

The North Carolina Healthcare Safety Net, 2005: Fragments of a Lifeline Serving the Uninsured

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In 2003, nearly 20% (1.4 million) of North Carolinians under age 65 lacked health insurance coverage.¹ Since the year 2000, more than 300,000 people have lost their health insurance—a 31% increase in the uninsured. With nearly one in five people living without insurance, North Carolina is, without a doubt, in the midst of a major healthcare crisis, and as healthcare costs continue to rise, there is little chance of an immediate respite.

Coping with the large, and still growing, number of uninsured is a national problem, but North Carolina has been harder hit than many states. As a result of recent trade relocation and downsizing, North Carolina lost a large number of manufacturing, textile, and technical jobs, which left thousands of people unemployed and uninsured. The downturn in the economy, together with the rising cost of health insurance, is making it more difficult for people to afford healthcare or healthcare insurance.

Most of the uninsured in North Carolina (62%) have annual incomes less than 200% of the federal poverty guidelines (FPG)—less than \$18,620 for an individual and \$47,140 for a family of four in 2004.² This makes it challenging for the uninsured to pay for needed healthcare. Even people who have insurance sometimes have difficulty paying for needed healthcare, but it is typically harder for the uninsured. The uninsured are less likely to have a regular source

of care and are more likely to delay or forgo needed care than people with insurance coverage. The uninsured in North Carolina were far more likely than those with insurance to report that they have no person whom they consider to be their personal doctor or regular healthcare provider in 2003 (50.7% compared to 12.4%, respectively).³ Approximately 15% of North Carolinians reported that there was a time in the last 12 months when they needed to see a physician, but could not due to cost; however, the uninsured were more likely to report this problem (41.2%) than those with insurance coverage (9.5%). Further, when the uninsured do seek care, they are generally sicker than the insured population and, as a consequence, experience poorer health outcomes.

What Is the Healthcare Safety Net?

The lack of health insurance coverage obviously affects the uninsured person and his or her family, but it also has a broader societal impact. Lack of health insurance coverage decreases

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worker productivity; negatively affects the health of children and, thus, their ability to learn; and has unfavorable financial implications for those healthcare providers who provide care to the uninsured. The state and federal funding sources available to meet the healthcare needs of the uninsured are not keeping pace with the growing needs. The increased numbers of uninsured and inability to raise revenues from third party payers or other sources is creating significant financial strain for many safety net institutions. Without these institutions, the capacity to provide healthcare services for the uninsured and other underserved groups would be seriously undermined.

Safety net providers are those who deliver a significant amount of healthcare to the uninsured, Medicaid, or other vulnerable populations, and offer services to patients regardless of their ability to pay. They typically provide healthcare services at no charge, on a sliding-fee scale, or help make services financially affordable in some other way.

Who Are the North Carolina Safety Net Organizations?

In North Carolina, the safety net consists of federally qualified health centers (e.g., community and migrant health centers), state-funded rural health centers, local health departments, free clinics, Project Access or Healthy Community Access Programs, school-based or school-linked health centers, hospitals, and other organizations that have a central goal of providing care to patients regardless of their ability to pay (see sidebar). Many private providers provide services to the uninsured, albeit not always on a sliding-fee scale.

While some safety net resources exist in most communities, they are not always sufficient to meet the many healthcare needs of the uninsured. Some communities have multiple safety net organizations, but the system of care is fragmented. Others have a basic capacity to provide primary care services, but cannot meet the need for specialty consults or referrals, prescription medications, or more complex care. Still other communities lack even the capacity to meet the basic primary care needs of the uninsured.

The Healthcare Safety Net Task Force

In December 2003, The Kate B. Reynolds Charitable Trust funded the North Carolina Institute of Medicine to establish a Healthcare Safety Net Task Force that would examine the adequacy of the existing safety net structure. The Honorable Carmen Hooker Odom, MA, Secretary for the North Carolina Department of Health and Human Services, and Sherwood Smith Jr., JD, Chair Emeritus of Carolina Power & Light (now Progress Energy), chaired the 48-member Task Force, which included representatives of safety net organizations and provider associations, state and local elected officials and agency staff, non-profits, and advocacy organizations. The Task Force met once a month for nearly one year (March 2004-January 2005).

