Chapter Seven

Financing Options for Safety Net Organizations

Safety net organizations typically receive financing from multiple sources, including Medicaid, Medicare, private third-party insurance, out-of-pocket payments, and charitable donations. The funding sources vary depending on the type of organization. This chapter identifies existing and potential funding sources to support safety net organizations and expand the availability of services to the uninsured. Specifically, the Task Force identified four different types of funding opportunities: 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) assisting safety net organizations with state funds; 3) enhancing Medicaid reimbursement for safety net organizations; and 4) ensuring that eligible individuals receive Medicaid in order to make more limited state funds available to serve uninsured individuals who cannot qualify for Medicaid.

As noted in Chapter 2, North Carolina currently has 1.4 million uninsured; 62% 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 program (North Carolina's State Children's Health Insurance Program). In December 2004, Medicaid provided health insurance to more than 1.2 million low-income North Carolinians, and NC Health Choice covered more than 120,000 low-income children.[1] 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 the low-income citizens of our state who rely on Medicaid to cover their healthcare needs. Any efforts to significantly cut or limit Medicaid or NC Health Choice, at either the state or federal levels, would critically impair the state's ability to address the healthcare needs of the uninsured. The recommendations in this chapter are contingent on the state being able to draw down federal Medicaid funds to continue to provide healthcare coverage to low-income populations.

Federal Funding For Safety Net Programs

President's Initiative for Health Center Growth and Expansion

In 2001, the Bush Administration established the President's Initiative for Health Center Growth and Expansion, which sought to increase the number of federally qualified health centers (FQHC) users by six million by creating 630 new FQHCs and expanding 570 existing centers. These funds are available to expand the services available to the uninsured.

Federally qualified health centers must satisfy certain basic criteria in order to receive federal funding. Funds must be used to create new access points (new starts or satellite operations), expand to a new location (satellite operations), add new services (expanded medical capacity), or expand the availability of existing services (service expansion grants). Organizations must demonstrate that increased numbers of patients need to be served in order to justify funding. Most (80%) of the new funds are designated for existing grantees, leaving 20% for new centers.

- *New access points:* New starts are available to organizations that do not currently receive Section 330 federal grant support (as described in Chapter 3) from the US Bureau of Primary Health Care. They are typically awarded to communities that lack other FQHCs. Centers that currently receive Section 330 grant funds can apply for a grant to open a satellite operation, but to receive new funds, the satellite operation must serve new patients. Centers can apply for satellite funds to open a new center in their existing service area if the satellite will serve a population/area that does not have access to care at the existing center or through other providers of care. Health centers must be operational within 120 days of the date when the grant is awarded. The maximum level of support for a new start or satellite is $650,000 per year, calculated on the basis of $150 in grant funds per community user or $200 per user for migrant or

seasonal farmworkers, public housing, or school-based center patients.[i]

- *Expanded medical capacity:* Only currently-funded Section 330 grantees can apply for expanded medical capacity grants. These grants are intended to be used to increase access to primary healthcare services at existing service sites, for example, by expanding the array of services offered, adding new medical providers, expanding hours of operation, or providing additional services through contractual relationships. To receive an expanded medical capacity grant, the center must show an anticipated increase in new users that equals at least 25% of current users or 3,000 people (whichever is less) for community health centers (CHCs) and school-based health centers; or an increase in new users of 10% or 1,000 for free-standing migrant health centers or Health Care for the Homeless sites. The maximum request for an expanded medical capacity grant is $600,000.[ii]
- *Service expansion grants:* Existing Section 330 grantees can also apply for service expansion grants to expand mental health and substance abuse services, oral health, or care management. The maximum award depends on the service to be expanded, for example, in 2004, the maximum awards were $150,000 for mental health and substance abuse, $250,000 for oral health, and $40,000 for care management to reduce health disparities.

The Bureau of Primary Health Care (BPHC) awards these funds on a competitive basis. A certain amount of these funds is set aside for public FQHCs. However, public health departments in North Carolina are unable to apply for FQHC status and funding because of a conflict with state legislation. Under the federal regulations, FQHC board governance structure must be consumer-dominated (at least 51%). However, NC legislation requires local health departments to have 11-member boards whose compositions are defined by the General Assembly (for more information see Chapter 3). This legislation restricts local health departments in the state from applying for federal funds that are available to public FQHCs.

