Access to comprehensive, quality health care services is critical to achieve and maintain health, prevent and manage disease, and achieve health equity. Throughout the task force process, task force members identified the need for comprehensive access to health care services as a critical component of pandemic preparedness. Individuals need to be able to receive affordable and high-quality health care services, including care for emerging infectious diseases as well as preventive care, acute care, and behavioral health and substance use services. In addition, as policymakers address learnings from the pandemic, it is important to prioritize a thorough understanding of the drivers and impacts of forgone care during pandemic closures or due to other circumstances.

Recommendation 8.1
Ensure access to high-quality, low-barrier health care before, during, and after public health emergencies.

Recommendation 8.2
Ensure comprehensive and equitable access to diagnostic testing services.

Recommendation 8.3
Ensure access to evidence-based substance use treatment and harm reduction services before, during, and after public health emergencies.

Recommendation 8.4
Examine the impact of the COVID-19 pandemic on access to and utilization of health care services.

The following organizations are responsible for implementing Recommendations 8.1 – 8.4:

- North Carolina General Assembly
- North Carolina Department of Health and Human Services' Division of Health Benefits (NC Medicaid)
- Private health insurers
- Local health departments
- Federally qualified health centers
- Health systems
- Laboratory partners
- Higher education institutions
- Public School Units (PSU)
- Community-based organizations
- Employers

RECOMMENDATION 8.1

The task force recognized the importance of comprehensive and affordable health insurance, as well as adequate access to safety net health care services, in order to improve health outcomes before, during, and following a pandemic. In 2020, 10.0% of all North Carolinians, including 16% of non-elderly adults (age 19-64) did not have health insurance.[1,2] While this reflects a decrease in the rate of uninsurance in the state, and national data is showing overall gains in coverage between 2020 and 2020,[3] there remain opportunities to provide coverage to those still currently uninsured.

As of August 2022, North Carolina is 1 of 12 states that have not expanded Medicaid eligibility, a provision under the 2010 Patient Protection and Affordable Care Act that provides states with funding incentives to expand Medicaid to cover individuals with incomes up to 138% of the federal poverty level. If North Carolina were to expand Medicaid eligibility, an estimated additional 500,000 to 600,000 residents would become eligible for Medicaid coverage.[4]

In 2021, the Biden Administration introduced additional financial incentives for states that have not yet done so to expand Medicaid,[5] including increasing the share of the costs that the federal government pays for the non-expansion population.

In addition to continuing the provision of the 2010 Affordable Care Act that guarantees federal payment of the large majority of Medicaid expenses for Medicaid expansion populations, the federal 2021 American Rescue Plan Act incentivizes states to expand Medicaid eligibility by increasing the Federal Medical Assistance Percentage (FMAP) by five percentage points for two years. The increased FMAP for traditional Medicaid populations could lead to an additional $1.7 billion in federal funds for North Carolina across the two years of the increase.[5] The estimated new state cost for expanding Medicaid eligibility across the same two years is $490 million.

In North Carolina, Governor Cooper and the North Carolina General Assembly are actively engaged in discussions to ensure the availability of health care services for North Carolinians. While expansion was not included in the fiscal year 2023 budget, leaders of both the Senate and the House committed to further negotiations with a goal of expansion.[6] As recently as August 2022, North Carolina lawmakers across the House, Senate, and Executive Branch remained publicly committed to reaching an agreement to expand Medicaid in the state.

A non-standing Joint Legislative Oversight Committee was established in early 2022 to gather data and learn from state and national experts in health care access and Medicaid expansion. The Committee on Access to Healthcare and Medicaid Expansion convened six times from February to April 2022 and aimed to identify several key topic areas to inform the 2022 legislative session and the development of Medicaid expansion legislation. Key to this study

were lessons learned from other states,[7] 39 of which (including Washington, DC) have expanded Medicaid. Nationally, more than 18 million individuals have received health insurance coverage through Medicaid expansion.[8] The uninsured rate for non-expansion states was 13.8% in 2019, while the uninsured rate was 8.5% in states that have expanded Medicaid[9].

On June 2, 2022, the North Carolina General Assembly passed House Bill 149 (An Act Expanding Access to Healthcare in North Carolina) through the Senate, in a 44–1 vote, providing a path for North Carolina to expand Medicaid coverage in the state.[a] Under House Bill 149, the expanded Medicaid program would be called "NC Health Works," and would provide Medicaid health insurance coverage for North Carolinians up to 138% of the federal poverty level. The state's portion of the cost for expanding Medicaid would be paid for partially through increased assessments of hospitals. The bill also specifies that some Medicaid-eligible individuals will be subject to work requirements as a provision of their eligibility, although similar provisions in other states have been struck down by federal judges.[10]

On June 23, 2022, the North Carolina House Committee on Health heard Senate Bill 408 (Rural Healthcare Access & Savings Plan Act), which also addresses Medicaid expansion. Senate Bill 408 would require the North Carolina Department of Health and Human Services (NCDHHS) to develop a Medicaid expansion plan (called a Medicaid Modernization Plan in the bill) that meets various criteria, including a stipulation for the department to negotiate a work requirement with the federal Centers for Medicare and Medicaid Services for Medicaid beneficiaries if NCDHHS believes that work requirements would receive federal approval. Senate Bill 408 also would create a new Joint Legislative Committee on Medicaid Rate Modernization and Savings. This committee would meet through the summer and fall of 2022 to decide if the Medicaid expansion plan created by NCDHHS meets the required criteria and can be voted on in December.[11,b] This bill passed the North Carolina House on June 28, 2022.

Development of the Medicaid Modernization Plan

Other criteria for the Medicaid Modernization Plan to be developed under SB 408 include:[11]

- **Expand Medicaid coverage for adults aged 18–64 with incomes up to 133% of the federal poverty level.**
- **Fund additional Medicaid coverage through an increase in hospital assessments.**
- **Develop legislation for increased hospital assessments to pay the non-federal share of an increase to Medicaid hospital reimbursements through the Hospital Access and Stabilization Program (HASP).**
- **Include an investment of $1 billion to address the substance use and mental health crisis, which would be paid for through savings incurred from the additional federal Medicaid match available under the American Rescue Plan Act (ARPA).**
- **Include specific proposals for improving access to health care in rural areas of North Carolina.[b]**

The bill would also direct the North Carolina Secretary of Commerce to create a collaborative plan for a statewide workforce development program.

At the federal level, recent legislation has included additional strategies to provide affordable health insurance coverage for individuals and families. The Inflation Reduction Act, signed by President Biden on August 16, 2022, will extend the health insurance premium subsidies originally included in the American Rescue Plan Act (ARPA). These subsidies apply to health insurance plans purchased in the Affordable Care Act (ACA) marketplaces, and after their enactment through ARPA, marketplace enrollment rose to historic highs. The provisions in the Inflation Reduction Act will extend these subsidies for an additional three years, and are projected to keep approximately 2 million people from losing health insurance coverage across the United States.[12] State and federal policies that aim to provide health insurance coverage through Medicaid and the ACA marketplaces may prevent individuals and families who lost employer-sponsored coverage from remaining uninsured, as well as alleviating the ongoing burden on businesses that may struggle to provide coverage for their employees.

