

## CHAPTER 4 SAFETY NET

### OVERVIEW

One of the major goals of the ACA was to increase access to care. Of the more than 1.7 million North Carolinians who are currently uninsured, 1.1 million are expected to qualify for insurance coverage if the ACA is implemented as the law is written.<sup>1</sup> Many of these people are already receiving some type of medical care from safety net organizations and private providers. The safety net is composed of organizations that have a mission or legal obligation to provide health care and other related services to uninsured and underserved populations. They include federally qualified health centers (FQHCs), school-based or school-linked health services, public health departments, rural health clinics, hospitals, free clinics, and other community-based organizations.<sup>2</sup> Safety net organizations have a track record of providing care to low-income, uninsured, and diverse populations that may not receive care from private community providers.<sup>3</sup>

Different safety net organizations provide primary and preventive services, access to specialty services, pharmaceutical services, dental and behavioral health services, and hospital services. Some safety net organizations work together to create integrated delivery systems of care for the uninsured. In many safety net organizations, services are provided for free or at reduced cost.<sup>2</sup> In North Carolina, there is a wide array of safety net organizations. Primary care and preventive services are provided by federally qualified health centers, school-based or school-linked health centers, rural health centers, local health departments, free clinics, and private providers. Hospitals also provide significant amounts of care to the uninsured and other low-income populations. The Office of Rural Health and Community Care through the North Carolina HealthNet initiative provides technical assistance and flexible mini-grants to local communities to support efforts to increase access and quality of care for the uninsured through a coordinated system of care, and to share and conserve limited resources through collaborative partnerships so that resources can be directed to needs that have no alternative funding source (ie, care/disease management, enrollment). HealthNet links Community Care of North Carolina's administrative infrastructure and networks of physicians and care managers with local and regional safety net organizations and indigent care programs that are providing free and discounted health care for the uninsured. However, communities are highly dependent on providers' donations for access to care and significant gaps remain. In addition, communities are often unable to leverage other resources or align resources for efficiencies across agencies.

North Carolina may not have sufficient numbers of new health care professionals to meet the increased demand for services that is likely to arise as people gain coverage. (See Health Professional Workforce chapter.) Further, many of the people who are currently uninsured have transportation and other barriers which will make it difficult to access private providers. Safety net organizations have traditionally served these populations, and will be needed to meet the health care needs of the newly insured. The ACA recognizes the important role of safety net providers and requires all Qualified Health Plans (QHPs), offered through the Health Benefit Exchange (HBE), to contract with safety net providers that serve predominantly low-income,

medically-underserved individuals.<sup>a</sup> In addition to the role that safety net organizations will play in meeting the health care needs of the newly insured, safety net organizations will be needed to meet the health care needs of the uninsured. In North Carolina, more than 700,000 nonelderly people are likely to remain uninsured. More than half (56.1%) of those uninsured are likely to have an income below 138% of the federal poverty level.<sup>4</sup> Safety net providers will need to continue to provide care for many uninsured individuals who cannot afford private insurance or are ineligible for public programs.

The ACA recognizes these challenges and included provisions to increase and strengthen the health care safety net. There was a particular focus on FHQCs as critical providers of primary care for the newly insured and uninsured. There was also an emphasis on expanding safety net capacity through school health centers and the National Health Service Corps. The Safety Net Workgroup examined these and other sections of the ACA along with the unmet needs of the safety net. Although there are many other types of safety net organizations in North Carolina, this chapter focuses only on those related to safety net provisions in the ACA. Some other safety net organizations are referred to in other chapters of this report. The Safety Net Workgroup strongly supported the inclusion of safety net organizations in all aspects of health care and reform including but not limited to health benefits exchanges, new models of care, prevention, quality, and workforce discussed in other chapters of this report.

