

**North Carolina Institute of Medicine
Healthcare Safety Net Task Force
Meeting Summary
October 13, 2004
NC Hospital Center, Cary, NC**

ATTENDANCE

Members: Tom Bacon, Gillian Baker, Andrea Bazán-Manson, Moses Carey, Lawrence Cutchin, Dick Daugherty, Leah Devlin, John Estes, Bob Fitzgerald, Olivia Fleming, Gary Fuquay, Rick Gilstrap, John Graeter, Fletcher Hartsell, Andy Hartsfield, Carmen Hooooker Odom, Johanna Irving, John Mills, Bill Pully, Wanda Sandel , Adam Searing, Shirley Sims, Sherwood Smith, Stephen Smith, John Sullivan.

Steering Committee: Dennis Harrington, Mark Holmes, Ben Money, Andrea Radford, Jeff Spade, Tork Wade, Aimee Wall, Tom Wroth.

Staff: Gordon DeFreise, Kristen Dubay, Thalia Fuller, Adrienne Parker, Pam Silberman, Kristie Weisner Thompson.

Others: Catherine Roach.

WELCOME AND OVERVIEW OF AGENDA

Task Force co-chairs Carmen Hooker Odom and Sherwood Smith welcomed the group to its third meeting. Handouts were provided to each attendee, which included a meeting summary from the September 23rd Safety Net Task Force meeting, proposed recommendations from the workgroup on areas of greatest unmet needs, draft recommendations from the workgroup on coordination and integrating safety net services, and comments from Alan T. McKenzie regarding ideas to expand private physician volunteering.

POTENTIAL RECOMMENDATIONS: REVIEW AND DISCUSSION

Pam Silberman, JD, DrPH
Vice President
NC Institute of Medicine

Dr. Pam Silberman began the meeting by explaining the day's purpose: to review recommendations from the Task Force's two workgroups on *Areas of Greatest Unmet Need* and *Coordination and Integrating Safety Net Services*. The draft recommendations were distributed prior to the meeting and Dr. Silberman reiterated the fact that these were preliminary recommendations. This meeting was scheduled to review the recommendations and hear Task Force member comments and suggestions. Dr. Silberman noted that some of the concerns already expressed by Task Force members will be addressed during the afternoon session when the Task Force begins to discuss financing issues and expanding the availability of medications to organizations that don't qualify as 340(b) organizations.

Prior to discussion of the draft recommendations, Dr. Silberman brought up the fact that the workgroup on *Areas of Greatest Unmet Need* was unable to come up with viable ideas regarding how to encourage and recognize physician volunteers. The only specific suggestion was offering tax credits to physicians who volunteer, but that was ruled out as an option because group members felt that many people volunteer in other areas with no financial reward and, thus, it would be inappropriate to reward physicians specifically. Therefore, Dr. Silberman requested other ideas about how to address this issue.

Most of the recommendations from the *Areas of Greatest Unmet Need* are related to collecting data on the uninsured in North Carolina. Dr. Silberman asked for feedback on the following workgroup recommendations:

Recommendation 2.1:

The North Carolina General Assembly should take steps to make health insurance coverage more affordable, or to expand health insurance coverage to more uninsured individuals.

This recommendation was included because the workgroup felt it was important that the Task Force to make a statement about the rising numbers of uninsured and the importance of making health insurance more affordable for all citizens.

Comment: Use AND, rather than OR in this statement.

Recommendation 3.1:

The Office of the Secretary should take the lead in creating a work group that includes publicly-funded local management entities (LMEs), behavioral health providers, primary care providers, safety net organizations, and representatives of consumer groups to monitor access to behavioral health services for the uninsured and other underserved populations. The Office of the Secretary should examine access to services for both the priority (target) populations and for those with less severe behavioral health problems. In addition, the work group should examine ways to expand the capacity of primary care providers to address some of the behavioral health needs of the uninsured and/or underserved populations. Information should be reported to the Mental Health Study Commission.

Dr. Silberman explained that the workgroup felt behavioral health is a critical element of the safety net that needs to be provided, despite the fact that it is not being dealt with in this Task Force. Therefore, the workgroup suggested including this recommendation to outline the importance of addressing behavioral health issues in the state.

Comments: This is already being done by the Secretary's office, thus, this recommendation should include the words "continue to" before "take the lead."

Recommendation 4.1:

The NC ORDRHD should assume responsibility to collect data on and monitor the capacity of the safety net on an ongoing basis. The data should include information on safety net organizations that provide the full array of primary care services, as well as those that provide dental, behavioral health, preventive services only or a less comprehensive array of clinical services. In addition, data should be collected on the uninsured who receive services through non-profit or public dental clinics, pharmacy clinics or other specialty providers.

The data monitoring the capacity of the safety net throughout North Carolina, which are currently being collected by the Task Force, are a good start on evaluating unmet need. However, when the Task Force ends, the North Carolina Institute of Medicine will not continue monitoring these data. NC ORDRHD, on the other hand, already collects some of these data, so the workgroup felt that it would be valuable to have them assume full responsibility for this data collection.

Comment: NC ORDRHD should not be the only organization responsible for these data. There could be a role here for the Sheps Center for Health Services Research and the University of North Carolina at Chapel Hill to collaborate on this issue because they could provide a much greater capacity to evaluate these data. Therefore, it would be useful to include, "in collaboration with the Sheps Center for Health

Services Research and other research institutions.”

Comment: It was really the partnership of many groups that provided us with access to these data. NC ORDRHD does not have leverage to access these data in the future without collaboration. Thus, this collection process should be a partnership with the free clinics, AHECS, hospitals, and others.

Recommendation 4.2:

Safety net healthcare organizations that receive state funding (through Medicaid, public health, or Community Health Grant funds) should be required to report information to the NC ORDRHD on the unduplicated number of and the number of visits (encounters) for uninsured patients who receive comprehensive primary care, dental, behavioral health, or other clinical services. The NC ORDRHD should create a standardized reporting form to ensure that the data is collected consistently across healthcare organizations. Other organizations that do not receive any state funding (such as free clinics) should be encouraged to provide similar information.

Dr. Silberman pointed out that the workgroup attempted to use Recommendation 4.2 to address some of the concerns raised about NC ORDRHD's access to data. This recommendation suggests requiring safety nets receiving state funding to report the information to NC ORDRHD and developing a partnership with free clinics, which would not be subject to this requirement.

Recommendation 4.3:

The NC ORDRHD should share these data with local Community Care of North Carolina groups, Healthy Carolinian organizations, local health departments, NC Association of Community Health Centers, NC Hospital Association, NC Free Clinic Association, and local medical societies so that they can use these data to identify areas of unmet need. Similarly, the data should be shared with NC Health Foundations, to help inform their grant making process.

Recommendation 4.3 acknowledges that data collection will be most valuable if it is distributed to communities so that it can be used to help identify areas with unmet need and generate ideas for addressing their needs.

Recommendation 4.4:

The NC ORDRHD should report these data to the Secretary, Governor, General Assembly, and NC Association of County Commissioners on a yearly basis to help inform policy makers of areas of greatest unmet need.