In addition to strategies to improve health insurance coverage in the state, there is also opportunity to improve access to care through more robust safety net services, including services through federally qualified health centers (FQHCs). FQHCs are public or private nonprofit organizations that receive federal funding for providing comprehensive primary and preventive health care services in medically underserved areas or for medically underserved populations, regardless of individuals' ability to pay[13] or their insurance status. Other safety net services include local health departments, free clinics, rural clinics, and school-based clinics, all of which provide much-needed services to those who are uninsured, underinsured, and/or those who may lack access to other types of providers.[13]

Policies to Improve Access to Prescription Medications

The task force also identified the need to ensure access to critical prescription medications during a public health emergency.

Individuals who require medication or procedures to treat or manage health conditions often encounter rules and policies required for approval of coverage of these medications and procedures by their health insurers. These policies, known as prior authorization, require physicians and other prescribers to provide documentation to the payer/insurer before the medication or procedure can be paid for and provided.[14] While prior authorization policies can add both time and administrative burden to the provision of health care services, providers and payers have implemented many strategies aimed at improving the process, such as use of electronic prior authorization systems and increased measuring of administrative burden to fully understand the impact on quality and outcomes of care.[14,15] During the COVID-19 pandemic, many states amended Medicaid rules requiring prior authorization of prescription medications. Suspension of these

[a] *House Bill 149 – Expanding Access to Healthcare, https://www.ncleg.gov/BillLookUp/2021/h149*

[b] *Senate Bill 408 – Rural Healthcare Access & Savings Plan Act, https://www.ncleg.gov/BillLookUp/2021/S408*

rules aimed to prevent further delays in receiving necessary prescriptions during the public health emergency, as well as to alleviate administrative burden for providers already facing daunting challenges in patient care and provision of services.[16] Many private insurers were also required to change prior authorization requirements for part of the pandemic.[17]

In March 2020, North Carolina Medicaid requested federal waivers that would allow the state to temporarily suspend Medicaid fee-for-service prior authorization requirements. The federal Centers for Medicare and Medicaid Services (CMS) allowed a waiver for North Carolina Medicaid that allowed NCDHHS to amend prior authorization processes required under North Carolina Medicaid.[18]

In the fall of 2021, the U.S. Office of the Inspector General released the results of a national audit designed to identify the ways in which states adjusted Medicaid prescribing and ensured that Medicaid beneficiaries continued to receive access to prescription medications during the COVID-19 pandemic. This audit consisted of a questionnaire given to 24 states asking them to identify changes they made to Medicaid policies pertaining to prior authorizations, early refills, prescription quantity limits, signature requirements, and prescriptions obtained via telehealth. States were also asked how they provided updated guidance to ensure Medicaid beneficiary access to prescription medications during the pandemic.[19]

Nearly all states involved in the audit (20 of 24) by the Office of the Inspector General made changes to prior authorization during the pandemic to improve access to medications. Examples include: Virginia extended current prior authorizations for any prescriptions that were set to expire before a certain date; the District of Columbia and New Mexico extended existing prior authorizations through the termination of the emergency declaration; New York extended approved prior authorizations for many maintenance drugs; and Colorado deferred prior authorization requirements on all drugs with an existing 12-month prior authorization approval in place.[19]

Many private insurers were also required to change prior authorization requirements for part of the pandemic.[17] In California, for example, insurers were required to adjust or eliminate processes for requesting prior authorization, including requests for exceptions to requirements that patients use less expensive medications or obtain off-formulary medications when drugs are unavailable due to supply chain interruptions.[17,20]

When health care is inaccessible or unaffordable, individuals may suffer poor health outcomes. Uninsured North Carolinians may not receive important preventive care services, may avoid treatment for acute illness and injury, and may also have poorly managed chronic health conditions.[21] Access to necessary medications may be impacted during a public health emergency, resulting in poor health outcomes, especially for individuals experiencing other difficult circumstances. Though data is still emerging about the overall impact of these policy changes on access to necessary prescription drugs during the pandemic, the task force recognized the importance of flexibility on requirements in order to ensure continuity in access. While health care services are clearly of dire importance during a pandemic or other infectious disease outbreak, regular and affordable preventive care, acute care, and chronic condition management are critical at all times. In response, the task force recommends:

RECOMMENDATION 8.1

Ensure access to high-quality, low-barrier health care before, during, and after public health emergencies.

Strategy 8.1a: The North Carolina General Assembly should increase access to and utilization of health care services for uninsured residents.

Strategy 8.1b: NC Medicaid and private insurers should explore opportunities to relieve prior authorization requirements for prescription medications.

STRATEGY 8.1a

Reduce the health insurance coverage gap.

The North Carolina General Assembly should increase access to and utilization of health care services for uninsured residents.

DESIRED RESULT

Accessible, affordable, and continuous health care that allows all North Carolinians the opportunity to be healthy and well.

WHY DOES THE TASK FORCE RECOMMEND THIS STRATEGY?

The task force recognized the many ways that access to timely, affordable, and high-quality health care was imperative during the pandemic. In addition, the task force recognized the ways that poor health outcomes and high rates of chronic conditions may contribute to the overall impact of the COVID-19 pandemic in our state. Research in other states, including research commissioned by the North Carolina General Assembly in the 2022 legislative session, provides insight into the role of Medicaid expansion and support of safety net services in improving health outcomes and reducing health care costs.

ADDITIONAL CONTEXT

During the declared federal public health emergency (PHE) ((declared on January 31, 2020, and extended as of this writing to October 13, 2022),[c] North Carolina Medicaid was required to continue health insurance coverage for all beneficiaries who were in the program at the start of the PHE, regardless of changes to their eligibility. At the expiration of the PHE, Medicaid beneficiaries whose benefits have expired must reapply to determine their continued eligibility.[22,23]

[c] *Administration for Strategic Preparedness and Response. "Renewal of Determination that a Public Health Emergency Exists." July 15, 2022. https://aspr.hhs.gov/legal/PHE/Pages/covid19-15jul2022.aspx Accessed September 14, 2022.*

While the North Carolina General Assembly has been debating Medicaid expansion for several years, in the meantime, as part of the 2021 Appropriations Act, the North Carolina General Assembly extended Medicaid benefits for low-income mothers for one year after a child is born from the six weeks postpartum that had previously been guaranteed. The state budget appropriated $62.8 million through 2023 for this effort, paid from additional hospital assessment receipts. As the current NCIOM Task Force on Maternal Health notes, expansion of postpartum Medicaid from six weeks to one year will contribute to improved maternal health outcomes and increased rates of breastfeeding, and help address the continuing rise in maternal mortality and morbidity by expanding access to care during the critical postpartum period, particularly for Black women in North Carolina.[24] While this expansion is both time-limited and limited in scope to people who give birth while covered by Medicaid, there is increasing recognition of the ways in which access to affordable health insurance coverage can improve health outcomes for North Carolinians.

In addition to strategies to improve health insurance coverage in the state, there is also opportunity to improve access to care through additional investments in more robust safety-net services, including services through federally qualified health centers (FQHCs).

STRATEGY 8.1b

Reduce administrative and logistical barriers to necessary prescription medications.

NC Medicaid and private insurers should explore opportunities to relieve prior authorization requirements for prescription medications.

DESIRED RESULT

Reduced administrative and logistical burdens to ensure continuous access to necessary prescription medications.

