NORTH CAROLINA INSTITUTE OF MEDICINE
2005 TASK FORCE ON THE NORTH CAROLINA HEALTHCARE SAFETY NET REPORT
2008 UPDATES TO RECOMMENDATIONS

There has been substantial progress in implementing the recommendations of the North Carolina Institute of Medicine Task Force on the North Carolina Healthcare Safety Net. In total, progress has been made in implementing 75% of the recommendations, in whole or in part. In addition, many groups are continuing to work on these recommendations.

Total recommendations: 28
Fully implemented: 4 (14%)
Partially implemented: 17 (61%)
Not implemented: 7 (25%)

COVERING THE UNINSURED

Recommendation 2.1: **PRIORITY RECOMMENDATION**
The North Carolina General Assembly should take steps to make health insurance coverage more affordable and to expand health insurance coverage to more uninsured individuals.
Partial Implementation

During the 2007 legislative session, the North Carolina General Assembly (NCGA) fully funded NC Health Choice and included new funds to expand children's health insurance (NC Kids' Care) to uninsured children in families with incomes between 200% and 300% of the federal poverty guidelines. This expansion was scheduled to go into effect July 1, 2008 but was delayed due to changes to the Centers for Medicare and Medicaid Services rules limiting states ability to expand state children's health insurance programs to children in families earning above 250% of the federal poverty guidelines. During the 2008 legislative session, the NCGA authorized the Department of Medical Assistance to create NC Kids' Care to cover uninsured children between 200-250% of the federal poverty guidelines. NC Kids' Care is scheduled to go into effect July 1, 2009 or upon reauthorization of the federal SCHIP program and approval of a state plan amendment. Additionally, during the 2008 legislative session the NCGA provided $9.4 million in recurring funding to expand the NC Health Choice program to support an additional 7,341 children.

In 2007, the legislature also extended Medicaid to youth ages 18-20 transitioning out of foster care and created the North Carolina Health Insurance Risk Pool (NCHIRP). NCHIRP will provide more affordable health insurance coverage for North Carolinians who face high insurance premiums because of their health beginning January 1, 2009.

During the 2007 legislative session, the NCGA appropriated $5 million in nonrecurring funds and $2 million in recurring funds to expand the health care safety net. An additional $2.9 million in nonrecurring funds were appropriated to sustain coordinated

networks for the uninsured through HealthNet. During the 2008 legislative session, the NCGA appropriated $2 million recurring funds and $4 million nonrecurring funds to support the health care safety net (Community Health Centers grants program), and an addition $2.8 million recurring and $950,000 non-recurring funds to sustain indigent care networks and support new collaborations through HealthNet.

DEFINING THE SAFETY NET

Recommendation 3.1:
The Office of the Secretary of the North Carolina 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 for both 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.
Partial Implementation

Progress has been made in expanding access to behavioral health services since 2005. All state-funded mental health, developmental disabilities and substance abuse services are directed towards the indigent population. Funding for these services has increased by $60 million.

Since 2005 the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMHDDSAS) has worked on a number of projects to increase access to behavioral health including: developing an appeals process for non-Medicaid eligible individuals to appeal a reduction/denial/termination of services; helping to pass equitable coverage for mental health services during the 2007 legislative session; and developing a comprehensive crisis services plan that will be reviewed by the 2008 Session of the General Assembly. DMHDDSAS is also working with Community Care of North Carolina (CCNC) and Local Management Entities through the ICARE initiative to integrate behavioral health and physical health care. This initiative is particularly focused on the indigent non-target population for whom state-funded MHDDSA services are not available through the specialty system. Additionally, the North Carolina General Assembly appropriated $2.2 million over two years to the North Carolina Office of Rural Health and Community Care to co-locate mental health specialists with CCNC primary care practices. These were nonrecurring funds.

Recommendation 3.2:
The Office of the Secretary should work with the North Carolina Pediatric Society, North Carolina Academy of Family Physicians, North Carolina Chapter of the American College of Physicians, North Carolina Psychiatric Association, other interested professional associations, and North Carolina 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 North Carolina Commission for Mental Health, Developmental Disabilities and Substance Abuse Services.

Full Implementation

The Office of Rural Health and Community Care (ORHCC) in conjunction with Community Care of North Carolina (CCNC), ICARE, the Division of Medical Assistance and others are working to increase co-location of behavioral health providers and primary care providers. In the co-location model, a mental health professional is located in a primary care provider's office; in reverse co-location, access to primary care is increased through by placing a primary care provider in a mental health care provider's office.