This recommendation was included to ensure that the groups with the most political clout and financial ability to address these issues are kept informed of unmet need throughout the state.

Recommendation 4.5a:

The NC ORDRHD, Division of Public Health, NC Community Health Center Association, NC Hospital Association, and NC Association of Free Clinics should work together to develop a planning package for communities interested in expanding their safety net capacity including, but not limited to, an identification of possible funding sources. These groups should work collaboratively to provide technical assistance to communities. Priority should be given to low-wealth, high-needs communities to help them develop additional safety net capacity. Cross-county or regional approaches should be considered, particularly for smaller, less populated, or resource-rich communities.

Dr. Silberman explained that this recommendation is an attempt to provide assistance and encouragement to local communities with the greatest unmet needs. The workgroup acknowledged that those communities are often the ones with the fewest resources to address the needs of the community.

Therefore, the workgroup suggested that a state planning team could work with the local communities to develop structured plans. The group recognized that some of the communities would not be able to make changes without assistance, so the recommendation focuses on encouraging network approaches.

Comment: This recommendation focuses on expanding, but it is important to support those communities that are struggling to maintain current programs. How about adding “or maintaining” after the “expanding?”

Comment: In creating these regional teams, it would be good to include AHEC because they can play a valuable role in this process.

Recommendation 4.5b:

The NC ORDRHD should take the lead in pulling together this statewide collaborative of safety net organizations that can develop the planning package. Once developed, information should be provided to county commissioners, local healthcare providers, community collaboratives (such as Healthy Carolinians and CCNC networks), and other interested non-profit organizations about the availability of the planning package and technical assistance.

Dr. Silberman explained that the North Carolina Institute of Medicine (NC IOM) believes it is valuable to identify one group as responsible for seeing that the recommendations are implemented, which is why NC ORDRHD was designated as the point agency in this case. This recommendation highlights the importance developing and informing communities about a planning package and technical assistance.

Q: Is there an expectation that NC ORDRHD is going to have a staff that can support and manage the implementation of this planning package?

A: The workgroup recognizes that NC ORDRHD will need financial support to complete this work, which is why Recommendation 4.5c was also included.

Recommendation 4.5c:

The NC General Assembly should appropriate \$_____ to the NC ORDRHD to support the development of safety net planning packages and data collection.

In order to support the NC ORDRHD in fulfilling the responsibilities outlined in these recommendations, the workgroup determined that it would be appropriate to recommend financial support for data collection and hiring staff to develop the safety net planning package.

Comment: The Public Health Task Force 2004, which will be finishing Tuesday, October 19, is also asking for funding to support local communities through the public health departments. Including a recommendation for more financial support that does not show coordination between these two Task Forces is not a good idea. It is important that these recommendations are coordinated with those from the Public Health Task Force 2004.

Comment: The work being designated to NC ORDRHD is one of the health department’s responsibilities. There may be some counties where capacity is insufficient to collect these data, but identifying unmet need is one of the ten essential services of the Department of Public Health. Therefore, unless this work designated to NC ORDRHD is united with that of the Department of Public Health, fulfillment of these recommendations could create another line of competition for the Department of Public Health.

Dr. Silberman responded to these comments suggesting that NC IOM would work with the Department of Public Health to see if this work is already being done and to see whether and how to modify this recommendation. The challenge is that it may be unrealistic to ask each local health department to collect

these data.

Recommendation 7.1:

NC General Assembly should continue and expand the appropriations supporting safety net organizations that provide primary care, dental, behavioral health, etc., to the uninsured and medically indigent. Additional funds should be available to include other non-profit organizations that have a mission to serve the uninsured and medically indigent.

Recommendation 7.1 was included to recognize that one-time funds are currently available to support safety net capacity. The workgroup believed this was a valuable resource and that it should be continued. Because this was supported through a one-time appropriation, this year's grants were distributed with an emphasis on supporting one-time, non-recurring needs. The work group thought there should be a commitment from the General Assembly to ongoing support. In addition, the workgroup suggested that this support be expanded to include other types of non-profit organizations with missions to provide healthcare to the uninsured, beyond those that currently qualify for the money.

Gordon H. DeFriese, PhD
President and CEO
NC Institute of Medicine

Dr. Gordon DeFriese presented the recommendations from the workgroup on *Integration and Collaboration*. He noted that there is some overlap in the recommendations from the two workgroups and similar recommendations will be merged before they are listed in the final chapters of the Task Force report. Dr. DeFriese also highlighted the differences between the words integration and collaboration and mentioned that it was important to be careful with the verbiage used because many organizations can be intimidated by the idea of integration.

Recommendation 1:

The Task Force acknowledges the fundamental role of the local health department to assess community health status broadly, including the availability and adequacy of the full continuum of healthcare services in each county. The periodic community health assessments submitted by each health department should include specific reference to the adequacy of personal healthcare services and include the participation of all stakeholder safety net provider organizations.

This recommendation is very similar to Recommendation 4.3 from the *Areas of Greatest Unmet Need* workgroup and will be captured in Chapter 4. Therefore, we can delete this recommendation from this section.

Recommendation 2:

All safety net organizations and providers, once identified, should be asked to submit (monthly, quarterly, annual?) reports to _____ through which estimates of the burden of care provided to uninsured and under-served populations in our state can be determined in a standardized way across all communities.

This recommendation is similar to Recommendation 4.1 from the *Areas of Greatest Unmet Need* workgroup. Dr. DeFriese emphasized the importance of reaching consensus on how to coordinate this activity. The integration and collaboration work group did not designate which agency or organization should collect this information. The Task Force may want to discuss other options so that this is not solely a government initiative. However, it is important that a visible group coordinate these recommendations. This line needs to be filled in at some point. This recommendation should be merged

with 4.1.

Recommendation 3:

Efforts should be made (by NC DHHS in partnership with associations of safety net healthcare providers) to clarify state laws regarding the confidentiality of medical records so that assignment of clients and the services of providers in different clinical sites can be offered more effectively and seamlessly.

Recommendation 4:

The NC General Assembly should enact legislation that guarantees the portability of medical records and their confidentiality. The NC General Assembly should clarify its confidentiality laws, and in doing so should specifically permit providers to collaboration (and share information) in the course of caring for a common patient.

Following the presentation of Recommendations 3 and 4, discussion surrounded the inclusion of HIPAA in Recommendation 4 because of its relation to confidentiality issues. One member suggested that the Task Force should be careful about recommending enacting legislation. It was also pointed out that many people are afraid to share information because of HIPAA regulations, despite the fact that sharing information is legally permitted under federal regulations. Another point focused on using the recommendation to recommend clarifying the existing laws because of the confusion related to HIPAA. It was also pointed out that HIPAA is not the barrier some people around the state run into because HIPAA actually allows information sharing for purposes of treatment. It is actually state law that is unclear about sharing information for treatment purposes, thus, it is state law that should be clarified in this way.

