

**NC IOM SAFETY NET TASK FORCE**  
**November 4, 2004**  
**Area L AHEC**

**ATTENDANCE**

*Task Force Members:* Thomas Bacon, Gillian Baker, George Bond, Moses Carey, Mike Cinoman, Richard Daugherty, Leah Devlin, Gary Fuquay, Rick Gilstrap, John Graeter, Bobby Greer, Paul Harrison, Carmen Hooker Odom, Tom Irons, John Mills, Shirley Sims, Sherwood Smith, John Sullivan, and Doug Yarbrough

*Steering Committee Members:* Mark Holmes, Andrea Radford, Tom Ricketts, Jeff Spade, and Torlen Wade

*Staff and other:* Mark Benton, Gordon DeFriese, Kristen Dubay, Thalia Fuller, Ben Money, Adrienne Parker, and Pam Silberman

**WELCOME**

Secretary Carmen Hooker Odom (Co-Chair)

**MEDICAID FINANCING OPTIONS: DISPROPORTIONATE SHARE HOSPITAL PAYMENTS AND MEDICAID SPEND-DOWN OPTIONS**

**Gary H. Fuquay**

Director

NC Division of Medical Assistance

*Explanatory note by Pam Silberman: Only certain “types” of people can qualify for Medicaid, including children, pregnant women, parents of dependent children, people with disabilities (disabled) or visual impairments (blind), and/or the elderly (65 or older). In addition, these individuals must be low-income, e.g., have incomes, and sometimes, resources below state-specified limits in order to qualify. The income and resource limits vary by eligibility category. Individuals who have too much income but who otherwise meet the Medicaid eligibility requirements may still qualify if they have medical bills that are equal to the difference between their countable income and the Medicaid medically needy income limits.*

*Example: Mrs. Jones is a 67-year-old widow, living on \$842/month in Social Security retirement income. She currently meets the categorical eligibility requirements (she is 65 years or older), and meets the resource requirements (she has no more than \$2,000 in countable resources). However, her income is too high to meet the general Medicaid income limits for older adults (\$776/month). Mrs. Jones can still qualify if she incurs medical bills equaling the difference between her income and the state’s Medicaid medically needy income limits (currently \$242/month for an individual). This difference is called the “spend-down” or Medicaid deductible. This spend-down is generally calculated on a six-month basis. Medicaid will pay for any additional health care expenses over the*

*amount of the spend-down for the rest of the six-month period; after which Mrs. Jones will have to incur new bills to meet another six-month deductible.*

*\$842 – Mrs. Jones monthly income*

*-242 – NC’s Medicaid medically needy income limits*

*\$600 – spend-down or deductible*

*x 6 – spend-down calculated on a six month basis*

*\$3,600 – Mrs. Jones will need to incur \$3,600 of medical expenses before Medicaid begins covering additional health care expenses.*

*Federal law limits the types of health care expenses that can be applied to the spend-down. Generally, individuals can only use health care bills that they have a liability to pay in meeting their spend-down. In other words, if someone else pays the bill, then the Medicaid applicant cannot use those expenses to meet the Medicaid spend-down.*

*There is one major exception to that rule. Federal law requires states to count the amount of free care provided by a state or local governmental program in the spend-down calculations.*

Gary Fuquay explained how some state and county funding programs could be used towards an uninsured patient’s spend-down, which could then qualify that person for Medicaid. Medicaid law allows an uninsured individual whose income does not meet the eligibility threshold, to use incurred medical expenses against his or her countable income, to bring the countable income below the Medicaid income limits. A calculation based on an individual’s income identifies how much of a “deductible” or “spend-down” a patient must spend on medical care before he or she will qualify for Medicaid coverage. All medical bills that are incurred by the individual, even if they go unpaid, qualify towards the spend-down. The potential issue for the Task Force to consider is whether there are other opportunities to help uninsured individuals meet their deductibles, without the client having to bear the full responsibility for medical expenses.

As federal Medicaid law requires, the state allows the value of state or county health programs that are not supported by federal funds to count towards the spend-down. Mr. Fuquay provided a list of county and state-funded programs that could be used towards an individual’s spend down. Those programs include the Cancer Control Program, Epilepsy Medication Program, Home Health Services Program, Renal Disease Program, School Health Fund, Sickle Cell Program, Medical/Eye Care Program, Personal Care Services, and Clozaril Payment Program. One of the tasks for the NC Division of Medical Assistance is to get with our sister divisions to confirm which of the listed state and county funded programs still qualify and if there are any additional programs to add to the list.

The federal government says that you cannot use state or county funds directly to pay for an individual’s spend-down (e.g., the state or county can’t contribute funds to the Medicaid program equaling a person’s spend-down or deductible amount).