The goal of the Task Force was to develop a plan to better coordinate and integrate existing safety net institutions, identify

Components of the North Carolina Healthcare Safety Net

Federally Qualified Health Centers (FQHCs)

There are 23 FQHCs in North Carolina with a total of 76 delivery sites, serving more than 272,000 patients in 56 counties. FQHCs, often referred to as community or migrant health centers, provide comprehensive primary healthcare services as well as health education, preventive care, chronic disease management, oral and behavioral health services, all on a sliding-fee schedule. These centers have seen a 32% increase in the number of uninsured patients served in the past five years, serving more than 122,000 uninsured patients in 2003.

State-Funded Rural Health Centers (RHCs)

The North Carolina Office of Research, Demonstrations, and Rural Health Development in the North Carolina Department of Health and Human Services helped to establish 83 rural health centers throughout the state, with 32 of these receiving on-going support from the state. In return for the ongoing operational funds, these centers must agree to provide care to low-income uninsured individuals on a sliding-fee scale. These state-funded centers served 21,252 uninsured low-income patients in 2003.

Local Public Health Departments

There are currently 85 local health departments covering all 100 counties, with 79 of these covering single counties and six serving multi-county districts. These agencies provided clinical and preventive health services to 641,601 patients in 2003, of whom 260,603 were uninsured.

Free Clinics

These are non-profit organizations serving low-income uninsured populations by drawing on local healthcare resources and lay/professional volunteers. There are currently 60 free clinics or pharmacies in North Carolina, serving 48 communities. Most of these clinics are open one or two evenings per week and serve those needing care on a first-come, first-served basis. Free clinics served 69,320 low-income patients in 2003 (with 59,840 offered primary care services and 9,480 served in specialized clinics providing only pharmaceutical or behavioral health services).

Project Access or Healthy Communities Access Programs (HCAPs)

These are local community initiated efforts to fill gaps in the array of healthcare services available to meet the needs of the uninsured. Typically, these initiatives help link the services of traditional safety net providers to healthcare services offered by private practitioners and hospitals in the community. The Project Access model has been implemented in nine North Carolina communities in the following counties: Buncombe, Watauga-Avery, Mecklenburg, Cabarrus, Mitchell-Yancey, Guilford, Pitt, Vance-Warren, and Wake.

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communities with inadequate systems to care for the uninsured and underinsured, ascertain possible funding sources (nationally and locally) that can be used to expand care to the uninsured, and ultimately to expand and strengthen the capacity of healthcare providers and safety net institutions to care for underserved populations. This article provides an overview of the Task Force's findings and principal recommendations.

Are Safety Net Services Available throughout the State?

On the surface, it appears that North Carolina has a wide array of safety net organizations, located throughout the state (see map 1). However, few communities have sufficient safety net resources to meet the healthcare needs of all of the uninsured. The Task Force collected data on the number of uninsured residents receiving care in existing safety net institutions and compared this to the estimated numbers of uninsured in each county. Using these data (the percentage of uninsured with no identified source of primary care), the Task Force determined that only 25% of all the uninsured across the state receive primary care services from safety net organizations. This combined with other studies showing that the uninsured 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 the safety net varies widely across the state. Some counties appear to have enough