## **SAFETY NET ORGANIZATIONS AS PROVIDERS OF CARE FOR THE NEWLY INSURED**

### ***Federally Qualified Health Centers***

Federally qualified health centers (FQHCs) are public or private nonprofit organizations that receive funds from the United States Bureau of Primary Health Care under section 330 of the Public Health Services Act.<sup>b</sup> FQHCs include community and migrant health centers, health centers for the homeless, public housing primary care, and school-based health centers. FQHCs must provide comprehensive primary and preventive health care services, and are required to provide enabling services including transportation, case management, outreach, and interpretation and translation. In addition, FQHCs are required by law to provide services to the uninsured on a sliding scale basis. In 2011, there were 28 FQHCs in North Carolina delivering care at 150 different sites. There were also three FQHC look-alikes providing services at twelve clinical sites<sup>c</sup> and a Migrant Voucher program that provides grants and reimbursement for clinical and outreach services.<sup>53</sup> More than 50% of the FQHC patients served in North Carolina were uninsured, and 95% had incomes below 200% FPL in 2010.

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<sup>a</sup> The law required QHPs to contract with “essential community providers” which is a subset of the broader category of safety net providers, and includes those providers—such as FQHCs, hospitals, family planning projects, Ryan White Care Act grant recipients, state-operated AIDS Drug Assistance Programs, black lung clinics, comprehensive hemophilia diagnostic treatment centers, Native Hawaiian Health Center, urban Indian organizations, and STD or tuberculosis treatment grantees who are eligible entities for 340B discount drug pricing. Patient Protection and Affordable Care Act, Pub L No. 111-148, § 1311(c)(1)(C).

<sup>b</sup> Health Centers Consolidation Act of 1996, Pub L No. 104-299.

<sup>c</sup> FQHC look-alikes are organizations granted status by the Bureau of Primary Health Care (BPHC) for conforming to the structure and services of an FQHC. They receive no Section 330 grant funding but do receive FQHC Medicaid reimbursement rates and other benefits. Look-alikes do not report their service statistics to the BPHC and their data is not reflected in federal funds brought into the state.

Congress created special payment rules for FQHCs because they are less able to cost-shift the costs of caring for the uninsured to other private payers. Thus, FQHCs receive higher Medicaid and Medicare reimbursements than most primary care providers and can obtain discounted medications through the 340B federal prescription drug discount program (see 340B program expansion section).

### ***Expanding and Strengthening FQHCs***

The ACA includes new appropriations to expand the number of FQHCs and to increase the number of people they can serve. As noted earlier, FQHCs have historically been a major provider of primary care and other health services to the uninsured. They are also likely to play a prominent role in providing services to the people who gain coverage in 2014. In Massachusetts, the numbers of patients that FQHCs served increased by almost 10% after the state passed its health reform legislation in 2006.<sup>6</sup> FQHCs in Massachusetts also continued to serve many of the state's uninsured patients. In fact, while the total number of uninsured patients that FQHCs served declined after its coverage expansion, the proportion of all remaining uninsured seen by FQHCs increased by 14%.<sup>6</sup>

Congress recognized the continued importance of FQHCs after the coverage expansion in 2014. The ACA initially appropriated a total of \$9.5 billion over five years to expand the number of community and migrant health centers nationally, expand the array of services provided, and increase the number of people they serve. The Bureau of Primary Health Care (BPHC) within the United States Department of Health and Human Services Health Resources and Services Administration (HRSA) issued a grant opportunity to support the establishment of new service delivery sites for FQHCs. The North Carolina Community Health Center Association, with financial support from Kate B. Reynolds Charitable Trust, worked with communities across the state to help them prepare grant applications. North Carolina submitted 30 applications; however, after the applications were submitted Congress cut the level of ACA funding available to support new FQHCs. The federal budget compromise reduced operational funding for existing FQHCs by \$600 million. Rather than cut services at existing centers, some of the \$9.5 billion ACA FQHC funds were diverted to keep existing FQHCs operating at the same level of funding.<sup>7</sup> Because of this reduced funding, North Carolina only received funding to create two new FQHCs through Greene County Health Care (Snow Hill) and Albemarle Regional Hospital Authority (Elizabeth City). The combined total of these two grants was \$1.5 million. Additionally, two other organizations were awarded \$80,000 planning grants to prepare plans to transition to FQHC: Triad Adult and Pediatric Medicine (Greensboro) and Community Health Interventions and Sickle Cell Agency (Fayetteville).<sup>8</sup>

