COMMUNITY-BASED HEALTH COVERAGE PROGRAMS:
Models and Lessons

A Series of Community Voices Publications

FEBRUARY 2004

BY

Sharon Silow-Carroll • Tanya Alteras • Heather Sacks

The Economic and Social Research Institute

Community Voices
HEALTHCARE FOR THE UNDERSERVED

www.communityvoices.org

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With eight communities across the nation, Community Voices, a program of the National Center for Primary Care at the Morehouse School of Medicine (www.msm.edu/ncpc), is targeted at ensuring the survival of the safety-net providers and strengthening community support services. For more information on Community Voices publications, please visit www.communityvoices.org.

Community Voices

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OVERVIEW

The number of people in the United States without health insurance for the entire year was 43.6 million in 2002, an increase of 2.4 million, or 5.8 percent since 2001, according to the U.S. Census Bureau. Most of the increase is due to a decline in employer-sponsored health coverage.[1] Factors contributing to this decline include a loss of jobs and job-based health coverage as a result of the economic slowdown; fewer (mostly very small) firms offering coverage because of double-digit premium growth; and workers rejecting employer-sponsored coverage because more of the rapidly rising costs are being shifted to them.

The consequences of the decline in employer-based coverage are exacerbated by the fact that unlike prior years, government health insurance programs have been largely unable to pick up the slack. Growth in government programs slowed, reflecting only a small increase in Medicaid enrollment.[2] As a result of declining tax revenues, states are finding it increasingly difficult to expand or even sustain current program levels. And the situation appears to be worsening. A national survey of the states indicated that 25 states planned to reduce Medicaid benefits, and 27 states planned to cut Medicaid eligibility in FY 2003.[3] These developments have put tremendous strain on the safety net delivery system, threatening its ability to continue serving uninsured and underinsured populations.

With no major national policy intervention to expand insurance coverage and strengthen the safety net on the short-term horizon, the ability of *communities* to address this growing crisis is critical. Some communities around the country are developing workable models of coverage that combine access to a set of health services with effective care management and outreach to vulnerable populations.

Community models are by no means a panacea or a substitute for state or national reform. But they can help make preventive and primary care services available to low-income people, improve health outcomes and thereby reduce costs in the long run, as well as restructure and shore up the delivery system. In addition, communities can test various models that, if successful, could be replicated in other communities and/or expanded to broader areas or to the state level. That is, they not only serve to improve access to essential health services *until* more broad-based coverage initiatives are implemented, but they also serve as the *testing ground* for that broad-based reform.

What follows are profiles of coverage programs that have some connection to the W.K. Kellogg Foundation's Community Voices (CV) Initiative. A few programs are the direct result of CV funding and planning. Other programs pre-existed the CV initiative, but benefited from the CV-inspired community collaboration and/or funding for specific activities, such as evaluations and care management development. One program, Access Health, was developed with support from the W.K. Kellogg Foundation prior to CV; its success helped inspire the creation of the CV initiative.

The programs described in this report are not the only community-based coverage programs in the U.S. — in fact, numerous programs have emerged around the country[4] — but this collection represents a range of up-to-date models. They vary in target population, benefit package, vehicle for coverage, size, cost, financing mechanism, lead agency, and stage of development. The following matrix summarizes the programs' key features.

Despite their diversity, the programs presented here have some commonalities. All of the models represent local collaborations of community-based organizations and safety net institutions that have joined forces to address serious community needs. All of them provide primary and preventive care and some care management services in an effort to expand access, improve health outcomes, and reduce long-term costs. And while they range from health plans awaiting implementation to "veteran" programs with years of experience, all of these

1 Employer-sponsored insurance fell from 62.6 percent of the population to 61.3 percent between 2001 and 2002. (*Health Insurance Coverage in the United States: 2002*, U.S. Census Bureau., September 2003, p. 1.)

2 The portion of the population covered by government health insurance programs increased from 25.3 percent to 25.7 percent. (Ibid.)

3 *State Budget Constraints: The Impact on Medicaid,* Kaiser Commission on Medicaid and the Uninsured, January 2003.

4 See, for example, *Community-Based Health Plans for the Uninsured: Expanding Access, Enhancing Dignity* (Silow-Carroll, et. al., Community Voices Publication, November 2001); *State and Local Initiatives to Enhance Health Coverage for the Working Insured* (Silow-Carroll, et. al., The Commonwealth Fund, October 2000); *Community Initiatives for the Uninsured: How Far Can Innovative Partnerships Take Us?* (Andrulis and Gusmano, New York Academy of Medicine, April 2000).

efforts are contributing to the policy debate by offering new models and valuable lessons with potentially broad applications to policymakers and community leaders.

An examination of the programs reveals the following themes and lessons:

- **One program will not cover all of the uninsured, and different strategies seem to be more successful for different populations.** Two general groups can benefit from community-based programs: 1) **working uninsured,** and 2) **indigent, primarily unemployed persons.** Some programs examined – Access Health, E-CAP, FirstPlan, Group Care, Turtle Trust, and HealthGap – target working uninsured people who are self-employed or working in businesses that do not provide health benefits. The intent is to offer affordable health benefits *through the workplace,* similar in varying degrees to private commercial insurance plans. Program planners have learned that working people tend to prefer mainstream-type coverage, and that subsidies can effectively leverage employer and employee contributions. These programs contrast with the "direct service" model (Family Care, Ingham Health Plan, Partners in Health Network, Primary Care Plan, and UNM Care Plan), which targets very low-income individuals, who are often unemployed. This population tends to have different medical and social needs, and can particularly benefit from case management, chronic care, and health promotion services.
- **Culture, values, and needs must be taken into account when designing programs.** Among the working uninsured, and among the indigent population, there are different needs and circumstances that must be taken into account when designing the structure, benefits, and outreach strategies. After selecting the target population, program planners must learn — through surveys, interviews, and focus groups — about that group's members' culture and values concerning health care, their desire and ability to purchase coverage, and their needs and preferences regarding benefits. Small employers and self-employed, uninsured people in Northern Manhattan, for example, expressed a preference for higher copays over premiums; this was incorporated into the cost-sharing feature of HealthGap. Turtle Health Plan is based on an understanding of the culture and specific needs of the Native American population in California.
- **There are benefits to integrating financing with delivery of care.** The community-based coverage programs described in this report are not just financing mechanisms, but involve an integration of financing with the organization and delivery of services. Partners in Health, for example, has built a network of health care providers, and trains providers in the use of evidence-based standards of care. Local initiatives' success with such "organized systems of care" could be useful as models for how to optimize coverage by delivering high-quality care cost-effectively.
- **Local initiatives can best ensure a "medical home."** Most of the coverage programs described here require enrollees to select a primary care provider or site as their "medical home." Care is then managed in a way that encourages utilization of primary and preventive care and reduces inappropriate use of emergency departments and duplication of services. The UNM Care Program, for example, has documented declines in hospital days, specialty care visits, and ER use. In addition, concentrating care management resources on people with chronic conditions who are identified as high-risk or high-cost users is particularly promising for managing costs; testing this strategy at a local level can pave the way for extending its use more broadly.
- **Sustainable financing is an ongoing challenge; communities must tap multiple sources and be creative.** The programs described in this report use a range and mix of financing mechanisms: county taxes, private foundation grants, enrollee premiums and copayments, employer contributions, tobacco settlement funds, federal matching DSH funds (see box, below), county-based social service funds, local hospital contributions (through charity care or actual funding), state funds, and in-kind (or discounts on) services by providers. In addition, the Turtle Health Plan includes a Medicaid/SCHIP component designed to increase enrollment in these state programs, which would free up Indian Health Service dollars to potentially expand the reach of the safety net for tribal communities. Many of these financing sources are temporary or vulnerable to fluctuation, however, making it difficult for the programs to remain secure over the long term. Waiting lists — indicating that more people could be served if greater funding were obtained — are not uncommon.