WHY DOES THE TASK FORCE RECOMMEND THIS STRATEGY?

Research has shown that during the early weeks and months of the pandemic, individuals encountered barriers in maintaining access to necessary prescription medications. Compared to 2019 baseline levels, overall volume of filled prescriptions fell by as much as 12%. In addition, new prescriptions fell by 37%, suggesting persistent barriers to accessing necessary medications during the pandemic.[25]

Even prior to the pandemic, health care providers recognized the ways in which prior authorization requirements may impact patient care. The American Medical Association states that insurers should "minimize disruptions in needed treatment," including "minimizing repetitive prior authorization requirements," noting that 88% of physicians report that prior authorization can interfere with continuity of care.[26] Other research shows that prior authorization may lower prescription drug costs, while at the same time providers report that prior authorization procedures impact provision of care, potentially leading to delays in care and administrative burden for both providers and patients.[27–30]

The task force recognized the need for improved and continuous access to prescription medications during a public health emergency as well as during non-emergency periods.

ADDITIONAL CONTEXT

To alleviate barriers to accessing needed medications during the COVID-19 pandemic, many states amended Medicaid rules requiring prior authorization of prescription medications. Prior authorizations are "approvals that may be required before a beneficiary may have a prescription filled for a drug that is covered by Medicaid."

In March of 2020, NC Medicaid requested federal waivers that would allow the state to temporarily suspend Medicaid fee-for-service prior authorization requirements. The federal Center for Medicare and Medicaid Services (CMS) allowed a waiver for NC Medicaid that allowed the department to amend prior authorization processes.[18] Many private insurers were also required to change prior authorization requirements for part of the pandemic.[17]

In addition, NC Medicaid reports that the provision of 90-day supplies of generic and brand name prescription drugs to Medicaid beneficiaries, as well as delivery of prescription drugs by mail, have been made permanent Medicaid policy.[d]

RECOMMENDATION 8.2

Since 2020, the importance of timely, accessible, accurate, and equitable diagnostic testing for COVID-19 has become increasingly clear. While at the beginning of the pandemic testing was critical for understanding the epidemiological patterns of the disease and informing mitigation measures, such as contact tracing, testing has also become a way for individuals and communities to understand overall community risk levels and to inform individuals' behaviors and choices, reducing risk of infection.

Early in the pandemic, North Carolina stakeholders began to understand the ways in which the disease was disproportionately impacting historically marginalized populations. Increased exposure through employment as frontline essential workers—including in low-wage food service, factory, and agriculture jobs—and greater rates of preexisting conditions, such as diabetes and obesity, were risk factors for higher disease severity and death.[31] State and local public health departments, as well as health systems and community-based organizations, identified several key strategies to ensure adequate access to diagnostic testing services, often relying on existing relationships and trusted partners to quickly implement accessible services.

[d] *Shannon Dowler, NC Medicaid Chief Medical Officer, NC Department of Health and Human Services. Written (email) communication. August 15, 2022.*

State stakeholders have reported that during the early months of the pandemic there was limited capacity for adequate laboratory services to meet the rising demand for testing. Some of this was due, in part, to a limited number of Emergency Use Authorization-approved tests, and the acute nature of the needed services hindered the development of long-term testing strategies. Labs needed to develop and provide different types of testing services, as well as flexible approaches that would allow them to adapt when faced with low or no supplies of necessary equipment and materials.[32]

As the North Carolina Department of Health and Human Services (NCDHHS) has noted in its *COVID-19 Response Interim Review*, the state initially had limited access to testing materials, and all test samples were sent to the Centers for Disease Control and Prevention (CDC) labs in Atlanta, GA. Once testing could be done by public and private labs in North Carolina, the number of tests available to the state quickly grew, but capacity for processing the tests was not yet sufficient to meet the needs; turnaround time was up to 14 days for COVID-19 test results in the early months of the pandemic. Capacity and turnaround times have varied during the pandemic based on demand, and NCDHHS reports improvements in processes and reductions in delays through intentional investment in supplies and personnel, and through ongoing coordination between laboratories.[33]

The NCDHHS interim review also outlines priorities in its initial testing capacity plan, including access to polymerase chain reaction (PCR) testing, engagement with laboratories across the state to share data and supply allocations, and use of federal funding to purchase additional lab equipment and allocate it in a way that would maintain overall lab capacity across the state.[33] Between March 2020 and present, numbers of daily tests have varied considerably, with a maximum of approximately 86,000 daily tests (note: does not include at-home testing).

Despite these efforts toward increasing testing capacity and ensuring testing availability, many challenges remained. Primary among these challenges was disparate access to testing. A study by North Carolina researchers examined testing distribution in the state during the first three months of the pandemic (March to June 2022) and found large disparities in testing (and cases) by race and by geographic location (urban versus rural) in this time period. The study used demographic and residential data to identify patterns in testing metrics, including tests per capita, positive tests per capita, and test positivity rate, which is an indicator of sufficient testing. Test positivity rate was highest among people of Latinx ethnicity, followed by non-Latinx Black individuals and American Indian individuals, and was higher among people living in rural areas across all ethnic groups. The researchers concluded that these results suggested uneven distribution of access to testing, which further exacerbated existing health inequities and disparate risk factors.[34] In addition, research has shown that historically marginalized communities are less likely to participate at mass testing sites, due to "poverty, access issues, inadequate information, logistics, and issues surrounding fear, stigma, and trust."[35]

Fortunately, state and local health departments, higher education, health systems, community-based organizations, and other partners quickly recognized the need for improved access to testing, particularly among historically marginalized populations and in rural areas. Starting in August 2020, North Carolina Central University's Advanced Center for COVID-19 Related Disparities (ACCORD) launched COVID-19 testing sites at 56 sites across 11 counties, providing testing as well as conducting survey research on attitudes and impact of the pandemic to inform testing and outreach strategies. ACCORD attributes the success of these initiatives to assistance from and collaboration with community partners, including churches and local nonprofit organizations.[36]

In response to emerging data on stark disparities in COVID-19 case rates, fatalities, and test-positivity rates among North Carolina's American Indian population, ACCORD also partnered with the Lumbee Tribe of North Carolina, the University of North Carolina at Pembroke, and community organizations to establish a partnership named Building Resistance and Vital Equity (BRAVE). The BRAVE partnership performed COVID-19 testing for Native Indians in the Lumbee tribal territory in Cumberland, Hoke, Robeson, and Scotland counties. Survey research conducted at these testing sites continued to inform testing response efforts, and work with trusted community organizations also allowed ACCORD and BRAVE to continue survey research to inform vaccination distribution policies and communication strategies later in the pandemic.[35]

RECOMMENDATION 8.2

Ensure comprehensive and equitable access to diagnostic testing services.

Strategy 8.2a: State and local health departments should enhance coordination with and support for laboratory infrastructure to ensure efficient testing services and procurement of necessary materials.

Strategy 8.2b: Stakeholders should develop standards of care and ongoing implementation strategies that incorporate best practices from innovative approaches implemented during the COVID-19 pandemic. Health systems, state and local health departments, laboratory partners, employers, schools, higher education institutions, and community-based organizations should identify the most successful strategies that prioritized continued access to diagnostic testing services, particularly among historically marginalized populations and/or those most heavily impacted. Strategies may include use of community health workers, mobile testing units, school- and employer-based services, faith-based organizations, and other approaches.