In FY 2007, the ORHCC designated $1 million in funding for co-location and reverse co-location grants. Forty-three practices, serving approximately 150,000 adults and 220,000 children, received funding for co-location through ORHCC in 2007. Of these, 36 practices requested and received funding for a second year of funding in 2008. An additional 15 practices will receive funding during FY 2008. Practices were eligible for up to $25,000 per year and funding was provided to practices located throughout the state.

ORHCC requires grantees to begin implementing evidence-based screening tools. Currently, approximately 50% of grantees are screening for depression using a national tool and ORHCC is promoting SBIRT, which calls for screening, brief intervention and referral to treatment, to screen for substance use disorders.

Recommendation 4.1: PRIORITY RECOMMENDATION

The North Carolina Office of Rural Health and Community Care[1] (ORHCC), in collaboration with the Cecil G. Sheps Center for Health Services 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.

- **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.**
- **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 ORHCC 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 ORHCC should create a standardized reporting form to ensure that the data are collected consistently across healthcare**

[1] Formerly the NC Office of Research, Demonstrations and Rural Health

organizations. Other organizations that do not receive any state funding, such as free clinics, should be encouraged to provide similar information.

c) **The ORHCC should share these data with local Community Care of North Carolina groups, Healthy Carolinian organizations, local health departments, the North Carolina Association of Community Health Centers, the North Carolina Hospital Association, the North Carolina Medical Society, the North Carolina Free Clinic Association, the North Carolina 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.**

d) **The ORHCC should report these data to the Secretary, Governor, General Assembly, and North Carolina Association of County Commissioners on a yearly basis to help inform policymakers of areas of greatest unmet need.**

Full Implementation

The North Carolina Institute of Medicine (NC IOM) worked with other organizations to create a Safety Net Advisory Council (SNAC) after release of the NC IOM Healthcare Safety Net Task Force report (See Recommendation 6.6 for a more complete description of the SNAC). The NC IOM, in conjunction with the SNAC, developed a safety net website that includes information on safety net organizations around the state, services offered, hours of operation, eligibility requirements for services (i.e., income limits, geographic limitations), whether the organization serves uninsured for free or on a sliding scale, and whether the organization is accepting new patients. The website, launched in June 2008, has information on approximately 250 organizations with 400 delivery sites including free clinics, local management entities, public health departments and others. This website is accessible at: www.nchealthcarehelp.org.

In addition, organizations were asked to provide information on numbers of uninsured by county. These data are to be aggregated so that the NC IOM, SNAC, statewide funders, and other organizations can identify the areas of greatest unmet needs.

Recommendation 4.2: PRIORITY RECOMMENDATION

The North Carolina Office of Rural Health and Community Care 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.

a) **The collaborative should include, but not be limited to: the Division of Public Health, the North Carolina Community Health Center Association, the North Carolina Hospital Association, the North Carolina Medical Society, the North Carolina Free Clinic Association, and the North Carolina 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 should be**

considered, particularly for smaller, less-populated, or resource-poor communities.

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.**

Partial Implementation

The NC IOM, in conjunction with the SNAC, developed a technical assistance manual: *Health Care Services for the Uninsured and Other Underserved Populations.* The manual was written to help community groups interested in developing or expanding health care services for the uninsured and other underserved populations. The manual includes chapters on: identifying need, leadership, community support, types of health care safety net organizations, financial considerations, choosing a type of safety net organization, and collaboration. It also includes information on where groups can obtain technical assistance, sources of private funding, and a detailed description of the requirements for different types of safety net organizations. The manual is available on the NC IOM website at: www.nciom.org.

In addition, The Duke Endowment and other foundations are helping to create a statewide safety net technical assistance center (See recommendation 6.6). The technical assistance center will work with communities in developing community collaborations to provide services to the uninsured and underserved populations, but will also assist in the development or expansion of the safety net infrastructure (i.e., primary care organizations, medication assistance programs, etc.).

Recommendation 4.3:
The North Carolina 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.
Partial Implementation

Most or all of the Project Access and free clinics that rely on health care professionals and health care organizations to provide free care for the uninsured have a system to recognize these providers for their services. However, there has not been any organized effort to recognize these professionals or institutions at the state level.

Recommendation 4.4: **PRIORITY RECOMMENDATION**

The North Carolina 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 North Carolina Medical Society and North Carolina 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.