Aside from the public health department issue, to date, North Carolina has had mixed success in obtaining grant awards, receiving on average about 3% of the grant funds.[iii] North Carolina's uninsured comprises, on average, about 3% of the uninsured population nationally. Thus, it might appear that North Carolina is receiving a fair share of the new funding. However, North Carolina started with a lower health center penetration rate than in many other states—i.e., a smaller percentage of individuals with incomes below 200% of the federal poverty guidelines are served by FQHCs. In North Carolina, only 7.4% of low-income individuals are served by FQHCs. A higher proportion of low-income individuals were served by FQHCs in 28 other states and the District of Columbia.[2] The percentage of low-income individuals served by FQHCs ranged from a low of 1.9% to a high of 40% (the average among states was 11.0%). North Carolina's FQHCs could serve a higher percentage of low-income individuals if awarded a more equitable share of grant funding.

North Carolina Health Choice

North Carolina has historically used all or most of its State Children's Health Insurance Program (SCHIP) federal allocation, and is eligible for reallocated funds from other states. The federal SCHIP funds are allocated based on a formula using the annual March supplement

i Organizations may also request $150,000 for one-time minor capital costs for equipment and/or alteration in the first year of the three-year grant cycle.

ii Similar to new starts and satellites, the grantee can use up to $150,000 of this for one-time capital projects to renovate or replace facilities or purchase equipment.

iii In FFY 2002, North Carolina submitted seven new access point applications (two were funded), nine expanded medical capacity applications (five were funded), and six service expansion applications (two were funded). In all, the state received $4.7 million dollars, or 2.9% of available federal funding in FFY2002. In FFY 2003, NC applicants submitted six new access point applications (four were funded), three expanded medical capacity applications (two were funded), and six service expansion applications (one was funded). In all, North Carolina received $3.5 million, or 3.3% of available federal funding in FFY 2003. In FFY 2004, North Carolina submitted nine new access point applications (two were funded), four expanded medical capacity applications (one was funded), and four service expansion grants (three were funded). In all, North Carolina received $2.2 million, or 3.4% of available federal funding in FFY 2004.

to the Current Population Survey (CPS); although many experts who have examined these data have concluded that the use of these data has led to consistent over- or under-counting of children in different states.[3] Specifically, the CPS sample size in many states is not large enough to accurately predict the number of uninsured low-income children in a state. In North Carolina, for example, the CPS sample did not include enough families to be able to make reliable estimates of the number of uninsured children at different ages and income guidelines.[4] Other studies have examined the federal allocation and found that the state SCHIP allocations have varied significantly between 1999 and 2002; and that half of this variation is due to random error in the estimates used to determine the number of uninsured children in a state.[5]

The fact that North Carolina has consistently spent all or most of its federal SCHIP allocation, while other states have tremendous difficulty spending their allocation (even after expanding the SCHIP program to cover parents of children) suggests that the funding formula is biased against states like North Carolina. The funding allocation should be reexamined to ensure that states that consistently run out of federal funds receive a more appropriate federal allocation.

NC AIDS Drug Assistance Program (ADAP) and Ryan White Comprehensive AIDS Resource Emergency (CARE) Act Funding

North Carolina is currently at a disadvantage in how Ryan White CARE funds are allocated. The two largest components of the CARE Act are Title I, which provides funding to metropolitan areas where the AIDS epidemic was originally centered, and Title II, which provides resources to state government agencies to serve the entire state. Title I and II funds are generally allocated using a formula based on the estimated number of people living with AIDS, but the states that have one or more Title I cities end up receiving significantly more resources than states without Title I cities, on a case-by-case basis. This is because people with AIDS living in Title I qualified cities are counted both in the Title I allocations and in the Title II allocations. North Carolina does not qualify for Title I funds, and as a result, receives proportionately less than states with Title I cities. This is a current problem, but will be an even greater problem in the future as the HIV/AIDS epidemic has been increasing much more rapidly in states with significant rural, poor, and minority communities such as North Carolina.