Other Task Force members noted that, in the areas of mental health, reproductive health, and HIV/AIDS records, it is important to be careful in suggesting changes to confidentiality laws because federal and state laws provide greater confidentiality protections in these areas, and advocates spend their lives defending patient confidentiality. Some members suggested rewording the recommendation to develop a path toward this integration without enacting new legislation, which could be very difficult. Other Task Force members focused on the need to have mental health, behavioral health, reproductive health, and HIV/AIDS advocates at the table when this integration of information is conducted. It was also suggested that a uniform consent form might allow organizations to share information within the existing system.

Recommendation 5:

Additional financial support should be given to NC ORDRHD to provide general technical assistance of various kinds to emerging community health planning efforts (and collaboration should be expected with other public and private organizations who can render technical assistance to emerging safety net organizations and planning efforts).

Recommendation 5 clearly illustrates consensus between both work groups that NC ORDRHD should receive additional financial support for its role in spear-heading these recommendations. This recommendation should be combined with recommendation 4.5c.

Recommendation 6:

Set aside funds to encourage collaboration among existing safety net organizations (e.g., state-funded HCAP program), building on the funds appropriated in the last legislative session. These collaborations should include provisions for the participation of business and industry groups, colleges and universities, faith-community organizations, etc.

Dr. DeFriese noted that this recommendation recognizes that collaborations can be costly and money

should be provided to support organizations that are willing to meet and collaborate.

Recommendation 7:

NC DHHS (or some other agency or organization) should undertake to disseminate detailed descriptions of various “models” or “best practices” found to work well in particular communities. Models should give emphasis to situations where funding follows patients needing care, not the providers of that care.

This recommendation brought up several questions about what types of programs are examples of situations in which funding followed the patients rather than the providers. Some Task Force members wondered if this was a reference to expansion of SCHIP or Medicaid. Others thought this recommendation was related to outlining models of successful coordination and collaboration. The group determined that these two ideas needed to be separated. Another Task Force member suggested that the examples should also provide ideas about finding funding agencies. Further clarity would be needed to identify models (aside from insurance models) where funding follows patients rather than directly to providers.

Recommendation 8:

Both public and private funding agencies should develop clearer and measurable criteria of “collaboration” and use such criteria in decisions regarding future safety net program support.

Recommendation 9:

Public and private funding agencies should develop (either themselves or through contract agencies) and make available technical assistance to emerging safety net provider organizations and community-based planning efforts with regard to: financial planning; healthcare information systems, record access, and confidentiality; and federal and state laws and regulations affecting the provision of safety net services, the organizational aspects of interagency cooperation with such issues as eligibility determination.

Recommendation 9 is similar to Recommendation 4.5 from the *Areas of Greatest Unmet Need* workgroup. Dr. DeFriese noted that many of these areas of technical assistance are already available in NC ORDRHD programs, but this recommendation recognized the need to make it possible for NC ORDRHD to provide more. This recommendation should be combined with recommendation 4.5.

Recommendation 10:

Given the fact that hospitals in North Carolina have shouldered a tremendous burden of after-hours and “emergency” care for uninsured and under-served populations, hospitals are encouraged to explore ways in which safety net organizations in their communities might be contracted to provide unassigned call coverage and other forms of after-hours care for persons requiring less-urgent attention from these populations.

This recommendation emerged from an understanding that some safety net providers are able to provide urgent care or after hour services, which could take some of the burden away from hospitals. The goal of this recommendation is to encourage collaboration between hospitals and safety net providers for non-emergency medical needs, when appropriate.

Discussion regarding this recommendation pointed out that many of safety net organizations do not want to do that type of unassigned call coverage and even if they do, many hospitals can't afford to pay them for that type of work. In addition, the recommendation raised issues related to EMTALA responsibilities because if a patient chooses to go to a hospital, they cannot be turned away. One alternative suggested was to advertise the safety nets availability for after-hours urgent care issues. If this was done, however,

it was questioned whether the load could be partially compensated for by the hospital. Lee County is an example of this because the hospital pays the health department to stay open later hours, and they compensate them for the reduction in costs related to the decrease in the number of patients admitted.

Another Task Force member suggested that the term “unassigned call coverage” be dropped from the recommendation because it refers to patients within the hospital. The term “less urgent” could be used instead.

Recommendation 11:

Local boards of public health should be enabled to develop structures that would make them eligible to participate in federal programs though which funding is available to support care for the uninsured.

Recommendation 12:

Create on-going state-level Safety Net Advisory Council that can continue to encourage collaboration at state level after NC IOM Task Force completes its work (expanded to include other safety net organizations, e.g., free clinics, hospitals, Project Access models, etc.)

This recommendation was included to encourage collaboration between safety net organizations at a state level, in order to facilitate similar collaborative efforts at the local level. However, Task Force members recognized that much of the collaborative work happens at the county and local level. Therefore, the Task Force should also develop ideas to encourage local collaborations. This idea prompted the suggestion of holding an annual conference of safety net providers. Some members felt that the CCNC and Healthy Carolinian groups could satisfy the local collaboration concerns, but others felt that this was not adequate or available in some counties.

Physician Volunteer Service

Following discussion of the draft recommendations, Dr. Silberman referred back to her earlier comment that the group must develop further recommendations related to how more private physicians and specialists could be encouraged to provide safety net services. One Task Force member had emailed ideas, which were distributed at the meeting. Dr. Silberman asked the group if they felt comfortable using those suggestions to develop recommendations.

A number of Task Force members cited the physician fear of malpractice and the potential for a lawsuit as a serious barrier to volunteerism. This fear was noted as very real, despite the fact that others noted there is very little history of malpractice lawsuits stemming from volunteer efforts within North Carolina or across the country. It was highlighted that the Federal Tort Claims Act allows a provider to be indemnified from a lawsuit when volunteering as an employee of a federal entity, if the clinic qualifies. This statute was recently expanded to also include volunteers in free clinics, if the free clinic meets certain federal requirements (which are currently difficult to document).

In an effort to ease concerns, it was suggested that a recommendation include the development of data on the lack of history of lawsuits, which could then be used in the education process to inform physicians. Another idea was to expand the availability of malpractice coverage to pay the defense costs of physicians who volunteer to provide charity care (and who are currently

protected from liability lawsuits under the Good Samaritan Statutes). This is similar to what is currently offered to retired physicians through Medical Mutual, but this same coverage is not available for actively practicing physicians. Similarly, another idea suggested setting up state funds to insure and cover the risks of physicians. Other states have done this type of risk management pool. The statewide Rural Obstetrical Care Incentive (ROCI) funds are another example, where OB-GYN physicians received a contribution toward their malpractice costs in exchange for working in a local health department.

When asked if there is a way to offer incentives for volunteerism, one Task Force member suggested that physicians are under tremendous pressure because their reimbursement is capped with contracts. This leads them to try and see more patients to cover their overhead. As a result, only a program following the Project Access model, which is an orderly, organized approach, would be successful in this pressure-filled environment.