Disproportionate Share Hospital (DSH) Payments

The Omnibus Budget Reconciliation Act of 1981 created the DSH program to compensate hospitals for the added costs of serving a disproportionate share of low-income uninsured and Medicaid patients. When a state makes such a payment, the federal government reimburses the state a portion of that amount, according to the state's Medicaid matching rate.

Although federal limits and rules apply, states have flexibility in designing their DSH programs, leading to much variation in the amount and distribution of DSH payments. A few states have used creative approaches that allow the use of DSH funds to support community-based coverage initiatives. In Michigan, for example, DSH payments help finance county indigent medical programs including the Ingham Health Plan and Access Health described in this report. In Ingham County, special DSH provider payments are made to the two local hospitals; the hospitals then relinquish the special payments to Ingham Health Plan (IHP) Corporation to fund IHP services for uninsured and former State Medical Plan enrollees. In Muskegon County, community contributions to the Access Health coverage program comprise federal DSH funds that match local dollars collected through grants and employer contributions.

- **State rules and legislation can facilitate community reform.** States can support local coverage initiatives even without providing actual dollars. West Virginia legislation, for example, allows local Community Access Program (CAP) grantees (Partners in Health Network) to develop pilot coverage programs that do not bear risk and are not subject to insurance rules and regulations. Michigan has allowed communities to use local funds to pull in matching federal DSH funds (Access Health, Ingham Health Plan). Dialogue between community collaboratives and state agencies and legislators is important to identify additional ways the state can encourage and support local programs.
- **Coverage initiatives can emerge from a wide range of institutions.** The initiatives described here have been developed and sponsored by many different types of organizations, including private managed care organizations, county health departments, safety net health systems, and universities. This illustrates that any one of a multitude of community entities can be a catalyst for change.
- **Collaboration, with each participant bringing its strengths, is critical.** Regardless of the sponsoring entity, collaboration is essential to develop, implement, and sustain coverage programs for the uninsured. Success appears to be based on the sharing of the burden and responsibility among enrollees, hospitals and other providers (particularly safety net systems), county health departments, and depending upon the model, employers, insurers, and occasionally universities. The contribution of each depends upon that entity's strengths and abilities. Some may be tapped for financing, others for political connections, and still others for outreach or educational functions. Alameda County's Family Care, for example, benefited from the trust that immigrants had in community health centers and used outreach systems that were already in place.
- **Success is fostered by strong leadership and a variety of organizational "capacities."** An evaluation of Community Voices efforts found that certain skill sets were most critical for achieving health access goals, including coverage programs at some sites. These "capacities," which are interrelated, include: strong and effective leadership, management skills for operationalizing vision and deploying resources effectively, establishment of relationships with community stakeholders (consumers, institutions), an effective communication strategy, and ability to leverage additional resources.[5]
- **Long-held beliefs may be disproved.** West Virginia's Partners in Health Network experience has proven that evidence-based care and care management can be

5 *Community Voices: Healthcare for the Underserved, National Evaluation*. Prepared by Abt Associates, Inc for the W.K. Kellogg Foundation, August 2003.

organized and delivered even in rural areas. The key has been the establishment of a support/resource center that provides education, technical assistance, data systems, and information about standards of care. Alameda County's Family Care has shown that we can reach, enroll, and change health-seeking patterns among immigrants by using trusted community-based health centers and culturally competent and linguistically accessible providers — disproving claims that immigrants do not understand health coverage and will not enroll in coverage products.

- **There is no "one size fits all" model.** Many of the programs' experiences indicate the need to balance adherence to objectives with flexibility to customize to the local situation. While strategies and tools that are successful in one setting can provide a good general model for other communities, it is important to obtain input from and participation of local stakeholders, such as consumers, providers, insurers, businesses, etc. This process is valuable not only for establishing a coverage program that best meets local needs; it also establishes new relationships that will continue to bear fruit in many ways (additional joint initiatives, aggregation of political influence, leveraging of new funding, etc.).
- **Limited funding means tough trade-offs.** All of the program planners had to address the trade-off of depth versus breadth of coverage, with different results. Family Care and UNM Care Plan offer comprehensive coverage similar to the Medicaid package, which makes coverage comparable and seamless across family members enrolled in different programs. But financial constraints have led most of the communities to place greater limits on services. Some designed plans to be comparable to commercial insurance (e.g., FirstPlan, Access Health), particularly for employer groups. Others have gone further to limit services to more basic primary and preventive care, case management, and some specialty services (e.g., Ingham Health Plan, HealthGap). The latter approach is based on decisions to maximize the number of beneficiaries, and to offer services that are otherwise not accessible to uninsured people and that could make a difference in long-term patterns and cost (primary care and care management), versus inpatient care that may be already "available" as charity care or through other public programs.
- **Programs face challenges securing specialist participation.** Partners in Health Network, Primary Care Plan, and Ingham Health Plan are among those that have had ongoing difficulties securing participation from specialists – due to limited reimbursement rates. Turtle Health Plan hopes to avoid this problem by paying rates above Medicaid reimbursement rates, though many coverage plans do not have this ability.
- **Coverage programs can benefit more than the uninsured.** Successful coverage programs can have many "winners" besides the enrollees who gain access to needed health services. Access Health employers report reduced turnover and a healthier workforce. Physicians and hospitals generally receive some reimbursement for previously uncompensated care. Safety net institutions may see less inappropriate (and largely uncompensated) emergency department utilization. When state and/or federal dollars contribute (Primary Care Plan, Group Care, Family Care, Ingham Health Plan, Access Health), this benefits the entire community by bringing additional resources to the area. Finally, people who are eligible but not enrolled in Medicaid and SCHIP are often identified through outreach for the new coverage plan and get assistance in applying for these state/federal programs.

Additional contributions and lessons from specific programs are included in the profiles that follow. Clearly, obstacles and challenges remain. But in a growing number of communities there is strong evidence that commitment, leadership, collaboration, networks, and tools are coming together and making a difference in improving health care for local, vulnerable populations. With proper support and sustained financing from state and/or federal sources, these models could flourish and provide the blueprints for broader reform.