In addition, the ACA includes \$1.5 billion for construction and renovation of FQHCs. Congress appropriated \$1 billion in new funding in FFY 2011, which increases to \$3.6 billion by FFY 2015.<sup>d</sup> North Carolina FQHCs received ACA grant funds totaling \$19.2 million to support capital improvements and renovations, and to expand access to care through existing FQHCs.<sup>9</sup> This funding was provided to support four FQHCs: Roanoke Chowan Community Health Center (Ahoskie), Blue Ridge Community Health Services (Hendersonville), First Choice Community

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<sup>d</sup> Patient Protection and Affordable Care Act, Pub L No. 111-148, § 10503, as amended by the Health Care and Education Reconciliation Act, Pub L No. 111-152, §2303.

Health Centers (Mamers), and Metropolitan Community Health Services (Washington). These funds are in addition to the \$33.3 million provided to 26 FQHCs through the federal ARRA funds.<sup>10</sup>

The ACA also includes special payment rules for FQHCs. QHPs that contract with federally qualified health centers must pay the center the same amount it would receive under Medicaid prospective cost-based reimbursement.<sup>e</sup> The ACA also requires the Secretary of the United States Department of Health and Human Services to develop a prospective cost-based reimbursement methodology in Medicare similar to that used for FQHCs in Medicaid.<sup>f</sup> The new methodology will be effective on or after October 1, 2014.

### ***Enhancing the Quality of Care Provided by FQHCs***

In addition to the grants to create new health centers, the United States Department of Health and Human Services also provided grant opportunities to increase the capacity of existing community health centers to provide patient-centered medical homes. The federal government offered two new funding opportunities:

- *Bureau of Primary Health Care’s Patient-Centered Medical Home (PCMH) Supplemental Funding Opportunity.* The Bureau of Primary Health Care announced supplemental awards to approximately 900 FQHCs nationwide to support the practice changes needed to transition to patient-centered medical homes. Eighteen FQHCs in North Carolina received this \$35,000 grant award. (FQHC look-alikes were not eligible for participation.) Grantees must “agree to seek recognition, increase their recognition level, or maintain the highest level as a PCMH through a national or State-based recognition or accreditation program.”<sup>11</sup> The following North Carolina Health Centers received this additional funding: Roanoke Chowan Community Health Center (Ahoskie); Medical Resource Center for Randolph County (Asheboro); Western North Carolina Community Health Services (Asheville); Piedmont Health Services (Carrboro); C.W. Williams Community Health Center (Charlotte); Lincoln Community Health Center (Durham); Stedman-Wade Health Services (Fayetteville); Gaston Family Health Services, (Gastonia); Blue Ridge Community Health Services (Hendersonville); First Choice Community Health Centers (Mamers); CommWell Health (Newton Grove); Robeson Health Care Corporation (Pembroke); Wake Health Services (Raleigh); Rural Health Group (Roanoke Rapids); Greene County Health Care (Snow Hill); Metropolitan Community Health Services (Washington); New Hanover Community Health Center (Wilmington); and Carolina Family Health Centers, Inc (Wilson). (See Chapter 8 for more discussion of patient centered medical homes.)
- *FQHC Advanced Primary Care Practice Demonstration.* This is a three-year demonstration project for FQHCs and FQHC look-alikes offered to approximately 500 health centers nationally. Funding is provided from the Center for Medicare and Medicaid Innovation, within the Centers for Medicare and Medicaid Services (CMS) and

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<sup>e</sup> Patient Protection and Affordable Care Act, Pub L No. 111-148, §§1302(g), 10104(b)(2).