*Q: Can people with HIV/AIDS use the value of AIDS medications provided through the AIDS Drug Assistance Program (ADAP) to meet their spend-down?*

*A: Potentially. ADAP is supported by both federal and state funds. The value of the medications provided with state funds might be able to be used to meet a person's spend-down if the state accounted for the federal ADAP funds separately from state ADAP funds (the value of federally supported programs can not be used to meet a spend-down).*

*Q: How did the Division identify the programs that are currently on the list?*

*A: In 2002, we went through and made a list of state and county-funded health programs and put it in the Medicaid manual. We want to go back and verify that these programs are operating with state or county funds, and not through federal or private funds.*

*Q: Are the value of the services provided through these programs actually being used to help potentially eligible individuals qualify for Medicaid?*

*A: This provision has not been widely implemented. In order for people to use the value of the services provided through state or county funds towards their spend-down, they must receive a statement of the cost of care provided by the agency. The client must then bring that to the county DSS, who will count the value of the services in determining the person's eligibility for Medicaid. Local health departments do not have a mechanism to generate a cost of care statement. Further, most state-operated programs do not generate these statements. As a result, Medicaid applicants have no way of accounting for the value of services provided on their behalf.*

*The state is in the process of developing an integrated client tracking system that will include, at a minimum, Medicaid, public health and mental health. Each client will be given a unique client identification number. Once this system is operational (targeted for July 2006), it should be relatively easy for the state to generate an electronic accounting of the cost of services provided under state funds (e.g., through public health purchase of care programs or mental health). The value of these programs can then be transmitted electronically to the Medicaid program to be used in determining whether an individual met their spend-down. But until the new system is developed, the state or county must generate a cost of care statement for clients to use to meet their spend-down.*

*Q: Right now, does someone actually get paid for these services?*

*A: Yes. The state is paying for it. They don't give the patient a bill. The local health departments know what their costs are but they don't have the mechanism to produce such a statement about the cost of care for each individual, so the patients can't take that to DSS to show that as part of the spend-down.*

*Q: Would free clinics have to receive state or county funds in order to qualify under this exception?*

*A: Yes. Otherwise, they would be supported by private donations, even if those are in the form of volunteering.*

*Q: Couldn't the Medication Assistance Program (MAP) be used for this?*

*A: Yes. We will explore the possibility of adding the MAP program to the list.*

*Q: How can a patient understand this if we can't? Health literacy is a real issue.*

*A: The provider gets paid, but the state will have to make sure the client gets this document and takes it to DSS. It's not complicated, but they have to receive the cost of care statement and then take it to DSS.*

*Comment: If we could get some of the ADAP clients eligible for Medicaid faster, they would get a more comprehensive set of services. This would be a real benefit in helping that group reach their spend-down. It would be useful if there was more communication between public health and DSS on this issue.*

*Q: Is there any way for donated time to qualify for this spend-down?*

*A: No. Project access models wouldn't qualify because they are not county or state-funded programs. Under the regular spend-down rules, the federal law requires that the patient incur the cost, and have a legal responsibility to pay the bill (even if the bill has not yet been paid at the time it is used for the spend-down). If the client no longer has a legal responsibility to pay the bill (for example, if the provider writes off the bill as charity care), then the patient can no longer use the bill towards the spend-down. The Department of Medical Assistance cannot be party to providers giving patients a bill just for the purpose of applying the bill towards the spend-down (e.g., without ever having any intention to hold the client responsible for paying it). A provider's billing and collection policies are ultimately up to the provider to set, but it should be founded on cost-structure strategies that would apply to any person that walks in the door.*

*Comment: Those that are not eligible for Medicaid are eligible for the Purchase of Care Program. The patient may not even know that the program could contribute towards the spend-down, so it is our job to let them know that it does qualify.*

*Comment: There are some opportunities here that we have not fully maximized to take advantage of the exceptions to the spend-down rules. We need to review the list from 2002, look into ADAP and MAP, and we may want to see if there are other programs that we haven't thought of yet. It would be valuable to have an accounting program that Medicaid could use to see if individual services can be used for a spend-down. For other non-qualifying groups, the regular spend-down rules apply.*

*Q: Is there a booklet that DSS produces to show people how to go through this process?*

*A: There is a guide from Medicaid on how to become eligible, and it describes the spend-down process.*

**Mark Benson**

Deputy Director

Division of Medical Assistance

Mark Benson explained the Disproportionate Share Hospital (DSH) program. It is a federal and state program that is available in all 50 states. Its primary purpose is to

provide a revenue stream to hospitals, and safety nets in particular, to cover their uninsured costs and Medicaid deficits. The federal allocation to North Carolina is \$420 million. Two thirds of that allocation is federal and one-third is non-federal. Although the sum is large, it does not cover all the uninsured, unreimbursed costs to hospitals. In fact, that amount doesn't even cover the Medicaid deficit alone. Last year, hospitals still had \$800 million of unreimbursed costs.

The North Carolina Medicaid State Plan defines the DSH program and provides detailed description of the various types of DSH and supplemental payments. These include:

| Type of Payment                        | Eligibility Criteria  | Payment Intended to Cover                    |
|--|---|--|
| State-owned Hospital DSH               | State Psychiatric and UNC Hospitals   | Unreimbursed uninsured care costs            |
| “Super” DSH                            | Non-State, qualified public hospitals that also receive for Basic Add-on DSH (QPHs)                               | Unreimbursed uninsured care costs            |
| Teaching Hospital DSH                  | QPHs with graduate medical education programs and \$2.5 million in unreimbursed uninsured care costs              | Portion of unreimbursed uninsured care costs |
| Teaching Hospital Supplemental Payment | Private hospitals with graduate medical education programs and \$2.5 million in unreimbursed/uninsured care costs | Portion of unreimbursed uninsured care costs |
| Critical Access Hospital (CAH) DSH     | Hospitals that are designated as CAH and meet Federal DSH criteria  | Medicaid deficits                            |
| Rehabilitation Hospital DSH            | Non-State Public Rehabilitation hospitals with more than 100 beds that qualify for Basic DSH                      | Portion of Medicaid deficits                 |
| Supplemental Payment                   | Hospitals that are paid by DMA under DRG system for more than 50 percent of their annual discharges               | Portion of Medicaid deficits                 |

The federal government establishes minimum standards for hospitals to qualify for DSH payments, but then gives the states the flexibility of establishing additional criteria. The federal regulations require (a) that Medicaid recipients account for at least one percent of the population served by the facility and (b) there must be at least two obstetricians on staff or at least two physicians willing to provide emergent maternity services.