Partial Implementation

The North Carolina Free Clinic Association convened a group to examine North Carolina laws pertaining to lawsuits against medical provider volunteers. The group pursued submitting legislation which would grant medical provider volunteers immunity from lawsuits, similar to current Virginia law, but found that North Carolina common law is not favorable to this type of change. The group is still considering submitting legislation to clarify the language in North Carolina's Good Samaritan Law.

In addition to reviewing North Carolina law, the North Carolina Free Clinic Association is also working with healthcare clinics to obtain deemed status for free healthcare clinic employees, eligible contractors and volunteers under the Federal Torts Claim Act (FTCA), which provides protection from malpractice lawsuits.[2] This work is being funded by The Duke Endowment. Thus far, 10 free healthcare clinics have been deemed and several others are in the process. The North Carolina Free Clinic Association also worked with Medical Mutual to develop a low fee policy ($100) for volunteer providers.

Recommendation 5.1:

The North Carolina Office of Rural Health and Community Care (ORHCC) and other safety net organizations should create a workgroup to meet with pharmaceutical companies to discuss:

a) **Simplifying and streamlining the Patient Assistance Programs, including the application forms, verification requirements, and eligibility requirements; and**

[2] The Federal Torts Claim Act (FTCA) of 1946 provides a process by which people who have suffered wrongful injury through the negligence or wrongdoing of a US government employee can be compensated. Under section 224 of the Public Health Service Act, employees of eligible health care clinics can be deemed federal employees qualified for protection under the FTCA. More information is available online from the US Department of Health and Human Services, Health Resources and Services Administration at: http://bphc.hrsa.gov/ftca/.

b) Creating bulk replenishment programs and other ways the pharmaceutical industry could help provide medications to safety net organizations. Information should be disseminated to safety net organizations and private physician practices about the best way to access existing pharmaceutical resources.

Partial Implementation

Nothing has been done to simplify and streamline the Patient Assistance Programs (PAP) since the publication of the Task Force report in 2005. However, the ORHCC has made some progress around improving access to free and/or low cost medications. To help community agencies access PAPs, ORHCC developed Medication Access and Review Program (MARP) software which is designed to automate access to the various forms and eligibility standards of PAPs. In partnership with the North Carolina Health and Wellness Trust Fund, ORHCC facilitates grant-supported community medication assistance programs, offering free medication assistance software (MARP) and technical support. As part of the grant, each site worked with private physician practices, local safety net and faith-based community organizations and others to provide education on accessing medications through their medication assistance program.

Recommendation 5.2:
The North Carolina 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 Access and Review Program (MARP) and medication assistance programs.
Partial Implementation

For the first time in 2007, the NCGA included funding for personnel at the Office of Rural Health and Community Care to support MARP software and technical assistance to medication assistance programs in their budget. No funding was provided for the local communities that administer medication assistance programs. The Health and Wellness Trust Fund continues to be the sole source of funding for the medication assistance programs and currently funds 60 medication assistance programs, most of which are set to expire in June 2009.

Recommendation 5.3: PRIORITY RECOMMENDATION
North Carolina private foundations should consider three-year start-up funding at $180,000 per year to the North Carolina Office of Rural Health and Community Care (ORHCC) to create a bulk medication replacement system.
Not Implemented

An ORHCC meeting with the top four pharmaceutical companies with representation in North Carolina yielded mixed responses. While the pharmaceutical companies support ORHCC's prescription assistance efforts and the software, MARP, developed to facilitate access to these programs, the companies had already committed to participate in the national "Partnership for Prescription Assistance" effort and did not see their leadership

supporting a competing cause. ORHCC determined that pursuing a bulk replenishment effort without pharmaceutical company support was not feasible.

Lacking pharmaceutical company support for a bulk purchasing initiative, ORHCC determined more North Carolinians could be helped by expanding the number of community sites offering prescription assistance. ORHCC currently oversees around 140 MARP community medication assistance programs, an increase of 55% since 2005.

Recommendation 5.4:
The North Carolina Office of Rural Health and Community Care should explore opportunities to expand 340B drug discount prices to low-income patients of other safety net organizations.
Not Implemented

The Office of Rural Health and Community Care is researching the feasibility of establishing a 340B pricing program for qualified populations.

