State of Maine | 132nd Legislature
Joint Standing Committee on Health Coverage, Insurance, and Financial Services
Testimony of Coleen Elias on behalf of Community Clinical Services
01/27/2026

Supporting:
LD 2151, "An Act to Improve Access to Affordable Prescription Drugs in Underserved Areas"
Sponsored by Senator Reny

Senator Bailey, Representative Mathieson, and members of the Joint Standing Committee on Health Coverage, Insurance, and Financial Services, I am Coleen Elias, of Community Clinical Services - one of Maine's 20 Community Health Centers (CHCs), also known as Federally Qualified Health Centers (FQHCs), and part of the largest independent primary care network in the state.

Our Health Center, with service sites in Lewiston, provides primary care and integrated mental health, substance use disorder treatment, and care coordination to over 8,000 patients annually. One of our service delivery sites, B-Street Health Center, is in Maine's top census tracts for poverty.

We strongly support LD 2151 and thank Senator Reny and the cosponsors for reintroducing this critical legislation to provide much-needed support for FQHCs and to strengthen access to and expansion of pharmacy services across Maine. Since this Committee unanimously advanced this bill as its top priority in 2024, conditions have only worsened, as continued pharmacy closures further limit access to care for the communities our health center serves.

Today, I am here to speak as a voice for the voiceless in advocacy for the patients who cannot take time off work, who cannot afford transportation, who are caring for children or elders, or who are simply too exhausted by survival to be here advocating for themselves.

LD 2151 matters because access to medication is not theoretical for our patients. It is the difference between stability and crisis. Between health and emergency. Between dignity and despair.

Many of our patients live in what is described as a pharmacy deserts. They do not own cars. Public transportation is limited and not affordable, unreliable, or nonexistent for the hours pharmacies operate. For some, picking up a prescription means walking long distances in Maine winters, coordinating multiple bus transfers, or choosing between groceries and a rideshare.

Let me be clear: A prescription does not help a patient if they cannot physically get the medication.

Mail-order pharmacies are often suggested as a solution - but for our patients, they do not bridge the gap.

Mail order does nothing for:

- A child with an acute ear infection who needs antibiotics today
- A patient discharged from the hospital who needs blood pressure medication tonight
- Someone in mental health crisis who cannot safely wait days for a medication adjustment
- A patient whose medication was changed during a visit and needs immediate counseling and follow-up

For acute and urgent needs, mail order simply does not work. Delays in medication are delays in care and delays in care lead to worsening conditions.

This challenge is compounded by the reality that pharmacology is inherently complex. There are hundreds of distinct medication classes and thousands of individual drugs, delivered through dozens of different formulations, each affecting the body differently. For patients managing multiple conditions - diabetes, heart disease, asthma, depression, anxiety, or substance use disorder - medications interact, change frequently, and require clear education. Expecting patients facing transportation, language, or economic barriers to navigate this complexity alone is unrealistic and unsafe.

That is why co-located pharmacy services within a community health center are transformative.

When patients can receive their medications in the same place where they receive primary care and integrated mental health services:

- Medication adherence improves
- Medication safety improves
- Patient understanding improves
- Outcomes improve

Our patients often manage multiple chronic conditions: diabetes, hypertension, asthma, depression, anxiety, sometimes alongside substance use disorder. These medications interact. They change. They require education.

When a pharmacist is embedded on site:

- Patients can ask questions in real time
- Confusion is addressed immediately
- Dangerous errors are prevented
- Language barriers are navigated
- Trust is built

Embedding a pharmacist on site also allows clinicians to practice at the top of their license. Instead of spending valuable visit time explaining pharmacy logistics or dosing instructions, clinicians can focus on diagnosis, care planning, prevention, and the human connection that medicine requires, while pharmacists, who specialize in medication management, do what they do best.

The result is more efficient care, better care, and more access.

And importantly, this model helps reduce avoidable emergency department visits.

We routinely see patients end up in the ED not because their condition was unavoidable but because it was unmedicated:

- Asthma exacerbations because inhalers weren't filled
- Hypertensive crises because blood pressure medication ran out
- Mental health decompensation because psychiatric medications were delayed

These visits are costly to the system and traumatic for patients.
They are also, in many cases, preventable.

LD 2151 recognizes a simple truth:
Access to affordable medication is a core component of healthcare—not an optional add-on.

By improving access to pharmacy services in underserved areas, this bill supports:

- Better health outcomes
- Reduced strain on emergency services
- More efficient use of healthcare dollars
- And most importantly, greater equity in who gets to be healthy

I urge you to support LD 2151 - for clinicians, for health centers, for communities and for the patients who cannot be here today, whose lives would be made safer, healthier, and more stable simply by being able to leave their appointment with the medication they need in hand.

Thank you for your time, your service, and your consideration.

Coleen L. Elias, MHA
Chief Executive Officer
Community Clinical Services, Inc.