

Health Reform: Safety Net Workgroup
Monday, May 23, 2011
North Carolina Institute of Medicine, Morrisville
9:00am-12:00pm
Meeting Summary

Attendees:

Workgroup Members: Chris Collins (co-chair), Benjamin Money (co-chair), Jason Baisden, Anne Braswell, Kellan Chapin, Robin Cummings, Katie Eyes, Elizabeth Freeman Lambar, Susan Mims, Chip Modlin, Connie Parker, Marilyn Pearson, Joy Reed, Karen Stallings, Flo Stein, Elizabeth Tilson, John Torontow, Ramon Velez, Kristin Wade

Steering Committee Members: Marti Wolf

NCIOM Staff: Kimberly Alexander-Bratcher, Thalia Fuller, Emily McClure, Arijit Paul, Rachel Williams

Other Interested Persons: Ester Adams-Sumara, Jim Baluss, Tami Eldridge, Carla Hales Gordo, Ginny Klarman, Sarah Lesesne, Jeff Spade, Carl Taylor, Gina Upchurch

Welcome and Introductions

Chris Collins, MSW, Deputy Director, Office of Rural Health and Community Care, North Carolina Department of Health and Human Services, Co-chair

E. Benjamin Money, Jr., MPH, CEO, North Carolina Community Health Center Association, Co-chair

Mr. Money welcomed everyone to the meeting.

Pharmacy Care—FQHCs and 340B

Carl D. Taylor, PhD, Director of Pharmacy Services, Piedmont Health Services

Dr. Taylor gave an overview of the 340B program that is administered by the Federal Office of Pharmaceutical Affairs. The program is meant to increase access to brand name prescription drugs at a lower cost for low income patients and increase revenue to participating providers. Pharmacy companies must participate in the program if they participate in the state Medicaid program already. The program uses a “best price” concept which offers the same lowest price to all participants. Participating providers can utilize the program through an in-house pharmacy, a contracted pharmacy, or both.

Dr. Taylor's presentation can be found here: [FQHCs and 340B](#).

Selected questions and comments:

- Q: Patients usually have many different prescribers. Does a prescription have to be from a participating provider to get the 340B price? A: If patient is referred by a participating physician to another provider who then prescribes a drug, then the patient can still get the 340B price. But, if patient goes to a provider on his/her own and gets a prescription, then it isn't covered under 340B.
- Q: How many community health centers in the state have 340B? A: Only eight to ten have in-house pharmacies with 340B. About 50 or 60 centers have contracts with outside pharmacies for 340B.
- Q: What are the barriers for community health centers starting a 340B program? A: Many centers think it is a huge expense to begin one.
 - Most established health centers have a 340B program. Smaller centers have contracts with pharmacies. Newer and smaller centers are working to establish contracts.
- Q: How does this program generate revenue? A: The cost of the drugs for the pharmacy is very low—about \$4. If the pharmacy charges \$5-10 per prescription, then profit is generated while still saving the patient money.
 - The amount of revenue received is somewhat volume dependent. Smaller entities might not profit as much from this program.

Pharmacy Care—Older Adults

Gina Upchurch, RPh, MPH, Executive Director, Senior PharmAssist

Ms. Upchurch discussed the importance of medication management in senior populations and Durham's Senior PharmAssist program. Problems with drug therapy arise when indication, effectiveness, safety and/or compliance are somehow affected. The most common drugs indicated in adverse drug events for adults aged 65 or older are insulin, warfarin, and digoxin.

Senior PharmAssist uses medication therapy management, financial aid, tailored referral, insurance counseling through the Seniors' Health Insurance Information Program (SHIIP), and medical records to reduce the number of adverse drug events in older adults 60 years or older in Durham. Financial assistance is given to those 60 years or older at or below 200% of the federal poverty level. Any Medicare beneficiary can receive insurance counseling services free of charge.

Ms. Upchurch's presentation can be found here: [Senior PharmAssist](#).

Pharmacy Care—Medication Assistance Programs

Ginny Klarman, Project Manager for Medication Assistance, Office of Rural Health and Community Care, North Carolina Department of Health and Human Services

Ms. Klarman reviewed medication assistance programs in North Carolina. The Medication Access and Review Program (MARP) uses software to ease administrative burden in establishing and maintaining a prescription assistance program (PAP). The software checks patient eligibility and potential adverse events, tracks costs of medications, and tracks the steps towards accessing medications. There is potential to integrate the data from MARP into medical data such as EHRs.