Recommendation 6.1:
The North Carolina 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.
Partial Implementation

During the 2007 legislative session, the General Assembly made some changes to existing state confidentiality laws. Specifically, the amended confidentiality provisions state: “Notwithstanding G.S. 8.53 or any other provision of law, a health care provider may disclose protected health information for purposes of treatment, payment, or health care operations to the extent that disclosure is permitted under 45 C.F.R. § 164.506 and is not specifically prohibited by other state or federal law.” As used in this subsection, "treatment, payment, or health care operations" are as defined in the Standards for Privacy of Individually Identifiable Health Information.

This amendment synchronizes state law and federal HIPAA regulations with respect to disclosures for the purposes of treatment, payment and health care operations (i.e., disclosure permitted without the patient's written permission). The amendment has not completely opened the door for the type of information sharing envisioned in this recommendation. Under the new state law, health care providers are now permitted to share information for treatment, payment and health care operations if HIPAA allows the sharing. However, the new law states that such disclosures are not permitted if they are "specifically prohibited by other state or federal law." Thus, any specific state laws that are more restrictive must still be given effect. For example, G.S. 130A-143 protects the confidentiality of information that identifies someone who has or may have a reportable communicable disease. That law allows disclosure for treatment purposes only with the

patient's written consent. Thus, if a safety net provider wants to disclose information to another safety net provider for treatment purposes and the records include information about the patient's reportable communicable disease (e.g., HIV, TB, syphilis), the provider must still obtain the patient's written consent.

Recommendation 6.2:
The North Carolina Office of Rural Health and Community Care should collect and disseminate descriptions of various models of collaboration and integration found to work well in particular communities.
Partial Implementation

This responsibility was assumed by the *North Carolina Medical Journal*. Beginning in November 2007, the *North Carolina Medical Journal* began featuring health care safety net collaborations. This special feature is called Spotlight on the Safety Net. Since the inception of this feature, the *North Carolina Medical Journal* has produced short descriptions of the following safety net community collaborations: the Durham Veterans Affairs Medical Center, the James D. Bernstein Community Health Center, the Community Health Network of Henderson County, the Gaston County Collaboration, and the Mecklenburg Emergency Medical Services Agency.

In addition, both the North Carolina General Assembly and The Duke Endowment have helped fund community safety net collaborations. See Recommendation 6.4 below.

Recommendation 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.
Full Implementation

There are currently 13 community collaborations (Project Access type collaborations) that are active and enrolling patients. Each of these community collaborations rely on many different health care, business, academic and other organizations to meet the health care needs of the uninsured. In addition to the many health care providers and organizations that donate their services, successful community collaborations engage the broader community to help meet the needs of the uninsured. For example, some community collaborations have worked with local businesses on fundraising efforts, or to obtain free or low-cost supplies, durable medical equipment or other services. Non-profit organizations help by providing interpreter services or assisting with health education. Social services agencies are integral to the effort of most community collaborations, assisting with eligibility and referring patients to other community resources. Additionally, members of faith-based organizations volunteer their time in free clinics or other community agencies, and often provide funding to help meet the needs of the uninsured. Further, some community collaborations have worked with researchers in local academic institutions to assist with the evaluation of health care outcomes and costs.

Recommendation 6.4: **PRIORITY RECOMMENDATION**

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.

Partial Implementation

North Carolina foundations have not convened a safety net best practices summit to focus on collaboration and integration. However, there has been a lot of activity from both the North Carolina General Assembly and The Duke Endowment to fund community collaborations for the uninsured. In SFY 2008, the North Carolina General Assembly appropriated $2.9 million in nonrecurring funds to the Office of Rural Health and Community Care to create HealthNet.[3] The Duke Endowment has committed a minimum of $4.5 million annually to establish a similar initiative, called Care+Share. The small amount of state and foundation funding used to support these community collaborations leverage huge contributions by community providers (physicians, nurses, physician assistants, pharmacists, other allied health professionals, and hospitals) who donate their time and services, as well as local contributions.

The two programs, HealthNet (NCGA) and Care+Share (The Duke Endowment) have similar components:

- *Eligibility screening*: Individuals must first be screened to determine eligibility for other public programs and to verify that they are uninsured.
- *Administration*: Community collaborations have some permanent staff who help determine eligibility, link patients to medical homes (if needed), enlist private providers to participate in the community collaborative, and help link patients to specialists (as needed).
- *Medical home*: Individuals must have a primary care provider who helps manage the patient's care. If the uninsured individual does not have a medical home, then the collaboration will help link the patient to a safety net organization or private primary care provider who will serve as the patient's medical home.
- *Access to diagnostic and specialty services*: Community providers (specialists) agree to treat a certain number of uninsured low-income individuals for free. Each individual provider can specify the number of patients they are willing to treat.
- *Hospitalizations*: Local hospitals agree to provide inpatient and outpatient services for free to eligible low-income uninsured individuals.