North Carolina also had the largest AIDS Drug Assistance Program (ADAP) waiting list of any state in the country in the 2004 program year. On June 23, 2004, President Bush made available $20 million in emergency funds to pay for drug therapies for people with HIV/AIDS. North Carolina was one of ten states that qualified for this program because of its large waiting list. Special funding for this initiative was expected for two years. For the first year, medications were to be provided directly to clients under a contract the Health Resources and Services Administration (HRSA) entered into with a private mail-order pharmacy. For the second year, funds were to be provided as part of the state's regular Ryan White allocation. However, it appears that Congress did not include the $20 million or the special language required to continue this initiative in the Omnibus Budget Bill for FFY 2005. As a result, North Carolina stands to lose access to the special funding provided last year to support the ADAP program. It would be advantageous to North Carolina if our congressional delegation to the United States Congress worked to "adjust" the FFY 2005 budget in order to assure that both the funds and the language required to continue this Special ADAP Initiative are included.

The Task Force recommended that the NC Department of Health and Human Services and other safety net organizations work with the congressional delegation to describe the problems the state is facing meeting the healthcare needs of the uninsured, and the problems that would be created by limiting federal Medicaid funding through a block-grant or other mechanisms. Further, the delegation should be encouraged to ensure that North Carolina receives its fair share of federal safety net, SCHIP, and Ryan White funds. In addition, as noted in Chapter 5, the congressional delegation should work to change the 340B drug pricing law to allow other safety net providers to obtain medications at the discounted prices. Therefore, the Task Force recommends:

Rec. 7.1. The NC Department of Health and Human Services, NC Community Health Center Association, NC Association of Free Clinics, NC Health Directors Association, NC Hospital Association, NC Medical Society, and other safety net organizations should work with the NC congressional delegation to support NC safety net organizations.

a) The NC congressional delegation should

oppose any efforts to create a Medicaid block grant or otherwise limit the availability of federal Medicaid funds to the states.

b) **In order to ensure that North Carolina receives its fair share of federal funding for federally qualified health centers (FQHCs), the NC congressional delegation should work to ensure that priority for new FQHC funding should be given to states that have higher than average proportions of uninsured, racial disparities, and/or a lower than average receipt of federal FQHC funds per low-income person.**

c) **The NC congressional delegation should also work to ensure that North Carolina receives its fair share of federal State Children's Health Insurance Program (SCHIP) and Ryan White CARE funds, and that Congress continue funding the Special AIDS Drug Assistance Program (ADAP) Initiative.**

d) **The NC congressional delegation should work to expand the 340B program to include free clinics, local health departments, and other non-profit or governmental agencies with a mission to serve low-income uninsured patients.**

In addition to inequitable distribution of federal funds, the Task Force believes that it is important for North Carolina to remove state legislative barriers restricting public health departments in the state from qualifying for federal FQHC status and funding. To eliminate these barriers, the Task Force recommends:

Rec. 7.2. The NC Health Directors Association should develop a legislative proposal to amend state laws to enable local boards of public health to create governance structures that would make them eligible to participate in additional federal programs through which funding is available to support care for the uninsured.

There are many other challenges to obtaining federal funds under the President's Initiative for Health Center Growth:

1) It is difficult to establish new organizations or sites because grantees must be operational within 120 days of when the grants are awarded. In determining if a site can be operational in 120 days, the Bureau of Primary Health Care examines whether applicants have a facility available and ready for occupancy and whether the applicant has providers available to serve at the new site or satellite location. This gives a competitive advantage to organizations that are functioning prior to the application.
2) Grant monies can only be used to support new patients. Many NC centers need ongoing funding to support their existing client base, and are concerned about expanding without the assurance that they have sufficient funds to cover existing operations.
3) There are very limited capital funds. Centers need to obtain outside funding to meet capital needs and coordinate other fundraising with potential BPHC grants. Historically, The Kate B. Reynolds Charitable Trust and The Duke Endowment have helped to fill this need, but there are not enough capital funds to address large capital needs.
4) Applying for grant funds takes significant grant writing expertise and a financial investment. This is particularly problematic in low-wealth communities that may lack the capacity to complete the approximately 200-page application required to compete for these federal funds.
5) One of the other factors the BPHC considers is the ability of the grantee to leverage other funds.

In the past, the NC Community Health Center Association and the NC Office of Research, Demonstration, and Rural Health Development (ORDRHD) have provided technical assistance to new applicants in submitting their grant applications and in applying for grant funds from NC foundations to meet their capital needs. The Kate B. Reynolds Charitable Trust and The Duke Endowment have historically helped provide funding to address some of the capital and infrastructure needs of FQHCs, hospitals, and other safety net organizations. While foundation funding has been available, it has not always been sufficient to meet all the capital and infrastructure needs. To apply for federal funds under the President's Initiative for Health Center Growth, organizations must have the capacity to be operational within 120 days after the grant is awarded, which is extremely difficult for new starts.