*Comment: Previously the DSH regulations did not list the word “emergent.” It is interesting that the DSH program requires the obstetricians. Some hospitals are dropping their obstetricians and it would be a shame if they would lose access to DSH funding as a result.*

*A: ObGyns must be employed or on contract with the hospital.*

*Q: If a hospital provided some prenatal care services and had an agreement with another hospital for patients to give birth there, would they still qualify for DSH? It seems like an FQHC that is a safety net, doesn't have ObGyns, but serves a population with much more than 1% Medicaid patient should qualify.*

*A: The hospital only qualifies if it provides in-patient care and FQHCs don't qualify because they are considered outpatient clinics.*

*Q: Could the hospitals be waiting for payments from private insurers and then get these "unreimbursed" costs covered by the DSH program?*

*A: It is accounted for in the program later, even if it happens. But, that doesn't usually happen. The really old unpaid debts are the ones being paid through DSH payments and they are so large that new charges aren't even considered for reimbursement.*

*Comment: In addition, payments from DSH don't even cover the Medicaid deficit, so they are not really going toward outstanding costs from the uninsured.*

*Q: What is the range of service to uninsured at hospitals in North Carolina?*

*A: In some hospitals, as much as 50% or more of the population is uninsured and/or receives Medicaid.*

*Comment: The NC DSH program is currently financed through intergovernmental transfers (IGTs) from public hospitals (e.g., public hospitals transfer funds to the Medicaid program who use the funds to draw down federal Medicaid DSH funds). There is nothing illegal in the use of IGTs, and most states are using them to finance part of their Medicaid program. However, Congress and CMS have expressed their concern over this financing mechanism. We should watch and see what happens with the politics. The whole intergovernmental transfer mechanism is probably going to be changed. The question that remains is how are we going to meet the needs of the uninsured if we can't finance DSH through IGTs? We need to make sure that the federal and state governments continue to fund DSH and provide support to help pay for uncompensated care to the uninsured and Medicaid deficits.*

## **IMPROVING ACCESS TO PHARMACEUTICALS: WHAT'S A STATE TO DO?**

Stephanie Geller, EdM  
Volunteers in Health Care

Stephanie Geller explained that her organization, Volunteers in Health Care, works with volunteer and safety net providers across the country to increase access to medical care, pharmaceuticals, and oral healthcare. She began her talk by putting the issue in context. She noted existing problems, including: high and rising pharmaceutical prices, lack of prescription drug coverage for many Americans, higher prescription drug costs for those without coverage, and patients not taking medications or administering them improperly to save money. The result is that many who are poor and lack prescription coverage are putting their health at risk.

These problems affect the uninsured, Medicare recipients, Medicaid recipients with limited coverage (e.g., Medicare recipients who receive limited Medicaid coverage that only covers some of Medicare's required cost-sharing), and the privately insured with limited coverage as well as healthcare facilities and local and state governments facing increasing drug costs. In 1999, 23% of Americans under the age 65 had no prescription drug coverage and in 2001, 36% of Medicare beneficiaries had no prescription drug coverage. In fiscal year 2004, 47 states and the District of Columbia implemented some type of cost containment initiative related to prescription drug coverage within Medicaid. For the privately insured, the average co-pays are now \$21 for preferred drugs and \$33 for non-preferred drugs.

Statewide drug assistance programs are trying to minimize pharmaceutical coverage gaps. In most states, these programs only target the elderly and disabled, but some cover the entire low-income population. Some type of statewide drug assistance program is available or authorized in 39 states, which use either a subsidy or a state-negotiated discount model.

Examples of some of the subsidy programs include the Maryland Pharmacy Assistance Program, which helps people with incomes at or below \$900 per month for an individual (\$1,041 for a couple) and assets below \$4,000 per month (\$6,000 for a couple). This program has some cost sharing, so the patient pays \$2.50 for generics and some brand name drugs and \$7.50 for other brand name products. The TennCare Rx program is a component of TennCare, which uses about a third of all of its dollars to pay for pharmaceuticals. The Wyoming Prescription Drug Assistance Program provides members with three free prescription drugs per month. However, it recently had to stop accepting new enrollments because costs were exceeding the state's ability to cover the program.

State-negotiated discount drug assistance programs exist in several states including Hawaii, Maine, and Michigan. These programs extend Medicaid drug coverage to other residents that don't have prescription drug coverage. The Hawaii Rx+ Discount Program provides discounts of 10-60% off the retail price to those with incomes up to 350% of the federal poverty level. Eligible residents can then use a prescription card to pay for their drugs at a community pharmacy. In Maine, the Rx Plus program helps those below 350% of the federal poverty guidelines save between 16 and 60% off brand name and generic medications. However, this program has faced court challenges and concerns from pharmaceutical companies. Michigan's MiRx Prescription Savings Program offers 20% off the retail price of pharmaceuticals for residents with no other drug coverage.

