 by the State General Fund (Non-Seed), an estimated \$2,271,841 by the General fund as MaineCare Seed, and \$3,335,158 from Fund for a Healthy Maine.

Substance Abuse Services are categorized in two broad categories – “Prevention” and “Treatment” that together include 14 programs. The Prevention programs focus on information and education, community programs and identification and referral of people who may be in need of treatment. The Treatment category spans the range of detoxification and residential programs as well as outpatient treatment. The Treatment portion of the State's budget was \$10,748,127 for all forms of Treatment. The Annual Report does not break down funding for outpatient treatment. The list of 69 agencies that receive funding for substance abuse treatment includes two (2) FQHCs (HealthReach and Regional Medical Center at Lubec), as well as several agencies that also provide mental health services for children and adults, and a few hospitals. However, the majority of agencies receiving funding for substance abuse treatment are not included on any other provider lists, meaning they provide only substance abuse services as part of the safety net.

Obligation to serve the Uninsured/Underinsured:

For people eligible for services under the State contracts (see discussion of population served below) organizations are required to provide services “without regard for income, within available resources”. Agencies are expected to bill for services when possible and may charge fees based on a sliding scale.

For people who are not eligible for State contract support, all agencies offer some type of sliding scale or allowance for people who cannot pay, but the degree to which this is done and how it is publicized varies across the agencies. Some agencies clearly state in their informational material that they have a sliding scale, include a statement about providing service “without regard for ability to pay” in their mission statement and/or publicize the dollar value of their charity care, while in other agencies, the availability only becomes apparent with a great deal of searching.

Population Served:

The population eligible for services under the State mental health contracts is very specifically defined. It includes people covered by the Augusta Mental Health Institute (AMHI) class action Consent Degree (class members) as well as people diagnosed as seriously and persistently mentally ill. Very specific diagnoses and eligibility criteria exist to define who is considered seriously mentally ill, for both adults and children. People who do not meet the eligibility criteria may receive services but may not be subsidized by the State contracts.

Eligibility criteria for State-supported substance abuse treatment are not as defined as for mental health services. Material issues by the Office of Substance Abuse (OSA) says “OSA funds pay for services for persons who cannot otherwise pay for their treatment”. However, many referrals come through the criminal justice system. Because State funding is limited, access for people without financial resources who seek services from the general population may be problematic.

Geographic Coverage and Service Gaps:

The State has contracts with several agencies for all types of services in each of its three regions. Furthermore, all the major agencies have multiple service delivery sites, so there is reasonably good site geographic coverage Statewide. Gaps in coverage are more due to restricted eligibility for State-supported services, limitations on resources to extend services to people who don't meet the criteria, and shortages of some types of providers in some parts of the State (e.g. child psychiatrists in the rural northern parts of the State).

B4. Mental Health and Substance Abuse Services: FQHCs

Provider Group Overview:

All of the 20 FQHCs (including the FQHC Look –Alike) provide mental health and/or substance services within at least one of their clinic locations on at least a part-time basis. These sites may provide counseling services to their general patient population or may focus on certain target populations.

A few FQHCs also receive State funds for mental health and/or substance abuse services but most provide the services out of their Section 330 funding (see discussion of State-contracted agencies above). Overall in 2004, Maine's FQHC organizations that receive 330 funds had mental health and substance abuse expenditures (not including costs of facilities and administrative overhead) totaling \$1.2 million were for mental health services, and \$600,000 were for substance abuse services.

Obligation to serve the Uninsured/Underinsured:

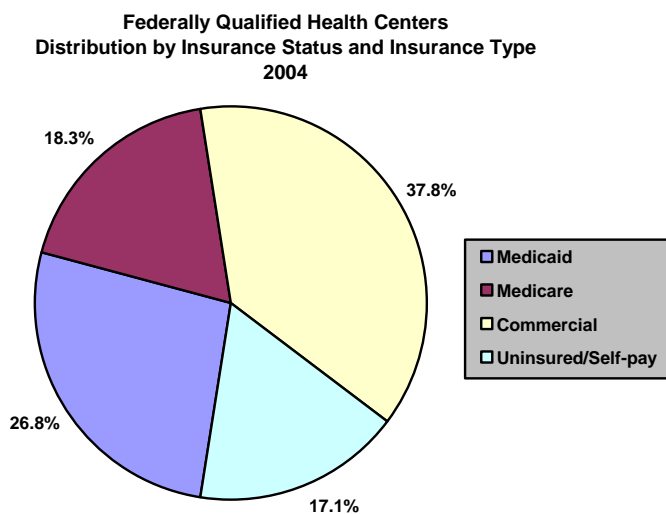
FQHCs have a regulatory and contractual responsibility to provide access to quality, comprehensive, coordinated, and culturally appropriate services to uninsured, low income populations without regard for a person's ability to pay. To the extent possible, FQHCs are expected to ensure access to oral health services in their service area to those they serve.

Population Served:

As mentioned above in an earlier section, FQHCs serve a broad cross section of the insured and uninsured populations in the service area but their target populations are low income populations, the uninsured, and those insured by Medicaid. In 2004, the overall distribution of patients served by any and all of the services provided by the FQHCs who received 330 funds was:

Unlike the State funding, Section 330 funding is not restricted to serving people who are seriously and persistently mentally ill, or class members, so FQHCs are an important part of the safety net for the general population. Unfortunately, despite efforts and some success in recent

years to expand services, FQHCs are still only able to serve a very small proportion of those needing services.



In 2004, FQHCs that received 330 funds provided mental health services to 3,098 unduplicated patients through 14,543 patient visits and substance abuse services to 684 patients through 6,167 patient visits. These numbers include those supported

through State contract dollars. While these numbers under-represent the volume of mental health and substance abuse services provided in FQHCs because services are often provided by primary care providers and not reported separately as mental health or substance abuse visits, they are still far below the need for such services in the State.

Geographic Coverage and Service Gaps:

The distribution of mental health and substance abuse services provided by FQHCs across the State mirrors the distribution of primary care medical services provided by these organizations. What should be made clear, however, is that in many cases services are provided on a very part-time basis.

B5. School-Based Health Centers

Provider Group Overview:

School Based Health Centers (SBHC) provide an array of basic primary care services within 26 of Maine's schools to all enrolled students regardless of insurance or ability to pay. The clinics are typically staffed by nurse practitioners, physician assistants, and registered nurses with backup from physicians at a sponsoring health care agency. In most cases the sponsor is a local hospital but health departments, FQHCs, and physician group practices also sponsor programs. SBHCs do not take the place of the regular school nurse, rather the two efforts work in concert, are often co-located, and do their best to coordinate their various activities and responsibilities.

Sites are located primarily through out Southern Maine. 14 sites are based in High Schools, 4 are based in schools that serve kindergarteners through those in high school, 1 is based in a school that serves Middle Schoolers and those in high school, 5 are based in middle schools, and 2 are based in elementary schools. SBHCs receive funds from numerous sources including federal, state, and local sources. Most sites receive significant financial and operational support from the Maine Center for Disease Control and Prevention's Teen and Young Adult Health (TYAH) Program.

There is considerable variation across the sites with respect to the array of services provided, depending on the resources available, the needs of the community, and the type of school setting. The sites pride themselves on providing a broad array of basic primary care services in an accessible, safe, and confidential manner. Services include check-ups, sick care visits, immunizations, and treatment of STIs. Staff also provide a significant amount of mental health and substance abuse counseling and often work collaboratively with local behavioral health agencies to coordinate referrals and services. SBHCs also work very closely with the areas providers, particularly the students' primary care providers to communicate about the services they are providing and make necessary primary care and specialty care referrals. Finally, sites provide basic case management and help students and families to navigate the areas health care system.

A survey of the 20 school-based health centers established in Maine prior to 2001 conducted by the School-based Health Council found that, of the 15 schools responding, 13% were elementary schools, 7% were middle schools, 66% were high schools, and 14% were a mixture of high school and lower grades. Eight of the 15 schools had behavioral health staff with an average of 17.2 hours of behavioral health services a week. The 11 schools providing information on the types of services provided reported that, on average, of students visiting the center: 33% had a preventive health visit, 38% received health counseling, 59% were screened for health risk behaviors, 9% received reproductive health care, 8% were seen for chronic physical health conditions, and 4% were seen for chronic mental health conditions.