Rec. 7.3. The NC health foundations should consider additional funding to meet the capital and infrastructure needs of healthcare safety net organizations.

In addition, the state has historically been at a competitive disadvantage compared to the states because it did not provide state funding to support health centers. Thirty-five other states provided funding to support FQHCs in 2003.[6] However, for the first time, the North Carolina General Assembly appropriated $5 million dollars in the 2004 legislative session to the Office of Research, Demonstrations and Rural Health Development in non-recurring funds to support and expand the services available to the uninsured and medically indigent through FQHCs or FQHC look-alikes.[7] These funds should help address several of the problems listed above. Some of the funds were allocated to new organizations, which will help them become operational so they can compete for the new start funds. Funds were also used to support and expand centers' existing operations. Moreover, these funds help make North Carolina applications more competitive, because they demonstrate another source of funds to provide care to the uninsured, meeting the "leveraging" requirement listed above.

State Funding to Support Safety Net Providers

FQHCs, Local Health Departments, State-Funded Rural Health Centers, and other Non-Profit Safety Net Organizations with a Mission to Serve Low Income Uninsured

In addition to the $5 million allocated to FQHCs or FQHC look-alikes, the North Carolina General Assembly also appropriated $2 million dollars to the ORDRHD to support care to the uninsured through state-funded rural health centers and local health departments. The funding for state-funded rural health centers is being used to expand the Medical Access Plan (MAP), which provides $68 per visit to pay for care to uninsured patients with incomes below 200% of the federal poverty guidelines (this program is described more fully in Chapter 3).

The Task Force recognized the importance of maintaining and expanding these state funds and of making similar funding available to other non-profit organizations that have a mission to serve low-income Medicaid and uninsured. To this end, the Task Force recommends that Section 10.3a of Session Law 2004-124 should be expanded and amended as follows:

> **Rec. 7.4. The NC General Assembly should appropriate, on a recurring basis, $6 million to be used for federally qualified health centers and those health centers that 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.**
>
> **Of the $5 million appropriated to state-designated rural health centers, public health departments, and other non-profit healthcare organizations, $140,000 shall be provided to the Office of Research, Demonstrations and Rural Health Development to develop planning packages for local communities interested in developing safety net programs, provide technical assistance, and collect data on the capacity of the existing safety net to meet the needs of the uninsured and medically indigent.**

School Nurses

North Carolina has a severe shortfall of school health nurses. School nurses help administer medications and perform clinical procedures for the growing number

of children with chronic illnesses and special health needs attending school.[iv] Nationally, the recommended ratio of school health nurses to student population is 1:750, but the North Carolina statewide average is 1:1,918 students. In 2002-2003, the nurse:student ratio varied from a high of one school nurse for every 473 students in one Local Education Authority (LEA) to a low of one nurse for every 7,082 students. Four LEAs had no school nursing at the time. The State Board of Education recommended that each LEA reach the 1:750 ratio within four years, and the 2004-2005 General Assembly responded by appropriating funding to fill 145 nursing positions (65 are time-limited). Even with the funding, there is still a need for 973 school nurses (without adjusting for increases in student enrollment) to achieve the 1:750 ratio. Therefore, the Task Force recommends that:

Rec. 7.5. The NC General Assembly should appropriate $11.35 million in SFY 2005-2006 and $25.95 million in SFY 2006-2007 to expand the number of school health nurses with the goal of fully implementing the school health nurse initiative over the next five years.

Medicaid Funding to Support Safety Net Organizations

The Medicaid program is a major payer for different safety net organizations, including FQHCs, FQHC look-alikes, rural health centers, local health departments, and hospitals. Generally, the state sets Medicaid provider reimbursement within certain upper payment limits established by the federal government. Under federal Medicaid law, certain providers are eligible for special payments and may or may not be subject to the general upper payment limits. For example, public organizations, such as local health departments or local management entities, are entitled to cost-based reimbursement for services provided to women and children.[8] FQHC, FQHC look-alikes, and federally-certified rural health centers (RHCs) are eligible for a modified cost-based reimbursement.[9] Hospitals that serve a disproportionate share of Medicaid and uninsured patients are eligible for higher reimbursement (called Disproportionate Share Hospital payments or "DSH").[10] These safety net organizations receive special payments because Congress recognized that they serve a high proportion of Medicaid and uninsured patients and are less able to cost-shift losses from serving these clients onto other payers.