The North Carolina Department of Health and Human Services, local public health departments, federally qualified health centers (FQHCs), higher education institutions, and other partners should continue and expand the convening of cross-sector work groups to identify, share, and plan implementation of best practices in improving access to testing services. Work groups should have an intentional and consistent focus on addressing and alleviating disparities and inequities in access to testing services. Participants should include health systems, community-based organizations, local public health leaders, and other community representatives.

STRATEGY 8.2a

Ensure the existence of laboratory infrastructure and supplies for testing services.

State and local health departments should enhance coordination with and support for laboratory infrastructure to ensure efficient testing services and procurement of necessary materials.

DESIRED RESULT

Timely and adequate provision of testing services and necessary materials during public health emergencies.

WHY DOES THE TASK FORCE RECOMMEND THIS STRATEGY?

In the early months of the pandemic, laboratory services had limited capacity to meet the rising demand for testing. Some of this was due, in part, to a limited number of Emergency Use Authorization-approved tests, and the acute nature of the needed services hindered the development of long-term testing strategies. Labs needed to develop and provide different types of testing services, as well as flexible approaches that would allow them to adapt when faced with low or no supplies of necessary equipment and materials.[32] It also took time for processing capacity for tests to become sufficient to meet state testing needs. Capacity and turnaround times have varied during the pandemic based on demand, and NCDHHS reports improvements in processes and reductions in delays through intentional investment in supplies and personnel, and through ongoing coordination between laboratories.[33] The task force recognized the need for ongoing coordination and partnership maintenance in order to ensure that the state, counties, and health systems have the capacity for necessary testing services and materials.

ADDITIONAL CONTEXT

Starting shortly after the beginning of the pandemic, in April 2020, NCDHHS began convening a Testing Surge Workgroup. This group was charged with developing an action plan to: "increase testing throughput and capacity (including serology); expand testing sites and diversity of testing options; address risks around testing supplies and PPE availability; and increase transparency around current testing capabilities of laboratory, clinical, and retail partners." The Testing Surge Workgroup was co-chaired by leaders across Duke Medical Center laboratories, the NC State Laboratory of Public Health (NCDHHS, Division of Public Health), and Old North State Medical Society, and comprised of policymakers and practitioners in academic and commercial labs, pharmacy, epidemiology, licensure, community groups, and local and state public health. The group aimed to develop best practices for improving testing capacity and access and implement successful strategies across the state.[37,38] The ongoing collaboration and partnership laid the groundwork for successful expansion of community-based testing; the task force recognized the need for additional and sustainable resources to ensure these sorts of groups are able to be quickly and effectively convened in times of public health emergency.

STRATEGY 8.2b

Prioritize historically marginalized populations and others at risk of disproportionate harm in strategies to ensure continued access to diagnostic testing services.

Health systems, state and local health departments, laboratory partners, employers, schools, higher education institutions, philanthropy, and community-based organizations should strategize opportunities to ensure continued access to diagnostic testing services, particularly among historically marginalized populations and/or those at risk of disproportionate harm. Strategies should utilize community health workers, mobile testing units, school- and employer-based services, faith-based organizations, and other approaches.

The North Carolina Department of Health and Human Services, local public health departments, federally qualified health centers (FQHCs), higher education institutions, and other partners should continue and expand the convening of cross-sector work groups to identify, share, and plan implementation of best practices in improving access to testing services. Work groups should have an intentional and consistent focus on addressing and alleviating disparities and inequities in access to testing services. Participants should include health systems, community-based organizations, local public health leaders, and other community representatives.

DESIRED RESULT

Equitably distributed and easily accessible diagnostic testing services for SARS-CoV-2 and other infectious diseases, with priority attention to historically marginalized populations and vulnerable groups, as well as intentional and meaningful inclusion of community voices in the development of strategies to ensure access to diagnostic testing services.

WHY DOES THE TASK FORCE RECOMMEND THIS STRATEGY?

Research in North Carolina has shown uneven distribution of access to testing in the early days of the pandemic, which further exacerbated existing health inequities and disparate risk factors.[34] In addition, research has shown that historically marginalized communities are less likely to participate at mass testing sites due to "poverty, access issues, inadequate information, logistics, and issues surrounding fear, stigma, and trust."[35]

State and local health departments, higher education, health systems, community-based organizations, and other partners quickly recognized the need for improved access to testing, particularly among historically marginalized populations and in rural areas. The task force recognized the successes of these efforts and the need for ongoing support and resources to maintain them.

ADDITIONAL CONTEXT

Throughout the pandemic, state leaders learned a tremendous amount about best practices and strategies to avoid when determining how best to increase access to testing. Programs such as the Community Testing High Priority and Marginalized Populations (CHAMP) initiative, which ran during July and August

2020, focused on identifying priority communities for improving access to testing. CHAMP identified nearly 200 priority communities, most of which had a high share of Black, Latinx, and American Indian residents and/or high rates of chronic disease or high-risk worksites, for improved testing. Working with contractors to provide additional testing in these communities, CHAMP provided 17,000 tests with 72-hour turnaround for results and used "secret shopper"-type evaluation to measure success of community outreach and adjust testing logistics to meet high volume.[38]

Innovative strategies, such as those discussed above, show enormous progress and ongoing dedication to improving access to accurate and timely testing. This innovation continues in current programs: In August 2022, NCDHHS announced a new program, funded in partnership with the Rockefeller Foundation, that will provide five free at-home COVID-19 tests to individuals within certain ZIP codes. The program will use the Social Vulnerability Index, a CDC-developed tool that incorporates 15 census variables to identify geographic areas most at risk during disasters and public health emergencies, to determine eligibility by ZIP code.[39]

In addition, the task force recognized the ways in which work groups and other partnerships that prioritized the perspectives, experiences, and expertise of community stakeholders in addressing inequitable access were successful in expanding testing and informing later processes, including vaccine distribution. Work groups including the Historically Marginalized Populations Work Group, convened by NCDHHS in March 2020 in order to provide feedback and guidance on NCDHHS' outreach and communications to historically marginalized groups in the state and develop a toolkit for ongoing communications, aimed to bring together diverse stakeholders and center community input in the development of strategies to address disparities in testing and other areas.[38] Private sector groups worked to build community collaborations focused on health equity and improving access to testing, vaccines, and address drivers of health such as economic opportunity and education. The Latinx Advocacy Team & Interdisciplinary Network for COVID-19 (LATIN-19) was created by clinicians at Duke University early in the pandemic to address health disparities within the Latinx community resulting from COVID-19. This multi-sector group quickly grew to over 700 members across academia, health care, local public health, community-based organizations, faith communities, education, and others .[40] LATIN-19 has been recognized across the state and nationally for its work in prioritizing community voice to build strategies that address disparities.[41]

Strategy 8.2b builds upon these lessons and ongoing innovations and aims to ensure a sustainable infrastructure to continue their application going forward.