While School-based health centers provide access to primary care services and do not deny care based on a person's ability to pay, they do not function as medical homes. School-based health

centers are typically not open 7-days a week, nor year-round. They are required to provide at least 8 hours of medical services per week. More than one half (53%) of the centers are open 25 hours or more a week and 20% have some services available in the summer. Furthermore, there is a great deal of variation across the clinics with respect to the services that are offered to their patients. SBHCs are not intended to replace the doctor or health care providers, but will work with them to better coordinate the student's health care plan. Most SBHCs in Maine do not have direct access to oral health, behavioral health, and the full range of specialty care services. However, where not offered at the SBHC, the center may offer referral services. Clinic staff provide health education, basic case management services, and do their best to coordinate care between the SBHC, the student's regular primary care provider, and any referral providers.

Obligation to serve the Uninsured/Underinsured:

In Maine, SBHCs provide services to all students at the schools regardless of insurance or ability to pay.

Population Served:

In 2004, 204,712 elementary and secondary students (Kindergarten through 12th Grade) were enrolled in Maine's public schools. Roughly 18,000 students (~9%) have access to services at the 26 SBHCs in Maine. From July 1, 2004 through June 30, 2005, 48% of students consented to receive services (8,683 students) and 47% of these students (4,123 students) utilized SBHC services. These 4,123 student users generated 10,611 encounters. Roughly 80% of these encounters were medical encounters and the remaining 20% were mental health encounters. 11% of those served were uninsured, 25% were insured by MaineCare, and 51% had some form of private insurance. Insurance status was unknown for 13% of the clinics users. 68% of the users were high school students, 22% were in grades 7 or 8, and 9% were in grades K through 6.

Geographic Coverage and Service Gaps:

SBHCs are located almost exclusively in the southern portions of the State. There are a number of sites in the rural Downeast portion of the State, but SBHCs are non-existent in Northern Maine. SBHCs play an extremely important role in all of the communities in which they operate. They expand access to services to a portion of the population that typically has limited access and often have high needs, particularly in some areas, such as behavioral health, family planning, and STIs. However, based on our interviews, SBHCs are not thought to serve as the core of the safety net for those they serve. Students are encouraged to have a separate primary care provider and when it is found that a student does not have a medical home or a regular primary care provider efforts are made to ensure that the appropriate referral is made.

B6. Public Health Departments

Provider Group Overview:

Three cities in Maine - Auburn, Bangor, and Portland - operate their own health departments that provide a range of basic primary care services to those who live in their cities. The range of services that the departments provide varies considerably.

City of Auburn - The City of Auburn provides a very limited array of preventive services to those in need including adult and child immunization clinics, a lead screening and education program, blood pressure screening services, and general health education. They also provide general case management services and administer a General Assistance program that ensure that Auburn residents living in poverty have access to basic necessities such as food, shelter, heating and cooking fuel, electricity, and over-the-counter drugs.

City of Bangor – The City of Bangor provides a broad array of basic primary care services to Bangor residents through a staff of public health officials and a number of public health nurses. There are five major programs.

- The Public Health Nursing Program provides health education, health monitoring and maternal and child health services to pregnant women and parents with children under 5. This program also provides health assessment and monitoring services to high-risk, low income older adults.
- The Children’s Dental Clinic provides mainly preventive and restorative oral health services to low income children under 18. The office also provides basic oral health education and occasionally endodontics, minor orthodontics, and surgical procedures.
- The Immunization Clinic provides immunizations for adults and children.
- The Sexually Transmitted Disease Clinic provides health promotion, prevention, counseling, testing, and treatment services related to STDs, including services for those at-risk or who have TB and HIV.
- The Women, Infants, and Children (WIC) Nutrition Program, with support from state and federal sources, works with low income families to ensure that they receive appropriate food, counseling, and other early childhood supports.