<sup>f</sup> Patient Protection and Affordable Care Act, Pub L No. 111-148, §10501(i)(3), amending 1834 of the Social Security Act, 42 USC 1395m.

the Health Resources and Services Administration (HRSA). The demonstration project is “designed to evaluate the effectiveness of the advanced primary care practice model, commonly referred to as the patient-centered medical home, in improving care, promoting health, and reducing the cost of care” by moving sites toward NCQA Level 3 recognition by the end of the three years.<sup>12</sup> CMS received more than 800 applications, and 18 sites representing ten FQHC organizations were selected for participation in North Carolina, including: First Choice Community Health Center (Spring Lake, Angier, Cameron); Gaston Family Health Services (Bessemer City); Greene County Health Care (Snow Hill, Greenville); Metropolitan Community Health Services (Washington); Opportunities Industrialization (Roanoke Rapids); Piedmont Health Services (Burlington, Prospect Hill); Roanoke Chowan Community Health (Colerain); Robeson Health Care Corporation (Pembroke, Maxton); Wake Health Services (Raleigh, Apex); and Rural Health Group (Norlina, Hollister, Whitakers). To help participating FQHCs undergo practice transformation and progress toward PCMH recognition, they will receive an \$18 quarterly care management fee per eligible Medicare beneficiary receiving primary care services. These quarterly payments are in addition to Medicare’s per visit payments. CMS and HRSA will provide technical assistance, and FQHCs are required to submit NCQA Readiness Assessment scores every six months.

### ***School-based or School-linked Health Centers***

School-based and school-linked health centers are designed to eliminate or reduce barriers to care for students.<sup>13</sup> A school-based health center (SBHC) is a medical office located on a school campus. A school-linked health center is a free-standing health care center affiliated with schools in the community. School health centers may provide primary care, mental health services, acute and chronic disease management, immunizations, medical exams, sports physicals, nutritional counseling, health education, prescriptions, and medication administration.<sup>2</sup> Nationally, a majority (64%) of school health centers provide services to children and families in the community as well as students at the affiliated schools.<sup>14</sup> There are 52 school health centers serving 22 counties in North Carolina. Most of these are school-based health centers, several are school-linked health centers, and a few health centers operate from traveling vans or buses to serve several schools.<sup>g</sup>

The ACA appropriated \$50 million toward capital expenses for SBHCs in each FFY 2010-2013, although it did not appropriate funding for operating expenses.<sup>h</sup> HRSA awarded \$95 million to 278 school-based health center programs across the country in July 2011. In North Carolina, nine sites were awarded more than \$2 million including Alamance-Burlington School System (Burlington); Bakersville Community Medical Clinic, Inc. (Bakersville); Blue Ridge Community Health Services (Hendersonville); FirstHealth of the Carolinas (Pinehurst); Lincoln Community Health Center, Inc. (Durham); Mitchell County Board of Education (Bakersville); Morehead Memorial Hospital (Eden); West Caldwell Health Council, Inc. (Collettsville); and Yancey County Schools (Burnsville).<sup>15</sup> The second round of awards was made in December 2011. HRSA awarded more than \$14 million to 45 school-based health center programs across the

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<sup>g</sup> Parker C. Executive Director, North Carolina School Community Health Alliance. Oral communication. April 12, 2012.

<sup>h</sup> Patient Protection and Affordable Care Act, Pub L No. 111-148, § 4101(a).

country including more than \$600,000 to two North Carolina SBHCs—Cherokee County Schools (Murphy) and Wilmington Health Access for Teens, Inc. (Wilmington).<sup>16</sup>

### ***Rural Health Clinics***

State-funded rural health clinics are nonprofit 501(c)(3) organizations that provide primary care, routine diagnostic and therapeutic care, and referrals for medically necessary and specialty services they do not provide. Some rural health clinics also provide dental, behavioral health, or enabling services. They are required to treat Medicaid and Medicare patients and receive cost-based reimbursements. While rural health clinics are not required to treat the uninsured, many of them do provide services to the uninsured.<sup>2</sup> There are 86 certified rural health clinics in North Carolina.

There are 28 rural health service delivery sites that receive state funding from the Office of Rural Health and Community Care (ORHCC) to help pay for indigent care. One of the requirements for ORHCC funding is that rural health clinics be located in either a health professional shortage area (HPSA) or medically underserved area (MUA).<sup>1</sup> In North Carolina, the ORHCC is responsible for designating communities as HPSAs. The HPSA designation allows communities to qualify for many sources of federal funding including the National Health Service Corps. The National Health Service Corps provides scholarships and loan repayment to health professionals who practice in HPSAs. . The ACA appropriated \$1.5 billion to expand the National Health Service Corps over five years.<sup>j</sup>

Recruiting new health professionals to underserved areas expands access to care for those communities. The Office of Rural Health and Community Care plays a critical role both in designating underserved areas as primary care, mental health, and dental HPSAs and recruiting primary care providers, psychiatrists, and dentists to serve in them. The Safety Net Workgroup strongly supports the Health Professional Workforce Workgroup recommendation to strengthen and expand the North Carolina Office of Rural Health and Community Care in order to recruit more health professionals to underserved areas. (See Chapter 5 for more information.)