Other statewide efforts to assist with access to medications include programs that help individuals access pharmaceutical company sponsored patient assistance programs. These programs help low-income seniors and the uninsured access medications and generally follow one of two models. The coordination model helps individuals apply to patient assistance programs, while the other model obtains medications through bulk donation and replenishment agreements with pharmaceutical companies.

Some bulk patient assistance program coordination efforts are statewide physician referral networks that include a pharmacy component. Kentucky was the first to establish such a program, Health Kentucky, in 1984. The Arkansas Health Care Access Foundation followed suit in 1989 and programs began in South Carolina (Communicare) and Georgia (Partnership for Caring and Foundation) in 1993 and 1994. New and emerging bulk programs include Medbank of Maryland and the Virginia Rx Partnership.

Individual patient assistance program coordination, on the other hand, generally focuses on the elderly or Medicare beneficiaries and is primarily used in southeastern states. Examples include the Alabama SenioRx Program, which provides assistance to patients who are ages 60 or older. This program stations enrollment workers in Area Agencies on Aging to help patients apply to patient assistance programs and money is provided for staff salaries and equipment, such as printers, computers, and fax machines. Georgia Cares is another example of this type of effort.

In the bulk model of patient assistance programs, agreements are negotiated that allow an organization to screen for eligibility and get bulk products, so neither the pharmaceutical company nor the provider have to deal with all the applications. This is also advantageous because the bulk products are available when the patient is on site, rather than needing to wait for the medication to arrive in mail following approval into the patient assistance program.

Communicare's evolution began in 1993 with a feasibility study funded by Blue Cross Blue Shield. The program, which started with a \$200,000 grant from the Robert Wood Johnson Foundation, now has a \$1.4 million annual budget. They have a line item in the state budget and receive funds from National Office of Rural Health. The first companies to sign on were Pfizer and Johnson & Johnson and the program now works with eight companies. Initially, Communicare medications were dispensed by local pharmacies around the state, but now the program runs its own mail order facility. Eighty percent of the medications are sent to doctors' offices or clinics and 20% go directly to patients' homes. Communicare partners with the South Carolina Free Clinic Association and provides 17 clinics and more than 135 different medications. Initially, Communicare patients received medications at no charge, but they recently instituted a \$20 annual fee.

Eligibility for Communicare is reassessed each year. South Carolina residents qualify if they are not covered by any form of health insurance, including Medicaid, Medicare and Veteran's benefits and have annual household incomes that fall within the income guidelines (between 100% and 165% of the federal poverty line). The patient must also be able to document one of the following conditions: currently employed, receiving unemployment compensation, receiving Social Security Retirement benefits, or receiving Social Security Disability benefits or Workman's Compensation. Communicare benefits include provision of a formulary of over 260 drugs, which are donated in bulk by pharmaceutical companies. Participating manufacturers include Abbott Laboratories, AstraZeneca, Bristol-Myers Squibb, Eli Lilly, GlaxoSmithKline, Johnson & Johnson, Pfizer, and TAP Pharmaceutical Products.

A 2002 study of the Communicare program found a significant reduction in the frequency of emergency department visits by Communicare patients. This statistic helped the program get support from the state and from healthcare facilities because the decrease in emergency department usage translated into significant public savings. It took Communicare about two years to get each company on board because of all the necessary negotiations. The program now receives about \$20 million worth of medications. Pfizer drugs represent about 50% of drugs donated. States that want to develop a Communicare-like program should be realistic about the time it will take to get the program off the ground and focus initially on the large pharmaceutical companies that patients use most frequently.

The new and emerging models in Maryland and Virginia function differently. Medbank of Maryland began by helping providers and patients complete patient assistance program paperwork. It offered software (RxBridge, eMedBridge) that helped with management. Recently, in 2002, the program opened a central mail order pharmacy, which accepts bulk donations. So far, it has established agreements to provide pharmaceuticals with Abbott, AstraZeneca, OrthoMcNeil, and Pfizer.

Another strategy currently in development is the Virginia Rx Partnership. The program is still in its infancy. It is enrolling healthcare facilities (including both free clinics and community health centers) that have their own pharmacies and negotiating bulk donation agreements with pharmaceutical companies on their behalf. Initially, the Virginia Rx Partnership is working with 18 free clinics and four community health centers that have their own pharmacies but the program plans to add other facilities as the program grows. GlaxoSmithKline has already signed on and the Virginia Rx Partnership is working to get other companies to participate. This model places a greater burden on the healthcare facilities, but also decreases the overhead cost to the program by requiring that participating facilities have their own pharmacies.

The Public Health Service 340B Pricing Program provides discounts on outpatient drugs to covered entities, including federally qualified health centers (FQHCs), FQHC Look-Alikes, migrant healthcare centers, and certain Disproportionate Share Hospitals. Discounts can only be used to purchase medications for patients of the facility. Participating facilities receive an average savings of 25-50% off the average wholesale price (AWP) for covered drugs, which are only those medications related to the conditions being treated at the facility (e.g., Ryan White facilities can only purchase drugs for HIV/AIDS while community health centers can purchase any drugs that would be used in a primary care setting). Savings may be used to reduce the price of drugs for patients or to expand the healthcare facility's resources (e.g., increase revenue and allow them to treat more patients, offer more services, etc.) Many facilities adopt a sliding scale fee that allows them to pay the entire medication cost for the neediest patients, pass the 340B savings on to some patients, and charge the highest income patients and those with good insurance coverage prices that are higher than the 340B price.