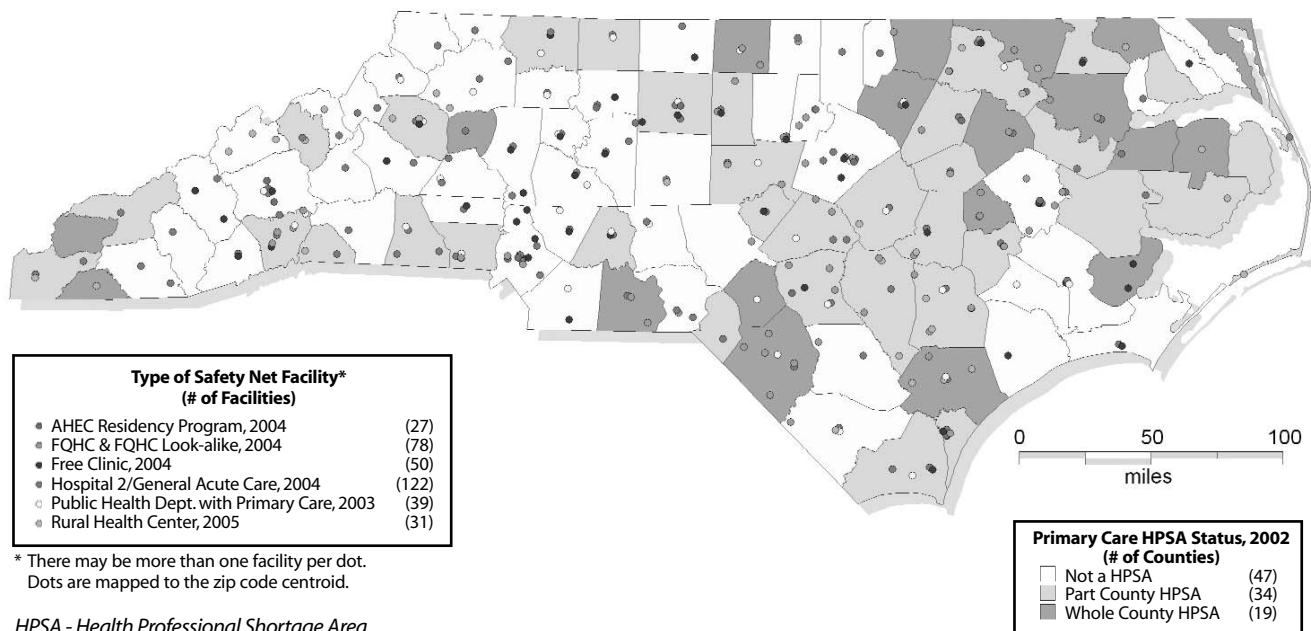
safety net providers to meet the primary care needs all of their uninsured, while others appear to have none. The Task Force identified 28 counties with the least safety net capacity. Thirteen of these counties also had lower than average primary care provider-to-population ratios, suggesting that it would be difficult for the private providers to meet the primary care needs of the uninsured in these counties: Brunswick, Columbus, Davidson, Edgecombe, Franklin, Granville, McDowell, Onslow, Randolph, Rockingham, Stanly, Vance, and Wilkes. Further, access to pharmaceuticals, specialty care, behavioral health, and dental services is still a problem in many communities, including those that have adequate primary care capacity.

A few communities have been able to develop integrated systems of care to address a broader range of healthcare services needed by the uninsured. However, this is the exception rather than the rule. Most communities have fragmented systems of care for the uninsured. 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 Uninsured and Access to Prescription Medications

Prescription drugs are a critical component of healthcare. More than 40% of all Americans take at least one prescription drug, and 17% take three.⁴ There has been a lot of public and

Map 1.
Safety Net Providers—North Carolina 2003-2005



HPSA - Health Professional Shortage Area

Produced by: NC Rural Health Research Program, Cecil G. Sheps Center for Health Services Research, UNC-CH.

Sources: NC Association of Free Clinics, 2004; NC Division of Facilities Services, 2004; NC Community Health Center Association, 2004; North Carolina AHEC, 2004; Office of Research, Demonstrations and Rural Health Development, 2005; NC Institute of Medicine, 2005; NC Division of Public Health, NC Division of Medical Assistance, 2003; Area Resource File, 2003.

media attention focused on the ability of Medicare recipients to pay for needed medications, but this same problem plagues the uninsured. A 2003 Kaiser health insurance survey found that 37% of the uninsured said that they did not fill a prescription because of costs, compared to 13% of people with insurance coverage.⁵

The pharmaceutical companies have tried to address this problem by offering free or reduced-charge medications through their Patient Assistance Programs (PAPs). Nationwide, 75 pharmaceutical companies offered approximately 1,200 different medications in 2003. More than 270,000 North Carolinians accessed medications through these programs.⁶ Yet, it is not always easy to obtain needed medications. Each manufacturer determines which drugs will be offered through their program and sets specific eligibility requirements. The application process can be laborious. It is often difficult for private physicians' offices as well as some smaller safety net programs to take advantage of these free medications, because of the programs' complexity. The North Carolina Foundation for Advanced Health Programs, Inc., with funding from The Duke Endowment, has developed software to assist providers and advocates in accessing appropriate PAP programs. Further, the North Carolina Health and Wellness Trust Fund has provided funding to community groups to help them develop medication assistance programs. These programs help individuals apply for free or reduced-cost medications and provide drug management to patients.

