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## Chapter Eight



## Conclusion

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**N**orth Carolina is in the midst of a quiet, but growing, healthcare crisis. The number of uninsured residents is rising at an alarming pace, and as healthcare costs continue to increase, there is little chance of an immediate respite (discussed in Chapter 2). Currently, almost one out of every five non-elderly North Carolinians is uninsured. Because of financial barriers caused by the lack of insurance coverage, the uninsured are more likely to delay care and, as a result, their health suffers. The uninsured are less likely to receive preventive health services, more likely to be diagnosed with more severe health problems, and more likely to die prematurely than those with insurance coverage.

Clearly, the lack of health insurance coverage affects the uninsured person and his or her family, but it also has a broader societal impact. Lack of health insurance coverage decreases worker productivity; negatively affects the health of children and, thus, their ability to learn; and has unfavorable financial implications for healthcare providers. The latter is particularly true for safety net providers, i.e., healthcare providers who serving a high percentage of uninsured, Medicaid, and other vulnerable patients. Safety net providers strive to meet the healthcare needs of the uninsured, but this has become increasingly difficult as the number of uninsured has risen without commensurate funding increases. Ideally, North Carolina would guarantee health insurance coverage to all residents to help them access needed healthcare services. However, this is a long-term goal; one that is unlikely to be met in the immediate future. A shorter-term goal, and the focus of this Task Force, is to ensure the availability and financial viability of the healthcare safety net.

Some of the uninsured access non-emergent healthcare services in hospital emergency rooms. This is not a cost-effective or desirable way to address non-emergency healthcare needs. Preferably, the uninsured would have an established relationship with a primary care provider who can provide comprehensive, coordinated, and continuous care. In many communities across the state, there are safety net services available to meet the primary care needs of the uninsured,

including federally qualified health centers, state-funded rural health centers, local health departments, school-based health services, free clinics, Project Access or Healthy Communities Access programs, AHEC teaching residencies, and/or hospital outpatient clinics (safety net services are discussed in Chapter 3). However, these services are not available in every community; and even where they do exist, they may not be sufficient to meet the healthcare needs of all of the uninsured. Private providers also help provide services to the uninsured, but the extent to which this occurs in each community is unknown. In recent years, the number of doctors who report providing charity care nationally has declined; it is unknown whether the same trend is occurring in North Carolina.

The Task Force collected data on the number of uninsured residents receiving care in existing safety net institutions and compared this to the estimated number of the uninsured in each county (discussed in Chapter 4). The difference was the number (and percentage) of uninsured for whom there was no identified source of primary care. ***Based on these analyses, the Task Force was only able to determine that about 25% of all the non-elderly uninsured received primary care services from safety net organizations.*** This, combined with other studies showing that the uninsured in North Carolina are less likely to have a regular healthcare provider and more likely to report access barriers, suggests that the healthcare safety net is not sufficient to meet the needs of the uninsured.

The percentage of uninsured served by safety net organizations varies widely across the state. In some counties, it appears that all or most of the uninsured have been able to access safety net services; while in others, there are no known safety net organizations available to meet the primary care needs of the uninsured. The Task Force identified 28 counties that have the fewest safety net resources to meet the primary care needs of the uninsured. Thirteen of these counties also had lower than average primary care provider-to-population ratios suggesting that, at least in these counties, it would be difficult for the private providers



to meet the unmet primary care needs of the uninsured. Furthermore, most communities across the state lack the full array of services necessary to meet the healthcare needs of the uninsured. Access to pharmaceuticals (discussed in Chapter 5), specialty care, behavioral health, and dental services is still a problem in many counties, including those with adequate primary care capacity.

Few counties have fully-integrated systems of care to address the full range of healthcare services needed by the uninsured; most counties have fragmented systems of care for the uninsured (discussed in Chapter 6). This is due, in part, to the difficulties in sharing patient information across providers, turf issues, and/or the need to compete for paying patients to help cover the

costs of caring for the uninsured.

The Task Force spent almost a year studying this issue and identified 28 recommendations (listed below) that could help strengthen and expand the existing safety net to better meet the healthcare needs of the uninsured. These recommendations propose a number of different actions, including: legislative action and/or additional funding, policy changes within the NC Department of Health and Human Services, action and/or collaboration between safety net organizations, and targeted grant making within foundations. Of these 28 recommendations, ten are considered the top priority and, if implemented, will have the greatest likelihood of expanding care to the uninsured. The priority recommendations are highlighted (shaded) in the table below:

RECOMMENDATIONS	Legislature	NC DHHS	Safety Net Organizations	Foundations	Other
<b>Chapter 2: Uninsured</b>					
2.1. The NC General Assembly should take steps to make health insurance coverage more affordable and to expand health insurance coverage to more uninsured individuals. (PRIORITY)	✓				
<b>Chapter 3: Safety Net Defined</b>					
3.1. The Office of the Secretary of the NC Department of Health and Human Services should continue its efforts to monitor access to behavioral health services for the uninsured and other underserved populations. The Office of the Secretary should examine access to services both for the priority (target) populations and for those with less severe behavioral health problems and should seek input from a wide variety of stakeholders including, but not limited to, publicly funded local management entities, children’s development services agencies, behavioral health providers, primary care providers, safety net organizations, and representatives of consumer groups.		✓	✓		Other health professionals
3.2. The Office of the Secretary should work with the NC Pediatric Society, NC Academy of Family Physicians, NC Chapter of the American College of Physicians, NC Psychiatric Association, other interested professional associations, and NC Area Health Education Centers program to 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 on this initiative should be reported to the NC Commission for Mental Health, Developmental Disabilities and Substance Abuse Services.		✓	✓		Other health professionals
<b>Chapter 4: Availability of Safety Net Services</b>					
4.1. The NC Office of Research, Demonstrations and Rural Health Development (ORDRHD), in collaboration with the Cecil G. Sheps Center for Health Services	✓	✓	✓	✓	Sheps Center, UNC-CH



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<p>Research at the University of North Carolina at Chapel Hill, should assume responsibility for collecting data and monitoring the capacity of the safety net on an ongoing basis.</p> <p>a) 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 numbers uninsured who receive services through non-profit or public dental clinics, pharmacy clinics, or other specialty providers.</p> <p>b) Safety net healthcare organizations that receive state funding (through Medicaid, the Division of Public Health, or Community Health Grant funds) should be required to report information to the ORDRHD on the unduplicated number and the total number of visits (encounters) for uninsured patients who receive comprehensive primary care, dental, behavioral health, or other clinical services. The ORDRHD should create a standardized reporting form to ensure that the data are 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.</p> <p>c) The ORDRHD should share these data with local Community Care of North Carolina groups, Healthy Carolinian organizations, local health departments, the NC Association of Community Health Centers, the NC Hospital Association, the NC Medical Society, the NC Free Clinic Association, the NC Division of Facility Services, and local medical societies so that they can use these data to identify areas of unmet need. Similarly, the data should be shared with North Carolina health foundations, to help inform their grant-making process.</p> <p>d) The ORDRHD should report these data to the Secretary, Governor, General Assembly, and NC Association of County Commissioners on a yearly basis to help inform policymakers of areas of greatest unmet need. (PRIORITY)</p>					
<p>4.2. The NC Office of Research, Demonstrations and Rural Health Development should take the lead in pulling together a statewide collaborative of safety net organizations to develop a planning package for communities interested in maintaining or expanding their safety net capacity.</p> <p>a) The collaborative should include, but not be limited to: the Division of Public Health, the NC Community Health Center Association, the NC Hospital Association, the NC Medical Society, the NC Free Clinic Association, and the NC Area Health Education Centers (AHEC) program. These groups should collaborate to provide technical assistance to communities. Priority should be given to low-wealth, high-need communities to help them develop additional safety net capacity. Cross-county or regional approaches</p>		✓	✓		✓ Local Community



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<p>should be considered, particularly for smaller, less-populated, or resource-poor communities.</p> <p>b) The planning package should include information on financial planning, possible funding sources, healthcare information systems, record access and confidentiality, federal and state laws and regulations affecting the provision of safety net services, and the organizational aspects of interagency cooperation with such issues as eligibility determination. Once developed, information about the availability of the planning package and technical assistance should be provided to county commissioners, local healthcare providers, community collaboratives (such as Healthy Carolinians and Community Care of North Carolina networks), and other interested non-profit organizations. (PRIORITY)</p>					
<p>4.3. The NC Medical Society, local medical societies, free clinics, Project Access models, and other community initiatives that encourage private providers to donate their services to the uninsured should develop systems to recognize providers for their services. Recognition should be provided at both the local and state levels.</p>			✓		
<p>4.4. The NC Free Clinic Association should take the lead in pulling together a group of health professionals and safety net organizations, including, but not limited to, the NC Medical Society and NC Project Access organizations to identify options to reduce the fear of and/or threat of malpractice lawsuits against providers who volunteer their time to serve the uninsured without compensation. At a minimum, the group should examine the existing Good Samaritan law to determine if further changes are needed to provide protection to physicians and other healthcare professionals who volunteer to provide services to the uninsured upon referral from an organized system of care for low-income uninsured. (PRIORITY)</p>			✓		
<p><b>Chapter 5: Prescription Drugs</b></p>					
<p>5.1. The NC Office of Research, Demonstrations and Rural Health Development and other safety net organizations should create a workgroup to meet with pharmaceutical companies to discuss:</p> <p>a) Simplifying and streamlining the Patient Assistance Programs, including the application forms, verification requirements, and eligibility requirements; and</p> <p>b) Creating bulk replenishment programs and other ways the pharmaceutical industry could help provide medications to safety net organizations.</p> <p>Information should be disseminated to safety net organizations and private physician practices about the best way to access existing pharmaceutical resources.</p>		✓	✓		



