People who are uninsured have greater difficulties obtaining needed health care services than individuals with insurance. As noted in Chapter 2, multiple studies have shown the adverse health consequences of being uninsured.[1-3] In comparison to people with health insurance coverage, the uninsured are less likely to receive clinical preventive services or care for their ongoing chronic illnesses. They are more likely to delay seeking care because of the costs, and therefore, are more likely to be diagnosed with severe health problems such as late stage cancer. They are also more likely to be hospitalized for preventable health problems. As a result, the uninsured are 25% more likely to die prematurely than those with health insurance.[1]

Access barriers have been growing in North Carolina over the last five years. The percentage of people who reported that they could not see a doctor when they needed to because of costs increased from 12% (2000) to 17.1% (2007). Further, the uninsured are far more likely to report this problem. In 2007, 47% of the uninsured reported that they could not see a physician because of cost, compared to approximately 10% of people with insurance coverage.[4,5] Although the lack of health insurance creates obstacles, it does not prevent the uninsured from receiving any care.

Although the lack of health insurance creates obstacles, it does not prevent the uninsured from receiving any care... There are numerous safety net health care organizations across the state with a legal obligation or mission to provide care to the uninsured.

North Carolina Safety Net Organizations

There are numerous safety net health care organizations across the state with a legal obligation or mission to provide care to the uninsured. Hospitals are the largest provider of care to the uninsured. Under the federal Emergency Medical Treatment and Active Labor Act (EMTALA), hospitals are required to screen and stabilize anyone who presents in the emergency department, regardless of ability to pay. However, emergency departments are not the appropriate place to provide routine or non-urgent care. This care would be better provided in an outpatient primary care setting.

There are other safety net organizations that are organized to provide free or reduced cost preventive, primary, and acute care, as well as chronic disease management to the uninsured.[6] These organizations include:

- ***Federally qualified health centers (FQHCs):*** FQHCs, which include community and migrant health centers, as well as health care for homeless programs, are the most comprehensive of the primary care providers for the uninsured. In 2007, there were 26 FQHCs in North Carolina with 125 different delivery sites, providing care to 194,845 uninsured individuals. FQHCs provide care to the uninsured on a sliding fee-scale basis. FQHCs receive some federal funds to help offset some of the costs to the uninsured, but the federal funds only cover, on average, about 32% of operating costs. All of the FQHCs provide comprehensive primary care services and other medical and non-medical services to help people access care (such as transportation and translation). Most also offer dental and pharmacy

services. FQHCs offer their patients the continuity of care, comprehensive array of services, and high quality expected of a medical home. In addition to the 26 FQHCs, there are 2 FQHC-look-a-likes that operate similarly to FQHCs but do not receive federal operating funds.[a]

- ***State-funded rural health centers:*** State-funded rural health centers are community-owned primary care practices that receive some financial support from the North Carolina Office of Rural Health and Community Care to help offset the cost of care to the uninsured. State-funded rural health centers earn operational support through the Medical Access Plan, a sliding scale program for uninsured patients with incomes below 200% of the federal poverty guidelines (FPG). In SFY 2008, there were 28 state funded rural health centers that received $2.6 million in state funding, of which $1.7 million was for direct indigent care. These centers provided care to 5,400 uninsured people in 2008. All of these centers are located in underserved rural areas.

- ***Public health departments:*** Public health departments generally offer more limited clinical services that focus on prevention and communicable disease control. However, 36 (42%) of the 85 health departments provide primary care to adults, and 51 (60%) provide primary care to children. In addition, 44 health departments offer dental services. Public health departments do not receive any specific state or federal funding to offset the costs of providing comprehensive primary care to the uninsured, but they do receive federal, state, or local funding to pay for the costs of preventive services.