RECOMMENDATION 8.3

The COVID-19 pandemic has caused or exacerbated challenges related to social isolation, unemployment, financial instability, and long-standing systemic and structural barriers to health care services and supports in communities across the state. These challenges have contributed to higher rates of anxiety, depression, and suicidal ideation, along with increased substance use and rising fatal and non-fatal overdose rates.[42] In North Carolina, an average of nine people died each day as a result of an overdose in 2020, representing an increase of 40% compared to 2019.[43] Based on provisional data from the North Carolina Department of Health and Human Services (NCDHHS), overdose deaths continued to rise in 2021 and during the early months of 2022.[44]

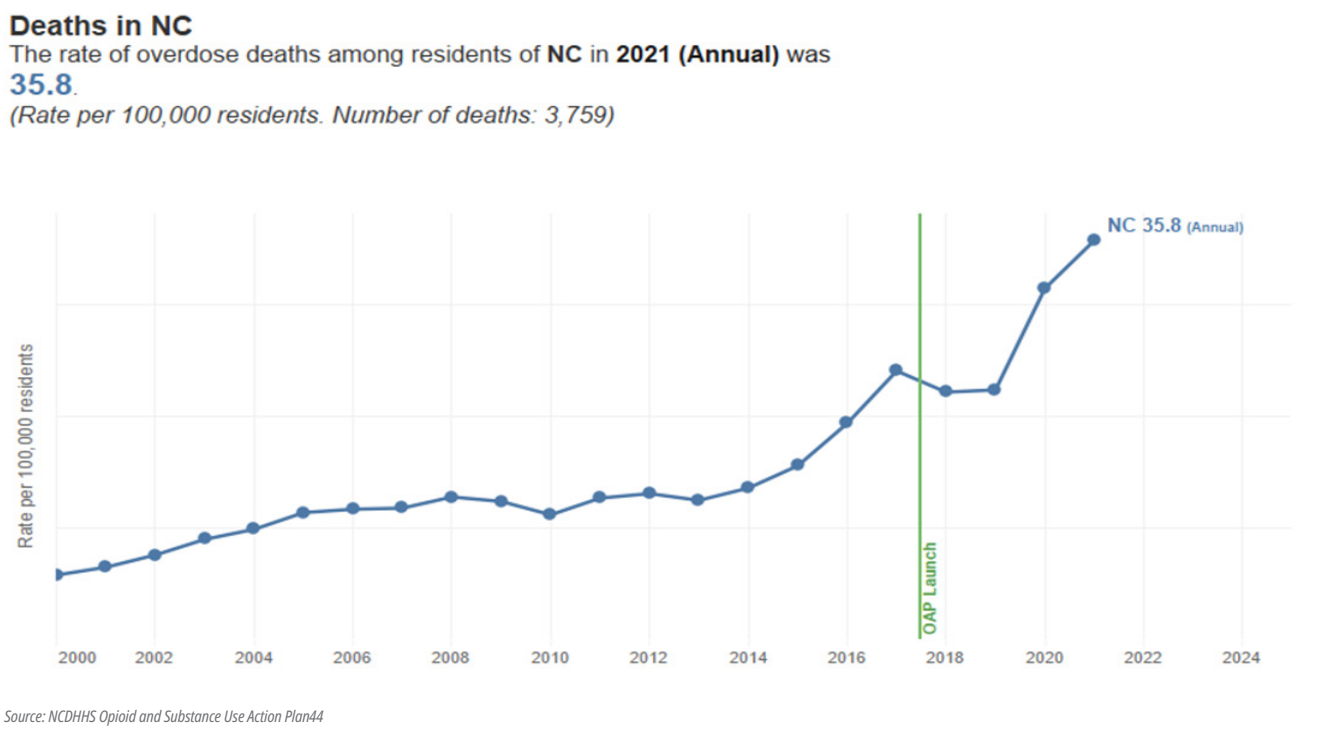
Throughout the COVID-19 pandemic, people of color and other historically marginalized populations [45] have been disproportionately impacted by overdose compared to other groups (**Table 1**). People who use drugs are also at higher risk of hospitalization, death, and other severe outcomes related to SARS-CoV-2 infection compared to other populations, due to higher rates of underlying health conditions, housing insecurity, incarceration and other forms of justice system involvement, and barriers to essential medications and other services.[46–49] People of color who use drugs are at particularly high risk of both overdose and severe COVID-19 outcomes, reflecting the intersectional inequalities faced by people with multiple marginalized identities.[47]

Table 1:[43] Overdose Death Rates by Year and Race (Non-Hispanic). Rate per 100,000 residents.

	2019 RATE	2018 RATE	% INCREASE
AMERICAN INDIAN/INDIGENOUS	43.3	83.6	93%
BLACK/AFRICAN AMERICAN	16.1	26.7	66%
WHITE	27.4	36.1	32%

Source: NCDHHS. North Carolina Reports 40% Increase in Overdose Deaths in 2020 Compared to 2019; NCDHHS Continues Fight Against Overdose Epidemic. Published March 21, 2022. Accessed August 23, 2022. https://www.ncdhhs.gov/news/press-releases/2022/03/21/north-carolina-reports-40-increase-overdose-deaths-2020-compared-2019-ncdhhs-continues-fight-against

Figure 1. Unintentional Overdose Deaths in North Carolina, 2000–2021



Source: NCDHHS Opioid and Substance Use Action Plan44

"A single life lost to an overdose is a life we should have saved. Stress, loss of housing and loss of employment for those in recovery caused by the COVID-19 pandemic has led to a backslide in our fight against substance use disorders. Improving behavioral health and resilience is a top priority for NCDHHS, and we will rally our community partners and our team to meet these new challenges as we focus on saving lives, prevention and the lasting supports needed for long-term recovery, including increasing the number of people with health insurance." – NC Secretary of Health and Human Services Kody H. Kinsley[43]

Initiatives to Address the Overdose Crisis During the COVID-19 Pandemic

At the federal level, the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Drug Enforcement Agency (DEA) issued guidance that allowed for expanded access to buprenorphine and methadone through take-home dosing, relaxed guidelines for initiation of treatment, and made other temporary changes to reduce the risk of overdose among people who use drugs in the early months of the COVID-19 pandemic.[50–52] In April 2021, the U.S. Secretary of Health and Human Services issued an exemption for certain statutory certification requirements related to training, counseling, and other services with the goal of expanding access to buprenorphine for patients under the care of providers licensed and registered to prescribe controlled substances by the DEA.[51] SAMHSA also preemptively authorized federally approved opioid treatment programs (OTPs) to continue providing take-home doses of methadone to patients in late 2021 in anticipation of an eventual expiration of the national declaration of emergency for the COVID-19 pandemic.[53] Despite these efforts, however, adoption of relaxed federal guidelines among providers and clinics in North Carolina has varied significantly, leading to inconsistent access to methadone in particular across the state.[53]

Expanded Access to Methadone During the COVID-19 Pandemic

"On March 16, 2020, SAMHSA issued an exemption to OTPs whereby a state could request 'a blanket exception for all stable patients in an OTP to receive 28 days of Take-Home doses of the patient's medication for opioid use disorder.' States could also 'request up to 14 days of take-home medication for those patients who are less stable but who the OTP believes can safely handle this level of take-home medication.' Almost two years since this exemption was granted, states, OTPs, and other stakeholders report that it has resulted in increased treatment engagement, improved patient satisfaction with care, and few incidents of misuse or medication diversion." – SAMHSA's Methadone Take-Home Flexibilities Extension Guidance[54]