The Task Force recognized the important role that Medicaid payments play in ensuring the financial viability of safety net organizations. Maximizing Medicaid reimbursement to these organizations is less expensive than spending 100% state funds for these purposes because the federal government pays approximately 62% of the costs of providing healthcare to Medicaid eligible patients. The Task Force was especially interested in enhancing Medicaid payments to those organizations that provide the most care to the uninsured, since these organizations have the most trouble finding other payer sources to cover these costs. The Task Force explored different ways of enhancing payments to FQHCs and RHCs, local health departments, and hospitals that serve a higher than average proportion of uninsured patients.

FQHCs and Rural Health Centers

In North Carolina, there is a wide variation in the percentage of health center patients who are uninsured. On average, 47.6% of the NC FQHC users in 2003 were uninsured, but this varied from more than 65% in five centers, to less than 30% in seven centers. The federal Section 330 grants paid to FQHCs are not directly tied to a center's number or proportion of uninsured users. Rather, an FQHC's base funding is determined by their initial estimate of the numbers of individuals in the center's target population that will be served by the center. The target population is a group of people who have barriers to care or health disparities based, for example, on income (below 200% of the federal poverty guidelines), being homeless, or migrant farmworker status. The target population does not need to be uninsured. Over the years, health centers have received small increases in their base grants, but this has not been tied to actual increases in the uninsured. Thus, health centers that have seen large increases in the uninsured have not received proportionally more

iv School health nurses help to provide nebulizer treatments, tube feedings, blood glucose monitoring, management of insulin pumps, and the development of emergency care plans. In addition, school nurses can help promote the physical, social, emotional, and educational growth and well-being of children.

money to address their increased numbers of uninsured. As a result, the current federal Section 330 grants paid to FQHCs are not directly tied to a center's number or proportion of uninsured users. Federal Section 330 grants averaged $254.12 per uninsured user, but the range per uninsured user varied from more than $500 per unisured user in four centers to less than $200 in five centers. Three of the five centers that had higher than average percentages of uninsured had lower than the state average of federal grants per uninsured user.

The percentage of uninsured patients seen in state-funded rural health centers also varies. For example, in 2003, more than 30% of patients were uninsured in four state-funded rural health centers, whereas less than 10% of patients were uninsured in two centers. The distribution between centers serving a high proportion of uninsured versus those serving a lower proportion is less divergent among the state-funded rural health centers compared to FQHCs because state-funded rural health centers receive less funding to serve the uninsured and, thus, have a greater mix of paying patients than do many FQHCs.

The Task Force recognized the importance of supporting institutions serving a disproportionate share of uninsured patients. Support is needed to ensure their financial ability to continue serving this population. Rather than seek 100% state funds for this purpose, the Task Force wanted to explore whether the state could enhance Medicaid reimbursement for these organizations.

Under the Benefits Improvement and Protection Act of 2000 (BIPA), state Medicaid agencies were required to use a prospective, cost-based reimbursement methodology to reimburse FQHC, FQHC-look alikes, and federally-certified rural health clinics (see Chapter 3 for a more complete description). This prospective, cost-based reimbursement was effectively the "floor;" states were required to use this reimbursement methodology but were free to develop an alternative payment system as long as it was *no less than* the BIPA methodology. Using this flexibility, the Task Force recommends that:

Rec. 7.6. The NC Division of Medical Assistance should explore different Medicaid payment rules that would provide higher reimbursement to FQHCs, FQHC look-alikes, and RHCs that serve a disproportionately high percentage of uninsured. New funds should be used to support and expand care to the uninsured.

Local Health Departments

Local health departments provide critical health services to Medicaid and other low-income uninsured patients. Some health departments are able to provide a comprehensive array of primary care services, while others provide more limited clinical services (such as immunizations, prenatal care, health screenings, and diagnoses and treatment of communicable or sexually transmitted diseases). Under federal Medicaid laws, public entities are entitled to cost-based reimbursement for their Medicaid services; however, under North Carolina's Medicaid reimbursement methodology, local health departments effectively receive less than full costs.