Many safety net providers also help their patients obtain needed medications, either by accessing PAPs or by offering free or reduced charge medications in-house. Despite these resources, ensuring that the uninsured obtain needed medications is still a problem. In many communities, providers are willing to volunteer to treat the uninsured, but are reluctant to do so if there is no assurance that the uninsured will be able to obtain the prescribed medications.

Collaboration and Integration

Few counties have the ability to meet the healthcare needs of all of the uninsured, regardless of how many or how few safety net organizations they have. However, there are some counties that have had more success. These counties have been able to work together to maximize their resources and to identify partners who can help in meeting the unmet healthcare needs of the uninsured.

There are various levels of collaboration and integration that have occurred throughout the state, ranging from periodic meetings of safety net organizations, community planning efforts and joint projects, to more elaborate inter-organizational agreements. In some counties, the hospital has collaborated with non-profit organizations to create primary care clinics for the uninsured. In other counties, local health departments have been successful in working collaboratively with FQHCs to expand care to the uninsured. Other counties have been able to develop more comprehensive systems of care, combining the efforts of traditional safety net providers with private providers

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School-Based or School-Linked Health Centers

Because school-age children, especially adolescents, are not always able to access comprehensive and coordinated systems of healthcare, some schools have established school-based or school-linked health centers to provide comprehensive primary care and mental health services to students. Currently, there are 27 comprehensive centers operating in middle and high schools in the state and another 12 centers that provide primary care services delivered by nurse practitioners or physician assistants. In addition to these health centers, many schools have hired nurses that can provide more limited health services to children.

Private Physicians

Physicians in private practice are a major source of care to the uninsured; many of whom provide services for reduced fees or at no charge. A national survey of households in 2001 revealed that nearly two-thirds of the uninsured reported a private practice physician as their regular source of care, and half of these respondents reported having received services in a physician's office. There has not been a North Carolina study to document the extent to which physicians in this state provide charity care, but most would agree that this is an important component of the healthcare safety net.

Area Health Education Centers (AHECs)

As part of its mission to meet the educational needs of the state's healthcare workforce, the AHECs in North Carolina support five residency programs in family medicine, three in rural family medicine, four in internal medicine, four in obstetrics/gynecology, three in pediatrics, and three in surgery. In 2003-2004, these programs provided services to 35,427 uninsured patients.

Hospitals

Almost all (110 of 113) general acute community hospitals in North Carolina operate emergency departments, which serve as an important safety net provider of last resort, regardless of ability to pay. In 2003, the uninsured represented 10% of outpatient visits, and of those, 22% (672,799 patients) were uninsured patients making emergency room visits.

Prescription Drug Programs

The largest source of free medications for the uninsured is the Patient Assistance Programs (PAPs) offered by private pharmaceutical companies. These programs vary a great deal from one company to another in terms of medications offered, eligibility requirements, and application processes. In addition, a few communities in North Carolina have seen the development of locally-organized pharmacy assistance programs to help low-income uninsured patients obtain needed medications. These programs fill a vital gap in the overall healthcare safety net, but at present levels of funding and availability, they are not able to meet all of the medication needs of the uninsured.

of care. For example, Project Access and Healthy Communities Access Programs (HCAP) help link the services of traditional safety net providers to healthcare services offered by private providers in the community. Generally, communities that have been able to develop integrated delivery systems for the uninsured have been more successful in meeting the healthcare needs of these populations.

Although many counties have been successful in establishing collaborative arrangements across safety net organizations, others have had more difficulty. Because there is little funding available to pay directly for services to the uninsured, safety net organizations often cross-subsidize the care they provide by using revenues from other paying patients. As a result, safety net providers in some counties compete for Medicaid or North Carolina Health Choice patients or other paying patients. Further, funding sources that are limited to certain types of safety net organizations sometimes create ill-will among other organizations that also provide care to the uninsured, but have no source of funding. In addition, there are other barriers—both real and perceived—that make it difficult to collaborate. For example, state medical confidentiality laws are perceived as obstacles to sharing patient information among providers who serve the same patients at different locations.