Federal funding has also been used to address rising overdose rates across the country during the pandemic. Congress passed a bill in December 2020 that authorized $4.25 billion in mental health and substance use emergency funds,[55] followed by $3.5 billion in block grant funding through the American Rescue Plan Act, which was signed into law by President Biden on March 11, 2021.[56] The Biden Administration also authorized an additional $2.5 billion in block grant funding to support states and territories in their efforts to address behavioral health challenges caused or exacerbated by the COVID-19 pandemic.[57]

In North Carolina, NCDHHS updated its Opioid and Substance Use Action Plan, which originally launched in 2017. The updated plan, known as Opioid and Substance Use Action Plan 3.0, launched in 2021, and includes an increased focus on equity and lived experiences of people who use drugs. The Action Plan includes efforts to measure and track progress in the state, and prioritizes four main goals:

- "Center equity and lived experiences by acknowledging systems that have disproportionately harmed historically marginalized people (HMP), implementing programs that reorient those systems, and increasing access to comprehensive, culturally competent, and linguistically appropriate drug user health services for HMPs.
- Prevent future addiction and address trauma by supporting children and families.
- Reduce harm by moving beyond just opioids to address polysubstance use.
- Connect to care by increasing treatment access for justice-involved people and expanding access to housing and employment supports to recover from the pandemic together."[58]

Expanded Access to Methadone During the COVID-19 Pandemic

"Succinctly, harm reduction is the celebration of any positive change, regardless of how small, as defined by the individual. It allows us to connect with people who use drugs and 'meet them where they are.' It creates better listeners and provides a framework for individualized care. Harm reduction philosophies appeal to people broadly. For some, the emphasis on personal responsibility, bodily autonomy, deregulation, and freedom of choice is powerful. For others, alleviating structural inequities, fostering social justice, and building community are motivating. And for still others, harm reduction is a calling, a spiritual sense of duty to show compassion to neighbors. What unites across the spectrum is a genuine desire to improve the health of our state by reducing the substantial negative health and social consequences of drug use."[59] – Dr. Nabarun Dasgupta, *North Carolina Medical Journal*

In response to the challenges presented by the COVID-19 pandemic, and in the context of an enduring epidemic of fatal and non-fatal overdoses, the task force recommends:

RECOMMENDATION 8.3

Ensure comprehensive and equitable access to diagnostic testing services.

Strategy 8.3a: The North Carolina General Assembly, North Carolina county commissioners, the North Carolina Association of County Commissioners, and the UNC School of Government should provide ongoing financial and technical assistance support to sustain existing harm reduction programs, including syringe services programs and naloxone distribution, before, during, and after public health emergencies to reduce the risk of fatal and non-fatal overdose and infectious disease transmission.

Strategy 8.3b: NC Medicaid and private payers should explore opportunities to increase support for, and provide incentives to, providers offering low-barrier access to evidence-based treatment with buprenorphine and methadone to reduce the risk of overdose and improve outcomes for people who use drugs.

Strategy 8.3c: NC Medicaid and private insurers, the UNC Injury Prevention Research Center, community-based harm reduction programs, and other partners should strategize opportunities to increase access to evidence-based treatment with buprenorphine and methadone in alignment with federal guidance during public health emergencies.

For each of the above strategies, *support* should include financial resources to modify spaces, adjust staffing, or take other necessary actions to reduce exposure to infectious airborne aerosols while providing services.

STRATEGY 8.3a

Provide funding to support and sustain harm reduction programs before, during, and after public health emergencies.

Strategy 8.3a: The North Carolina General Assembly, North Carolina county commissioners, the North Carolina Association of County Commissioners, and the UNC School of Government should provide ongoing financial and technical assistance support to sustain existing harm reduction programs, including syringe services programs and naloxone distribution, before, during, and after public health emergencies to reduce the risk of fatal and non-fatal overdose and infectious disease transmission.

DESIRED RESULT

Ongoing funding to support and sustain evidence-based harm reduction programs such as syringe services programs (SSPs) and naloxone distribution programs before, during, and after public health emergencies, understanding that these programs are essential to reducing the risk of fatal and non-fatal overdose and infectious disease transmission in communities across the state.

WHY DOES THE TASK FORCE RECOMMEND THIS STRATEGY?

The task force underscored that harm reduction programs are critical to reducing the risk of overdose and infectious disease transmission in North Carolina's communities as they distribute unused syringes, naloxone, and other supplies, while also providing guidance, support, and resources to people who use drugs. SSPs and naloxone distribution programs have been extensively supported in academic research[59] and by NCDHHS,[43] along with other state and national health care associations, including the American Medical Association (AMA).[60,61]

ADDITIONAL CONTEXT

The North Carolina General Assembly and North Carolina county commissioners, which determine funding priorities and allocate funds at the state and local levels, are the entities involved in **Strategy 8.3a**.

In July 2021, North Carolina Attorney General Josh Stein announced a historic $26 billion national settlement with three drug distributers and one manufacturer.[62] Approximately $750 million is available to address the opioid epidemic in North Carolina, 85% of which will be directly allocated to counties for implementation of prevention and treatment strategies.[63] As counties decide on the most appropriate strategies for opioid settlement fund allocations, it is important that local leaders receive not only adequate financial resources, but also information on evidence-based harm reduction strategies most appropriate for implementation within their communities.[64]

STRATEGY 8.3b

Consider opportunities to increase access to low-barrier, evidence-based treatment.

Strategy 8.3b: NC Medicaid and private payers should explore opportunities to increase support for, and provide incentives to, providers offering low-barrier access to evidence-based treatment with buprenorphine and methadone to reduce the risk of overdose and improve outcomes for people who use drugs.

DESIRED RESULT

Increased access to low-barrier treatment with buprenorphine and methadone to reduce the risk of overdose death and improve outcomes for people who use drugs before, during, and after public health emergencies.

WHY DOES THE TASK FORCE RECOMMEND THIS STRATEGY?

Ensuring access to evidence-based treatment with buprenorphine and methadone is critical to reducing the risk of overdose among people who use drugs. **Strategy 8.3b** is designed to specifically increase access to low-barrier treatment, which prioritizes the reduction of drug-related harms over abstinence from drug use by supporting flexible attendance, reducing or eliminating urine drug screening requirements, and allowing patients engaged in ongoing drug use to continue their treatment.[65] Low-barrier treatment programs are tailored to patients who may have complex needs, helping to maintain continuity of care, supporting rapid treatment access,[66,67] and reducing stigma surrounding drug use by reflecting a harm reduction-oriented approach. As a result, low-barrier treatment programs can better serve individuals who have been unable to stay in treatment programs with strict requirements around abstinence from drugs, frequent appointments, and participation in counseling and urine drug screening.[66]

ADDITIONAL CONTEXT

NC Medicaid, a program within the Division of Health Benefits in the North Carolina Department of Health and Human Services, and private insurers are the entities involved in **Strategy 8.3b**.

STRATEGY 8.3c

Explore opportunities to increase access to buprenorphine and methadone in alignment with guidance from federal agencies.

Strategy 8.3c: Representatives from NC Medicaid and private insurers, the UNC Injury Prevention Research Center, community-based harm reduction programs, and other partners should strategize opportunities to increase access to evidence-based treatment with buprenorphine and methadone in alignment with federal guidance.