IDEAS TO EXPAND THE AVAILABILITY OF LOW-COST MEDICATION TO SAFETY NET PROVIDERS

Andy Hartsfield

Vice President, Public Policy & Advocacy
GlaxoSmithKline (GSK)

Mr. Hartsfield gave an overview of pharmaceutical pricing. In the pharmaceutical industry, there are public- and private-sector markets. The public sector makes up 30-40% of the market and includes Medicaid, ADAP (AIDS Drug Assistance Programs), federal programs, PHS (Public Health Service), and state drug assistant programs. They have mandated discounts.

Pharmaceutical companies sell the majority of their drugs to wholesalers, who sell to the rest of the market. Pharmaceutical companies set one price—called wholesale acquisition cost (WAC) or net wholesale price (NWP). After pharmaceutical companies sell to wholesalers, they don't have any control over the price. The wholesale market sells to retail market. The retail market sets the price for consumers. There are three or four major wholesalers in the country, but thousands of smaller wholesalers, so drugs may go through multiple wholesalers before they reach retailers.

Table 1 includes some examples of retail and WAC prices in Indiana for a particular medication. Retail prices vary based on geography and other factors from \$73.49 to \$117.00, or a 10%-76% mark-up over WAC in this particular case.

Table 1. Retail Brand Price Survey – Indiana (March 2003)

Avandia (4mg/30 tabs)	Retail Price	Mark-up over WAC
WAC	\$66.58	
GSK Orange Card	\$60.76	
Low Cost Rx (Chains-Indianapolis)	\$73.49	10%
Wal-Mart Pharmacy (Chains – Greenwood)	\$73.62	11%
Henderson Drugs Inc. (Indep.-Franklin)	\$84.46	27%
K-Mart Pharmacy (Chains – Greenwood)	\$88.23	33%
Walgreens (Chains-Indianapolis)	\$90.99	37%
Hamaker Pharmacy (Indep.-Indianapolis)	\$93.95	41%
CVS Pharmacy (Chains – Greenwood)	\$103.99	56%
Tucker Pharmacy (Indep.-Indianapolis)	\$108.22	63%
Medicine Shop (Indep.-Indianapolis)	\$117.00	76%

A New York survey found the following range of retail prices for various drugs: from \$82.49 to \$114.29 for Vioxx (25mg/30 tabs), from \$250.19 to \$372.97 for Lamisil (250mg/30 tabs), and from \$47.20 to \$144.97 for Allegra (60mg/60 tabs), from \$110.36 to \$178.25 for Cipro (500mg/20), from \$124.39 to \$179.30 for Nexium (40mg/30 tabs).

“AWP” or Average Wholesale Price is a price calculated and reported by Facts and Comparisons, First DataBank, Inc., and other third party data vendors for brand name drugs. Since Mr. Hartsfield joined the industry 13 years ago, he reported that the outside reporting services calculate AWP based on a formula (20-25% above WAC). It is not necessarily a price that anyone pays; it is used for reimbursement formulas. Every state has its own reimbursement formula for Medicaid. North Carolina pays AWP-10%. Other states pay different discounts off AWP. Some states pay WAC plus a percentage. The State also pays a dispensing fee to pharmacists (\$4 for dispensing brand name drugs and \$5+ for dispensing generics) (See example 1).

Example 1:

WAC: \$100

AWP: \$125

NC Medicaid pays AWP-10% or \$112.

Dispensing fee: \$4.00

Total for medication is \$116.

Q: Why is the dispensing fee handled separately rather than built in to the price of the drug?

A: I am not sure, but they are probably trying to reimburse the pharmacist for their time and expertise, which may not relate to price of drug.

Pharmaceutical companies are required to pay a rebate to the state. The rebate comprises three parts:

- 1) minimum rebate ~ 15%.
- 2) best price rebate – must pay the best price negotiated by other providers.
- 3) CPI penalty – for every drug, go to the point when the drug was introduced in the market, and track general inflation rate (CPI). Then look at how much the drug price increased during the same time period. Pharmaceutical companies have to pay an additional rebate based on the difference between their drug price inflation and CPI. Thus Medicaid is protected from any price increases greater than the rate of inflation.

To continue with Example 1, if the medication costs \$116, then the state would get approximately a \$15 minimum rebate (15%), a \$5 discount (assuming that there is a “best price” that is 5% below the minimum) and a \$4 discount (assuming the price of the drug was increased over a period of time 4%

more than the increase in CPI). The net state price would be approximately \$92. If the pharmaceutical company pays a total rebate of \$24 to the state Medicaid program (\$15 minimum + \$5 best price + \$4 CPI), the 340(b) program price would be approximately WAC minus \$24 or in this case, \$76. The state pays more because they are paying for the retail markup and dispensing fees. The state calculates its Medicaid reimbursement to pharmacies based on AWP while the 340(b) program pricing is calculated based on a base called the Average Manufacturers Price (AMP), which is usually very close to WAC.

Even though the Medicaid program and the 340(b) program receive the same rebate/discount from a manufacturer, in any given quarter those net prices could be very different. That's because if Medicaid rebates are based on commercial activity in quarter one, those rebates are calculated and paid during quarter two, and that rebate amount sets the discount level in quarter three for the 340(b) program. The Medicaid program also has a dispute resolution process that could, subsequently, adjust the rebates up or down, yet those changes may not be reflected in the 340(b) discounts.

The 340(b) organizations can pay wholesalers mark-ups and fees for the drugs they receive. Wholesalers are drug warehouse and delivers. Wholesaler mark-ups generally range from 1-5% per drug. They make money based on volume.

Q: Do federally qualified wholesalers (prime vendors) get a lower price than other wholesalers?

A: To my knowledge, there is only one approved prime vendor who can attempt to negotiate lower prices, but I don't think that program has proven very successful.

Comment: One potential recommendation is to expand 340(b) eligible organizations to include more "safety net organizations" such as free clinics.

Comment: In the retail price example, the WAC price for Avandia in March 2003 in the United States was \$66. According to one Task Force member, you can buy the same drug in Canada for \$71 or less. For people who can't get safety net or Medicaid discounts, they may want to buy from Canada. Many of these prices advertised in Canada don't include substantial shipping fees that are charged and many of these sites require customers to agree to extensive waivers of all rights in the event of injury. Mr. Hartsfield does not condone the practice.

A: Everyone has a different level of risk aversion. If a person walks into a reputable Canadian pharmacy and purchases a drug, the odds are greater that they are receiving a genuine brand name drugs. However, if they purchase a drug over the Internet, they have no way of knowing where that order is being sent or where the drugs are being shipped from, and therefore, run a greater risk that the drugs are not legitimate.

If we look at the macro economic picture of healthcare, we spend approximately \$1.7 trillion in healthcare (based on 2002 national healthcare expenditures) each year. Only 10% of that is spent on drugs. If we want to tackle healthcare costs, you can't have a significant impact by simply trying to cut drugs costs. The cost for individuals in many cases, however, is not inconsequential. Pharmaceutical companies try to address this issue through patient assistance programs and pharmacy discount cards. For example, GSK alone gives away approximately \$1 million per day in free drugs through its indigent patient program.