There have been other efforts to expand the use of 340B pricing. States are encouraging the creation of FQHCs, providing loans to health centers to start a pharmacy or partner

with an existing community pharmacy, and encouraging referral relationships between organizations that allow them to make expanded use of 340B pricing. One example is the Coordinated Care Network (CCN) in Pittsburgh. CCN is arranging for a local FQHC to provide case management services to patients covered by a Medicaid managed care organization so that the HMO can get medications at 340B prices. There are some very interesting models that extend 340B pricing to organizations and individuals that are not always seen as being covered. If you are considering these options, it is important to seek help from legal counsel and/or to obtain advice from the Public Hospital Pharmacy Coalition (PHPC) and Pharmacy Services Support Center (PSSC).

Statewide bulk purchasing cooperatives, such as the California Safety Net Purchasing Alliance, would include both 340B and non-340B entities. Such cooperatives would have huge purchasing power due to the involvement of large payers, such as public hospitals. In California, a Pharmacy and Therapeutics Committee and preferred drug list were developed and required approval from the Office of Pharmacy Affairs. This model is not running yet, but is an interesting idea.

There are also state free clinic and primary care association efforts. The free clinics in the Great Lakes Region began purchasing volume drugs and supplies (such as glucose test strips and inhalers) in bulk and recently developed a relationship with ANDA to get a 5% discount on generic medications in exchange for providing the company with more business.

The Texas Association of Community Health Centers has a 340Better program, which is often able to secure prices that are lower than the 340B ceiling price, because they purchase in such large volumes. The volume discounts are provided because so many health centers participate. In fact, health centers across the country can participate in the program even if they aren't located in Texas. It would be interesting to see if any North Carolina health centers would benefit from participating. It might also be possible for North Carolina to get such volume discounts if it established a large safety net collaborative like those in California or Texas.

Another role the state can play is to advise safety net providers about pharmaceutical access issues. Medicine for People in Need is one example of a program that provides this type of assistance. It has offered conference call trainings, statewide and regional conferences, development of a safety net purchasing collaborative, technical assistance, policy analysis, research, and collaboration with Volunteers in Health Care on a newsletter, *Rx for Access*.

States can also work together to develop multi-state bulk purchasing agreements such as the National Legislative Association on Prescription Drug Prices (NLaRx), Northern New England Tri-State Coalition, and Pharmacy Working Group. These agreements extend the purchasing power that would normally be available to a single state. Currently, they are trying to get better prices for drugs for the states' Medicaid beneficiaries.

Other programs are facilitating the purchase of medications from other countries. I-Save-Rx allows drug purchasing from Canada, Ireland, and the United Kingdom. Participating states include Illinois, Wisconsin, and Missouri. The program has a contract with CanaRx, a Canadian pharmaceutical benefit manager, to refill prescriptions. The patients must get the initial prescription filled in US, but can get three-month supply refills from Canadian pharmacies. The participating pharmacies have been inspected by Illinois officials and the program offers 100 of the most commonly prescribed brand name medications.

States conducting formal studies or creating task forces on pharmacy assistance programs include the Rhode Island Blueprint study by the Heinz Family Philanthropies, which is evaluating various ways to reduce drug costs in the state, and, of course, the North Carolina Institute of Medicine's Safety Net Task Force.

Volunteers in Health Care resources available to you include: the *Starting a Pharmaceutical Access Program* and *Using Pharmaceutical Company Patient Assistance Programs* manuals; the RxAssist website ([www.rxassist.org](http://www.rxassist.org)); the RxAssist Plus software; the *Rx for Access* newsletter developed in partnership with Medpin ([www.rxforaccess.org](http://www.rxforaccess.org)); and past teleworkshops on patient assistance programs (PAP) and Rx Outreach, a generic PAP offered by Express Scripts. Information on all of these resources is available at [www.volunteersinhealthcare.org](http://www.volunteersinhealthcare.org).

Useful Websites include:

National Conference of State Legislatures - [www.ncsl.org](http://www.ncsl.org)

Maine Rx Plus Program -- <http://www.maine.gov/dhhs/mainerx/>

Communicare - [www.commun-i-care.org](http://www.commun-i-care.org)

Medbank of Maryland – [www.medbankmd.org](http://www.medbankmd.org)

Public Hospital Pharmacy Coalition - [www.phpcrx.org](http://www.phpcrx.org)

Pharmacy Services Support Center - <http://pssc.aphanet.org> (includes information about the value of using the prime vendor)

Coordinated Care Network -- <http://www.coordinatedcarenetwork.org/>

Medpin - [www.medpin.org](http://www.medpin.org)

Free Clinics of the Great Lakes Region - [www.fcglr.net](http://www.fcglr.net)

Texas Association of Community Health Centers – [www.tachc.org](http://www.tachc.org)

I-Save-Rx – [www.i-saverx.net](http://www.i-saverx.net)

## **SAFETY NET FINANCING OPTIONS, ENCOURAGING VOLUNTEERISM, AND POSSIBLE PRESCRIPTION DRUG OPTIONS: DISCUSSION OF RECOMMENDATIONS**

Pam Silberman, JD, DrPH

North Carolina Institute of Medicine

Pam Silberman reviewed draft recommendations that were developed based on discussions at previous task force meetings. She requested feedback on the recommendations, which were related to safety net financing options, encouraging volunteerism, and prescription drug options.

## **Safety Net Financing Options: Recommendations**

Dr. Silberman reiterated that recommendations presented are options to be discussed, rather than completed recommendations.