City of Portland – The City of Portland operates an extensive array of public health, social service, and health programs for men, women, and children. Services range from basic public health services such as maternal and child health programming and STD services to comprehensive direct primary care services such as a dental clinic and full services primary care clinics. The City’s services can be categorized into four major areas:

- Family Health. The City provides direct home and school based services to expecting parents, infants, young children, and adolescents through a Maternal and Child Medical home Visiting Program and a series of School Bases Health Centers.
- Health Promotion. The City provides a broad range of health promotion and health education programs geared primarily to adults that includes: cancer screening

services; substance abuse education, outreach, and counseling; and the facilitation of a series of community health coalitions.

- Infectious Disease. The City operates a number of immunization and STD clinics that provide immunizations to adults and children as well as health promotion, prevention, counseling, testing, and treatment services for those at-risk or who have a variety of STDs, including TB and HIV.
- Primary Care Services. The City operates and/or sponsors a number of health clinics that provide direct primary care services to the indigent as well as to low income populations who reside in Portland and in the case of the Free Clinic, in all of Greater Portland. The Portland Free Clinic serves those who are uninsured and provides a comprehensive array of basic primary care service (see description above). The Health Care for the Homeless Program is an FQHC, 330 funded clinic that also provides a broad array of primary care medical and behavioral health services but exclusively to the homeless. Finally, the City offers preventive dental services to low income residents of Portland of all ages.

Obligation to serve the Uninsured/Underinsured:

All three of the health departments have a mission-driven obligation to serve low income insured, uninsured, and underinsured populations either free of charge, at greatly discounted rates, or based on a sliding fee scale. A number of the programs also have a contractual obligation due to the requirements of their funders.

Population Served:

All three of the health departments serve a broad cross section of those that reside in their cities with an emphasis on underserved, high-risk populations, including those who are low income and/or uninsured.

Geographic Coverage and Service Gaps:

Except for the Portland Free Clinic, all of the cities services are provided exclusively for those who reside in the cities in which they operate. The Portland Free Clinic serves nineteen towns in the Greater Portland area but 80% of those served are from Portland, South Portland, or Westbrook.

B7. Family Planning Association of Maine

Provider Group Overview:

Many health care providers described in other sections provide family planning and reproductive health services. This section specifically describes the primary care-related services provided by the Family Planning Association of Maine (FPA), which receives and manages Federal Title X Family Planning funds as well as significant State funding for family planning and other related

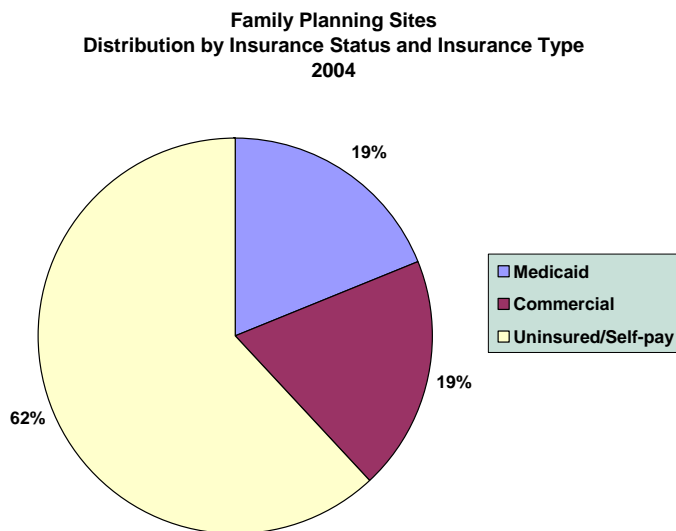
services including oral and injectable contraceptives, emergency contraceptives, screening, diagnosis and treatment of sexually transmitted infections and breast and cervical cancer screening in 30 clinic sites located throughout the State. FPA directly operates some clinical sites. Most of the clinic sites, however, are operated under contract to delegate agencies that in turn operate services at several clinic sites. Some of these are FQHCs, which integrate their family planning services into their primary care programs. Many other delegate agencies also provide health and social services that extend beyond the family planning services supported by FPA. For these delegate agencies, FPA provides technical support and quality assurance as well as funding. In addition to the services listed above, FPA provides many other patient, provider and community education services and surgical services, but these are not in the scan of the primary care safety net.