The state uses a two-step process to pay local health departments.[v] First, local health departments receive payments for services to Medicaid eligible patients. The amount of this payment is based on a fee established by the Division of Medical Assistance. This fee is based loosely on historical costs, but does not reflect actual current costs. Second, at the end of the year, the state "cost-settles" with local health departments. The fee-for-service payments are compared to the health department's actual costs. The health department then is entitled to the difference between Medicaid payments and actual costs as part of their year-end reconciliation. However, unlike other safety net providers who receive the full difference, local health departments are only paid the federal share of this difference (not the state or local share). In effect, local health departments only receive 62% of the difference between their interim payments and their true costs. As a result, public health departments have been paid between $10-$12 million less than their actual costs annually for a number of years.

Currently, local health departments must use local dollars and/or other federal funds to cover the uncompensated costs of treating Medicaid clients. The Task Force recommended that the Division revise this payment

v This payment methodology applies to both local health departments and the Children's Developmental Services Agencies (CDSA). CDSAs have been paid $2-4 million less than their actual costs annually.

methodology to ensure that local health departments receive their full costs of treating Medicaid patients. If health departments received full Medicaid reimbursement, then they would have more funds available to serve the uninsured. This is important, because the amount of care provided to the uninsured has increased in recent years, but the amount of federal or state funds that can be used to cover the costs of caring for these patients has not increased commensurately.

In addition, the Task Force discussed using performance-based contracting to ensure that all or a portion of the new funds are used to provide primary care services to the uninsured; and that other funds can be used to provide population-based or other clinical services to the uninsured.

Based on this, the Task Force recommends:

Rec. 7.7. The NC Division of Medical Assistance should assure that reimbursement to local health departments for Medicaid services will be at actual cost (same as for FQHCs, RHCs, and CHCs). Rates should be adjusted annually to account for the full cost to provide services or the annual cost settlement payment should 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).

Hospitals

Hospitals that serve a disproportionate share of Medicaid and uninsured patients are eligible for enhanced payments called Disproportionate Share Hospital (DSH) payments. DSH payments help hospitals cover their Medicaid deficits, since Medicaid typically pays less than a hospital's actual costs (for example, Medicaid pays hospitals 80% of their costs for outpatient services provided to Medicaid patients). DSH payments, along with related supplemental payments, are also intended to help cover the costs of caring for the uninsured. States have flexibility in designing their DSH programs, as long as two basic federal requirements are met: at least 1% of the hospital's patients receive Medicaid and the hospital has two obstetricians on staff.

North Carolina has developed a number of different DSH payments that are targeted to certain types of hospitals. A major portion of DSH funds available to North Carolina are used by state-owned hospitals to cover cost deficits incurred in providing services to Medicaid and uninsured patients. Other DSH and related supplemental payments are intended for non-state hospitals, teaching hospitals, Critical Access Hospitals (CAH), rehabilitation hospitals, and hospitals that are Medicaid Health Maintenance Organization contractors. In general, these payments are proportional to deficits incurred in providing services to either Medicaid or uninsured patients. These payments have significantly improved Medicaid reimbursement to hospitals, but the net financial impact on recovering costs incurred for the unreimbursed, uninsured services is relatively modest.

The Task Force recommended that the Division of Medical Assistance explore options to provide additional support to those hospitals that have a high percentage of uninsured in their patient mix. Similar to other safety net organizations that serve a high percentage of uninsured patients, these institutions have less ability to recover their costs for uncompensated care. In addition, the Task Force recognized that there were other public policy reasons for enhancing payments to certain institutions, for example, if a hospital provides a critical healthcare service that is not readily available in the local area.

The Task Force recommended that the Division of Medical Assistance explore different payment methodologies to more effectively address the needs of these hospitals.

Rec. 7.8. The NC General Assembly, NC Division of Medical Assistance, and NC State Employees Health Plan should consider options to enhance payments to hospitals that serve high proportions of uninsured patients or that meet identified health shortage needs by providing other critical health services.

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.

Community Care of North Carolina

Approximately 70% of Medicaid recipients in North Carolina are enrolled in some form of managed care. Most are enrolled in a primary care case management program, either Carolina ACCESS or Community Care of North Carolina (CCNC). Carolina ACCESS, started in 1991, was a system that linked Medicaid recipients to a primary care provider who was paid a small monthly case management fee to help coordinate and manage all of the patient's care. CCNC builds on ACCESS by adding disease management and case management to the care of Medicaid patients. CCNC is built around local networks of providers, including primary care providers, the health department, social services, and a hospital. The networks provide additional education and support for individuals with certain chronic health conditions or high costs. CCNC currently operates in 68 counties and serves approximately 550,000 Medicaid recipients. The program is scheduled to operate on a statewide basis by the end of 2005.