### ***Hospital Emergency Departments and Other Services***

Hospital emergency departments and outpatient and inpatient clinics are a major part of the health care safety net. Despite increasing capacity in primary care safety net providers, many people go to the emergency room for care. According to Table 89 of a recent CDC report, in 2009, more than 21% of adults over the age of 18 had at least one emergency department visit in the past year, and 8% had two or more visits.<sup>17</sup> A recent CDC study reports that only 8% of emergency patients have a medical condition that is not urgent.<sup>18</sup> Having an urgent medical condition is not the same as having an emergency medical condition. Other studies report that 60% of patients in the emergency department could be treated elsewhere.<sup>19</sup> Emergency department utilization was 93% higher among people with a family income below the poverty level compared with those with a family income at least four times the poverty level, according to Table 89 of the CDC report.<sup>17</sup> Emergency departments are not the optimal place for people to get routine primary care.

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<sup>i</sup> Gilbert R. Primary Care Systems Specialist, Office of Rural Health and Community Care, Department of Health and Human Services. Oral communication. April 12, 2012

<sup>j</sup> Patient Protection and Affordable Care Act, Pub L No. 111-148, § 10503.

The North Carolina College of Emergency Physicians formed an Access to Care Committee to respond to the ACA and to develop models to maintain access to care for Medicaid patients while reducing costs. A key recommendation from that group was to form alternative networks of health care for patients without an emergency medical condition or for patients whose emergency medical condition has been stabilized. The Committee identified categories of patients who might present to an emergency department for treatment who could be more appropriately treated in another health care setting.<sup>k</sup> The patient categories include dental complaints, chronic pain complaints, and behavioral health complaints.<sup>20</sup> Preliminary planning for the project between the Committee and the Community Care of North Carolina has already begun.

The ACA appropriated \$24 million per year for five years beginning in FY 2010 for competitive grants for regionalized systems for emergency response.<sup>l</sup> It also authorized \$100 million per year for six years beginning in FY 2010 in grants for trauma care centers and to expand service availability<sup>m</sup> and \$25M in FY2010 for emergency services for children<sup>n</sup>. Based on the work of the Access to Care Committee and in response to the funding opportunity, the Safety Net Workgroup recommends:

**RECOMMENDATION 4.1: DEVELOP AN EMERGENCY TRANSITION OF CARE PILOT PROJECT**

- a) The North Carolina College of Emergency Physicians (NCCEP) and Community Care of North Carolina should work with the North Carolina Hospital Association, North Carolina Department of Health and Human Services, Care Share Health Alliance, the North Carolina Community Health Center Association, North Carolina Dental Society, North Carolina Foundation for Advanced Health Programs, North Carolina Free Clinic Association, Governor’s Institute of Substance Abuse, and others to develop an emergency care pilot project to address common conditions that present to the emergency departments but could be more effectively treated in other health care locations. The pilot project should focus on:**
- i) Dental complaints**
  - ii) Chronic conditions**
  - iii) Behavioral health issues**
- b) NCCEP and partners should seek funding for the emergency transition of care project through the United States Assistant Secretary for Preparedness and Response for regionalized systems for emergency care and from other federal sources.**

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<sup>k</sup> All patients who present to an emergency department are required by law to have a medical screening exam to ensure that an emergency medical condition does not exist. Consolidated Omnibus Budget Reconciliation Act of 1985, Pub L No. 99-272, § 9121, enacting Sec. 1867 of the Social Security Act, 42 USC 1395dd.

<sup>l</sup> Patient Protection and Affordable Care Act, Pub L No. 111-148, § 3504.

<sup>m</sup> Patient Protection and Affordable Care Act, Pub L No. 111-148, § 3505.