Obligation to serve the Uninsured/Underinsured:

FPA is required by federal law and the terms of its State contract to provide access for low income, uninsured people without regard to ability to pay. Eighty (80%) of their patients are at or below 100% of FPL. Title X requires that people below poverty receive free services and that a sliding fee scale is offered for people up to 250% of the FPL.

Population Served:

FPA serves both men and women from adolescence through the remainder of their lives. The vast majority of people served, however, are women from their teens through their reproductive years. In 2004, FPA served 29, 826 women and 1,765 men and provided 54,880 visits.



Approximately one third (10,000) of the women served are over 35. Teens make up another third Maine has about 40,000 girls age 15-19, an estimated 50% of whom are sexually active and FPA is serving 10,000 of these girls. FPA staff estimates that about 90% of its services are for primary women’s health care and 10% are specialty and surgical services. For many women, FPA clinics serve as the woman’s main source of health care.

Geographic Coverage and Service Gaps:

FPA strives to make their services geographically accessible and has managed to locate clinic sites so that most people don't have to travel more than 15 miles for family planning services. Although many clinic sites are operated on a part-time basis, services are located in rural and urban areas throughout the State.

IV. Opportunities to Expand And Strengthen The Safety Net

In addition to describing the primary care safety net in Maine, the environmental scan is intended to help MeHAF target its resources to strengthen and even transform the safety net. Several opportunities were specifically mentioned as part of the key informant interview and others became apparent in the analysis of safety net providers. Following are some major areas for MeHAF to consider in its future programming and grants-making activities

- Work to achieve greater integration among components of the safety net. During the environmental scan somewhat of a conundrum emerged. On the one hand, Maine was described as a small State where everyone could name all and personally knew most of the people involved in the health care safety net. On the other hand, very few people could comprehensively describe the safety net nor did they know much about providers other than the ones they worked with directly. Similarly, there was a great deal of information in various places about the safety net, but few thorough descriptions of its key components or their interrelationship. Just as is this case in most of the United States, it became clear both from the interviews and our analysis that, there is no true safety net care system in Maine. Some types of providers showed strong collaboration with similar types of providers (e.g. FQHCs, access programs and some mental health agencies collaborated well among themselves) and in a few localities, good local systems were in place. For the most part, however, each provider is doing the best they can given the resources available to them. Stimulating more and better collaboration among the component parts of the safety net is one place MeHAF can potentially help truly transform the safety net to make best use of the services currently available, improve quality, achieve efficiencies and ultimately lead to a true system of care both at the local level and Statewide.

Opportunities for enhanced collaboration exist among all provider groups but are particularly urgent among mental health and substance abuse providers and between mental health, substance abuse and primary care. Despite a few innovative projects and a few agencies that provide the full scope of services, the mental health, substance abuse and primary care provider communities still operate independently of one another. Moreover, there are still hundreds of agencies involved in the primary care mental health and substance abuse safety net, and mental health and substance abuse services are often provided in separate agencies. The urgency to address greater integration of primary medical mental health and substance abuse services is due to the extreme need for mental health and substance abuse services in the State combined with limited resources to support services for people other than those who are seriously and persistently mentally ill, or class members. Moreover, research has shown that integrated models work best for many population groups. For example, older adults a growing population with many unmet mental health and substance abuse needs prefer and do better when these services

are integrated with their primary care setting. At the same time, new opportunities are present that encourage additional collaboration including the newly integrated DHHS and movement of mental health services into managed care.

- Support capacity development both through new safety net providers and enhanced capabilities within current providers. Greater collaboration is critical to strengthening Maine's safety net, but can not alone address all the gaps in services or unmet needs. Compared to other States, Maine has fairly good geographic coverage for primary medical care safety net services, particularly if RHCs, hospital-employed and private physicians can be involved more as safety net providers. Some geographic gaps still exist (refer to NHSC vacancies and FQHC discussion), but the more serious gaps are for specific services and/or specific population groups. Some of the most critical needs noted in the scan include mental health counseling for adults and adolescents who are not diagnosed as seriously and persistently mentally ill, mental health and substance abuse services specifically focused for older adults, substance abuse counseling for people who have not come through the criminal justice system, psychiatry for children in the northern part of the State, and oral health services, particularly for adults, Statewide.