- ***Free clinics:*** Free clinics generally provide more limited primary care and preventive services and have more limited hours of operation than regular clinics. There were 77 free clinics in different communities across the state in 2007, serving approximately 71,973 uninsured patients. Services are provided for free to low-income, uninsured individuals. Free clinics are generally supported through private donations and community fund raising. They rely on the donated effort of local providers as well as services and supplies donated by the community. Blue Cross Blue Shield Association of North Carolina supports free clinics, but the funding is not sufficient to meet the ongoing operational costs of any of the free clinics.[b]

a Federally qualified health center (FQHC) look-alikes receive some other benefits provided to FQHCs, including access to low-cost medications and higher reimbursement from Medicaid and Medicare. Sometimes new organizations attempting to obtain FQHC status first apply to be a FQHC look-alike before converting to FQHC status.

b Blue Cross Blue Shield Association of North Carolina has provided a $10 million grant to the North Carolina Association of Free Clinics over 5 years to expand and support free clinics (2008-2013). On average, each free clinic receives approximately $30,000, which is not enough to support one-full time administrative staff.

- ***Other nonprofit safety net organizations:*** There are several other types of safety net providers that offer some preventive, primary, acute, or chronic care services to the uninsured. Some of these organizations are unique to specific communities; others are outpatient clinics operated by hospitals. In 2007, there were 53 school-based or school-linked health clinics providing services to students and/or families.

Existing public and private funding is insufficient to meet the needs of the growing number of uninsured. Some safety net organizations are having more difficulty than others remaining financially viable given their patient mix. For example, low-income, uninsured patients comprise an average of 51% of the patient population for community health centers. In some centers, more than 80% of the patient population is low-income uninsured. Those organizations serving a larger proportion of uninsured are doing so without commensurate financial support.

Some safety net organizations are having more difficulty than others remaining financially viable given their patient mix... Those organizations serving a larger proportion of uninsured are doing so without commensurate financial support.

Private physicians also provide care to the uninsured. However, on the national level, the number of physicians who reported providing charity care has declined. Between 1997-2005, the percentage of physicians who reported providing charity care declined from 76% to 68.2%.[7] While North Carolina data are not available, there are some positive indications that North Carolina physicians are still committed to providing charity care. Many volunteer through free clinics or at other safety net organizations. Others provide care directly to the uninsured through their offices. Physicians who are part of medical school faculty often provide care to the uninsured in their teaching clinics. In addition, some private physicians have a contractual commitment to provide care to the uninsured in their practices. For example, the North Carolina Medical Society Foundation (NCMSF) operates the Community Practitioner Program (CPP). The CPP offers loan repayment to physicians, physician assistants, and nurse practitioners in return for a commitment to practice in underserved areas. As part of their commitment, community practitioners must also agree to treat uninsured patients on a sliding scale basis. The CPP is currently supporting 83 practitioners. Data are not currently available on the numbers of uninsured they are treating.[c]

In addition to the safety net organizations and private providers who offer preventive, primary care, and chronic care management, there are other organizations that offer more specialized services to the uninsured.

- ***Medication Assistance Programs:*** The Health and Wellness Trust Fund (HWTF) has given grants to establish medication assistance programs that help low-income, uninsured people apply for free medications through pharmaceutical assistance programs. The Health and Wellness Trust Fund is currently supporting 53 Medication Assistance Programs (MAP). In SFY 2008, these organizations helped 27,418 patients obtain more than $27 million in free medications. Since the inception of the

c The Community Practitioner Program (CPP) is in the process of collecting data on the numbers of uninsured seen by CPP practitioners, but data are not yet available.

MAP program in 2003, HWTF has awarded MAP grants to a total of 99 organizations. These organizations helped nearly 100,000 patients receive more than $146 million in free medications. In addition, The Duke Endowment and the North Carolina Foundation for Advanced Health Programs worked with the North Carolina Office of Rural Health and Community Care to develop the Medication Access and Review Program (MARP). This software helps link low-income uninsured to appropriate pharmaceutical assistance programs. The MARP software system is used by many of the Medication Assistance Programs and by other safety net organizations across the state. The Office of Rural Health and Community Care provides technical assistance for this software, supporting more than 135 sites utilizing the MARP software system.

In 2007, nearly 24% of all emergency department visits (or more than 900,000 visits) were by people who lacked insurance coverage...8% of all hospital services were provided to the uninsured.