Financing Options

Many safety net organizations receive some financing from a variety of sources, including Medicaid, Medicare, private third-party insurance, out-of-pocket payments, and charitable donations. The source and proportion of funding from different sources varies across institutions and types of organizations.

By far, Medicaid is the largest funding source for those who would otherwise be uninsured. In North Carolina, the federal, state, and county governments expended approximately \$8.5 billion in SFY 2004 to cover 1.5 million low-income individuals during the year; most of these people would have been uninsured but for the Medicaid program.⁷ Medicaid is also a major revenue source for many safety net organizations, including hospitals, FQHCs, rural health clinics, health departments, non-profit health clinics, school-based health centers, and other private providers who care for the uninsured. North Carolina Health Choice, the State Children's Health Insurance Program, is another major revenue stream for some safety net providers. The federal and state governments paid approximately \$188 million to cover close to 175,000 previously uninsured children through North Carolina Health Choice in SFY 2004.⁸

In addition to funding for Medicaid and North Carolina Health Choice (which pays for services provided to people insured through these programs), there are limited funds available to support care for the uninsured through safety net organizations. For example, the federal government provides some funding to support operational costs for FQHCs, and the state provides limited funds to help pay for care to the uninsured through state-funded rural health centers. In addition, the North Carolina General Assembly appropriated \$7 million in

non-recurring funds last year (2004) to help support and expand the services available to the uninsured and medically indigent through certain safety net organizations, including FQHCs, FQHC look-alikes, public health clinics, and state-funded rural health centers. At the time this article was being written, it was still uncertain whether these funds would be continued in the 2005 budget. Some new federal funds are available to increase the number of people who can be served by federally qualified health centers through the President's Initiative for Health Center Growth; however, funding under this initiative is competitive, and North Carolina health centers have only been awarded approximately 3% of new funds over the last three years. The federal, state, and/or county governments also provide funds that offset some of the costs of providing specific services to the uninsured (e.g., child and maternal health services or services provided to people with HIV/AIDS).

While limited funding is available to help subsidize care to the uninsured, it is not sufficient to cover all of the costs, and is not well-targeted to those safety net organizations that provide the largest share of care to the uninsured. Certain safety net organizations provide a disproportionate share of care to uninsured patients, and as a result, these organizations collect a smaller share of their revenues from paying patients. This makes it harder for these institutions to pay for the care provided to the uninsured. The proportion of uninsured patients seen by different safety net providers varies across organizations:

- On average, 47.6% of the North Carolina FQHC users in 2003 were uninsured, but this varied from more than 65% in five centers, to less than 30% in seven centers.
- On average, 21% of patients in state-funded rural health centers were uninsured. This varies from more than 30% of patients who were uninsured in four state-funded rural health centers, to less than 10% of patients who were uninsured in two centers.
- The percentage of total hospital discharges attributable to the uninsured varied from a high of more than 10% in nine hospitals to a low of less than 2% in 14 hospitals; and the percentage of hospital discharges attributable to both Medicaid and the uninsured varied from a high of more than 35% in nine hospitals to a low of less than 10% in 10 hospitals.

The increased numbers of uninsured and inability to raise revenues from third party payers or other sources is creating significant financial strains for many of these organizations.

Recommendations

The Task Force formulated a set of 28 recommendations that could help strengthen and expand the capacity of healthcare safety net providers to address the healthcare needs of the growing numbers of uninsured in the state. These recommendations are fully described in the formal report issued by the North Carolina Institute of Medicine,⁹ but they are generally described here.

The recommendations offered by the Task Force address four principal sets of issues facing the healthcare safety net organizations in our state. These are: (1) the need to ensure that the uninsured have health insurance coverage; (2) expanding the capacity of the healthcare safety net to meet the needs of the uninsured; (3) developing systems to better integrate existing safety net services in local communities; and (4) increasing funding to support the work of safety net providers. Brief explanations of each of these four sets of issues are offered below.

The need for additional insurance coverage for the uninsured.