While it is unlikely that the State will authorize additional State funding to support safety-net operations, MeHAF can be helpful providing objective data and facilitating discussions to define issues and options for State policy makers, should funding opportunities present. Furthermore, it may be possible to redirect or more efficiently utilize existing State funding to cover at least some unmet needs. For example, the current plan to move Medicaid recipients into managed care may lead to some consolidation of provider agencies resulting in system-wide cost-savings that could be reprogrammed. Again, MeHAF can help by helping to articulate the issues.

Providers need operating funds to support safety net services either to cover the costs of serving additional uninsured patients and/or providing non-reimbursable supportive services that are essential to effective access. Although MeHAF can not provide ongoing operational funding it can and should continue to help programs obtain operational funding to enhance capacity; by supporting demonstration projects that position providers for more substantial funding, assisting in grant writing through educational forums or one-on-one assistance, or providing start-up funding for programs that can become self-sustaining.

MeHAF can also support activities that expand capacity without funding for new programs or services. For example, sharing "best practice" approaches and providing training to assist general medical providers provide some mental health and substance abuse services within the primary medical care setting (or conversely helping mental health and substance abuse providers identify primary medical care issues) can help extend capacity in key areas.

- Increase involvement of providers who may not normally be considered part of the safety net. Many providers are involved in providing safety net services, but are not always identified as being part of the safety net. These include hospitals and their physician

practices, RHCs, primary care residency programs and independent private practitioners. While the environmental scan was able to identify some of the ways these provider types participate in the safety net, much more needs to be understood including: the specific policies each provider has related to serving low-income uninsured patients; how their policies are actually implemented; the volume of safety net services provided; which population groups (geographic or demographic) are served; the extent they serve as “medical homes”, and, challenges these providers face in providing current levels of services or expanding services. Involving more diverse provider groups could be accomplished by convening meetings including these groups or for these groups as well as encouraging funding applications from places that have not historically applied for Foundation funding. The benefits to this increased involvement include gaining a better understanding of who is served where and therefore having a better understanding of where major gaps exist. Another benefit is that different provider types may gain a better understanding of how each is contributing leading to more organized and stronger systems of care at the local level.

Involving independent private practitioners including physicians, licensed mental health and substance abuse professionals, dentists and hygienists represent a special challenge because they are so disperse and their practices are so variable. MeHAF could help involve more private practitioners in organized and coordinated care systems by building on the approach taken and lessons learned by the exiting Health Care Access Programs. These programs have been successful in organizing volunteer providers into care systems for the uninsured and are one important way to bring committed individuals into the system and support them.

Recognizing and involving more types of providers in discussions about the safety net is not without challenges. In some communities there may be a long history of competition, distrust and even animosity between provider types. Also, some providers may pay lip service to participating in the safety net but really be more focused on strengthening their revenue base or securing greater market share. However, to truly ensure access to health services for all Maine residents, will require the participation of as many providers as possible; the traditional safety net providers can only begin to meet the need for services.

➤ Move the Dialogue beyond Primary Care to Encompass all Safety Net Providers.

One of the themes that emerged in the scan was that, despite having most of the pieces necessary, Maine, like most places, does not have a true safety net system. Additional efforts to integrate primary care components of the safety net including mental health and substance abuse services are important to begin forming that system. However, until all components of the system (primary care, specialty care, hospital services, residential/long term care, home care etc) are strong and work together, the system will remain extremely fragile. Critically, recruiting and retaining the health professionals that sustain the safety net depends on having resources across the spectrum of care.

The diversification of hospitals into vertical health delivery systems is an example of this type of interdependence and a strategic response to the need to approach the safety net

from a community/regional systems perspective. Several instances of FQHC expansion or development of access programs, with strategic support from community hospitals provide other examples of this interdependence.

Although it must be acknowledged that systemic change is inevitably a long-term, complex process, MeHAF has an opportunity to provide leadership in strengthening the full safety net system by better portraying the complete story of the safety net and taking a role in facilitating dialogue, joint planning and strategy development at community and State level.