Q: Why is the Medicaid reimbursement formula higher in North Carolina than in most southeastern states?

A: The reimbursement formula of AWP-10% plus the dispensing fee is set by the North Carolina General Assembly.

Pharmaceutical companies calculate their rebates the same regardless of what reimbursement level the state determines for retail pharmacies.

GSK has to determine best price and calculate a figured called AMP (Average Manufacturer Price), which is often very close to WAC. The state determines its usage level and the unit rebate amount, invoices GSK, and GSK pays the rebate or they discuss any discrepancies that exist. Both sides sometimes make mistakes. There is a dispute resolution process, and adjustments can be made. These rebate amount determines the price for 340(b) programs. However, there is a time gap. Generally, Medicaid rebate calculations for the particular quarter of a year will determine the 340(b) prices two quarters later.

Q: What is WAC? Does every wholesaler pay this?

A: The WAC is set by each drug company for each drug. That is the price paid by wholesalers. Wholesalers take possession of the drugs and then sell to the retail outlets, usually with very small mark-ups.

Q: Do the FQHC's get a lower price than other wholesalers?

Comment: The 340(b) price is determined according to federal law. A licensed 340(b) wholesaler can potentially give a sub-ceiling price based on volume. Most 340(b) entities can negotiate with the wholesaler. They don't have to work with a prime vendor.

Comment: If a pharmaceutical company gave a significant discount to an entity that is not entitled to 340(b) pricing, it could set a new "best price" under the Medicaid program that could increase the company's rebates to the state for their entire Medicaid market. The 340(b) pricing is a federal issue, so we don't have as much influence with these policies as we do on state policies.

For each drug dispensed to a Medicaid beneficiary, the State Medicaid agency reimburses the pharmacy based on the state formula, but then receives a rebate from the pharmaceutical company. The initial Medicaid payment is funded with federal, state and county dollars. The federal contribution will vary by state. Data indicates that the net cost to the state is approximately 25 to 30 cents on the dollar for drugs they reimburse through their Medicaid program (estimated relative payments for prescription drugs as a percent of AWP). It's a good deal for the state. On average the rebates on Medicaid average 20-25%, but states also have to give counties and the federal government their share.

There are more effective ways to address healthcare costs today through better management of chronic disease. For example, in 1997 the city manager of Asheville, NC, looked at their employees with chronic diabetes. They discovered these employees were costing the city more than \$7,000 per person in medical costs. The city manager decided to implement a program that trained local pharmacists to counsel people with diabetes and offered to provide drugs at no charge if they joined the program. Drugs costs for employees with chronic diabetes were about \$1,000 per year per person prior to the program and went up to about \$3,000 per person after five years. After the program was implemented, the employees who participated improved their blood glucose levels and their cholesterol levels. Sick days were cut in half. Health improved significantly. The total medical costs per person were reduced to from over \$7,000 to \$4,500-\$5,000 per person per year. This was sustained for more than five years. If you just look at the drug costs, you wouldn't think the plan worked. Healthcare should be about managing the disease not focusing on cutting the drugs.

In 2003, GSK provided medicines worth approximately \$205 million to more than 400,000 low-income patients in the United States. Every single day GSK provides more than \$1 million worth of medicines to low-income patients through their programs.

GSK is a founding member of Together Rx™, a group of six major pharmaceutical companies offering savings to qualified seniors on over 155 prescription medicines through a single card. Together Rx has helped over 1.4 million cardholders save more than \$477.8 million on their prescription medicines. More than 157,000 seniors have benefited from savings obtained through GSK Orange CardSM.

In 2003, GSK provided medicines worth over \$8,772,000 to low-income patients in North Carolina, filling over 47,000 prescriptions through our patient assistance programs. To date, GSK has provided over \$1 million in HIV medicines to North Carolina's recipients. In North Carolina there are over 72,000 Together Rx cardholders who have saved \$24.9 million on their prescriptions. In 2002 the pharmaceutical industry provided medicines at little or no cost to over 267,400 low-income North Carolina residents.

Q: Group pharmacies talk about ordering individually versus in bulk. It is easier to order in bulk rather than having to send it to each patient individually.

A: To my knowledge, GSK doesn't provide bulk shipping through our patient assistance program.

Comment: GSK programs are difficult for some safety net organizations to work with because the safety net organization has to be considered a retail pharmacist for at least four months to get the drugs. This won't help safety net organizations because the drugs are shipped to the patient's house. Safety Net organizations need drugs to come to the safety net organization so that they can provide education to the patient. Patient compliance with prescription medication is a huge problem. Just because drugs go to the patients doesn't mean that they take it or take it correctly.

Comment: We hear a lot of complaints about the GSK program. There is a new program now that should make it better. HelpingPatients.org brings together America's pharmaceutical companies, doctors, patient advocacy organizations, and civic groups to help low-income, uninsured patients get free or nearly free brand-name medicines. It offers a single point-of-access to more than 275 public and private patient assistance programs, including more than 150 programs offered by pharmaceutical companies. It is available in both English and Spanish languages, and it is free and completely confidential. Mr. Hartsfield offered to facilitate a discussion with between GSK, free clinics, and 340(b) organizations about how to improve the program.

Q: Is there a way to capture the savings and channel them into existing resources for the safety net?

Comment: The Medicare Drug Program will go into effect in 2006. At the safety net level, there is a lot of value. Low-income people are getting a generous benefit, with no donut hole. The copays, where applicable, are minimal and premiums covered. For people with incomes above 150%, it may be more of a decision because of premiums and donut hole.

Comment: Under current Medicare prescription drug discount cards, recipients get \$600 per year in 2004 and 2005—a \$1,200 total credit to use for prescription drugs. For those who are also enrolled in Senior Care, it's a \$2,400 in credit. It is absolutely critical to sign up by December 31st to get both year's discounts.

Comment: We have found that more and more pharmaceutical companies are saying patients have to exhaust all of their resources under Senior Care and the pharmaceutical assistance programs before they can take advantage of the pharmaceutical industries' Patient Assistance Programs.

CUMBERLAND COUNTY MEDICATION ACCESS PROGRAM (CCMAP)

Catherine Roach

Pharmacist and Program Manager
Cumberland County Medication Access Program

The Cumberland County Medication Access Program is located in Fayetteville, NC. CCMAP was created to assist eligible Cumberland County residents in obtaining free life-saving medications and to enhance compliance and management of chronic long-term diseases. Since it was created it has expanded to include residents of Harnett and Sampson Counties.

Richard H. Parks, Chief Executive Officer of Cape Fear Valley Health System initiated the CCMAP idea by planning to open a free pharmacy. He had accomplished this in a previous job he had in Georgia. The George state lottery now pays for that program.

CCMAP is a community collaboration with support from the Cape Fear Valley Health System, the Cumberland County Health Department, The CARE Clinic, Better Health of Cumberland County, Cumberland County Mental Health, the Cumberland County Department of Social Services, and the Cumberland County Health Care Council.