- ***Hospital Services:*** Hospitals are a major source of health care for the uninsured. Many hospitals have charity care policies, providing free or reduced cost inpatient or outpatient services to the uninsured with incomes below certain prescribed income limits. In addition, all hospitals that have emergency departments provide some care to the uninsured. In 2007, nearly 24% of all emergency department visits (or more than 900,000 visits) were by people who lacked insurance coverage.[8] This constituted a 15% increase in visits by the uninsured since FY 2005. In addition, hospitals provide substantial inpatient services to the uninsured. More than 6.5% of all inpatient visits were for the uninsured. In total, 8% of all hospital services were provided to the uninsured.[9] This includes, but is not limited to, services provided through the emergency department, outpatient surgery or other outpatient clinics, laboratory and diagnostic services, and inpatient care. North Carolina hospitals incurred more than $850 million in uncompensated care costs provided to the uninsured in FY 2007.[d]
- ***Dental Safety Net Clinics:*** Many FQHCs and health departments operate safety net dental clinics that offer an array of dental services to the uninsured and/or low-income people who have Medicaid or NC Health Choice. In addition, some hospitals and other non-profit organizations offer dental services. There are more than 160 different safety net clinics in 75 counties across the state.[e]
- ***Behavioral Health Services:*** Local management entities (LMEs) help manage, coordinate, and arrange for mental health, developmental disabilities, and substance abuse services for certain people who meet the state's definition for priority or target populations. There are currently 24 LMEs covering all 100 counties.

d Uncompensated care includes charity care and bad debt.

e Data in the North Carolina Institute of Medicine safety net website, *www.nchealthcarehelp.org*, indicated that there were 161 different safety dental net clinics across the state. Most of these clinics were in public health departments (64), followed by federally qualified health centers (38) and free clinics (27). The majority of dental clinics (87) serve both adults and children, but 51 of the clinics are limited to serving children only, and 21 are limited to adults.

Nationally, data suggest that more than half of all the uninsured are unaware of safety net health care providers, even when the provider is within five miles of where the person lives.[10] Thus, the North Carolina Institute of Medicine created a website to provide information on available safety net organizations, by county, that provide free or reduced cost care to the uninsured. The website, *www.nchealthcarehelp.org*, provides information on safety net organizations that provide preventive, primary care, specialty care, pharmacy, dental, behavioral health, and enabling services (such as transportation and interpreter services). The website also includes hours of operation, services provided, geographic coverage area, and geographic reach of the different safety net organizations.

Despite the availability of many of these safety net organizations across the state, available data suggest that these providers do not have the capacity to meet the needs of the growing number of uninsured. The North Carolina Institute of Medicine estimated that only 25% of the uninsured were receiving services through primary care health care safety net organizations in 2003.[11] Recent data suggest some progress, but there are still significant unmet needs. As a result, many people without insurance rely on the emergency department when they need care. This is neither the appropriate nor the most cost-effective place to provide primary care services, and is contributing to the overcrowding of hospital emergency departments. And while private physicians help address the health care needs of the uninsured, they are unable to address all unmet needs.

Despite the availability of many of these safety net organizations across the state, available data suggest that these providers do not have the capacity to meet the needs of the growing number of uninsured.

In 2005, the North Carolina General Assembly created the NC Community Health Centers Grants program to begin to expand the availability of safety net services across the state.[12] Grants are distributed, on a competitive basis, to federally qualified health centers, state-designated rural health centers, free clinics, local health departments, school-based health centers, and other nonprofit organizations that provide primary and preventive services to low-income, uninsured patients. Funding can be used to increase access to preventive and primary care services; establish safety net services in counties where services do not currently exist; create new services or augment existing services provided to the uninsured, including preventive and primary care, dental services, pharmacy, and behavioral health; or increase the capacity necessary to serve the uninsured by enhancing or replacing facilities, equipment, or technologies.

The NC Community Health Centers Grants Program has been funded at different levels since it was created. Most of the funding has been in non-recurring funds. (See Table 7.1.)

Table 7.1
Funding for NC Community Health Centers Grants Program Has Been Largely Non-Recurring

	Recurring	Non-recurring
SFY 2005		$7 million
SFY 2006	$2 million	
SFY 2007	$2 million	$3 million
SFY 2008	$2 million	$5 million
SFY 2009	$2 million	$4 million

Source: Silberman P. Community collaborations to care for the uninsured. Presented to: the North Carolina Institute of Medicine Health Access Study Group; December 10, 2008; Morrisville, NC.