DESIRED RESULT

Increased access to buprenorphine and methadone for North Carolinians who use drugs through widespread adoption of federal policies developed with this goal in mind.

WHY DOES THE TASK FORCE RECOMMEND THIS STRATEGY?

The task force recognized the need to develop strategies to encourage providers and clinics across the state to adopt federal guidance designed to increase access to evidence-based treatment with buprenorphine and methadone. The COVID-19 pandemic caused significant disruptions in access to treatment services for North Carolinians with opioid use disorder, as many were unable to obtain take-home doses of their medication or initiate treatment due to COVID-19 mitigation measures or inaccessible telehealth services.[68–70] Studies have shown that take-home dosing, when available, promotes retention in treatment and is not associated with medication diversion or negative health outcomes.[68,71,72]

Strategy 8.3c is designed to bring representatives from NC Medicaid, private insurers, the UNC Injury Prevention Research Center, community-based harm reduction programs, and other partners together to develop and implement strategies that increase access to these essential medications in alignment with relaxed or modified federal guidelines. **Strategy 8.3c** also encourages these groups to work collaboratively to leverage their existing efforts to increase access to buprenorphine and methadone for North Carolinians in need.

ADDITIONAL CONTEXT

As described earlier in this section, the pandemic resulted in federal guidance to improve access to buprenorphine and methadone through take-home dosing, relaxed guidelines for initiation of treatment, as well as exemptions for some certification requirements for training, counseling, and other services related to access to these medications. However, access remains inconsistent across the state.

There are several state initiatives that work to improve collaboration and develop cross-sector learning and strategies to improve access to medication-assisted treatment. UNC ECHO for MAT, supported by the North Carolina Department of Health and Human Services (NCDHHS)/Substance Abuse and Mental Health Services Administration (SAMHSA) and the Agency for Healthcare Research and Quality's (AHRQ), focuses on bringing health care providers and community partners together to evaluate barriers to medication-assisted treatment, develop needed resources for providers, and identify strategies to expand access. Currently working in all 100 counties of North Carolina, UNC ECHO for MAT is an example of a beneficial collaborative partnership to address issues pertaining to access to medication-assisted treatment.[73]

Telehealth also provides an opportunity for improved access to medication-assisted treatment, especially for related medical and counseling services, as is currently included in Medicaid telehealth coverage.[74] Partners named in **Strategy 8.3c** should include telehealth policy in opportunities considered for improving access. Please see **Recommendation 8.4** in this chapter for additional information about telehealth during the pandemic.

RECOMMENDATION 8.4

In the early weeks and months of the COVID-19 pandemic, there was a dramatic decline in the utilization of health care for emergent needs, elective procedures, and preventive care, such as well visits and vaccinations. Beyond the direct impact of COVID-19 on individuals affected with the virus, health care providers and researchers began to examine the broader population health and financial impacts of forgone care during this pandemic. The Carolinas Pandemic Preparedness Task Force recognized the need, in coming years, for additional and thorough study of the impacts of this missed and delayed care on health outcomes, financial burden to individuals and to the health system, and health equity.

"The clinical impacts of forgone care started long before COVID-19. COVID-19 just placed a spotlight on the health disparities and the health inequities that we have seen and continue to see. The longer we permit the current systems, policies, and institutions to remain and implicit biases to play a role, the more lasting these trends will become, only exacerbating the divide we see in our communities." ***– The late Ophelia Garmon-Brown, MD, Chief Community Wellness and Health Equity Executive, Novant Health, North Carolina Institute of Medicine Annual Meeting, December 2020***

Telehealth Policy Revisions to Address Access to Care

During the first few months of the COVID-19 pandemic, health care providers and policymakers recognized the urgent need for policy solutions to address forgone care. In response to the COVID-19 pandemic, Session Law 2020-4 (House Bill 1043)[e] and Session Law 2020-3 (Senate Bill 704)[f] were passed by the North Carolina House and Senate on May 2, 2020, and signed into law by Governor Cooper on May 4. Included in the almost $1.6 trillion in federal funds from the federal CARES Act to provide financial relief related to the pandemic were several provisions intended to address additional need for telehealth services during the COVID-19 pandemic. These provisions allocated funding for entities including the North Carolina Department of Health and Human Services for enhanced telehealth services and other health-related needs in rural communities and for local health departments.[e,d,75] Other provisions that could be used to provide expanded telehealth services and improve access to care included the COVID-19 Rural Hospitals Relief Fund, the COVID-19 Teaching Hospitals Relief Fund, and the COVID-19 General Hospitals Relief Fund.[e, f, 75, 76]

There have also been federal, state, and private payment reforms related to improving access to telehealth services. In March 2020, the Trump Administration announced expanded Medicare coverage for telehealth clinical visits so older Americans could access health care services from home, reducing the risk of exposure to COVID-19 for both patients and health care providers.[77] Prior to this announcement, Medicare coverage for telehealth was narrower and only paid clinicians for routine visits for patients living in rural areas. Under the new policy, telehealth services were reimbursed at the same amount as in-person services. Private payers also increased their coverage of telehealth services; in North Carolina, the largest private insurer, Blue Cross and Blue Shield of North Carolina, covered telehealth services at the same payment rate as in-person visits and also eliminated cost-sharing for telehealth services.[78]

In April 2020, North Carolina Medicaid also received a temporary waiver from the federal Centers for Medicare and Medicaid Services to increase flexibility around enhanced telehealth services during the COVID-19 pandemic.[79] The policy changes included removal of restrictions on technologies that can be used to deliver services. In addition, the pool of eligible telehealth providers was expanded to include clinical pharmacists, licensed clinical social workers (LCSWs), licensed clinical mental health counselors (LCMHCs), licensed marriage and family therapists (LMFTs), licensed clinical addiction specialists (LCASs), and licensed psychological associates (LPAs). Under this policy change, no prior authorizations or approvals were required for receipt of telemedicine services through NC Medicaid.[80]

[e] *Session Law 2020-4, https://www.ncleg.gov/Sessions/2019/Bills/House/PDF/H1043v7.pdf*
[f] *Session Law 2020-3, https://www.ncleg.gov/Sessions/2019/Bills/Senate/PDF/S704v6.pdf*

Temporary closures of medical facilities, cancellations or delays of elective medical procedures, and shifts to telehealth services impacted individuals' access to and ability to receive care. In addition, many people were impacted by layoffs or other changes in employment, potentially affecting their ability to afford care. Of the 79% of respondents who reported in the Johns Hopkins COVID-19 Civic Life and Public Health Survey, fielded in July 2020, that they needed medical care between March and May of 2020, more than half (52%) reported missing or delaying this care. Reasons included fear of being infected with SARS-Cov-2 (29% of those who missed or delayed care) and financial concerns (7%).[81] Respondents who were unemployed were more likely to report missing needed medical care than employed respondents, and those who were uninsured were more likely to attribute missed or delayed care due to financial concerns than respondents with public or private health insurance coverage. Additional survey findings included: 29% of respondents reported missing a preventive care appointment; 26% reporting missing an outpatient general medical visit; 8% reported missing an outpatient mental health appointment; and 6% reported missing an elective surgery.[81]