Funding comes from a number of sources. The Duke Endowment and the Kate B. Reynolds Charitable Trust have each provided \$300,000 (\$600,000 total) over three years. The Cumberland County Health Care Council donated \$12,000. The CARE Clinic funded a full-time position for one year at \$27,225. The Cumberland Community Foundation has awarded CCMAP \$250,000 over five years. Additional funding comes from the North Carolina Senior Care Program through The North Carolina Health and Wellness Trust Fund Commission (NCHWTFC), which has awarded CCMAP \$450,000 over three years. Fund dispersal began in 2003. The NCHWTFC also awarded CCMAP an Expansion Grant for \$250,000 over two years. Fund dispersal began in 2004.

CCMAP also receives in-kind donations. The Cumberland County Health Department provides Office space and pays for the utilities and one pharmacist. Cape Fear Valley Health System covers the pharmacist/program director's salary, which decreases over three years (1st year - 100%, 2nd year - 50%, 3rd year - 25%). Cape Fear Valley Health System also provides the accounting services, funds dispersal, information systems, technical assistance, and 501(c)(3) status. The CARE Clinic, local physicians, and drug company sales representatives provide drug samples. These samples provide even further medication assistance to patients.

CCMAP has one pharmacist/program director, one lead prescription assistance coordinator/pharmacy technician, three prescription assistance coordinators/pharmacy technicians, and one scheduling coordinator (secretary). Through the Senior Care program they have another full-time pharmacist, one half-time pharmacist, and three prescription assistance coordinators/pharmacy technicians.

Enrollment Qualifications

Residents of Cumberland, Harnett, and Sampson county are eligible if they are on a stabilized dosage of medication, do not have insurance coverage for outpatient prescription drugs, do not qualify for government or third-party programs (such as Medicaid that provide for prescription medications), has a household income within 200% of the Federal Poverty Guidelines. Pfizer has expanded their income guidelines so they can help more people.

CCMAP began seeing patients in July 2002 and currently has 1980 active patients with a waiting list of 575 applicants. Patients are referred to CCMAP from social services and health departments. Of the

2,000 patients being served, 500 are involved in a medication management program. These are Senior Care patients.

To obtain medications, the patient must first complete a CCMAP application. The patient is then scheduled to meet with a pharmacist for medication management and a brown bag review. The patient leaves the interview with a 30-day supply of sample medications and completed applications (except for a physician signature) for all medications available from manufacturer's programs. The pharmacists also check the patient's pulse respiration, and blood pressure during patient visits. A large percentage of patients cannot understand the basic prescription's directions due to low literacy levels. The pharmacists go over them twice with patients who cannot read.

CCMAP asks that each patient have their application signed by their physician. The rationale behind doing it this way is two-fold. First, the individual needs some responsibility in this process, and second, the physicians may lose applications if they are sent to them in the mail. Patients return applications signed by a physician to CCMAP where patient income verification is then attached and mailed to the appropriate pharmaceutical manufacturer. A 90-day supply of medications is then mailed to CCMAP by the manufacturer and dispensed to the patient with counseling by a pharmacist. CCMAP continues to reorder and dispense medications for all active patients as well as adding any additional chronic medications that the patient may be prescribed in the future. Most patients are on an average of seven drugs. CCMAP calls the patient each time a drug comes arrives.

As of today, CCMAP has dispensed 9,474 sample prescriptions at a value of \$940,287 AWP (Average Wholesale Price) and 21,933 Medical Assistance Program (MAP) prescriptions at a value of \$4,878,481 (AWP). The total value of prescriptions dispensed to date is \$5,818,768 (AWP). These are 90-day supplies so in reality it's about 60,000 prescriptions each year. The average CCMAP patient receives about \$1,800 in free medications each year.

Comments and Questions

Q: Is there any charge for the medications?

A: No.

Comment: The paperwork is tremendous. That's what most of our time is spent on. Merck has simplest application and reorder process. Some companies will start with you and then at some point cut you off. There is a wide range of the kind of help available in the industry.

Q: Are patients successful in returning the prescription application signed by physicians back?

A: Usually, but some physicians are charging patients \$15 to sign a form. Physicians should want to sign the form and not make it harder for the patient by charging a fee. Helping patients access medications should make treating the patient easier for the physician in the long run because they will be dealing with a healthier patient who takes less time in the office.

Comment: Physicians have to review a patient's chart before they can sign the form. It takes some time.

Comment: People should use the Senior Care card. It's free money. None of us know what is going to happen with Medicare in two years. A lot of money is spent on packaging for shipping to send drugs to individuals. If we had centralized centers to dispense these drugs and make sure patients qualify, we could save money now wasted on shipping and paperwork.

Q: The FQHCs have access to free medications from Pfizer Share the Care, are you linked in any way to this program? Can the FQHC purchase these medications and share them with the collaborators?

A: Free clinics aren't eligible for this program. CCMAP does not qualify for the 340(b) programs. To qualify for Pfizer's Share the Care program, the organization must be a licensed pharmacy and the patient must have an income below 200% FPL.

Q: Who employs the CCMAP staff?

A: Cape Fear Valley Health System.

POTENTIAL FINANCING OPTIONS

Pam Silberman, JD, DrPH

Vice President

NC Institute of Medicine

FQHC/RHC

Dr. Silberman reviewed how FQHCs and RHCs are reimbursed (discussed more fully in a prior meeting). FQHC and RHCs are reimbursed according to one of two methods. As part of the Benefits Improvement and Protection Act of 2000 (BIPA)¹, Congress mandated that states use a prospective cost-based reimbursement method in Medicaid to pay FQHCs and RHCs. The costs are established using an average of 1999/2000 costs, inflated forward using the primary care component of Medicare. States can use an alternative methodology that is no less than the BIPA formula, as long as it is agreed to by the FQHCs or RHCs. In North Carolina, centers have the option of using the older cost-based methodology (in effect prior to the BIPA rules) that includes a cap or the prospective cost-based methodology (BIPA).

The federal statute gives states the authority to develop different reimbursement systems, as long as these methods are no less than the BIPA prospective cost-based method. Task Force members had previously talked about the need to provide additional financial support to organizations that are serving a disproportionate percentage of uninsured, as they have less ability to cost-shift to cover the costs of providing care to the uninsured. Although FQHC receive some funds from the federal government, and state-funded RHCs receive some funds from the Office of Research, Demonstrations and Rural Health Development, these funds are not sufficient to cover all of the costs of services to the uninsured.

There is currently wide variation in the percentage of patients served by these organizations who are uninsured. For example, the percentage of uninsured range from:

FQHC: 78.4% (high) to 16.4% (low)

RHC: 59.7% (high) to 6.2% (low)

Based on this, Dr. Silberman suggested that one possible recommendation from the Task Force could be:

Rec. #__. DHHS should explore different Medicaid payment rules that would provide higher reimbursement to FQHC/RHC that serve a disproportionately high percentage of uninsured. New funds should be targeted to support and expand care to the uninsured.