<sup>n</sup> Patient Protection and Affordable Care Act, Pub L No. 111-148, § 5603, amending Sec. 1910 of the Public Health Service Act, 42 USC 300w-9.

### ***Enhancing Hospital Community Benefits***

Hospitals also help meet the health care needs of the broader community. For example, North Carolina hospitals provide charity care to many low-income uninsured patients, make cash and in-kind contributions to community groups, and get involved in other community health activities.<sup>21</sup>

The ACA establishes new requirements for charitable hospitals. These hospitals must have a publicly available financial assistance policy including information on how charges are calculated, billed, and collected. The charges for emergency or other medically necessary care for the uninsured were limited to what a person with insurance would be charged.<sup>o</sup>

The North Carolina Hospital Association works with hospitals to help meet these requirements. The Hospital Community Benefits Report webpage voluntarily lists the financial assistance policies for all North Carolina hospitals that have made them public since 2007.<sup>22</sup> Guidance is available to help hospitals calculate their community benefits so that data may be reported uniformly across hospitals. In FY 2010, North Carolina hospitals provided \$853 million in free care.<sup>23</sup>

The ACA also requires hospitals to conduct a community health needs assessment and take steps toward addressing those health needs. It also required “input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health”.<sup>p</sup> The required health assessment is similar to the community health assessment that each health department in North Carolina is required to conduct. The North Carolina Hospital Association and North Carolina Division of Public Health are working together to encourage community hospitals and local health departments to collaborate in conducting their community health needs assessments.<sup>24</sup> In response to the collaboration between hospitals and health departments, the Workgroup recommends:

#### **RECOMMENDATION 4.2: INVOLVE SAFETY NET ORGANIZATIONS IN COMMUNITY HEALTH ASSESSMENTS**

- a) As part of the hospital and local health department community health assessments, these organizations should:**
  - i. Solicit input from patients and a broad range of stakeholders and community leaders.**
  - ii. Include data from safety net organizations and other community-based organizations that serve low-income, uninsured individuals within the hospital and public health service area.**
  - iii. Examine access to quality care issues along with population health and other community health needs through broad, open solicitation input from multiple partners.**
  - iv. Use stakeholder and patient input to develop common criteria for determining priorities for implementation.**

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<sup>o</sup> Patient Protection and Affordable Care Act, Pub L No. 111-148, § 9007.

<sup>p</sup> Patient Protection and Affordable Care Act, Pub L No. 111-148, § 9007(a), enacting § 501(r)(3)(i) of the Internal Revenue Code of 1986, 26 USC 501(r)(3)(i).

- b) In implementing community health needs priorities, hospitals and public health departments should collaborate and partner with organizations that have a demonstrated track record in addressing the high priority needs.**
- c) Local communities should use the community health assessment action plan to pursue funding resources and strategically allocate existing resources.**

The ACA also expands the 340B discount drug program to more hospitals. The 340B drug program provides deeply discounted prescription drugs for certain types of safety net providers including FQHCs and hospitals that receive Medicare disproportionate share hospital (DSH)<sup>q</sup> payments. The program was expanded to include children’s hospitals, free-standing cancer hospitals, critical access hospitals, and sole community hospitals<sup>r</sup> In North Carolina, 29 of the currently eligible FQHCs<sup>s</sup> and 70 of the currently eligible hospitals are participating in the program. The Office of Rural Health and Community Care assists critical assess hospitals in the state process. The savings the 340B program affords to safety net organizations could be used to reinvest those funds in other community benefits or services to the underinsured and uninsured patients they serve. To support the expansion of the 340B program in North Carolina, the Workgroup recommends:

**RECOMMENDATION 4.3: EXPAND 340B DISCOUNT DRUG PROGRAM ENROLLMENT AMONG ELIGIBLE ORGANIZATIONS**

**The North Carolina Division of Medical Assistance and Office of Rural Health and Community Care of the Department of Health and Human Services , North Carolina Hospital Association, and North Carolina Community Health Center Association should continue their efforts to encourage DSH hospitals, critical access hospitals, sole community hospitals, rural referral centers, and federally qualified health centers to enroll in the 340B drug discount program, and to extend the capacity to provide discounted medications to more community residents who are patients of those 340B providers.**

**HELPING LINK UNINSURED TO APPROPRIATE INSURANCE COVERAGE**

Volunteers and other safety net providers have a direct connection to many underinsured and uninsured people. Many safety net providers offer health education, transportation, and connection to other community resources. In that role, patients look to their safety net providers for information about health care.