Health Coverage Initiative Summary Matrix

Program Name	Structure & Administration	Target Population, Eligibility & Enrollment	Scope of Services	Financing
Access Health Muskegon County, MI	Subsidized coverage program for working, uninsured individuals in small to mid-size businesses. The model is a "three-way shared buy-in" where employers, employees, and the community each cover a portion of the cost	Small and mid-size businesses that have not provided health insurance in the past 12 months and median wage of workers is $11.50 per hour or less 1,500 enrollees in 400 businesses in 2003	Physician services, inpatient and outpatient hospital services, emergency and ambulance services, prescription drugs (on formulary), diagnostic labs/x-rays, and home health and hospice care	30% of cost is employer ($46/ month); 30% of cost is employee ($46/ month); and 40% of costs are from the community; Special DSH funding;$5 copayment for PCP visit and generic prescriptions (50% copayment for non-formulary drugs);$20 copayment for specialist visit
Alliance Family Care Alameda County, CA	A comprehensive health coverage program for low-income families in which one or more members qualify for Medicaid or SCHIP, but others are uninsured. Enrollees choose a community health center as a primary care provider, which manages care delivery. Administered by the Alameda Alliance for Health, a non-profit health plan.	Uninsured families, including undocumented immigrants, up to 300% of the FPL. Relatives of Medicaid and SCHIP enrollees are particularly targeted. 7,300+ enrollees in 2003	Comprehensive benefit package similar to Medicaid. In addition to primary and preventive care, package offers dental, mental health, and Rx coverage. Monthly premiums but no point-of-service copayments for primary care or hospital care.	$15 million from Alameda Alliance reserve fund $3 million from tobacco tax settlement $1 million from California Health Care Foundation $400,000 from California Endowment CV support for enrollee survey and staff time
Alliance Group Care Alameda County, CA	A health plan specifically for unionized workers in the field of in-home, social service delivery (IHSS). Provider network similar to that in Family Care above. Administered by the Alameda Alliance for Health.	IHSS workers who have operated in the county for at least 70 hours over the previous two months Approx. 2,200 enrollees in 2003	Primary and preventive care, inpatient and outpatient hospital, lab and x-ray, Rx, limited mental health and substance abuse services, acupuncture, chiropractic care, and other services. No vision services.	$1.5 million in tobacco settlement funds $5.5 million in state and federal matching dollars $8 monthly premium, and some point-of-service copayments

Health Coverage Initiative Summary Matrix

Program Name	Structure & Administration	Target Population, Eligibility & Enrollment	Scope of Services	Financing
First Plan Moore County, NC	Private insurance plan administered by managed care organization; offers reduced premiums to low-income workers in small businesses and premium incentives to employers who had not provided coverage	Uninsured small businesses with low-income workers Of 760 workers in 64 businesses enrolled, 61 members receive subsidies and 26 businesses receive premium discounts as of 1/04	Choice of typical commercial small group point-of-service products	Agreement by providers to accept lower rates, employer and employee contributions, additional subsidies by FirstHealth and outside funders
HealthGap Northern Manhattan, NY	Model of an insurance program intended to address the lack of affordable health insurance for working adults and small businesses	Adults between the ages of 19-64 with incomes up to 250% the FPL; did not cancel or decline employment-based coverage in the past 12 months The goal is to enroll 3,500 people by the end of the third year	Physician services, labs/x-rays, outpatient mental health and substance abuse, home health care, and pharmacy services	Copayments and government funding to subsidize premiums
Ingham Health Plan Ingham County, MI	Community-sponsored coverage program that places enrollees into a medical home or a regular source of care. Administered by the Ingham Health Plan Corporation at participating locations and by participating providers.	Uninsured residents in the county with incomes up to 250% the FPL; former enrollees in the State Medical Plan (SMP) who do not qualify for Medicaid 15,300 enrollees as of January 2003	Outpatient physician services, primary and specialty care, outpatient laboratory and radiology services, and prescription drugs; Former SMP enrollees also receive outpatient hospital services, emergency services, and durable medical supplies	Special DSH payments that combine local government health care funds from county tax revenues, state funds designated for SMP enrollees, and federal Medicaid DSH matching funds $5 copayment for primary care, x-rays, and generic drugs $10 copayment for specialty care and brand name drugs

Health Coverage Initiative Summary Matrix

Program Name	Structure & Administration	Target Population, Eligibility & Enrollment	Scope of Services	Financing
Partners in Health Network WV	Nonprofit rural health network serving patients in south-central WV	Uninsured residents with incomes under 200% of the FPL 4,000 enrollees as of September 2003	Enrollees receive access to discounted or free primary care and hospital inpatient and outpatient care; those identified with chronic or complex health problems receive care/disease management	CAP grant funding, care management component developed with CV support
E-CAP Partners in Health, WV	Pilot health coverage assistance program for uninsured employees of small businesses; provides low-cost, prepaid defined health benefits by a limited number of health care providers	Employed at least 16 hours per week with an employer that has entered into agreement with Partners in Health; family income below 185% the FPL; between 19 and 64 years of age; and not covered by health insurance for at least six months There is a cap of 500 enrollees	Primary care, preventive care, case management, most hospital outpatient and inpatient services, and limited specialty care	Employers and/or enrollees pre-pay $49 per member per month; $5 co-payment per provider visit $100 per inpatient admission $25 per emergency department visit
Primary Care Plan El Paso County, TX	Coverage program that provides a medical home for residents in the community through preventive and primary care. Administered by the El Paso First Health Network	Adults over age 19 with incomes below 100% of the FPL who are residents of El Paso County and not eligible for other publicly supported health programs There is a cap of 7,000 enrollees	Outpatient primary and preventive care, labs/x-rays, limited in-network specialty care, case management, emergency room services, immunizations, prenatal and gynecological care, and prescription drugs	The El Paso County Hospital District contributes $2 million per year which includes DSH funding; $5 co-payments per office visit

Health Coverage Initiative Summary Matrix

Program Name	Structure & Administration	Target Population, Eligibility & Enrollment	Scope of Services	Financing
Turtle Health Plan Sacramento, CA	A Medicaid and SCHIP managed care organization for individuals receiving safety net care at Indian Health Service clinics across California. The genesis of the plan is the California Rural Indian Health Board CRIHB).	Medicaid and SCHIP eligible individuals who choose Turtle Health Plan as their Medicaid managed care provider. Enrollment expected to begin in July, 2004; expected enrollment between 20-30,000	California's Medi-Cal and Healthy Families benefit package and cost-sharing.	Medicaid and Healthy Families provider reimbursement mechanism.
Turtle Trust Sacramento, CA	A group coverage product that will be marketed to employers of American Indian casinos and other organizations funded through the Indian-controlled primary care clinics. Administrated by the Turtle Health Plan.	Uninsured workers age 19-64 in companies or organizations eligible to participate in the program. Expected enrollment of 30-35,000	Two benefit packages—standard and luxury – will both provide comprehensive primary care, Rx benefits, hospital care, and specialty care. The luxury package will have a lower deductible and higher premium than the standard package. Point-of-service copayments will vary between the two packages.	Funding is currently not secured. The plan hopes to pull together a combination of private and public funders to raise at least $500,000 so it can begin enrolling individuals in 2004.
UNM Care Program Bernalillo County, NM	A managed care and case management program for the high-utilizing indigent population in Bernalillo County. Administered by the University of New Mexico in conjunction with local Federally Qualified Health Centers (FQHC) network and the county.	Uninsured residents of Bernalillo county with income up to 235% of the FPL. Undocumented residents are not eligible. 15,000 enrollees as of September 2003	Medicaid look-alike package including physician services, inpatient and outpatient hospital care, laboratory and x-ray services, limited dental care, and discounted pharmaceuticals. Behavioral health is not covered, but may be received at participating clinics.	All funding is provided through the county's indigent care fund, with in-kind services provided by providers participating through the First Choice FQHC network. CV funding supported for some policy work conducted on behalf of the program.