Public Health

Under federal Medicaid law, public health departments as public entities are supposed to receive cost-based reimbursement. Currently, local health departments are being paid less than actual costs. Health departments are reimbursed for services rendered based on an outdated cost structure (that has not been rebased for several years). At the end of the year, there is a settlement process where the state is supposed

¹ More information on BIPA can be found at <http://www.cms.hhs.gov/healthplans/bipa/>

to make up the difference (between the ongoing payments and full costs). However, in this process, the state only pays local health departments the federal share (not the state or county shares). As a result, there are some estimates that public health departments are paid between \$12-\$18 million less than their costs. New funds should be used to support care to the uninsured.

To address this issue, the Task Force could consider a recommendation such as:

Rec.#___. The NC Division of Medical Assistance should rebase the local health department cost structure to more accurately reflect current costs. In addition, local health departments should receive full Medicaid reimbursement during settlement process. New funds should be targeted to providing care to the uninsured (comprehensive primary care, population-based services, or other more targeted clinical services).

Community Care of North Carolina

Community Care of North Carolina (CCNC) is a Medicaid primary care case management program that provides case management and disease management to the Medicaid population. Services are provided through local networks of health and social services providers that include, at a minimum, primary care providers, hospital(s), divisions of social services, and local health departments. The program is being expanded statewide through regional networks. Early data suggests that CCNC is saving money in its asthma and diabetes initiative through reduced hospitalizations.

CCNC networks may also be a vehicle to expand care to the uninsured. The networks typically include most of the safety net organizations in a community. If they could receive funding, they may be able to provide similar service to the uninsured population (similar to what is currently being provided in Cabarrus and Pitt counties through HCAP grants).

Therefore, another potential recommendation for the Task Force to consider include:

Rec.#___. DHHS should consider developing a system of “shared savings” with regional CCNC networks. Savings that are retained by regional networks would be used to provide health services to the uninsured.

Medicaid “Spend-Down”

Currently, in order to qualify for Medicaid, an individual must meet certain requirements: categorical (“type of person”), income, and resources. First, a person must be the right “type” of person. For example, Medicaid is limited to children under the age of 21, pregnant women, families with dependent children, people with disabilities (meeting the Social Security disability standards), or older adults (65 or older). Non-elderly adults who are not disabled and who do not have children cannot qualify for Medicaid, regardless of how poor they are. Second, a person’s income must be below a specified income limit (which varies depending on the categorical program for which the person is applying). Finally, Medicaid generally has resource limits (e.g., the amount of money a person can have in a bank). Individuals who meet the categorical (type of person), and resource rules, but who have too much income may still qualify if they meet a Medicaid “spend-down.” These individuals must incur medical bills equaling the difference between their countable income and the Medicaid medically needy income limits.

Example: Disabled woman with \$842 in monthly income and few other assets (resources). Her income is too high to meet the categorical income restrictions for disabled individuals (maximum income = \$776/mon).

Medicaid Spend-Down Calculations:

\$842	Monthly income
<u>-\$242</u>	NC medically needy income limits for an individual
\$600	Monthly spend-down
<u>x 6</u>	Spend-down calculated on a six month basis
\$3,600	Six month spend-down (or deductible)

Generally, individuals can only use healthcare bills that they have incurred and for which they have a legal obligation to pay in meeting their spend-down. Thus, if a hospital or healthcare provider provides free care (such as in a free clinic or Project Access model), the uninsured person can not use the value of the services to meet their deductible or spend-down.

There is one exception to this rule. Under federal Medicaid laws, individuals can use healthcare expenses paid by a state or county-funded program (other than Medicaid) to meet the spend-down.

The federal Medicaid manual states:

3628. When countable income exceeds the MNIL [medically needy income limits] for the budget period, deduct from that income certain medical and remedial care expenses *incurred by an individual, family, or financially responsible relative that are not subject to payment by a third party unless the third party is a public program of a State (or territory) or political subdivision of a State (or territory). Deduct incurred medical and remedial care expenses paid by a public program (other than a Medicaid program) of a State (or territory).* Once countable income is reduced (by applying these deductions) to an amount equal to the MNIL, the individual or family is income eligible.

3628.1 Expenses That Must Be Deducted--Deduct from countable income the medical and remedial care expenses ...that are not subject to payment by a third party. **(Such deductions are allowable even if the expenses are paid by a public program (other than the Medicaid program) of a State or territory if the program is financed by the State or territory.)**

State or Territorial Public Program--A program that is operated (i.e., administratively controlled) by a State or territory (including a political subdivision thereof).

State or Territorially-Financed Program--A State or territorial public program whose funding, except for deductibles and coinsurance amounts required from program beneficiaries, is either:

1. appropriated by the State or territory directly to the administering agency, or
2. transferred from another State or territorial public agency to the administering agency.

Under this law, services provided under the state-funded ADAP (AIDS Drug Assistance Program), other Purchase of Medical Care programs that are run through local health departments, or state MAP funds should be able to be used as deductions to help an otherwise eligible Medicaid recipient qualify for Medicaid. Once a person qualifies for Medicaid, ~63% of the healthcare costs would be paid by the federal government. This would free up state-only dollars to cover more uninsured.

Based on this, the Task Force may want to consider the following recommendation:

Rec.# _____. The Division of Medical Assistance 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

Comment: We should look what other states are doing –we need to see how CMS in the Atlanta office is interpreting the Medicaid spend-down issue.

Q: Should we worry about overburdening the county DSS offices if we ask them to determine eligibility for these programs?

A: Some people may already be eligible for services. We want to make sure they get into DSS offices so that their eligibility can be determined.

Expansion of Medication Access Program (MAP) Funding

The NC Office of Research, Demonstrations and Rural Health Development (ORDRHD) has limited funding to help pay state-funded rural health clinics for the services provided to the uninsured with incomes below 200% of the federal poverty guidelines. (This was discussed more thoroughly in the April Task Force meeting). ORDRHD currently pays \$67 per visit for eligible uninsured. Approximately \$1.6 million is used annually to pay for the MAP program. Because of the limited funding, this program is limited to state-funded rural health clinics. Other organizations with similar missions (e.g., FQHC, other RHC, or other non-profit organizations organized to serve the uninsured) cannot receive this funding. One option the Task Force may want to consider involves expanding MAP funds to help pay for services provided to the uninsured in other organizations.

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 RHC, FQHC, or other non-profit organizations in both urban and rural areas).

Comment: In communities without safety net organizations, maybe we should provide MAP funding to primary care physicians who serve uninsured. \$X per visit for uninsured with incomes below 200% FPG.

Hospitals

Hospitals have different Medicaid payment methods, depending on the service (e.g., inpatient, outpatient, or psychiatry) and type of hospital (e.g., teaching hospital or small rural hospital). For example, small rural hospitals (Critical Access Hospitals) receive cost-based reimbursement. Teaching hospitals receive some graduate medical education funds. Medicaid typically pays hospitals less than costs. Certain hospitals get payments in addition to their regular Medicaid payments. Hospitals that serve a disproportionate share of Medicaid and uninsured are eligible for an enhanced Medicaid payment (Disproportionate Share Hospital payment or “DSH”). However, DSH only helps bring hospitals closer to “costs,” it is not sufficient to cover the costs of providing healthcare services to the uninsured.