According to the North Carolina Office of Rural Health and Community Care, "if all new [Community Health Center Grants] project applications could have been funded, it is estimated that an additional 60,000 persons could have received improved access to health care this year."

Last year (SFY 2008), grant awards were given to 71 organizations.[13] In total, the funds are expected to serve 39,000 uninsured patients through a variety of projects, including:

- 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;
- 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.

Because of funding limitations, all of the organizations seeking grant funds could not be funded. According to the North Carolina Office of Rural Health and Community Care, "if all new project applications could have been funded, it is estimated that an additional 60,000 persons could have received improved access to health care this year. Core primary care, pharmaceutical, and dental services would have been provided in an additional eighteen counties across the state."[13]

In the past, most of the funding has been distributed to support replacement of facilities, equipment, or technology. State funds have not been used as directly to expand the availability of services for the uninsured because funding has been largely non-recurring. Organizations generally need to hire staff to support large-scale expansion of safety net services; however, most organizations are reluctant to do this without a source of ongoing support. Further, the funding for safety net organizations has not kept pace with growing needs. State funding, for

example, has remained relatively constant between SFY 2005-2008, but the numbers of uninsured grew by more than 250,000 between 2004 and 2007.[14]

Additional recurring funding is needed to support safety net expansion. Because only about 25% of the uninsured are receiving care through safety net organizations, this suggests there may be as many as one million uninsured people in the state who are not linked to safety net organizations that serve as a medical home. To provide primary care services to these individuals would conservatively cost $150 million/year.[f] Realistically however, safety net organizations can not immediately ramp up to provide this level of support to the uninsured. Thus, the Health Access Study Group recommended phasing in expanded support to safety net organizations. In addition to the $2 million in recurring funds that are already in the state budget, the Study Group recommends:

Recommendation 7.1 (PRIORITY RECOMMENDATION)

The North Carolina General Assembly should increase funding to expand safety net capacity. The North Carolina General Assembly should:

a) Appropriate $8 million in new recurring funds in SFY 2010 to the Office of Rural Health and Community Care to support the Community Health Center Grants program. Funding should be used to expand the safety net infrastructure so that safety net organizations can hire staff to establish community-based medical homes and expand the availability of preventive, primary, chronic disease management, specialty, dental, behavioral health, and/or pharmacy services for the uninsured. Some of the funds should be targeted to support safety net organizations that are providing a disproportionate share of care to the uninsured.

Developing Systems of Care for the Uninsured

In most communities, the uninsured have more health care needs than can be addressed by existing safety net organizations. Further, the care that is available is often fragmented. Communities can provide more effective care and address more of the needs of the uninsured by developing systems of care that include specialty services, diagnostic services, hospitalizations, medications, and disease and care management. Several communities across the state have developed these community collaborations to address the health care needs of the uninsured. These collaborations typically involve primary care and specialty practitioners who agree to provide free or reduced cost care for some of the low-income, uninsured patients in their community. The collaborations include local hospitals who agree to provide inpatient and outpatient services for free to eligible individuals.

f This estimate is based on $150 per person, which is the amount that the Bureau of Primary Health Care suggests that community health centers use when submitting a budget to the Bureau of Primary Health Care for federal funding. The $150 is not expected to cover all of the patient's costs. The Bureau of Primary Health Care anticipates that community health centers will find other funds to support care for the uninsured (including state, local, or other support). In North Carolina, the actual cost of providing medical care per patient was $286/year (which was less than the national average of $386/medical patient).

While most of the community providers agree to provide services to eligible uninsured individuals for free or on a sliding scale, there are still costs in developing this system of care. Communities must be able to screen individuals to determine eligibility for these community programs (i.e. the individual must be uninsured and have incomes below certain community-established income guidelines). Communities may also need funding to help purchase medications that are not available through prescription assistance programs.