[3] The Joint Conference Committee Report on the Continuation, Capital, and Expansion Budget, HB 1473. North Carolina General Assembly 2007 Session. Legislative Change #10, Section G. http://www.ncleg.net/sessions/2007/budget/budgetreport7-27.pdf (Accessed May 27, 2008)

- *Medication assistance*: The community collaboratives help patients access free pharmaceuticals (from pharmaceutical assistance programs) or have small pools of money to help patients purchase needed medications.
- *Disease and care management*: Partnering with CCNC's community care networks, many of the community collaboratives are providing disease and care management to help coordinate care across multiple providers and provide patients with the education and support needed to help them manage their chronic health problems.
- *Quality improvement:* Building on CCNC and the new Health Care Quality Alliance, these community collaborations are beginning to focus on quality improvement initiatives to enhance the quality of care provided to the uninsured.
- *Common Outcome Measures:* The community collaboratives will collect similar outcome measures to demonstrate the benefits to the uninsured, communities and the state.

The HealthNet and Care+Share programs are working collaboratively to support funding to multiple communities across the state. There is currently an interim management group comprised of the Office of Rural Health and Community Care, North Carolina Community Health Center Association, North Carolina Hospital Association, North Carolina Medical Society, North Carolina Division of Public Health, North Carolina Association of Health Care Access, North Carolina Foundation for Advanced Health Programs, and North Carolina Institute of Medicine who have worked to develop a common application and funding criteria across these two funding sources. There are also plans to create a technical assistance center that will work with local communities to help develop safety net capacity and create community collaborations of care for the uninsured. The Technical Assistance center is governed by a larger group—which in addition to the groups listed above—also includes other North Carolina foundations and representatives of other safety net organizations and governmental organizations.[4] The goal of this larger effort is to enhance the infrastructure and develop community capacity to create seamless systems of care for the uninsured.

[4] The Advisory Board governing this initiative includes representatives of the major health care foundations in the state: The Duke Endowment, Kate B. Reynolds Charitable Trust, NC Health and Wellness Trust, Blue Cross and Blue Shield Foundation of North Carolina. The Advisory Board also includes representatives of safety net organizations or state agencies providing services to low-income uninsured people, including: the Office of Rural Health and Community Care, Community Care of North Carolina, Division of Public Health, Division of Mental Health, Developmental Disabilities and Substance Abuse Services, Office of Minority Health and Health Disparities, North Carolina Medical Society, Old North State Medical Society, North Carolina Hospital Association, North Carolina Community Health Center Association, North Carolina Association of Free Clinics, Area Health Education Centers program, prescription assistance programs, Healthy Carolinians, dental safety net organizations, local departments of social services, existing community collaborations, and consumer representatives. The work of the SNAC is coordinated with the Care+Share Advisory Board, and may eventually be incorporated into this larger group.

Recommendation 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.
Partial Implementation

The North Carolina Hospital Association is an active participant in the HealthNet and Care+Share community collaborations. See Recommendation 6.4 for more information.

Recommendation 6.6: PRIORITY RECOMMENDATION
The North Carolina 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 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.
Full Implementation

The North Carolina Institute of Medicine convened a Safety Net Advisory Council (SNAC) after the completion of the Health Care Safety Net Task Force report. SNAC members include state and local representation from: Cecil G. Sheps Center for Health Services Research, North Carolina Area Health Education Centers Program, North Carolina Association of Free Clinics, North Carolina Community Health Center Association, North Carolina Division of Public Health, North Carolina Hospital Association, North Carolina Medical Society Foundation, and North Carolina Office of Rural Health and Community Care. The SNAC meets approximately 3 times per year.

The SNAC has had three primary responsibilities: 1) SNAC members (or organizational representatives) serve as grant reviewers to review the Community Health Center grant proposals for the North Carolina Office of Rural Health and Community Care (See Recommendation 7.4), 2) SNAC members helped write and/or review sections of the technical assistance manual to help communities create or expand health care safety net resources (See Recommendation 4.1), and 3) SNAC members helped design the Safety Net website to capture information about existing safety net organizations across the state (See Recommendation 4.1).