ACCESS HEALTH
Muskegon Community Health Project
MUSKEGON COUNTY, MICHIGAN

OVERVIEW
Access Health is a county-wide, subsidized coverage program for working uninsured individuals in small to mid-size businesses. It was developed by the not-for-profit Muskegon Community Health Project (MCHP) through a grant from the Kellogg Foundation's Comprehensive Community Health Models initiative. The model is a "three-way shared buy-in" in which employers, employees, and the community each covers a portion of the cost. Access Health enrollment began in September 1999 and has proven to be sustainable. In 2003 it is serving approximately 1,500 people in 400 businesses.

VALUE AND CONTRIBUTION
Access Health was never meant to cover all of the uninsured in the county. It was acknowledged that there are different groups of uninsured, with different needs and different financial circumstances. Access Health targets those businesses and individuals with a desire for health coverage and some ability to contribute toward that coverage.

Access Health has demonstrated that a coverage product benefits not only newly covered individuals, but also other community members including employers, health care providers and the local safety net. At full enrollment, it is projected that Access Health will generate $5 million in new financing for county providers. It takes some of the burden off safety net providers, making room for people who really need such "free" care. Participating employers report that they are experiencing lower turnover and a healthier workforce.

The three way share model has been replicated in other communities around the country, and may be expanded to counties around Muskegon. But the program's director stresses that community-based health is not a "plug and play business." While the general model can be the starting point, a coverage program must reflect the values of the community, and its development must involve participation by local providers, businesses, and consumers. In fact, the planning process for Access Health has established new relationships and partnerships among the community stakeholders.

TARGET POPULATION AND ELIGIBILITY
Access Health targets small to mid-sized businesses who cannot afford commercial insurance. It can accommodate 3,000 full- or part-time working individuals. Dependent coverage is available, although families are encouraged to enroll eligible children in Medicaid or SCHIP. The following firms are eligible:

- Small to medium-sized businesses, defined as having up to 150 "eligible" workers (eligible employees are full- or part-time workers who are not seasonal, temporary, or covered by other insurance);
- The business has not provided health insurance for the past 12 months; and
- The median wage of eligible employees is $11.50 per hour or less.

OUTREACH AND ENROLLMENT
During development, Access Health used marketing consultants to conduct consumer research, develop community support, utilize free media, develop a marketing plan, and launch the project. A professional sales staff person sells the product to eligible businesses. Recently, MCHP has made an agreement with insurance brokers to market Access Health to eligible firms. The brokers agreed to forgo a commission, but they would try to get the employer to "upgrade" to commercial coverage after a year. The assumption is that after employers "get used to signing the checks," some would be more likely to purchase commercial insurance. (Some have already made this transition.) That is, Access Health can be a step in the process of shifting employers from no health coverage to private health insurance.

COVERED SERVICES
Access Health covers physician services, inpatient and outpatient hospital services, emergency services, ambulance services, prescription drugs (formulary), diagnostic lab and x-ray, home health, and hospice care. There are no pre-existing condition exclusions. With 97% of providers in the county participating in the program, members enter mainstream health care.

Copayments are required for most services, and are designed to encourage primary and preventive care. For example, a primary care physician (PCP) office visit requires a $5 copay, and a specialist visit requires a $20 copay. Generic prescriptions (formulary) require a $5

copay; for prescriptions not on the formulary, members must pay 50 percent of the cost.

It was important to local providers and consumers that Access Health offer a comprehensive set of benefits. Physicians wanted the ability to refer patients for specialty and inpatient care when necessary, without putting patients at risk for personal debt or bankruptcy. Also, the community wanted to reduce the level and cost of uncompensated care, which is generally shifted onto privately insured small groups.

Management of Care

New members are required to designate a PCP and to obtain a physical examination during the first six months of coverage. Despite the added cost of the exams, it was deemed important to identify risk factors and chronic diseases so that management of these conditions could begin as early as possible.

Also, MCHP is developing software to enable its own case managers to identify heavy users of the health care system. They will be able to communicate with participating providers in "real time," helping to address problems and coordinate services such as diabetes management, smoking cessation, and weight management.

Financing

The three-way shared buy-in requires the employer to contribute 30 percent of the cost, the employee contributes 30 percent and a community pays the remaining 40 percent. Providers also contribute. Ninety-seven percent of county practitioners participate in Access Health; they receive Medicare rates plus 20 percent, but then donate 10 percent back to the program toward administrative expenses.

As of August 2003, the employee and employer cost is $46 per month for adult coverage. The community contribution comprises federal DSH funds that match local dollars collected through grants (e.g., the United Way) and the employer contribution. The program also receives a small amount of federal funding unrelated to DSH.

Each $1 in local funds pulls in $1.29 in federal DSH funds. The state of Michigan played an important role by allowing the DSH funds to be used in this way, and by permitting the program to function outside state insurance regulations (hence, Access Health is not an insurance plan, but rather a coverage program). The program has had to peg its growth to the availability of the DSH funds, though the state is trying to free up additional DSH dollars through a Medicaid waiver.

Contact for More Information

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Alliance Family Care and Group Care

Alameda Alliance for Health

ALAMEDA COUNTY, CALIFORNIA

Overview

The Alameda Alliance for Health (the Alliance), a not-for-profit managed care plan in Alameda County, California, is the county's principal Medi-Cal (Medicaid) and Healthy Families (SCHIP) provider. In addition, the Alliance offers two coverage products for low-income, uninsured people in the county. **Alliance Family Care,** which has been in operation since July 1, 2000, is a subsidized Medi-Cal look-alike program providing coverage to uninsured families with income up to 300 percent of the FPL, regardless of immigration status. Alliance Family Care has just over 7,300 members in 2003. **Alliance Group Care** is a subsidized product targeting in-home supportive services (IHSS) workers. This program has just over 2,200 members in 2003. Funding for both products comes from a combination of public and private sources.