<sup>q</sup> Disproportionate Share Hospital (DSH) adjustment payments provide additional help to those hospitals that serve a significantly disproportionate number of low-income patients. The state receives an annual DSH allotment to cover the costs of DSH hospitals that provide care to low-income patients that are not paid by other payers, such as Medicare, Medicaid, the Children’s Health Insurance Program (CHIP) or other health insurance. This annual allotment is calculated by law and includes requirements to ensure that the DSH payments to individual DSH hospitals are not higher than these actual uncompensated costs. HHS Recovery. Disproportionate Share Hospital (DSH). U.S. Department of Health and Human Services website. <http://www.hhs.gov/recovery/cms/dsh.html>. Accessed April 12, 2012.

<sup>r</sup> Patient Protection and Affordable Care Act, Pub L No. 111-148, § 7101.

<sup>s</sup> 30 FQHCs and FQHC-LAs are eligible to participate in the 340B program. The newest FQHC is not yet listed as participating in the program. This participation may include onsite pharmacies, contracts with local community pharmacies, or a combination of the two methods. Wolf, M. Clinical Programs Manager, North Carolina Community Health Center Association. Oral Communication. January 25, 2012

The ACA requires that Health Benefits Exchanges (HBE) establish a program to award grants to entities that serve as navigators. It described the role of a navigator and the entities that may serve as navigators. The duties of a navigator include public education; distribution of fair and impartial information; facilitation of enrollment in Qualified Health Plans (QHPs); provision of referrals for grievance, complaint, or question about their health plan; and provision of information in a manner that is culturally and linguistically appropriate to the needs of the population being served.<sup>t</sup> In order to receive a grant, an organization must demonstrate that it has, or could readily establish, relationships with employers and employees, consumers (including uninsured and underinsured consumers), or self-employed individuals likely to be qualified to enroll in a QHP.<sup>u</sup> (More information about the Health Benefit Exchange and navigators is provided in the Health Benefits Exchange chapter.)

In North Carolina, safety net providers have established relationships with the diverse uninsured population that is traditionally hard to reach. These established relationships provide a unique opportunity for safety net providers to serve as navigators for their patients, thus the Workgroup recommends:

**RECOMMENDATION 4.4: ALLOW SAFETY NET ORGANIZATIONS TO FUNCTION AS PATIENT NAVIGATORS**

- a) The Health Benefits Exchange (HBE) should train and certify staff at safety net organizations to serve as patient navigators. In accordance with the ACA, these groups would be required to:**
  - i. Provide public education to raise awareness of qualified health plans (QHPs).**
  - ii. Distribute fair and impartial information.**
  - iii. Facilitate enrollment in QHPs.**
  - iv. Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman or other appropriate state agency for an enrollee with a grievance, complaint, or question about their health plan.**
  - v. Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served.**
  - vi. Meet standards to avoid conflict of interest.**
- b) As staff of safety net organizations, they should also educate consumers and patients about appropriate use and location of care.**

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<sup>t</sup> Patient Protection and Affordable Care Act, Pub L No. 111-148, § 1311(i).

<sup>u</sup> Entities may include trade, industry and professional associations, commercial fishing, ranching and farming organizations, community and consumer-focused nonprofit groups, chambers of commerce, unions, resource partners of the Small Business Association, and other licensed insurance agents and brokers, and other entities that can carry out duties and meet statutory responsibilities.