Recommendation 7.1: PRIORITY RECOMMENDATION
The North Carolina Department of Health and Human Services, North Carolina Community Health Center Association, North Carolina Association of Free Clinics, North Carolina Health Directors Association, North Carolina Hospital Association, North Carolina Medical Society, and other safety net organizations should work with the North Carolina congressional delegation to support North Carolina safety net organizations.

a) **The North Carolina congressional delegation should oppose any efforts to create a Medicaid block grant or otherwise limit the availability of federal Medicaid funds to the states.**
b) **In order to ensure that North Carolina receives its fair share of federal funding for federally qualified health centers (FQHCs), the North Carolina 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.**
c) **The North Carolina 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 continue funding the Special AIDS Drug Assistance Program (ADAP) Initiative.**
d) **The North Carolina 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.**

Partial Implementation

Many of the North Carolina health care professional associations and state agencies have worked with and continue to work with the North Carolina congressional delegation to support safety net organizations, oppose efforts to limit the availability of federal Medicaid or SCHIP funds, and ensure that North Carolina receives its fair share of federal funding for other federally-funded health programs (such as Ryan White CARE, Aids Drug Assistance Program (ADAP), and funding for Federally Qualified Health Centers). While these organizations have not been fully successful in ensuring that North Carolina receive an increased share of federal funding, there have been some positive developments. For example, North Carolina received additional funding for the federal ADAP program. In addition, since the issuance of the Safety Net Task Force Report in 2005, health centers have competed for, and received, a total of $9,875,610 in additional grant funding. In 2007 the Health Resource Services Administration (HRSA) created a High Poverty County Initiative. Sixteen NC counties were identified as eligible for funding through this initiative; of these seven submitted applications. As a result Buncombe, Franklin, Iredell, and Randolph counties received health center funding totaling $2,175,000 or nearly 6% of the total $36.9 million in available funding. This is a greater proportion of the total federal funding than North Carolina received in the past.

In addition, there has been a lot of activity to try to increase North Carolina's SCHIP federal allotment. North Carolina would have received significantly more federal funding in the SCHIP reauthorization bill that was vetoed by the President. There is a good chance that North Carolina will receive increased SCHIP funding in the next Congressional session.

Recommendation 7.2:
The North Carolina 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.
Not Implemented

Upon further study, the North Carolina Association of Local Health Directors felt that it was not strategic to seek a statutory change to the composition of local Boards of Health as that would open up the possibility of "unintended" changes as well. They decided that a more effective approach would be to work in their communities to establish stronger partnerships with other safety net providers. These partnerships can then develop community solutions to addressing the gaps, which capitalizes on the strengths of each safety net partner. Community Care of NC and Care+Share provide excellent opportunities for effective collaborations on these issues.

Recommendation 7.3:
The North Carolina health foundations should consider additional funding to meet the capital and infrastructure needs of healthcare safety net organizations.
Partial Implementation

Several of the major North Carolina foundations provide infrastructure support to health care safety net organizations. For example:

- *Blue Cross and Blue Shield of North Carolina Foundation support for free clinics*: The Blue Cross and Blue Shield of North Carolina Foundation recently announced its second $10 million over five years to support free health care services provided by 74 free clinics in 79 counties across the state.[5]
- *Health and Wellness Trust Fund support for prescription assistance programs*: The Health and Wellness Trust fund supports organizations that help low-income uninsured people apply for free or reduced cost pharmaceuticals. Funding for these Medication Assistance Programs (MAP) began in 2003. To date, the Health and Wellness Trust Fund has provided funding to more than 84 organizations providing MAP services.
- *Kate B. Reynolds Charitable Trust*: The Health Care Division of the Kate B. Reynolds Charitable Trust has historically provided grants to improve access to services for low-income uninsured or other underserved populations. Kate B. Reynolds Charitable Trust has also provided significant financial support to help expand access to services for underserved populations and capital and programmatic support to meet the preventive, primary care, dental, and behavioral health needs of underserved populations.
- *The Duke Endowment*: The Duke Endowment has provided significant financial support to help expand access to services for underserved populations and capital and programmatic support to meet the preventive, primary care, dental, and behavioral health needs of underserved populations.