Value and Contribution

The main motivating factor behind the creation of Alliance Family Care program was the 167,000 uninsured, low-income families in Alameda County. The Alliance was aware of the disparities in access to health care in the county, as well as the problems facing immigrant families in which some members were eligible for publicly funded coverage while others were not. At the same time, the Alliance wanted to address the issue of the working uninsured and the pressures facing those who do not qualify for public assistance, yet could not afford private coverage. The Alliance and its local partners created a coverage program that helped fill these

gaps. Family Care coverage can be combined with publicly funded programs, and covers entire families with a seamless system of enrollment. It harnesses the strength of the local health care safety net system through an affordable, family-centered, comprehensive health plan with a network that includes those providers.

Initial expectations were that the Alliance would enroll 2000 members over five years. Instead, they reached their current membership after only 3 years. These high and rapid enrollment rates disprove claims that immigrants do not understand health coverage and will not enroll in coverage products. Rather, Alameda County has found that if you offer an affordable, comprehensive product and combine it with access to care at community-based centers with culturally competent and linguistically accessible providers, immigrants will enroll. Alliance Family Care provider sites Asian Health Services and La Clínica have gained the trust of the community and are the health care sites of choice by many program enrollees. Concerns do still exist among undocumented immigrants that they may face public charge penalties, but the Alliance and their local partners are working with outreach workers and health care staff to educate these individuals that they can obtain coverage without public charge concerns.

The program has had an impact on the use of preventive care. An evaluation of Alliance Family Care conducted by the University of Michigan found that Alliance Family Care enrollees used a higher number of preventive services once they were enrolled than prior to enrollment. In addition, 2003 HEDIS results showed high child immunization rates for Family Care enrollees and high screening rates for diabetics.

Covering IHSS workers through Alliance Group Care has value beyond providing critical coverage to an uninsured, working population. It supports a model of cost-effective home-based/community care vs. institutional care by helping ensure a healthier workforce and helping to attract and retain skilled and dedicated workers.

Alliance Family Care

Target Population and Eligibility

Alliance Family Care targets uninsured family members with children who are enrolled through the Alliance in either Medi-Cal, Healthy Families, or Alliance Family Care, and who do not qualify for other public health programs. To be eligible, a family must have an annual income no greater than 300 percent of the FPL, live within Alameda County, and enroll all children in their household in whichever of the three above-mentioned programs for which they are eligible. When designing the program, the Alliance found that over half of the uninsured immigrants in the county have at least one family member who is an undocumented immigrant. This understanding of the mixed immigration status that is common among immigrant families led to the decision to not make immigration status a qualifying factor for coverage.

Outreach and Enrollment

As of July 1, 2003, just over 7,300 individuals were enrolled in Alliance Family Care and 2,500 family members were on a waiting list. As noted above, early enrollment was higher than estimated, which justified the Alliance's decision not to implement a formal outreach strategy. Rather, as part of a long-standing, county-wide enrollment program, community clinics and community-based organizations conducted most of the enrollment. Asian Health Services and La Clínica, in particular, coordinated outreach efforts. At Asian Health Services, four community health workers who speak Cantonese, Mandarin, Vietnamese, and Korean conducted outreach in the Asian community. They made presentations on health care coverage options and public charge issues at nail salons, sewing factories, churches, etc. La Clínica hired a Spanish-speaking enrollment specialist to enroll individuals. The county also included Alliance Family Care in several successful enrollment events and initiatives.

In terms of retention, there has been a consistent re-enrollment rate of over 97 percent annually. Enrollment is currently capped and will remain so until the Alliance can tap into an increased and sustainable funding stream. It was hoped that the state's Health Insurance Flexibility and Accountability (HIFA) waiver, which would cover parents in SCHIP, would provide funding for Alliance Family Care, but implementation of the waiver has been postponed until at least 2006. However, it is hoped that other initiatives are enacted that will help provide more stable funding. These include AB1524, which will allow counties to use local dollars to match unused federal SCHIP funds to expand

coverage to parents, and California's First Five Commission's Health Access for All Children, which will provide premium payments for children age 0-5 who do not qualify for public programs.

Covered Services
Alliance Family Care offers coverage for a comprehensive set of health care services that specifically was designed to mirror the Medi-Cal and Healthy Families benefit packages. This enables the families to have a "seamless" health care experience whereby all family members can access similar benefits (including vision and dental), use the same providers, and get care in the same locations. In addition, if a family member becomes ineligible for Medi-Cal, there is an easy transition to Alliance Family Care. Such seamless coverage is particularly important since the Alliance currently has the highest Medi-Cal enrollment in the county (Blue Cross is the only other provider).

Families are responsible for a monthly premium, which varies according to age. Children age 18 or younger (or up to age 23 if a full-time student) pay $10 per month, while adults between 19 and 64 pay between $23 and $120 per month. There are no copayments for primary and preventive care services, nor for hospital-based services. Physician visits, pharmaceuticals, and emergency department visits do require nominal copayments.

Management of Care
Alliance Family Care enrollees choose a primary care provider located at one of the participating care sites. Specialty care is covered but, as is typical in the safety net system, is often difficult to access.

Financing
Through a combination of private and public funds, the Alliance is able to highly subsidize care for Alliance Family Care enrollees, thereby keeping cost-sharing at an affordable level. The bulk of the funding comes from the Alliance itself, which provides almost $15 million out of its reserve funds. Grants from the California Healthcare Foundation ($1 million), The California Endowment ($400,000) and the county tobacco settlement fund ($2 million) provide the balance of funding. Another $950,000 is pending. The Alliance used funding from the W.K. Kellogg Foundation's Community Voices Initiative to support a Family Care evaluation. Finally, a county-wide enrollee satisfaction survey was conducted, for which the Community Voices grant provided $50,000 and in-kind staff time for management and oversight.

Alliance Group Care

Target Population and Eligibility
Alliance Group Care was created to provide coverage to the county's approximately 7,000 IHSS workers, who generally do not have access to employment-based insurance. There is no income eligibility requirement, but enrollees must work in Alameda County as an IHSS home care worker for the prior two months, be authorized to work a total of 70 hours or more during those two months, and continue to be authorized to work at least 35 hours per month thereafter. Alliance Group Care does not provide dependent coverage.

Outreach and Enrollment
As of July 1, 2003, enrollment in Alliance Group Care was just over 2,200 individuals. Outreach activities are conducted via the IHSS union in collaboration with the Alliance and the Public Authority, the employer of record. All three entities were involved in developing the product, designing the outreach strategies, such as direct mailers and union meeting presentations, and evaluating the program. Initially, all three entities assumed that English and, to a lesser degree, Spanish were spoken by most of the workers. However, through this process, they realized that there were significant numbers of Cantonese and Mandarin speaking workers. To assist them with outreach and evaluation, the union hired a part-time Chinese community liaison.

Covered Services
The Alliance Group Care benefit package includes preventive care, physician services, hospital inpatient and outpatient care, laboratory and x-ray services, emergency room care, pharmaceuticals, and limited mental health, substance abuse, acupuncture, chiropractic care and other services. Dental care was added as a benefit and negotiations for vision care are underway. Enrollees are responsible for an $8 per month premium. Physician services, preventive care visits, and some

pharmaceuticals[6] do not require a copayment, while hospital, ER, brand name and generic drugs, and some other services require a $5 point-of-service copayment.