### **Hospital Financing Options**

**Rec. \_\_\_\_.** DHHS should consider other options to enhance Medicaid payments to hospitals that serve a high proportion of uninsured patients.

- New funds should be targeted to expanding care to the uninsured.

Dr. Silberman mentioned that this recommendation came out of our earlier discussions. She asked the group if they still thought it was worth recommending.

*Q: Do you have to specify what these options would be?*

*Q: My understanding is that the current Disproportionate Share Hospital (DSH) program doesn't differentiate very much between hospitals that are serving a huge amount of uninsured and Medicaid patients and those that are serving a lesser amount. Should there be some recognition for those providing the most care to the uninsured? Could the program pay a different percentage to hospitals that provide less care to the uninsured and Medicaid patients?*

*A: The state could develop a different DSH payment mechanism that pays a different percentage to hospitals based on the percentage of patients (and/or costs) attributable to Medicaid and/or the uninsured.*

*Q: Why would the number of uninsured or Medicaid patients served make a difference if the mechanism is based on the percentage of what the hospital is spending?*

*A: Because those hospitals serving more uninsured don't have enough paying patients to cover the costs of serving the uninsured and they may go out of business.*

*Comment: If you pay some hospitals more, the others will lose out because we don't have unlimited funds.*

*A: Yes, but this refers to additional funds.*

*Comment: In the narrative of the report, we may need to provide examples to better help the readers understand the options.*

*Q: If we found more state money, could we draw down more federal dollars?*

*A: We couldn't draw down additional DSH funds because the \$442 million is a DSH maximum from the federal government. However, North Carolina hasn't reached the upper limit for regular hospital payments under Medicaid, so the state does have flexibility in enhancing hospital reimbursement, and potentially the state could develop a payment mechanism that enhances payments to high-safety net burden hospitals.*

*Q: Does the \$442 million increase over time? Is there a formula so some states increase more?*

*A: The amount has increased, by a percentage, but it is the same percentage for all states.*

*Comment: If you develop a system to give more money to hospitals serving a greater percentage of the uninsured and Medicaid population, you may still have a situation where two hospitals serve the same percentage of uninsured, but one has access to AHEC teaching money or other resources, and the other doesn't.*

*A: We could build in something saying, "looking at other funds that are already provided to serve the uninsured, they should consider other options to enhance Medicaid payments."*

*Q: It may be important to include a provision to provide flexibility to the state to enhance payments to hospitals that offer services that the state encourages, such as inpatient mental health services.*

*Comment: Hospitals expressed their concerns that they can't change the makeup of their population and they may go out of business as they serve more and more uninsured.*

*Comment: There are two issues around DSH. The way you draw it down and the way you distribute it. DSH is financed through intergovernmental transfers from public hospitals across the state. The funds are distributed to many North Carolina hospitals (whether public or non-profit). The type of consideration you are discussing (basing it on a percentage of uninsured served) wasn't put into the original distribution agreement. The distribution agreement could theoretically be changed, but it might be difficult to do that while the state is still negotiating with the Centers for Medicare and Medicaid Services about the old DSH distribution system. Regarding increasing the general Medicaid preferential rate, it could be done, but the General Assembly would have to agree to fund it.*

*Comment: The budget neutrality favors the "haves" so we will have to find new money in the system.*

*Comment: Put a principle in the recommendation that we need to seek greater fairness or recognize that these other funds be taken into consideration during distribution.*

*Comment: It would read better if it said "enhance payments to hospitals," rather than Medicaid. Enhancing Medicaid payments could be a bullet point underneath.*

*Comment: Add State Employee Health Plan. We must put in some target for this action because otherwise the state is too amorphous and it won't get done.*

*Comment: Add to the recommendations that the General Assembly should appropriate funds for this purpose.*

*Comment: There is a group that wants to modify the DSH program to better reflect the proportion of uninsured and Medicaid patients being seen by each hospital, but nothing has changed because the future of the program is unclear.*

*Q: What ought to be considered a safety net hospital? What percentage of uninsured/Medicaid served would qualify? What would the criteria be?*

### **Medicaid Spend-Down Financing Options**

**Rec. \_\_\_\_. DHHS should modify the Medicaid spend-down rules to allow applicants to count the value of healthcare services paid by state and county programs in meeting their spend-down.**

- **DHHS should develop better systems at the state level to facilitate this process.**

*Comment: How about adding “study and evaluate opportunities to expand state and county participation.”*

*Comment: We ought to make it clear that this is a federal requirement, not a state option.*

*Comment: We ought to put something in this report about the NC Medicaid Management Information System that will be implemented in July 2006.*

### **FQHC/RHC Financing Options**

**Rec. \_\_\_\_ DHHS should explore different Medicaid payment rules that would provide higher reimbursement to FQHCs/RHCs that serve a disproportionately high percentage of uninsured.**

- **New funds should be targeted to support and expand care to the uninsured.**

### **Public Health Financing Options**

**Rec. \_\_\_\_. DHHS should explore different Medicaid payments to enhance payments to local health departments. For example:**

- **DMA should rebase local health department cost structure to more accurately reflect current costs;**
- **Local health departments should receive full Medicaid reimbursement during the settlement process (similar to other public providers);**
- **New funds should be targeted to providing care to the uninsured (comprehensive primary care, population based services, or other more targeted clinical services).**

### **CCNC Financing Options**

**Rec. \_\_\_\_ DHHS should consider developing a system of “shared savings” with regional CCNC networks.**

- **Savings that are retained by regional networks should be used to provide similar health services to the uninsured.**

The next meeting will focus on these recommendations. We will send them out before that so that you can send us feedback. You have in your materials the draft of the 4<sup>th</sup> chapter, and we will try to get you the next chapter so that you will have almost a complete draft of the report before the final meeting.