[5] For more information about the initiative, see:
http://www.bcbsncfoundation.org/elements/media/files/BCBSNCF_NCAFC_Extend_Partnership.pdf

Recommendation 7.4: **PRIORITY RECOMMENDATION**

The North Carolina General Assembly should appropriate, on a recurring basis, $6 million to be used for federally qualified health centers and those health centers that 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 indigent and other medically underserved populations. The funds shall be used to:

a) **Increase access to preventive and primary care services by uninsured or medically indigent patients in existing or new health center locations;**
b) **Establish health center services in counties where no such services exist;**
c) **Expand the 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;**
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;**
e) **Increase capacity necessary to serve the uninsured by enhancing or replacing facilities, equipment, or technologies; and**
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.**

Partial Implementation

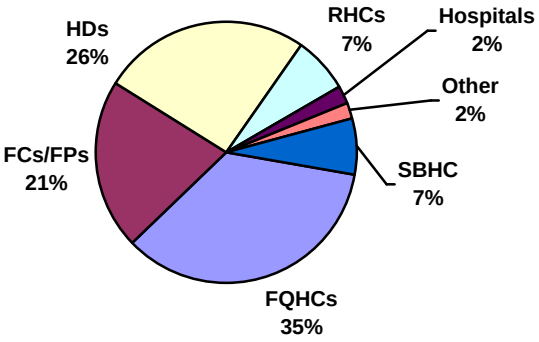
In SFY 2005 the NCGA created and began funding the Community Health Grants program. The purpose of the funding was to: 1) increase access to preventive and primary care services for uninsured or medically indigent patients in existing or new health center locations; 2) establish community health center services in counties where no such services exist; 3) 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; and 4) increase capacity necessary to serve the uninsured by enhancing or replacing facilities, equipment, or technologies. The NCGA has provided various levels of funding to support the Community Health Grants program since its inception (See Table 1).

Table 1
North Carolina General Assembly Appropriations to Health Care Safety Net Community Health Grants Program

Year	Recurring	Nonrecurring	Total
SFY 2005	$0	$7.0 million	$7.0 million
SFY 2006	$2.0 million	$0	$2.0 million
SFY 2007	$2.0 million	$3.0 million	$5.0 million
SFY 2008	$2.0 million	$5.0 million	$7.0 million
SFY 2009	$2.0 million	$4.0 million	$6.0 million

During the 2007 legislative session, the NCGA appropriated $5 million in nonrecurring funds and $2 million in recurring funds to expand the health care safety net.[6] The funds were distributed across the state, on a competitive basis, to organizations that serve low-income uninsured individuals.

Chart 1
Distribution of SFY 2008 Community Health Center Grants



Abbreviations: FQHC (Federally Qualified Health Center), FC (Free Clinic), FP (Free Pharmacy), HD (Health Department), RHC (State funded rural health center), SBHC (school-based health center).

The $7 million appropriated by the NCGA was divided into three pools: approximately $2 million to provide continued support to SFY 2006-2007 community health grantee projects, $375,000 for operational increases for school-based health centers (as required in the appropriations act) and the remaining monies to fund new programs and capital initiatives.[7] Less than one percent of the funds were allocated to the North Carolina Office of Rural Health and Community Care for administration. The maximum grant awards ranged from $25,000 for school-based health center operational grants, to $75,000 for continuation, new project, and small capital grants, and $150,000 for large capital grants.

In total, 45 organizations received Community Health grants in SFY 2008. Some of the funded projects include:

- Expansion of core primary care services in Alamance, Bertie, Buncombe, Cabarrus, Caldwell, Cleveland, Davidson, Edgecombe, Franklin, Greene, Guilford, Henderson, Hertford, Hyde, Iredell, Johnston, Lincoln, Madison, Mecklenburg, New Hanover, Northampton, Robeson, Rowan, Rutherford, Surry, Wake, Wayne, and Yadkin counties;

[6] Sec. 10.6(a) of Session Law 2007-323
[7] Information excerpted with permission from the NC Office of Rural Health and Community Care's report entitled, Summary Report on the SFY2007-2008 Community Health Grants Fund, submitted to the Senate and House Appropriations Committees on Health and Human Services and Fiscal Research dated May, 2008.

- Expansion of behavioral and mental health services in Caldwell, Mecklenburg, and Northampton counties;
- Expansion of pharmaceutical services to the uninsured and medically-indigent in Alamance, Gaston, Iredell, Lincoln, and Mecklenburg counties; and
- Expansion of dental services to the uninsured and medically indigent in Alamance, Cabarrus, Caswell, Durham, Edgecombe, Gaston, Harnett, Iredell, Jackson, Mecklenburg, Person, Robeson, and Yadkin counties.