Management of Care
As with Alliance Family Care, Alliance Group Care enrollees choose a primary care provider located at one of the participating care sites. Again, specialty care is covered but often difficult to access.

Financing
For its Group Care program, the Alliance secured a combined total of $1.5 million annually from the tobacco settlement funds as well as county-based social service agency dollars. This money was then used to draw down $5.5 million in state and federal matching dollars through a variety of programs and intergovernmental transfers. The Alliance used funding from the W.K. Kellogg Foundation's Community Voices Initiative to support a Group Care evaluation.

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FIRSTPLAN
FirstHealth of the Carolinas
MOORE COUNTY, NORTH CAROLINA

OVERVIEW
FirstPlan is a new group of health care coverage products for small businesses available through FirstCarolinaCare, Inc., a subsidiary of FirstHealth of the Carolinas, a not-for-profit health system in the rural mid-Carolinas. Under the new program, FirstCarolinaCare health benefit plans are offered to small businesses, with subsidies available from FirstHealth and other outside sources to low-income workers, and premium discounts available if employers meet certain criteria.

The program was launched in September/October 2002, and as of January 1, 2004, 61 members receive premium subsidies, and 26 businesses receive premium discounts in the form of "CareCredits." Nearly 800 workers (majority not subsidized) in 64 businesses are enrolled in FirstPlan products; including dependents, there are more than 1,100 covered individuals, more than 200 of whom were previously uninsured.

VALUE AND CONTRIBUTION
As insurance carriers are exiting the small group market, the FirstPlan products are particularly valuable. To the extent FirstPlan continues to enroll previously uninsured individuals, it has the potential to reduce the inappropriate use of emergency rooms at the hospitals, reduce uncompensated care among local physicians and clinics, and improve patterns of care. Also, it may help reduce dependency on entitlement programs.

FirstPlan is based on the principle of shared contribution among employers, employees, and health care providers, so that no one group bears the entire financial burden. Unlike the "3-share model" seen in Muskegon County, MI, and other communities, FirstPlan is unique in that it is sponsored by a local health delivery system, provides subsidies only when deemed necessary, and uses an actual insurance vehicle, obligated to meet all state insurance requirements.

FirstPlan is an effort to enroll and mainstream the working uninsured, maintaining dignity by providing benefits and administration that is the same for all small groups. The plan emphasizes disease management for high-risk enrollees, and has an educational component that teaches new enrollees how to access the system. The providers view the program as beneficial because previously unreimbursed care will be covered by insurance. Also, uninsured people who had stayed away from the health care system will now be encouraged to become regular users and address their medical needs in appropriate ways.

The program will be monitored closely to track feasibility, sustainability, and potential for replication in other communities. Program administrators stress that the model can be replicated only if shared responsibility and participation is secured from an insurer, hospitals, and providers in a region. If it succeeds, FirstPlan will provide a powerful lesson that a private insurance plan targeted to small businesses can offer affordable coverage to many low-income persons and still remain financially viable

6 Prescriptions administered in an inpatient setting, a doctor's office, or an outpatient facility, as well as contraceptive drugs and devices.

Target Population and Eligibility

The program targets small businesses (50 employees or fewer); initially those that were previously uninsured. Premiums may be subsidized for workers earning $9/hour or less, if the business has 100 percent employee participation and the employer contributes at least 50 percent of the premium. The amount of the subsidy is based on the employer's perception of the employee's ability to pay; with the employee contributing around $50 per month for employee-only coverage, the subsidy amount makes up the difference of the full premium. Also, FirstPlan premiums for a business may be reduced up to 20 percent as allowed by North Carolina Department of Insurance statutes through "CareCredits." All insurers in the state have the flexibility to set rates for a group 20 percent higher or lower than their filed rates (often to attract low risk groups), if they provide justification for doing so. FirstCarolinaCare uses this flexibility to structure FirstPlan differently, to attract the groups with uninsured employees. A firm that had not offered coverage before, for example, could get a 5 percent premium reduction. FirstPlan's CareCredits are based on criteria related to: employer contribution rate for employees and dependents, participation level among workers; and coverage history. So far, reduced group premiums average 7 to 10 percent for 25 businesses.

FirstCarolinaCare plans to enroll 500 previously uninsured members annually, and can subsidize up to 1,000 low-wage workers.

Outreach and Enrollment

After implementing the program in one county, FirstPlan has expanded sales and secured provider participation in two additional counties. Initially, there was no advertising for this product, because the carrier wanted to focus on uninsured firms and grow the plan slowly. After the initial phase, however, local advertising began in September 2003.

Developing partnerships with the community is the key strategy for communications and marketing. A FirstCarolinaCare salesperson contacts businesses that, according to a previous survey, have not provided coverage and employ low-wage workers. She meets with the employer and workers, describes the product, and addresses the workers' questions and possible concerns. While the subsidy program does not exclude previously insured groups, FirstCarolinaCare preferred to target uninsured businesses first.

Covered Services

When designing FirstPlan, FirstCarolinaCare considered an HMO product with limited choice of providers, but analysis indicated it would bring only minor price savings compared with more flexible plans. Further, focus groups with several employers, employees and providers indicated that these groups did not want a watered down or "cheapened version" of commonly offered benefit plans. And mainstreaming a traditionally underserved population was one of the carrier's key priorities. As a result, FirstCarolinaCare decided to offer the same type of point of service plans offered to other businesses. Benefits include physician care, inpatient and outpatient hospital care, lab/x-ray, occupational therapy/physical therapy/chiropractic care, behavioral health, prescription drugs, and other services. A variety of copay and deductible options are available.

Management of Care

The care management component integrates utilization information with education, medical resources, and coordination to manage the longer-term needs of members. New enrollees are assessed through health risk appraisals and health screenings and those deemed high-risk for certain conditions are referred to the FirstCarolinaCare disease management program. The case manager develops care plans and arranges for additional services not available within the network. High-risk pregnancies and infants, for example, are referred to a case management services program under contract with FirstCarolinaCare.

The closely coordinated care management should result in improved outcomes and more efficient use of Plan resources. Further, FirstCarolinaCare nurses and case managers visit the businesses to discuss potential health problems and how to address them, and a telephone nurse helpline is available.

Financing

The subsidies are financed through FirstHealth and outside grants, including a one-year federal appropriation of $490,000. In addition, community physicians have agreed to accept reduced reimbursement (tied to Medicare 2001 rates) for subsidized patients. A concerted campaign by a

physician leader and FirstCarolinaCare staff has achieved near universal physician acceptance of this arrangement. The planning and development for FirstPlan was supported by a Community Voices grant from the W.K. Kellogg Foundation.

Contact for more Information

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HealthGap

NORTHERN MANHATTAN, NEW YORK

Overview

HealthGap is a model of an insurance program intended to address the lack of affordable health insurance for working adults and small businesses. The model was developed for the Northern Manhattan Community Voices Collaborative by Community Premier Plus, Inc. (CPP), a not-for-profit health plan serving low-income individuals in northern Manhattan. Planners hope to obtain state support to pilot test the program in designated neighborhoods of Northern Manhattan and perhaps, other regions of the state.