The primary barrier that the uninsured face in obtaining needed health services is lack of insurance coverage. Not only does lack of coverage affect the ability of individuals to access needed services, but it also affects a person's health status. To address this issue, the Task Force recommended that the North Carolina General Assembly take steps to make health insurance coverage more affordable and to expand health insurance coverage to more individuals and families who are currently uninsured. Until the uninsured have coverage, the Task Force recognized the importance of supporting and expanding existing safety net capacity to be able to meet more of the vital healthcare needs of the uninsured. In a very real sense, the healthcare *safety net* is just that, a stop-gap set of programs and voluntary efforts to minimize the effects of lack of healthcare insurance coverage for a growing segment of our population. The problems caused by lack of adequate health insurance coverage cannot be solved until most or all of those now uninsured, for all or part of a year, are included in some form of insurance to meet their healthcare needs.

The need for increased safety net capacity to address the healthcare needs of the uninsured. Because there is not unlimited funding or resources to support new or expanded safety net services across the state, the Task Force attempted to identify those communities or counties with the greatest unmet needs. The Task Force was able to collect data from some safety net providers about the number of uninsured people who received primary care services in the prior year, but these data were not uniformly available across types of safety net organizations. Data are not currently available from private practitioners, or from hospital emergency departments or outpatient clinics. Further, there are few sources of data to identify the capacity of communities to address the behavioral health, dental health, specialty, and medication needs of the uninsured. The Task Force recognized the importance of collecting these data, in order to target new resources to the communities most in need and to monitor the capacity of the safety net to address the healthcare needs of the uninsured over time. Therefore, the Task Force recommended that the North Carolina Department of Health and Human Services take the lead in monitoring services provided by public and private safety net providers across the state. In addition, the Task Force recommended that the Department, along with other safety net organizations, help develop a planning package and provide technical assistance to communities interested in expanding their safety net capacity.

The Task Force also recognized that there are barriers in

existing laws that discourage some private practitioners from volunteering their time to serve the uninsured. Some private providers have expressed concern that they may be subject to a lawsuit for a bad health outcome if they provide services to the uninsured. Although North Carolina already has a Good Samaritan statute that provides protection against monetary liability, it does not currently shelter providers from the cost (either financially or emotionally) of having to defend a lawsuit. The Task Force identified a need to make the act of volunteering to serve the uninsured less of a burden, and recommended that the North Carolina Free Clinic Association work with the North Carolina Medical Society and other safety net providers to explore other ways of reducing the barrier that potential malpractice claims create to encouraging private practitioners from volunteering to serve the uninsured.

The Task Force was also concerned with assuring access to needed medications by those who are served by various safety net providers. A recommended therapeutic regimen is meaningless without the ability to follow through with access to prescribed medications. While there are some resources available to provide needed medications through the pharmaceutical companies' Patient Assistance Programs (PAPs) or through local safety net organizations, the current resources are insufficient to ensure that the uninsured can obtain necessary medications. There is also a federal program that allows certain safety net organizations to negotiate for highly discounted medication prices (called the 340B program). However, federal law restricts the 340B drug discount program to certain safety net organizations, including FQHCs, public health, and some hospitals. The deeply discounted prices are not available to free clinics, state-funded rural health centers, or other non-profit safety net organizations. Thus, the Task Force made a series of recommendations aimed at expanding the availability of low-cost or free medications to the uninsured. First, the Task Force recommended that existing programs to help low-income uninsured individuals access free or reduced-cost medications through the PAPs be expanded and that the pharmaceutical companies streamline and simplify the PAP application process. The Task Force also recommended that Congress expand the 340B drug discount program to include more safety net organizations. In addition, the Task Force recommended that state philanthropic organizations provide funding to help the North Carolina Department of Health and Human Services establish a bulk purchasing program that would help negotiate volume discounts from pharmaceutical companies for safety net organizations around the state.

Strengthening safety net integration and collaboration efforts. The patchwork of services, programs, and organizations serving the uninsured is being stretched in a number of directions as the demand for care among the uninsured has increased. Few communities in our state have been able to meet all the needs of the uninsured, regardless of how many providers of such care there are. The Task Force identified the need for increased levels of collaboration and, in some cases, the potential for the integration of services and organizations, in order to more effectively meet the needs of those served by safety net providers.

In communities with few or no safety net providers, these issues do not arise. But, in communities where multiple organizations are serving, often with overlapping efforts, the same uninsured populations, the need for collaboration is more evident. The Task Force therefore recommended a number of efforts to encourage collaboration among safety net providers and ways to encourage the involvement of professional and business organizations in these community-wide efforts.