### **Community Health Grants**

**Rec. \_\_\_\_.** The NC General Assembly should appropriate \$\_\_\_\_ to ORDRHD to maintain and expand the Community Health Grants program. Funds should be distributed to support safety net organizations that provide primary care, dental, behavioral health and other health services to the uninsured and medically indigent on a sliding scale basis.

- \$\_\_ should be available to support Federally Qualified Health Centers (currently \$5 million);
- \$\_\_ should be available to support Local Health Departments (currently \$1 million);
- \$\_\_ should be available to support Rural Health Clinics (currently \$1 million);
- \$\_\_ should be available to support other non-profit organizations that have a mission to serve the uninsured and medically indigent.

### **MAP Financing Options**

**Rec. \_\_\_\_.** The NC General Assembly should appropriate \$\_\_\_\_ to the MAP program to cover more uninsured with incomes below 200% of the federal poverty guidelines who are receiving care in other non-profit clinics including other RHCs, FQHCs, or other non-profit organizations in both urban and rural areas.

These two recommendations are substantially similar and cover the same groups of safety-net organizations. However, the existing community health grants funding and the MAP program are very different programs. To some extent they look like they are serving the same purpose. Is there a preference for reimbursing per visit or more globally, or recommending them both? MAP right now is limited to rural health and is only for medical care. The question is whether we should use one or the other recommendation or a hybrid of the two. Also, if we recommend that the General Assembly continue and expand the existing Community Health Grants program, should we specify how much should go to certain organizations? Should we recommend continuing current appropriations levels or change the amount of the appropriations?

The Community Health Grants subcommittee will meet before the next Task Force meeting. The Task Force agreed that they could look at these two recommendations and come back to the Task Force with suggestions on what to recommend.

*Q: National healthcare efforts under this administration will be increasing tax credits and providing more grant money for federally qualified health centers (FQHC). Does anyone know what that will mean in terms of increased funding to health centers?*

*Maybe we will want to look at a different way of distributing the money in the future if there will be more money available?*

*A: In North Carolina, we still have a low rate of health centers. We need to build up the number of health centers to take advantage of more federal money.*

*Comment: We should recommend that North Carolina legislators hold the federal government to their promise of providing more money for FQHCs.*

*Comment: In the past, southern states were given a preference in the distribution of new FQHC funds, because of the high level of health disparities in the region. However, these preferences were eliminated. We need to talk to Senators Burr and Dole to say that we need those preferences in the legislation.*

*Comment: A representative from the task force should sit with Senators Burr and Dole to see how North Carolina can take advantage of this situation.*

*Comment: North Carolina also didn't take advantage of its planning capacity to figure out where its new clinics and services should be.*

*Q: Do some states have a very specific process? Who is the process run by?*

*A: Some states have been able to examine where they can ask for support for a specific program and where they can expand support. Most of the money has gone to expansion. In addition, many of the locations where new health centers are needed don't have the capacity to get started. If the existing centers could identify areas that need new centers and provide some help, that would be good. Two-thirds of the money is already specified towards expanding satellite offices. If you are an FQHC Look-Alike, then you can't get the grants.*

*Comment: I think we should have a shared message that we can all use to show a consistent, clear strategy.*

*Comment: It is important to keep the component that allows you to provide something that is more than medical services.*

### **Federal Safety Net Funds**

**REC. \_\_\_\_. NC CHCA, NCAFC, DHHS, and NC IOM should work with the Congressional delegation to provide additional resources to safety net organizations.**

- The delegation should ensure that North Carolina receive a fair share of federal safety net funds;**
- The delegation should work to expand the 340B program to free clinics, other non-profit organizations and others that have mission to serve low-income Medicaid recipients and the uninsured.**

### **Encouraging Volunteerism: Organized Systems of Care**

**Rec. \_\_a.** The NC General Assembly should appropriate \$\_\_\_ to the ORDRHD to support the maintenance and expansion of Project Access or other similar models of care to the uninsured.

- Funding should be limited to a maximum of \$10 per low-income uninsured person in the community;
- Funding must be matched with a similar commitment from the local community;
- At least 50% of state funds must be used to help purchase medications or systems that secure medications prescribed for enrolled patients for care provided in private doctors' offices.

**Rec. \_\_b.** To qualify for such funding, the local initiative needs to demonstrate:

- 1) A community-wide effort that includes at least 50% of primary care providers, 50% of specialist physicians, the hospital, health department, federally qualified health center (if available), free clinic (if available), state funded rural health clinic (if available), and department of social services;
- 2) A commitment from the local hospital to provide services to the uninsured;
- 3) A system for distributing care for the uninsured equitably across community providers;
- 4) A system to arrange for necessary referrals to specialists for low-income uninsured patients who are receiving primary care services from other community safety net resources;
- 5) Capacity in the program to screen and determine financial eligibility for free or reduced cost services;
- 6) Capacity to assist eligible uninsured patients in applying for free medications through pharmaceutical manufacturers programs or otherwise show a capacity to meet the medication needs of the patients;
- 7) Some capacity to provide needed enabling services such as transportation, case management and/or interpreter services;
- 8) Capacity to track state funding and report the number of patients served, types of services provided, and value of donated services.