An additional $2.9 million in nonrecurring funds were appropriated to sustain coordinated networks for the uninsured through HealthNet. (See Recommendation 6.4).

During the 2008 legislative session, the NCGA appropriated $4 million in nonrecurring funds and $2 million in recurring funds to expand the health care safety net, and an additional $2.9 million in recurring funds and $950,000 in nonrecurring funds to sustain coordinated networks of care for the uninsured through HealthNet.[8]

Recommendation 7.5: PRIORITY RECOMMENDATION
The North Carolina 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.
Partial Implementation

During the 2007 legislative session, funds were appropriated by the NCGA to create an additional 66 school nurse positions. In aggregate, funding for additional school nurse positions since 2004 has improved the school nurse to student ratio in North Carolina from 1:1,897 to 1:1,280. The improving ratio is due not only to generous funding provided by the NCGA, but also to the local health departments, local education agencies, hospitals, and communities who are committed to supporting school nurses across the state. The state remains committed to the goal of achieving the nationally recommended ratio of 1:750.

Recommendation 7.6:
The North Carolina Division of Medical Assistance should explore different Medicaid payment rules that would provide higher reimbursement to FQHCs, FQHC look-alikes, and RHCs that serve a disproportionately high percentage of uninsured. New funds should be used to support and expand care to the uninsured.
Not Implemented

No action has been taken to implement this recommendation.

[8] Health and Human Services Budget Changes 9, 10 of the Joint Conference Committee Report on the Continuation, Expansion and Capital Budgets. House Bill 2436. July 3, 2008. Available online at: http://www.ncleg.net/sessions/2007/budget/2008/conferencecommitteebudgetreport.pdf.

Recommendation 7.7:
The North Carolina 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 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).
Not Implemented

No action has been taken to implement this recommendation.

Recommendation 7.8:
The North Carolina General Assembly, North Carolina Division of Medical Assistance, and North Carolina 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.

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;**
b) **The General Assembly should appropriate new funds for this purpose;**
c) **In distributing new funds, the state should recognize other funds the hospitals receive to serve the uninsured; and**
d) **New funds should be targeted to expanding care to the uninsured.**

Not Implemented

No action has been taken to implement this recommendation.

Recommendation 7.9:
The North Carolina Division of Medical Assistance should explore the possibility of creating a system of "shared savings" with regional CCNC networks. Savings that are retained by regional networks should be used to provide similar health services to the uninsured.
Partial Implementation

The North Carolina Community Care Network, Inc. submitted a grant application to the Centers for Medicare and Medicaid Services (CMS) for a Medicare waiver. (The North Carolina Community Care Network is the statewide network of local Community Care of North Carolina (CCNC) networks). The demonstration project will be operated in several regions of the state and will apply the medical management and care coordination strategies of CCNC to the dually eligible (Medicare and Medicaid) and to patients with Medicare only. Improved care will benefit North Carolina's elderly citizens and will save money. The resulting cost savings obtained from better management of Medicare recipients would be shared between CMS and CCNC. The savings returned to CCNC will be reinvested locally for different purposes, including enhancing the array of services

available to people with Medicare or providing CCNC network services to the uninsured. The 646 waiver is currently pending in CMS.

Recommendation 7.10:
The North Carolina 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:

a) **Explore which programs are eligible for this deduction, including, but not limited to, Division of Public Health purchase of care programs, AIDS Drug Assistance Program (ADAP), mental health, and MAP programs.**
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.**

Not Implemented

No action has been taken to implement this recommendation.

Recommendation 7.11:
The North Carolina 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:

a) **Create a simplified application form,**
b) **Extend the length of time for recertification, and**
c) **Explore the possibility of eliminating the assets test for families with children.**

Partial Implementation

The Division of Medical Assistance (DMA) has implemented a 10 page mail-in application for the aged, blind and disabled. There has been no action on extending the length of time for recertification or in eliminating the asset test for families with children. When this recommendation was developed, DMA was mailing out reenrollment forms for children enrolled in North Carolina Health Choice or Health Check when their enrollment was up for renewal. DMA is now working on a similar system to use for the aged, blind and disabled. Additionally, counties now have the option of completing mail-in or telephone reviews rather than requiring recipients come into the office.