NCRx is a state PAP which provides financial assistance to Medicare Part D beneficiaries under a specified income level. The program is funded through the Health and Wellness Trust Fund and current budget proposals eliminate funding after June 30, 2011.

Checkmeds is a medication therapy management program for all Medicare Part D enrollees. The program offers medication review, prescriber consultation, patient compliance consultation, patient education and patient monitoring. There are no income requirements for this program.

Ms. Klarman's presentation can be found here: [Medication Assistance Programs](#).

Selected questions and comments:

- Medicare Part D plans are not incentivized to provide meaningful medication therapy management (MTM).
- NCRx had the highest rate of return of all the Health and Wellness Trust Fund programs. Many low income seniors will have to move to alternative plans that do not cover their medications well due to losing funding for NCRx.
- Q: How will the ACA affect the need for MTM services? NCRx covers seniors at or below 175% of the federal poverty level. The ACA expands Medicaid to those at or below 138% of the poverty level. Once NCRx is discontinued there will be a gap.
 - Another gap due to the Medicaid expansion is that once beneficiaries between 100% and 138% federal poverty level turn 65, they will no longer receive Medicaid since those over 65 can only receive Medicaid if they are at or below 100% federal poverty level.

Model of Expanded Access—CCNC-UP

Jim Baluss, Administrator, Access East, Inc.

Mr. Baluss discussed the CCNC-Uninsured Parents (CCNC-UP) program. CCNC-UP is a five year pilot in Warren and Pitt/Greene counties funded through a State Health Access Program

grant. The program offers coverage for uninsured parents with an income less than 133% of federal poverty level who have children enrolled in an insurance plan (including Medicaid, NC Health Choice or private plans). Parents pay an enrollment fee of \$20 to receive a limited number of services including preventive screenings, annual physicals, primary care visits, behavioral health visits, hospital benefits, and some durable medical equipment. Prescription drugs, dental services, maternity/family planning and assisted living are not covered. The program aims to improve access to basic health care for uninsured parents, increase the number of eligible children enrolled in public health insurance programs, and help the state prepare for the 2014 Medicaid expansion.

Mr. Baluss' presentation can be found here: [CCNC-UP](#).

Selected questions and comments:

- Q: Are health outcomes through this project being tracked? A: Yes. It's going to be retrospective. Over time, outcomes can be compared to a cohort of children not in the program. The outcomes will hopefully show that having parents in care improves children's health.
- The CCNC program enables continuity of care for those going between Medicaid and being uninsured. There needs to be a system in place to track patients once the health benefits exchange is created and they may change insurers between the exchange and Medicaid.
 - This pilot can potentially tease out some system problems.
 - The federal government wants to use the information from this project as a way to inform decisions on health reform.
- There have been enrollment problems in Pitt County. Patients can get care at the hospital without paying upfront rather than pay co-pays through this program. It is important to help patients understand that the care at the medical center is not actually free.

Updates

The workgroup was updated on the progress of the Bridges to Health program. The program targets high emergency department users and has seen a 72% reduction in emergency room utilization in the cohort population within the first nine months. Many participants have also improved functionally through gaining employment. A pilot of this program is being planned for the Medicaid population.

The workgroup also received a handout with draft recommendations to review for the next meeting.

Next Meeting—June 14 at 9:00am

The next meeting will be a discussion of potential recommendations.

Public Comment Period

- Loss of medication assistance counselors has had a direct impact on the number of medical homes Cape Fear Health Net can provide. Most medical homes are provided by free clinics. The number of patients that can be supported is determined on the ability to process PAP applications. Grants can be written for providers, but if the pharmacy can't be staffed then there cannot be a medical home.
- A lot of free clinics use recurring funds to hire providers to increase access. In the house budget bill, salaries are capped for state funded workers. This is counterintuitive to hiring providers.
 - Any state agency funding a non-profit must cap staff salaries. This will have a huge impact for CCNC, the Office of Rural Health and Community Care, and NC Health Net. Viable providers cannot be secured with a salary cap.