Value and Contribution

HealthGap has the potential to provide health care to the uninsured population who "fall between the cracks" of other coverage programs. In New York, for example, state-subsidized Healthy New York insurance products are less expensive than other private plans, but remain too expensive for many small businesses and self-employed individuals in Northern Manhattan. Family Health Plus, the state's Medicaid expansion program for adults, excludes the working poor who earn more than 150 percent of the FPL (for parents) or 100 percent of the FPL (for adults without dependent children).

HealthGap was designed after surveying small business owners, their employees, livery cab drivers, street vendors, and small business customers about their desire for and ability to purchase coverage, and their preferences for benefits. For example, the surveys found that the target population prefers higher copays to high premiums. The model was also shaped by a detailed assessment of the eligible population and from feedback from area hospitals, researchers, and other stakeholders.

The program will require ongoing subsidization of premiums from an outside source. Planners hope that New York State will continue its active role in pilot testing innovative coverage models by supporting a HealthGap demonstration. The knowledge gained would help inform other states and communities about the impact of specific cost-sharing features, benefit designs, and outreach and enrollment techniques on certain segments of the low-income, uninsured population.

Target Population and Eligibility

HealthGap would target uninsured owners and employees of small businesses (less than 50 workers), self-employed persons, their spouses, and possibly part-time or full-time workers who live in but do not work in the Northern Manhattan service area. They must meet the following criteria:

- Income up to 250 percent of the FPL;
- Screened and found ineligible for Medicaid/Family Health Plus;
- Did not cancel employment-based coverage over past twelve months or declined coverage; and
- Age 19-64.

HealthGap would aim to enroll up to 3,500 people by the end of its third year. Year-end projections are 1,200 members (year 1); 2,400 members (year 2); and 3,500 members (year 3).

Outreach and Enrollment

Experience with facilitated enrollment for Family Health Plus and Child Health Plus (New York State's SCHIP program) and community surveys indicate that HealthGap would require a focused marketing approach. Most local businesses such as retail stores, hair salons, and restaurants have little knowledge about health insurance and may require an intense outreach and education campaign. The self-employed, such as livery cab drivers, do access regular health care (such as checkups for work), but also have little experience with health insurance. Outreach and enrollment would take place through existing CPP programs, which include a large marketing staff, enrollment processing resources, and community-based marketing and educational strategies that have successfully built enrollment in other publicly funded programs.

Covered Services

HealthGap would offer a benefit package consisting of: physician services, labs/x-ray, outpatient mental health/substance abuse, home health care, and pharmacy services. In light of the broad acceptance in the community of paying *something* for care up front (as opposed to paying monthly premiums for "potential" benefits), there are copays; e.g., $15 for a primary care physician visit; $30 for a specialist visit; $50 for emergency room care; $150 for ambulatory surgery; $20 per generic prescription; and $40 per brand name pharmacy (with an annual maximum $2,500 pharmacy benefit with formulary restrictions).

Planners originally included inpatient care, but then removed it after hospitals asserted that existing arrangements to offset uncompensated inpatient care costs (payments from New York's bad debt and charity pools, DSH funds) are functioning adequately. These existing programs meet part of the need for financing inpatient services, but do little if anything to pay for the other services (especially preventive care) included in the HealthGap benefit package. The removal of inpatient benefits helped to significantly reduce the cost of HealthGap.

Management of Care

Copays are structured to encourage primary and preventive care. There are no copays, for example, for diabetic nurse education, glucose meters and supplies, immunizations, nutritionist services, and health education classes.

As a community health plan serving the local Medicaid and SCHIP population, CPP already has in place a number of mechanisms for managing care and promoting appropriate utilization of services, which it would extend to HealthGap. These include educating new members about benefits, identifying and contacting individuals who have not used the system, identifying high-risk members and employing intensive case management, targeting outreach to certain populations, and educating providers about member needs.

It is anticipated that providing access to uninsured people in the community would result in larger social benefits, such as enhanced productivity and job retention.

Financing

A number of design features would help keep the cost of HealthGap down:

- Provider risk-sharing (physicians receive capitated payments for enrollees);
- Intensive case management of serious conditions;
- Emphasis on preventive care and health education;
- Copays for many services;
- Staying in-network for most services; and
- Use of existing administrative infrastructure to reduce cost of recruitment, retention, and utilization management.

However, the model requires government funding to subsidize premiums, and program planners are considering ways to achieve this. Preferably, the subsidies would cover the full cost so that premiums would not be required of members. This would encourage enrollment and reduce the risk of adverse selection.

An average weighted premium is estimated at $130 per member per month. Using target enrollment projections, the estimated premium costs are: $1 million, $2.4 million, and $3.8 million for each of the first three years, respectively.

The design and development of the HealthGap model was supported through a Community Voices grant to Columbia University from the W.K. Kellogg Foundation

Contact for More Information

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Ingham Health Plan

Ingham Health Plan Corporation

INGHAM COUNTY, MICHIGAN

Overview

The Ingham Health Plan (IHP) is a coverage program that provides primary care, specialty care, outpatient lab, x-ray, and prescription drugs to low-income, uninsured county residents and former enrollees of the State Medical Plan (SMP)[7]. Implemented in 1998, IHP is gov-

7 The State Medical Plan is a state program for individuals with very low incomes who do not qualify for Medicaid. Many of these individuals have chronic health conditions, particularly mental health and substance abuse problems.

erned by the nine-member Ingham Health Plan Corporation (IHPC) Board of Directors. IHPC was created by the Ingham County Board of Commissioners and is a nonprofit organization that oversees the health plan.

Value and Contribution

Ingham County and the Ingham County Health Department have identified care of its uninsured population as a high priority, and the county is actively involved in IHP's implementation and operation. IHP enrollees are linked to a "medical home" where primary care is provided and specialty care is arranged.

The primary focus of IHP is on increasing access to primary care, specialty care, diagnostic services and prescription drugs. In addition to being assigned a primary provider, enrollees carry a membership card, obtain medicine from virtually any pharmacy in the county, and are referred for specialty care and diagnostic services. The program receives high marks from enrollees who say they are treated with dignity. A recent survey revealed that many enrollees do not consider themselves as being uninsured because they have access to care and medicine, similar to the insured population. The program can document the number of people who are receiving medicine for diabetes, hypertension, and depression – three common health problems of the insured and uninsured alike.

The role of Ingham County in the formation of the IHP demonstrates that county government can be a catalyst for expanding access in the community. The ongoing role of the Ingham County Health Department in the operation of the program and in supporting the IHPC Board of Directors demonstrates that a progressive health department can play a significant role in the operation of a health plan that is financed with county, state, and federal funds. The IHP financing and organizational model has been used in several other communities in Michigan to accomplish similar results and is attracting attention from other communities in other states.

IHP is starting its sixth year and continues to provide services to uninsured people at a low cost. While the cost of care for the former SMP population is considerably higher, this is due to differences in the population, in the drug benefit, and in other benefits between the two categories of enrollees. Michigan, like most other states, has experienced budget difficulties that have slowed the growth of the program and required some adjustments in its benefits.