The state is in the midst of a disagreement with the Centers for Medicare and Medicaid Services about how it uses its DSH funds. It is not clear how much flexibility the state has in establishing different hospital reimbursement rules. However, once CMS and North Carolina work out these disagreements, and CMS provides more instructions on hospital financing, the state may want to consider different hospital reimbursement systems. For example, the Task Force may want to consider a recommendation such as:

Rec.# ____. The Division of Medical Assistance should consider other options to enhance Medicaid payments to hospitals that serve a high proportion of uninsured patients. Funds should be targeted to expanding care to the uninsured.

Options to Encourage Private Providers to Serve Uninsured Patients

The Task Force recognized the important role that private physicians play in the provision of care to the uninsured. Many communities lack sufficient safety net capacity to meet the healthcare needs of the growing uninsured population. Further, national studies suggest that most of the uninsured receive their care from private physicians. Unfortunately, studies also suggest that there is a growing reluctance among private providers to provide charity care. Nationally, the percentage of physicians who reported providing charity care fell from 76% to 71% between 1997 and 2001. Access to specialty care is a particularly acute need. Even in communities that have sufficient primary care capacity, the uninsured have difficulties accessing specialty services.

The Task Force identified a number of factors that could discourage private providers from volunteering their time to serve the uninsured. Some providers are reluctant to treat the uninsured for fear that they will be deluged with large numbers of uninsured seeking care. In addition, providers do not have the time to investigate whether an individual is truly needy—uninsured and unable to pay—or whether a person has the ability to pay for needed care. In the past, providers have also been reluctant to provide services if they thought that all of the patients' healthcare needs could not be met. For example, some providers were unwilling to provide services if their patients were unable to obtain the prescribed medications or other specialty referrals. Providers have limited time to volunteer because of the need to see enough paying patients to cover the costs of their practice. And finally, some providers are afraid that they may be subject to lawsuit for a bad health outcome; and the uninsured, particularly low-income uninsured, may be more prone to poor health outcomes because of the effects of poverty and lack of ongoing primary and preventive services. The Task Force developed a set of recommendations to remove these barriers in order to encourage more providers to provide services to the uninsured. Some of the recommendations support Project Access models or other "fair share" systems that equitably divide care to the uninsured among multiple community providers, other recommendations focus on the potential liability concerns.

Project Access or Fair Share Systems: Project Access or other "fair share" models have been successful in distributing care among primary care and specialists in the community, so that no particular provider feels overwhelmed with large numbers of uninsured patients. Another benefit of an organized system of care, such as a Project Access or Healthy Communities Access Program, is that the program can screen people to determine financial eligibility for free care, and may be able to help with scheduling and reminder phone calls to ensure that patients keep their medical appointments. Project Access models or other similar systems can also help arrange for necessary specialty care, and provide some access to medications. However, these models are not available in every community; and need some financial support to help the ongoing administrative costs of running a program. Therefore, the Task Force could consider a recommendation such as:

Rec.# ____. The North Carolina General Assembly should appropriate \$___ to the Office of Research, Demonstrations and Rural Health Development, 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. This 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 physicians offices. To qualify for such funding, the local initiative would need to demonstrate:

- a) A community-wide effort that includes at least 50% of primary care providers, 50% of specialty 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;
- b) A commitment from the local hospital to provide services to the uninsured;
- c) A system for equitably distributing care for the uninsured across community providers;
- d) 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 (such as the health department, federally qualified health center, and/or free clinic);
- e) Capacity in the program to screen and determine financial eligibility for free or reduced cost services;
- f) 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;
- g) Some capacity to provide needed enabling services, such as transportation, case management, and/or interpreter services.
- h) That the organizations or programs that receive state funding track and report on the number of patients served, types of services provided, and value of donated services.

Of the funds appropriated, \$____ shall be provided to the Office of Research, Demonstrations and Rural Health Development to provide technical support to communities wishing to create Project Access like systems, and to support communities with existing systems to enhance and sustain the quality of care.

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 the state-levels, and may include testimonials of patients who have been assisted by the provider.

Malpractice: The Task Force learned that some healthcare providers are reluctant to provide care to the uninsured due to the fear of a malpractice suit. North Carolina laws already provide some protection to healthcare professionals who volunteer services to provide care to the uninsured without receiving compensation. The law protects providers who provide free care in local health departments, community health centers, or free clinics, or who provide free services to patients referred by one of these organizations, from liability from damages (as long as the damages were not the result of wanton conduct or intentional wrongdoing) (NCGS §90-21.16).

This Good Samaritan statute provides some protection against monetary liability, but does not cover the costs of having to defend a lawsuit. Retired physicians can get volunteer coverage for the costs of defense for \$100/year from Medical Mutual; but this same coverage is not available to providers who have active practices, and some private policies do not cover the healthcare services provided outside the physicians office or hospital. While there are no known lawsuits filed against volunteer physicians; the fear of lawsuit (whether real or imagined) discourages some providers from volunteering to serve the uninsured. The Health Insurance Portability and Accountability Act of 1996 included provisions to extend the Federal Torts Claims Act to physicians who volunteer in free clinics, however this provision was not implemented until recently.² It is unclear at this time how difficult it will be for volunteer physicians and/or free clinics or other community organizations that provide free care to qualify for this coverage. Therefore, the Task Force could consider a recommendation such as:

Rec.# _____. The NC Medical Society, NC Free Care Association, NC Project Access organizations, and NC Health Directors Association should work together to identify options to reduce the fear of and/or

² See www.brhc.hrsa.gov/freeclinicsftca/application.htm.

threat of malpractice lawsuits against physicians 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 then be distributed throughout the state to local medical societies and in risk-management seminars.
- b) Examining the existing 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 malpractice lawsuit.
- c) Examining options to provide low-cost malpractice coverage to physicians and other health professionals to help them defend the cost of malpractice insurance, 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 for some of the costs of volunteer physicians.
- e) Examining legislative options to provide financial support to providers to help offset the costs of malpractice insurance needed to cover the defense costs for providers who volunteer their time providing healthcare to the uninsured through free clinics, Project Access models, health departments and/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 Portability and Accountability Act of 1996.

DISCUSSION

Comment: Pharmaceutical companies need to work together to develop common eligibility requirements and application forms. How can we communicate that as part of this report?

Comment: We still have problems in some counties where public health is being left with all the uninsured, when FQHC/RHC is serving the insured patients that used to be served (and reimbursed) by local health departments. This also affects free clinics. When the FQHC is having financial problems, the uninsured are shifted to free clinics.

Comment: In some communities, FQHCs see the reverse, with health departments and other organizations sending uninsured to the FQHC because of the federal requirement to serve everyone. These comments and others speak to the need for some type of state level steering committee to provide an ongoing venue to encourage real collaboration and guidance on how to address when something doesn't work.

At the next meeting we will break into workgroups to talk more about pharmacy options and financing options. In the meantime, please send us your comments, corrections, and suggestions.

ADJOURN