The program began by focusing on managing the care of people with asthma and later expanded to cover diabetes. In addition to these two health problems, CCNC networks are also involved in managing high-cost cases, reducing the unnecessary use of the emergency room, and pharmacy management. Participating providers are expected to use evidence-based clinical practice guidelines to assess patients; develop treatment plans; help educate patients about how to manage their own care; and, when appropriate, use medical equipment (such as inhalers or glucose monitors). An early assessment of the program showed that it yielded modest cost savings primarily by reducing hospitalizations for people with asthma and diabetes.[11] In addition to the statewide disease management initiatives, local networks have also been involved in managing high-risk pregnancies, depression, attention deficit and hyperactivity disorder, sickle cell anemia, and gasteroenteritis. In the last legislative session, the General Assembly also directed the Department of Health and Human Services to:

> "... contract with a physician-owned and managed network that has demonstrated success in improving the cost-effectiveness of Medicaid services in at least one state other than North Carolina. The Department shall develop a payment methodology that may include sharing savings with contractors providing medical management services but the methodology shall not allow increased spending relative to current appropriations." (Sec. 10.11 of Session Law 2004-124).

Currently, any savings realized in CCNC is returned to the program. Local networks are not able to use any of the savings. In contrast, if the state contracts with a managed care organization (MCO), the MCO may be able to keep any savings realized from better care management or reduced hospitalizations. The Task Force was interested in exploring whether the state could develop a shared savings system with the local CCNC networks; with the requirement that any savings realized as a result of better care management would be used to expand services to the uninsured. Therefore, the Task Force recommends:

> **Rec. 7.9. The NC 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.**

Ensuring Eligible People Are Enrolled in Medicaid

Medicaid, a publicly financed health insurance program, is limited to low- and moderate-income individuals who meet certain categorical, income, and resource requirements. For example, only certain types of people are eligible, including pregnant women, children (under the age of 21), families with dependent children, people with disabilities, and/or the elderly (age 65 or older). Childless adults who are not disabled and not elderly cannot qualify for Medicaid, regardless of how poor they are. In addition to these categorical restrictions, the state establishes certain income and resource limits for the different program categories.

Medically Needy Eligibility

The state has not fully implemented federal Medicaid rules that help certain individuals with high medical bills qualify for Medicaid. As noted above, Medicaid is typically limited to individuals with incomes below the Medicaid income limits. However, some individuals with higher incomes can also qualify. Otherwise eligible individuals can qualify if they have

medical bills equaling the difference between their countable income and the state's Medicaid medically needy income limits.

Example: Mrs. Jones is a 67-year-old widow, living on $842/month in Social Security retirement income. She currently meets the categorical eligibility requirements (she is 65 years or older), and meets the resource requirements (she has no more than $2,000 in countable resources). However, her income is too high to meet the general Medicaid income limits for older adults ($776/month). Mrs. Jones can still qualify if she incurs medical bills equaling the difference between her income and the state's Medicaid medically needy income limits (currently $242/month for an individual). This difference is called the "spend-down" or Medicaid deductible. This spend-down is generally calculated on a six-month basis. Medicaid will pay for any additional healthcare expenses over the amount of the spend-down for the rest of the six-month period; after which Mrs. Jones will have to incur new bills to meet another six-month deductible.

$842	—	*Mrs. Jones monthly income*
-242	—	*NC's Medicaid medically needy income limits*
$600	—	*spend-down or deductible*
x 6	—	*spend-down calculated on a six month basis*
$3,600	—	*Mrs. Jones will need to incur $3,600 of medical expenses before Medicaid begins covering additional healthcare expenses.*

Federal law limits the types of healthcare expenses that can be applied to the spend-down. Generally, individuals can only use healthcare bills that they have a liability to pay in meeting their spend-down. In other words, if someone else pays the bill, then the Medicaid applicant cannot use those expenses to meet the Medicaid spend-down.

There is one major exception to that rule. Federal law requires states to count the amount of free care provided by a state or local governmental program in the spend-down calculations.