*Comment: This recommendation is not needed because it is a bit repetitive of other funding recommendations. However, another recommendation should include the idea that technical assistance to ORDRHD should be provided to help communities build a system that is appropriate to the community (including HCAP, Project Access, etc.).*

*Comment: Programs should not limit the proportion of funds spent on pharmaceuticals versus other programs.*

*Comment: I don't like the idea of starting a whole new program when we are already asking for appropriations for existing programs, such as public health. Why create a new program to take away money from other things?*

*Comment: It isn't a good idea to include any specific name in the recommendations, because it could look self-serving.*

The consensus is that this recommendation isn't needed but the technical assistance piece for ORDRHD to help communities build any new systems is important to include under the other recommendation for ORDRHD.

### **Encouraging Volunteerism: Recognition**

**Rec. \_\_\_\_.** The NC Medical Society, local Medical Societies, free clinics, Project Access models, and other community initiatives that encourage private providers to donate their services to the uninsured should develop systems to recognize providers for their services. Recognition should be provided at both the local and state levels, and may include testimonials of patients who have been assisted by providers.

*Comment: Statewide recognition may be the only thing that is different about this recommendation from what already goes on in existing communities.*

*Comment: This is very much needed, but it shouldn't come out of this task force because it takes away the focus from the other recommendations.*

*Comment: I attended one of the Governor's recognition ceremonies and it was very nice. We could suggest that they incorporate these types of programs to highlight and honor doctors who serve many uninsured patients.*

*Comment: There are a lot of HCAP projects in the state and should be included in these volunteerism models. Physicians love to hear from patients.*

*Comment: It is important to include encouraging the doctors to continue volunteering in this recommendation.*

*Comment: Hospice recognition could be used as a model.*

*Comment: It would be good to include data from around North Carolina to give recognition within the report.*

*Comment: Leave this recommendation in the report, but prioritize the recommendations and place this one at the end. Make it more general and include that recognition should be done at the local level.*

### **Encouraging Volunteerism: Malpractice**

**Rec. \_\_\_\_.** The NC Medical Society, NC Free Clinic Association, NC Project Access organizations, and NC Health Directors Association should work together to identify options to reduce the fear of and/or threat of malpractice lawsuits against providers who volunteer their time to serve the uninsured without compensation. Such options may include, but not be limited to:

- a) Collecting information about the history of malpractice lawsuits brought against healthcare professionals who donate their time to provide charity

services to the uninsured at free clinics, Project Access models or in private offices. The information should be distributed throughout the state to local medical societies and in risk management seminars.

- b) Examining the Good Samaritan laws to determine if further changes are needed to provide additional protections to shield physicians and other healthcare professionals who volunteer to provide services to the uninsured from liability or the costs of defending a lawsuit.
- c) Examining options to provide low-cost malpractice coverage to physicians and other health professionals to help them defend malpractice suits, similar to the limited policy offered by Medical Mutual to retired physicians who volunteer in free clinics.
- d) Creating a risk pool to help pay some of the malpractice costs for volunteer providers.
- e) Examining the legislative options to provide financial support to providers to help them offset the costs of malpractice insurance needed to cover defense costs for providers who volunteer their time providing healthcare to the uninsured through free clinics, Project Access models, health departments or federally qualified health centers.
- f) Exploring the Federal Torts Claims Act to determine if volunteer health professionals can obtain malpractice coverage under Section 194 of the Health Insurance and Portability Act of 1996.

#### **Expanding the Availability of 340B**

**Rec. 6.1.** The NC General Assembly should pass a resolution urging the NC congressional delegation to support the expansion of the 340(B) program to include free clinics and other organizations serving the uninsured.

#### **Collaboration b/t GSK and Safety Net Organizations**

**Rec. 6.\_\_.** Safety net representatives should create a workgroup to meet with pharmaceutical companies to discuss:

- Improving the Patient Assistance Programs by simplifying and streamlining the application forms for the various prescription drug assistance programs;
- Creating bulk replenishment programs and other ways the pharmaceutical industry could help provide medications to safety net organizations;
- Starting with pharmaceutical companies that are manufacturing and receiving tax benefits.

#### **Technical Service Center for Prescription Assistance**

**Rec. 6.\_\_.** The NC General Assembly should appropriate \$\_\_\_\_\_ to ORDRHD to expand technical assistance for prescription assistance programs

- Expand availability of MARP
- Centralize bulk replenishment programs that are distributed to safety net organizations across the state
- Create other ways to obtain low cost medications for the uninsured

**Lower Cost Prescriptions from Other Countries**

**Rec. 6.\_\_. To help people without health insurance coverage who need prescription drugs, the NC General Assembly should explore the adoption of efforts like the I-Save-Rx program of Wisconsin and Illinois, which helps improve access to lower-price prescription drugs from other countries while addressing safety concerns.**

*Comment: Will this recommendation negatively affect the credibility of this report? That should be considered before we make a final decision to include it.*

*Comment: Maybe should not mention that program, specifically, because we don't know if it is one we support.*

Dr. Silberman closed the meeting by reviewing the Task Force chapters that will be provided to all Task Force members.

Dr. DeFriese brought up the fact that there aren't any clear recommendations to private foundations in the state. The Task Force members agreed that this needs to be reviewed.