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5.2. The NC General Assembly should support the Health and Wellness Trust Fund's efforts to support and expand prescription assistance programs, including, but not limited to, expanding the availability of Medication and Access Review Program (MARF) and medication assistance programs.	✓			✓	
5.3. North Carolina private foundations should consider three-year start-up funding at \$180,000 per year to the NC Office of Research, Demonstrations and Rural Health Development to create a bulk medication replacement system. (PRIORITY)		✓		✓	
5.4. The NC Office of Research, Demonstrations and Rural Health Development should explore opportunities to expand 340B drug discount prices to low-income patients of other safety net organizations.		✓	✓		
<b>Chapter 6: Coordination and Integration of Services</b>					
6.1. The NC General Assembly should enact legislation that clarifies existing state confidentiality laws to ensure that safety net providers are allowed to share identifiable health information with each other when providing care to the same patients, consistent with applicable federal law. The legislation should include heightened protections for particularly sensitive information, such as mental health and communicable disease information.	✓				
6.2. The NC Office of Research, Demonstrations and Rural Health Development should collect and disseminate descriptions of various models of collaboration and integration found to work well in particular communities.		✓			
6.3. In addition to healthcare providers, local safety net collaborations should encourage the participation of business and industry, colleges and universities, faith-based organizations, social service agencies, non-profits, and other interested groups in community collaborations to provide care to the uninsured.			✓		Universities Business Others
6.4. North Carolina foundations should help convene a best practices summit of safety net organizations that will focus on collaboration and integration. This summit would help local communities identify ways to build and strengthen their capacity to meet the healthcare needs of the growing uninsured population, and to reduce barriers to interagency collaboration and integration. Summit participants should include representatives of existing safety net organizations at the state and local levels. One of the outgrowths of this summit would be to develop clearer and measurable criteria of collaboration to guide future decisions for safety net program support by public and private funding agencies. (PRIORITY)			✓	✓	
6.5. Hospitals should take the lead to develop collaborations with local safety net organizations to help ensure that the uninsured have appropriate medical homes and after-hours care for persons requiring non-emergent attention.			✓		



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<p>6.6. The NC Institute of Medicine should create an on-going state-level Safety Net Advisory Council that can encourage state-level and local safety net collaborations and can help monitor the implementation of the Healthcare Safety Net Task Force’s recommendations. The group should include the full array of existing safety net organizations, including health departments, federally qualified health centers, free clinics, hospitals, medical societies, Project Access and Healthy Communities Access Programs, medication assistance programs, and other non-profit agencies providing care to the uninsured. (PRIORITY)</p>			✓		✓ NC IOM
<b>Chapter 7: Financing Safety Net Services</b>					
<p>7.1. The NC Department of Health and Human Services, NC Community Health Center Association, NC Association of Free Clinics, NC Health Directors Association, NC Hospital Association, NC Medical Society, and other safety net organizations should work with the NC congressional delegation to support NC safety net organizations.</p> <p>a) The NC congressional delegation should oppose any efforts to create a Medicaid block grant or otherwise limit the availability of federal Medicaid funds to the states.</p> <p>b) In order to ensure that North Carolina receives its fair share of federal funding for federally qualified health centers (FQHCs), the NC congressional delegation should work to ensure that priority for new FQHC funding should be given to states that have higher than average proportions of uninsured, racial disparities, and/or a lower than average receipt of federal FQHC funds per low-income person.</p> <p>c) The NC congressional delegation should also work to ensure that North Carolina receives its fair share of federal State Children’s Health Insurance Program (SCHIP) and Ryan White CARE funds, and that Congress continues funding the Special AIDS Drug Assistance Program (ADAP) Initiative.</p> <p>d) The NC congressional delegation should work to expand the 340B program to include free clinics, local health departments, and other non-profit or governmental agencies with a mission to serve low-income uninsured patients. (PRIORITY)</p>		✓	✓		✓ Congress
<p>7.2. The NC Health Directors Association should develop a legislative proposal to amend state laws to enable local boards of public health to create governance structures that would make them eligible to participate in additional federal programs through which funding is available to support care for the uninsured.</p>			✓		
<p>7.3. The NC health foundations should consider additional funding to meet the capital and infrastructure needs of healthcare safety net organizations.</p>				✓	
<p>7.4. The NC General Assembly should appropriate, on a recurring basis, \$6 million to be used for federally qualified health centers and those health centers that</p>	✓	✓	✓		