The Task Force recognized the need to create an ongoing state-level Safety Net Advisory Council (SNAC) that can continue the work of the Task Force and encourage state-level and local safety net collaborations and integration efforts. The SNAC would be charged with collecting and disseminating “best practices” and models for service organization and delivery. Additionally, the SNAC should work with North Carolina foundations to help convene a best practices summit that would help local communities identify ways to build and strengthen their capacity to meet the healthcare needs of the growing uninsured population and reduce barriers to interagency collaboration and integration.

The Task Force also heard that existing state confidentiality laws have created barriers to sharing patient information across safety net providers—even when providing services to the same patients. The Task Force recommended that the General Assembly enact laws to clarify 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.

Increased funding to support and expand the existing safety net system. The Task Force identified four strategies that could help provide financial support for care to the uninsured: (1) ensuring that North Carolina receives its fair share of federal funding for safety-net programs, including funding from the President’s Initiative for Health Center Growth and Expansion; (2) expanding state funds to support safety net organizations; (3) enhancing Medicaid reimbursement for safety net organizations, to help ensure that Medicaid reimbursement is at least sufficient to cover the costs of treating these patients; and (4) ensuring that individuals who are eligible for Medicaid enroll in the program, in order to make more limited state, local, or federal funds available to serve uninsured individuals who cannot qualify for Medicaid.

Although the Task Force spent considerable time trying to identify new sources of funding, the Task Force’s highest recommendation was to maintain the state’s major safety net funding source: Medicaid. As noted earlier, North Carolina has 1.4 million people who are uninsured; 62% of them have incomes below 200% of the federal poverty guidelines. The numbers of uninsured would be much larger without the existence of Medicaid and the North Carolina Health Choice programs. There is currently some discussion at the federal level about turning Medicaid into a block-grant program. This could be devastating to the state, safety net providers, and to low-income citizens of the state who rely on Medicaid to cover their healthcare needs. (See the open letter from Governor Easley on page 120-121) In addition, Task Force members felt strongly that the state was not getting its fair share of existing

federal funds through the State Children’s Health Insurance Program (North Carolina Health Choice), the President’s Initiative for Health Center Growth (which funds FQHC health center expansion), Ryan White CARE funds for people with HIV/AIDS, or the Special AIDS Drug Assistance Program. Therefore, the Task Force recommended that the North Carolina Department of Health and Human Services and other safety net organizations work with the North Carolina Congressional delegation to: (1) oppose efforts to limit the availability of federal Medicaid funds and (2) ensure that the state receive its fair share of other funds available to underwrite health services for the uninsured.

Although new federal funds are available to expand the availability of healthcare services through FQHCs, there are barriers that prevent local health departments from applying for these funds. One such barrier is the state-required composition of local health department boards. Federal laws mandate that the governance structures of FQHCs be predominantly composed of the safety net organizations healthcare consumers; however, state law prescribes that local health departments boards be composed primarily of healthcare or other professionals. Thus, even though the populations served by health departments and FQHCs are the same, or very similar, local health departments are ineligible for this federal support. The Task Force recommended that the General Assembly give county commissioners the authority to change the local health department board composition in order to make these agencies eligible for federal funding.

The Task Force also recommended continued and expanded state funding for safety net organizations. Last year, the North Carolina General Assembly appropriated \$7 million in one-time funds to expand the availability of healthcare services to the uninsured through new or existing safety net organizations: \$5 million to FQHCs and \$2 million for state-funded rural health centers and/or local health departments. The Task Force supported the General Assembly’s efforts and recommended that this funding be expanded to \$11 million on a recurring basis: \$6 million for FQHCs and \$5 million for state-funded rural health centers, local health departments, or other non-profit safety net organizations with a mission of serving the uninsured.

Another need that has surfaced in many policy discussions in recent years is the need for additional school health nurses. The Task Force was aware of the important role these nurses play in meeting the primary healthcare needs of children and adolescents in our public schools. For many children, and especially for adolescents, school nurses are the only healthcare professionals they see, yet North Carolina has a shortage of such personnel. The recommended ratio of school nurses to students is 1:750; the statewide ratio in North Carolina is 1:1,918. Last year (2004), the General Assembly appropriated funds to enable the hiring of an additional 145 nurses to work in the public schools (with 65 of these positions time-limited). Even with this additional funding, there is still a need for 973 nurses to meet these recommended ratios. The Task Force recommended an additional appropriation to accomplish this goal.