Top of mind for public health practitioners, health care providers, and policymakers were concerns about the disparate impact of missed and delayed care on vulnerable populations. During the first year of the pandemic, data have shown an increase in excess deaths from conditions including diabetes, dementia, hypertension, heart disease, and stroke .[82] Overdose deaths have also increased since the start of the pandemic. While these data unequivocally underscore the tremendous importance of ensuring that individuals receive the care they need for chronic and acute conditions during a public health emergency,[83] they must also be considered in light of persistent inequities in rates of many of these conditions. In North Carolina, mortality rates for nearly all the top causes of death are persistently higher for Black North Carolinians than for White North Carolinians.[84] In addition, Black and especially Hispanic North Carolinians are more likely to be uninsured, at rates of 13% and 31%, respectively, compared to White residents (10 %).[84] Black and Hispanic North Carolinians are also more likely to have incomes lower than 200% of the federal poverty level, at rates of 51.1% and 63.6%, respectively, compared to White North Carolinians at 30.7%. These disparities suggest that missing or delaying needed preventive care and management for chronic conditions, as well as the reasons for this missed or delayed care—such as financial concerns or unemployment—may also have a disparate impact across race and ethnicity.[85]

An Urban Institute analysis found that Black adults were more likely than either White or Hispanic adults to report missed or delayed care (39.7% versus 34.3% and 35.5%, respectively). Black adults were also more likely to report missing or delaying multiple types of care. The analysis also found that reasons for missing or delaying care also varied by race and ethnicity: Black adults and those with lower incomes were more likely to report missing or delaying care due to worry about exposure and infection by the virus.[83] Of all respondents who reported missed or delayed care, more than three-quarters had one or more chronic condition, such as hypertension, diabetes, respiratory illness, heart disease, cancer, kidney disease, and mental health disorders. Notably, respondents also reported that missing or delaying care had a significant impact on their ability to work or perform daily activities, or that the missed care worsened existing health conditions.

While it remains too early to understand the full impact of missed and delayed care during the pandemic, the task force recognized the need for additional robust study of the overall impact on morbidity, mortality, and health inequities. Recent data from California have shown a decline in life expectancy during the pandemic, from 81.4 years in 2019 to 79.20 years in 2020 and 78.37 years in 2021. In addition, the differences in life expectancy between highest- and lowest-income census tracts increased from 11.5 years in 2019 to 14.67 years in 2020 and 15.51 years in 2021.[86] Such findings are alarming and bear many lessons for health care providers and policymakers regarding how to address inequitable access to needed care during a public health emergency.

The task force also recognized the need for understanding different types of financial impacts of missed and delayed care, for both individuals and for the overall health care ecosystem. In North Carolina, the pandemic quickly began to have a detrimental impact on the fiscal viability and financial security of rural hospitals, small private providers, and long-term care providers, many of which were in a financial crisis before the pandemic. The financial viability of rural hospitals, which is often precarious, depends on sufficient volume of services, such as elective surgeries, that are reimbursed at higher rates. When hospitals had to cancel or delay procedures, they lost this critical source of revenue. In addition, rural hospitals often had fewer ICU beds, staff, and other necessary resources to cope with the virus than hospitals in metropolitan areas, leading to financial and resource strain. At the beginning of the pandemic, state and federal governments allocated resources to offset the impact of COVID-19 on rural areas and hospitals. In May 2020, the roughly 50 rural hospitals in North Carolina were appropriated $65 million dollars from the federal CARES Act by the North Carolina General Assembly. The funds allocated to rural North Carolina hospitals could be used to cover some of the lost revenue from forgone elective procedures, among other purposes.[87] Since the start of the pandemic, care and claims have rebounded to pre-pandemic levels.

Researchers have also begun to examine the impact of missed and delayed care on provision of low-value care. Low-value care, generally defined as "services that provide insufficient clinical benefit and increase health care costs," is estimated to waste more than $1 billion annually, and to also present potential physical and mental harm to patients. The large drop in elective procedures and outpatient visits at the beginning of the pandemic, including types of screenings considered to be low-value care, offers an opportunity for researchers and health care professionals to align findings about costs and overall morbidity and mortality with revisions to preventive care recommendations, treatments, and payment policies that better reflect improved quality of care and lower costs.[88]

RECOMMENDATION 8.4

Examine the impact of the COVID-19 pandemic on access to and utilization of health care services.

Strategy 8.4a: Academic research centers, including (but not limited to) the UNC Gillings School of Global Public Health, Sheps Center for Health Services Research, Wake Forest University Maya Angelou Center on Health Equity, Duke-Margolis Center for Health Policy, and others, should examine the impact and burden of missed or delayed health care during the COVID-19 pandemic. Subjects of study should include drivers of missed care, data on resumption of care, impact on health care costs, health outcomes, and projected disease burden. Policymakers should use study results to inform ongoing policies to improve access to preventive and acute care during a public health emergency.

DESIRED RESULT

Comprehensive understanding of the impacts of missed and delayed care on population health and financial stability of individuals and the health care system.

WHY DOES THE TASK FORCE RECOMMEND THIS STRATEGY?

TThe task force recognized the need for understanding the varied impacts of missed or delayed care due to the COVID-19 pandemic. As described above, many factors, including closed medical facilities, cancelled or delayed elective procedures, and other changes in the delivery of health care services impacted whether and how care was received. Financial strain and fear of infection with COVID-19 were also factors in some individuals' decisions to miss care.[81]

The task force recognized data from the first year of the pandemic that showed increase in excess deaths from conditions including diabetes, dementia, hypertension, heart disease, and stroke, as well as the potential impact of inequities in these conditions. As noted earlier in this chapter, more than three-quarters of all respondents who reported missed or delayed care also had one or more chronic condition, such as hypertension, diabetes, respiratory illness, heart disease, cancer, kidney disease, and mental health disorders. Other differences were also reflected in some individuals' decisions about receiving care: Black adults and those with lower-incomes were more likely to report missing or delaying care due to worry about exposure and infection by the virus.[89]

In addition to the need for greater understanding of the reasons for and the health impacts of missed or delayed care during the pandemic, the task force also recognized the need for ongoing research into the financial impacts, for both individuals and for the overall health care ecosystem. A greater understanding of the ways in which missed and delayed care may have impacted the short- and long-term financial viability of health care providers, especially rural hospitals and small private providers, is crucial for policymakers and administrators.

ADDITIONAL CONTEXT

Providers across North Carolina report varying reasons for and potential impacts of missed or delayed care, including potential impacts on future rates and/or severity of serious illnesses such as cancer. At the 2020 North Carolina Institute of Medicine Annual Meeting, Dr. Emmanuel Zervos, surgical oncologist at Vidant Health, discussed the clinical impacts of missed care: A 71-year-old African American woman was diagnosed with breast cancer just before the pandemic began. Her care team initiated chemotherapy and planned a curative surgery to remove a large tumor. But a month after the pandemic began, the patient started to experience obstacles to receiving her care. She was afraid of contracting COVID-19 at the hospital and was unable to bring her support person with her to appointments. Zervos remembered, "This has played out over and over again in our service line. We won't know the impact for quite some time, but we know there will be a detrimental effect on outcomes for what is considered routine cancer care."

Dr. Zervos also reported an abrupt decrease in cancer screenings at Vidant in April 2020, and while screening returned to normal levels, nearly 4,500 patients missed being checked for cancer at Vidant in the meantime.[89]

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