## **CARE FOR THOSE THAT REMAIN UNINSURED**

### ***Free Clinics***

Free clinics are nonprofit, usually 501(c)(3), organizations that are governed by local boards of directors. Most free clinics offer primary care and preventive services and treat both acute and chronic conditions. The majority of free clinics offer pharmaceutical services through either an on-site pharmacy or a voucher system with local pharmacies. Some free clinics offer limited dental services. Others offer a broader range of supportive services including health education, case management, and nutritional counseling.<sup>2</sup> Each free clinic sets its own eligibility guidelines for people who can be served. Services are provided for free to the uninsured with incomes below a certain income threshold and others may be charged on a sliding-fee scale. Free clinics generally have more limited hours of operation than regular health clinics. They vary from being open one or two evenings a week to having multiple day and night clinics.<sup>2</sup> There are 79 free clinics across North Carolina. Free clinics provided more than 200,000 patient visits and delivered \$167.6 million in free care in 2010.<sup>25</sup>

Volunteers are the cornerstone of the free clinic movement. Health care providers and staff volunteer their time to provide services and support to patients. In order to provide services, these volunteers need medical malpractice insurance. The Health Insurance Portability and Accountability Act (HIPAA) granted medical malpractice coverage through the Federal Tort Claims Act (FTCA) to volunteer free clinic health professionals. The ACA extends medical malpractice coverage to free clinic board members, officers, employees, and individual contractors.<sup>v</sup> The extension of malpractice insurance to more free clinic staff and board members allows these organizations to direct their already limited funding toward patient care or other needed services. Nationally, there are 170 free clinics participating in the FTCA program, and 15 of those are in North Carolina.<sup>w</sup>

### ***Continued Need for Safety Net Organizations***

Safety net organizations are designed to fill gaps in the overall health care system and will still be needed after the full implementation of health reform. Many of the newly insured population will experience barriers to care including provider shortages, transportation, language, and other barriers.<sup>26</sup> The variety of insurance programs and eligibility requirements may cause people to transition between public and private insurance programs as their income changes, which may cause coverage gaps. In addition, we still expect to have more than 700,000 people who are uninsured, even after full implementation of the coverage expansion.

The safety net will continue to play an important role in meeting the health care needs of both the newly insured and the people who remain uninsured. Workgroup members recognized the need for safety net organizations to continue to meet, on a periodic basis, to facilitate ongoing collaborations and communication. In the past, a group of safety net organizations met on a periodic basis (called the Safety Net Advisory Council or SNAC) in order to foster

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<sup>v</sup> Patient Protection and Affordable Care Act, Pub L No. 111-148, § 10608.

<sup>w</sup> Personal communication. FTCA Free Clinic Program, Health Resources and Services Administration, Bureau of Primary Health Care. January 11, 2012.

communication between the various organizations.<sup>x</sup> The SNAC also serves as the advisory group to help the ORHCC distribute state Community Health Center grant monies.<sup>27</sup> However, this workgroup has not been as active in recent years as it was when it was first created in 2005. Thus, the workgroup recommended that the Safety Net Advisory Council reconvene to identify communities with greatest unmet needs, increase collaboration among safety net organizations, and work together to help monitor and collaborate on future funding opportunities. In addition, the Safety Net Workgroup members recommended that safety net organizations provide data to the NCIOM website<sup>28</sup> to maintain up-to-date information on available safety net resources.

**RECOMMENDATION 4.5: RECONVENE THE SAFETY NET ADVISORY COUNCIL**

- a) The Safety Net Advisory Council should reconvene with facilitation assistance provided by Care Share Health Alliance in order to:**
  - i. Determine the future role of the Council in the state.**
  - ii. Identify communities with the greatest unmet needs using hospital and public health collaborative community health assessments and other safety net data tools.**
  - iii. Increase collaboration among agencies in a region to leverage resources as part of a larger service network.**
  - iv. Monitor safety net funding opportunities and disseminate them to appropriate organizations.**
  - v. Make a recommendation and plan for integrating safety net tools, including the NC Health Care Help website and county level resources.**
  - vi. Serve as a unified voice for the safety net.**
- b) North Carolina foundations and other agencies that provide funding to safety net organizations should encourage their recipients to submit or update data to the NC Health Care Help website on a regular basis.**

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<sup>x</sup> A Safety Net Advisory Council (SNAC) was convened in response to the NCIOM Task Force on the Healthcare Safety Net (2005). Initially, this group met quarterly to exchange ideas and advance their common mission to provide free and reduced cost health care services to North Carolina residents.

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