The Task Force also recommended that the North Carolina Department of Health and Human Services explore options to enhance Medicaid reimbursement to safety net organizations that serve a higher than average proportion of uninsured patients and that the state ensure that local health departments—like other publicly-funded health providers—receive cost-based reimbursement for the clinical services they provide. Any new funding provided to FQHCs, FQHC look-alikes, rural health centers, hospitals, and/or health departments should be targeted toward serving the uninsured.

The Task Force suggested ways to capture savings that the state is currently realizing through implementation of the Community Care of North Carolina program (CCNC), a system that provides case management and disease management services to improve the health of Medicaid recipients with chronic or complex health problems. At the present time, local CCNC networks cannot retain any funds that are saved as a result of improved care management for these Medicaid recipients. In contrast, managed care companies that offer contract services to low-income populations are able to retain realized savings. The Task Force recommended that the Division of Medical Assistance explore the possibility of creating a system of “shared savings” with regional CCNC networks. The shared savings system would enable the networks to use their savings to support the provision of services to the uninsured.

Finally, the Task Force made a series of recommendations to ensure that uninsured individuals who are currently eligible for Medicaid are enrolled in the program. Ensuring Medicaid coverage for those who are eligible would help target the limited state funds for safety net providers toward uninsured individuals who cannot receive coverage elsewhere. National data suggest that only 72% of eligible children and 51% of eligible non-elderly adults enroll in Medicaid.¹⁰ Many eligible individuals do not know they are eligible for coverage or are discouraged because of the stigma attached to applying for public programs. Others are discouraged because the application process is difficult to complete. The state has made significant progress in simplifying the Medicaid and North Carolina Health Choice application process for children, but the state has not yet incorporated these simplifications into the adult Medicaid application process. To address this problem, the Task Force recommended that the state streamline and simplify the Medicaid program for adults, by creating simplified application forms, extending the length of time for recertification, and exploring the possibility of eliminating the resource test for families with children (just as the state has already done for families that apply on behalf of their children only). The Task Force also recommended that the state modify Medicaid policies to make it easier for individuals with high medical expenses to qualify for Medicaid.

Summary

North Carolina is in the midst of a quiet, but growing healthcare crisis. The number of uninsured residents is rising at an alarming rate—and a faster rate than in most other states. Almost one of every five (20%) non-elderly North Carolinians

have no health insurance, which means a sizeable portion of our population has unmet healthcare needs. As healthcare costs continue to increase, North Carolina is likely to continue seeing increased numbers of uninsured. Until we can dramatically reduce the volume of the uninsured, there will be a continuing and growing need for governmental, private sector, and voluntary healthcare providers to serve this population.

In this issue of the Journal, we have attempted to draw attention to the volume and variety of services, programs, and organizations involved in meeting this important healthcare need among our state’s most vulnerable populations. The organizations involved in rendering these services, and the private physicians and other healthcare professionals who give of their time and talents to meet these needs, are stretched to their limits in most communities. The Task Force has recommended several concrete steps that would shore up safety net organizations’ and individual providers’ capacity/ability to meet these needs. Some of these steps will require rather straightforward changes in regulations and laws governing the provision of healthcare services. Others will require appropriation of funds to augment the public, private, and voluntary support now given through these safety net provider organizations in support of their efforts to serve the uninsured.

While some effort needs to be made to bring these issues to the attention of the state’s Congressional delegation in Washington, DC, many of these problems should not have to wait for federal action. The needs are great, and the demands for service are increasing among those organizations and professionals who have assumed these responsibilities in counties and communities across our state. For those with healthcare insurance, these problems and their administrative complexities may seem of remote interest and concern. But, for the people who depend on the safety net services, these problems can mean the difference between health, work, and opportunity, or between disease, disability, or death. There is a genuine collective benefit to meeting the healthcare needs of the uninsured, for the health and wellbeing of a fifth of our state’s population affects the health of all of us. Depending on a stop-gap, safety net to maintain the health of such a large segment of our population is a societal risk we all must confront. Failure of any part of the healthcare safety net could be detrimental to the stability of the larger healthcare system on which we all depend. **NCMJ**

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