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<p>meet the criteria for federally qualified health centers, and \$5 million to be used for state-designated rural health centers, public health departments, and other non-profit healthcare organizations with a mission to serve the uninsured and other medically underserved populations. The funds shall be used to:</p> <ul style="list-style-type: none"> <li>a) Increase access to preventive and primary care services by uninsured or medically indigent patients in existing or new health center locations;</li> <li>b) Establish health center services in counties where no such services exist;</li> <li>c) Expand the NC Office of Research, Demonstrations and Rural Health Development's Medical Access Program (MAP) to safety net providers who currently receive no financial support for indigent care and who are located in high-needs counties;</li> <li>d) Create new services or augment existing services provided to uninsured or medically indigent patients, including primary care and preventive medical services, dental services, pharmacy, and behavioral health;</li> <li>e) Increase capacity necessary to serve the uninsured by enhancing or replacing facilities, equipment, or technologies; and</li> <li>f) Create or augment community collaborations or integrated delivery systems that have the capacity to expand health services to the uninsured or medically indigent patients.</li> </ul> <p>Of the \$5 million appropriated to state-designated rural health centers, public health departments, and other non-profit healthcare organizations, \$140,000 shall be provided to the NC Office of Research, Demonstrations and Rural Health Development to: develop planning packages for local communities interested in developing safety net programs, provide technical assistance, and collect data on the capacity of the existing safety net to meet the needs of the uninsured and medically indigent. (PRIORITY)</p>					
<p>7.5. The NC General Assembly should appropriate \$11.35 million in SFY 2005-2006 and \$25.95 million in SFY 2006-2007 to expand the number of school health nurses with the goal of fully implementing the school health nurse initiative over the next five years. (PRIORITY)</p>	✓		✓		
<p>7.6. The NC Division of Medical Assistance should explore different Medicaid payment rules that would provide higher reimbursement to FQHCs, FQHC look-alikes, and rural health clinics (RHCs) that serve a disproportionately high percentage of uninsured. New funds should be used to support and expand care to the uninsured.</p>		✓	✓		
<p>7.7. The NC Division of Medical Assistance should assure that reimbursement to local health departments for Medicaid services will be at actual cost (same as for FQHCs, RHCs, and CHCs). Rates should be adjusted annually to account for the full cost to provide services or the annual cost settlement payment should</p>		✓	✓		



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include the full share (county, state, and federal) of Medicaid payments. New funds should be targeted to providing care to the uninsured (comprehensive primary care, population-based services, or other more targeted clinical services).					
<p>7.8. The NC General Assembly, NC Division of Medical Assistance, and NC State Employees Health Plan should consider options to enhance payments to hospitals that serve high proportions of uninsured patients or that meet identified health shortage needs by providing other critical health services.</p> <p>a) Options may include, but are not limited to, increasing Medicaid or other reimbursement to achieve this goal or exploring whether Disproportionate Share Hospital-related supplemental payments can be used for this purpose.</p> <p>b) The NC General Assembly should appropriate new funds for this purpose.</p> <p>c) In distributing new funds, the state should recognize other funds the hospitals receive to serve the uninsured.</p> <p>d) New funds should be targeted to expanding care to the uninsured.</p>	✓	✓	✓		State Employees Health Plan
7.9. The NC Division of Medical Assistance should explore the possibility of creating a system of “shared savings” with regional Community Care of North Carolina (CCNC) networks. Savings that are retained by regional networks should be used to provide similar health services to the uninsured.			✓		
<p>7.10. The NC Division of Medical Assistance (DMA) should ensure that the federal Medicaid spend-down rules that allow applicants to use the value of healthcare services paid by state and county programs in meeting their spend-downs are fully implemented. In so doing, the DMA should:</p> <p>a) Explore which programs are eligible for this deduction, including, but not limited to, Division of Public Health (DPH) purchase of care programs, AIDS Drug Assistance Program (ADAP), mental health, and MAP programs.</p> <p>b) Work with the other state agencies that administer these programs to develop cost of care statements, and, ultimately, develop systems to facilitate the exchange of information about the value of services provided across programs to simplify the spend-down process for applicants.</p>		✓			
<p>7.11. The NC Division of Medical Assistance should continue its work to simplify the Medicaid application process for parents, people with disabilities, and older adults. Specifically, the Division should:</p> <p>a) Create a simplified application form,</p> <p>b) Extend the length of time for recertification, and</p> <p>c) Explore the possibility of eliminating the assets test for families with children.</p>		✓	✓		