"3628. When countable income exceeds the MNIL [Medically Needy Income Limit] for the budget period, deduct from that income certain medical and remedial care expenses incurred by an individual, family or financially responsible relative that are not subject to payment by a third party unless the third party is a public program of a State (or territory) or political subdivision of a State (or territory). ***Deduct incurred medical and remedial care expenses paid by a public program (other than a Medicaid program) of a State (or territory). (emphasis added)*** Once countable income is reduced (by applying these deductions) to an amount equal to the MNIL, the individual or family is income eligible.

3628.1 Expenses That Must Be Deducted.— Deduct from countable income the medical and remedial care expenses ...that are not subject to payment by a third party. ***(Such deductions are allowable even if the expenses are paid by a public program (other than the Medicaid program) of a State or territory if the program is financed by the State or territory.)***"

There are a number of state-funded health programs that provide, and pay for, services to potential Medicaid-eligible individuals. If these individuals were made eligible for Medicaid, then the state-only funds would be available to serve more uninsured individuals who do not qualify for Medicaid. Currently, the Division of Medical Assistance has identified nine state-funded programs that would meet these federal requirements, including cancer prevention and control, epilepsy medication, home health services, renal disease, school health funds, sickle cell anemia, medical/eye care, personal care services, and clozaril programs.[12] The Task Force identified other state-funded programs that might also meet these requirements, including the Aids Drug Assistance Program (ADAP), the MAP program, and state-funded mental health, developmental disabilities, and substance abuse services.

Although the Division of Medical Assistance has policies to enable individuals to use the costs of state-funded programs to help them meet their Medicaid deductible, this is rarely, if ever applied. These state-funded health programs do not typically generate statements of the costs of the services. As a result, there is no way for a local Department of Social Services to know how much to apply toward the deductible. To address this issue, the Task Force recommended that state funded programs generate a statement of the cost of service, which can then be given to the local

Department of Social Services to use towards the deductible. In the longer term, as DHHS redesigns its Medicaid management information system, it should have the capacity to share information electronically about costs of state-funded services provided by other DHHS agencies.

To ensure that the federal Medicaid spend-down laws are implemented and that eligible individuals qualify for Medicaid, the Task Force recommends:

Rec. 7.10. The NC Division of Medical Assistance (DMA) should ensure that the federal Medicaid spend-down rules that allow applicants to use the value of healthcare services paid by state and county programs in meeting their spend-downs are fully implemented. In so doing, the DMA should:

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.

Streamlining the Eligibility Process

National data suggests that only 72% of eligible children and 51% of eligible non-elderly adults enroll in Medicaid.[13] Census data suggests that there were approximately 177,000 uninsured children in North Carolina with incomes below 200% of the federal poverty guidelines who were eligible for either NC Medicaid and/or NC Health Choice, but were not enrolled.[14] Many eligible individuals do not know that they are eligible for this coverage or are discouraged because of the stigma attached to applying for public programs. Others are discouraged because the application process is so difficult to complete. The state has made significant progress in simplifying the Medicaid and NC Health Choice application for children. North Carolina has a two-page application for both programs, and individuals can apply in person or by mail. In contrast, adults have to go into the local Department of Social Services to fill out a 10-page application. However, the Division of Medical Assistance is in the process of simplifying the application and allowing them to be mailed to local Departments of Social Services. The Division is pilot testing the new form and mail-in application process in Cleveland, Duplin, Granville, Guilford, Forsyth, Onslow, and Wake Counties and hopes to be able to implement the process statewide later in 2005.

In addition to a simplified application form, other states have done more to simplify the eligibility determination processes to make it easier for eligible people to qualify for assistance. For example, 37 states and the District of Columbia have a 12-month certification period for parents, whereas North Carolina requires families to reapply every six months. Twenty-one states have eliminated the asset test requirements for low-income families as a means of streamlining the eligibility process, improving the productivity of eligibility workers and reducing administrative costs, and making the enrollment process more accessible for families.[15] Eliminating the asset test was not found to be very expensive, because there are very few denials of Medicaid coverage for low-income families due to excess assets.[16] North Carolina still requires families to prove that their assets (e.g., savings accounts or other liquid assets) are below certain state-established thresholds.

Rec. 7.11. The NC Division of Medical Assistance should continue its work to simplify the Medicaid application process for parents, people with disabilities, and older adults. Specifically, the Division should:

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.

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7 Section 10.3(a) of Session Law 2004-124.

8 42 C.F.R. §431.615(c)(4). State Medicaid agencies must pay local health departments and other Title V grantees for the cost of services furnished Medicaid recipients by or through the grantee.

9 42 USC § 1396a(bb).

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