The goal is to develop systems of care similar to the model offered to Medicaid recipients through Community Care of North Carolina (CCNC). Ideally, the uninsured will be linked to a medical home and offered disease and care management to help them manage their chronic or complex health conditions. These community collaborations will also help patients access other health services (including specialty care and hospitalizations) and medications. As with CCNC, providers will be linked into statewide quality improvement efforts offering the best evidence-based care. The community collaborations will include all existing safety net organizations (including hospitals, private practitioners, safety net organizations, and others), which will engage in community-wide planning to reduce duplication, improve efficiency, and improve care for the uninsured. Ultimately, the care provided to the uninsured through these community collaborations should lead to improved health outcomes, and a reduction in preventable hospitalizations and unnecessary use of the emergency department.

Sixteen communities, covering 27 counties, received HeatlhNet funding in the first year. The Office of Rural Health and Community Care estimate that these collaborations will help provide a medical home to close to 50,000 uninsured patients, at a cost of approximately $43 per enrollee.

In 2008, the North Carolina General Assembly began funding HealthNet, to support the development of community collaborations for the uninsured. Last year (SFY 2009), the North Carolina General Assembly appropriated $2.8 million in recurring funds and $950,000 in non-recurring funds to the Office of Rural Health and Community Care to support HealthNet.[12] To receive state funding, communities must demonstrate that they are working with their local CCNC network, that they are linking patients to a medical home, and that they are collaborating with other health care organizations to expand services to the uninsured.

Sixteen communities, covering 27 counties received HealthNet funding in the first year. The Office of Rural Health and Community Care estimate that these collaborations will help provide a medical home to close to 50,000 uninsured patients, at a cost of approximately $43 per enrollee. The HealthNet funds are not used to support the medical costs associated with caring for the uninsured. Generally, services are donated through the community collaborations or are provided through an existing safety net organization. Rather, the HealthNet funds are used to support the infrastructure needed to sustain the community collaboration (e.g. eligibility determinations, provider referral systems, disease and care management, and information systems).

In addition to the Health Net funds, The Duke Endowment (TDE) is also supporting the development of community collaborations. To date, TDE funds have been used to support 16 organizations, covering 23 counties. The organizations include hospitals, free clinics, Project Access networks, and independent organizations. Some of the projects funded were to develop community collaborations, while other funding

went to safety net organizations with the goal of later developing these into broader community collaborations. Together, HealthNet and TDE funds have been used to support community collaborations covering 47 counties. An additional 24 counties are either in the process of implementing community collaborations or have expressed interest in planning, organization, and implementation of the same. Additional state funding beyond the $2.8 million in recurring funds is needed to further expand the number of community collaborations of care for the uninsured. To achieve this goal, the Health Access Study Group recommends:

Recommendation 7.1 (PRIORITY RECOMMENDATION)

The North Carolina General Assembly should increase funding to expand safety net capacity. The North Carolina General Assembly should:

b) Appropriate $2.2 million in new recurring funds in SFY 2010 to the Office of Rural Health and Community Care to support the HealthNet program. Funds should be used to sustain existing community collaborations to care for the uninsured and expand networks to other parts of the state.

Care Share Health Alliance

A statewide organization, Care Share Health Alliance, has been created to coordinate grantmaking and technical assistance provided to support care for the uninsured across the state. The goal of Care Share Health Alliance is to help communities strengthen their safety net infrastructure (i.e. safety net organizations providing care to the uninsured) as well as develop community collaborative systems of care for the uninsured. Care Share Health Alliance is comprised of representatives of all the major health care foundations, Office of Rural Health and Community Care and other state agencies, safety net organizations, health professional organizations, and other organizations that support community care to the uninsured.[g] Care Share Health Alliance includes a funders committee, to help coordinate grant making to ensure that the limited state and private foundation funds are used as efficiently as possible to support care for the uninsured. In addition, Care Share Health Alliance will have staff that can work with community groups across the state to help these groups develop both the safety net infrastructure and the community collaborations needed to sustain care for the uninsured.

The goal of Care Share Health Alliance is to help communities strengthen their safety net infrastructure… as well as develop community collaborative systems of care for the uninsured.

g The Board includes representatives of the major health care foundations in the state: The Duke Endowment, Kate B. Reynolds Charitable Trust, North Carolina Health and Wellness Trust, North Carolina Blue Cross and Blue Shield Foundation of North Carolina. The 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, prescription assistance programs, Healthy Carolinians, dental safety net organizations, local departments of social services, existing community collaborations, and consumer representatives.

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