In addition to IHP, the Corporation administers additional access programs, including a new insurance program designed to provide basic health coverage and inpatient care for workers in small businesses that do not offer health insurance. The program, called Ingham Advantage, is a fully insured program that will be subsidized by IHPC and Ingham County. The idea is that IHPC and Ingham County will contribute about $60 per member toward the monthly cost of the premium, with the employer and/or employer and employee contributing the remainder of the premium. The program was planned to begin in November, 2003.

Target Population and Eligibility

Enrollment in IHP is currently 14,500 members (12,500 uninsured and 2,000 former SMP enrollees). This represents roughly half of the estimated uninsured population in Ingham County. The current enrollment consists of county residents with incomes up to 250 percent of the FPL, along with former SMP eligible individuals (SMP eligibility is $265 per month). Due to budget constraints, the income eligibility standard for new enrollees is 150 percent of the FPL.

Outreach and Enrollment

Individuals are referred to IHP by outreach workers who work at neighborhood centers, by social service agencies, participating hospitals, or by word of mouth. Enrollment specialists assess each applicant to determine whether they are eligible for other coverage programs.

Covered Services

Both the uninsured residents and former SMP enrollees receive outpatient physician services, primary and specialty care, outpatient laboratory and radiology services, and prescription drugs. The former SMP enrollees also receive outpatient hospital services, emergency services and durable medical supplies. While inpatient hospital services are not covered, most IHP enrollees do receive hospital care because both hospitals have active and generous charity care programs. The IHPC also provides a small grant to each hospital based on their proportion of charity care provided to IHP enrollees. The uninsured residents have a $5 copayment for primary care, x-rays, and generic drugs. There is a $10 copayment for spe-

cialty care and brand name drugs. The program's prescription drug benefit uses a strict formulary of generic drugs with a few brand name alternatives in order to control costs of this expensive benefit.

While primary care has been accessible, specialist participation in IHP has been a challenge. Some enrollees must travel distances to receive certain specialty services (neurosurgery, orthopedics, ENT, and dermatology); also, these providers have discretion over which patients to accept.

Management of Care

Case managers work with enrollees and their families to discuss care needs, develop a care plan, select and coordinate access to specialty care, and assess eligibility for Medicaid and other public coverage programs. IHP currently contracts with 31 primary care sites. Virtually all pharmacies accept the IHP card.

In response to budgetary concerns, adjustments have been made in the management of care in order to contain costs. For example, in July 2003, the IHP implemented a more stringent policy for exceptions to the formulary on the SMP side of the program. A physician's office must call an IHP nurse to request an exception to use a medication that is now excluded from the formulary. The intent is to encourage doctors to provide lower cost alternatives when possible. Another adjustment has been to monitor and identify enrollees using multiple physicians, and encourage them to use their primary care provider as a care manager.

Financing

In addition to copayments charged to enrollees, the primary source of financing is provided through a special disproportionate share hospital (DSH) payment. The special financing mechanism combines local funds from county tax revenues, state funds designated for SMP enrollees, and federal Medicaid matching funds. The three sources total about $9 million in fiscal year 2003. The funds come to the community as a provider payment under DSH to the two local hospitals which relinquish 100 percent of the special payment to the IHPC. The IHPC then arranges for and pays for covered services.

The Ingham County Health Department contracts with the IHPC to coordinate primary care providers and administrative services to implement the program. The health department coordinates enrollment, provides case management, coordinates flow of data, and performs other functions that are related to operating a health plan. IHP is a component of the Community Voices initiative that is funded by the W.K. Kellogg Foundation.

Contact for More Information

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Partners in Health Network and E-CAP

Partners in Health Network, Inc and West Virginia Community Voices

WEST VIRGINIA

Overview

Partners in Health Network, Inc. (PIHN) is a nonprofit rural health network serving patients in 11 counties in south-central West Virginia. Through a HRSA Community Access Program (CAP) grant, PIHN provides 4,000 low-income, uninsured residents with access to free or discounted primary care and hospital inpatient and outpatient care. Members obtain an enrollment card and are assigned a primary care provider. Those identified with chronic or complex health problems receive care/disease management based on a model developed with Community Voices funding. PIHN serves primarily as a resource center that supports this care management of chronic diseases.

To serve PIHN's employed adult enrollees and help bring in a steady flow of revenue, PIHN has recently developed the **Employers-Community Access Program (E-CAP).** E-CAP is a pilot health coverage assistance program that is expected to begin in late 2003. It is a low-cost, prepaid program offering defined health benefits provided by a limited number of healthcare providers. The program's purpose is to help employed uninsured adults overcome financial barriers to health care access, and to promote reliable and efficient health care services through access to primary care and care management. It will enroll up to 500 residents in two West Virginia counties.

Value and Contribution

Although a formal evaluation is not yet complete, a number of lessons have already emerged from PIHN's experiences that can guide other communities planning cover-

age initiatives. PIHN has illustrated that even among small clinics in rural areas, it is possible and helpful to organize and deliver evidence-based care and care management for chronic conditions. A support/resource center can provide the tools, education, technical assistance, and data systems to establish and maintain such a program across a network of providers. Making these support services available does entail additional costs (which are being measured), although savings connected with improved health outcomes and reduced emergency room visits are likely in the long run.

PIHN has found that strategies that promote successful care management include: talking with providers about care management objectives and methods, and establishing standards of care; offering models for effective medical record-keeping and patient education materials; reviewing potential costs and revenue; and working together on work flow and delegation of staff to help meet care standards. PIHN also has found benefits in innovative care management strategies such as shared medical appointments and telemedicine (described further below). In general, the process requires adherence to the program's objectives but with a willingness to customize to a local situation.

The E-CAP program will serve as an important test of a model that leverages employer and employee contributions to support improved delivery and management of services that would otherwise be largely unmanaged and uncompensated. This experiment (and others in the state) was made possible through state legislation that allows communities to develop health plans without being bound by insurance department rules.

Partners in Health Network

Target Population and Eligibility

Individuals in 11 counties in south-central West Virginia who are uninsured with incomes under 200 percent of FPL are eligible for PIHN enrollment.

Outreach and Enrollment

As of September 2003, 4000 individuals have enrolled through seven federally qualified health centers, rural health clinics, and hospital emergency departments at the time they come in for services. Enrollment specialists (CHIP/Medicaid outreach workers) at the sites facilitate enrollment in PIHN and other publicly-funded health programs. In addition, brochures describing PIHN are available at various community organizations, though these have not played a major role in enrollment.

Covered Services

Enrollees receive a card that provides access to discounted or free primary care, care management (if deemed appropriate), and hospital inpatient and outpatient care by a nonprofit rural health network comprised of eight hospitals, eight primary care centers and one public health department. The discounts are based on a sliding scale tied to income, though most members have income below 100 percent FPL and receive the free care. Some specialists are participating and negotiations are proceeding to include more, though this has been difficult.

Management of Care

Nearly 50 percent of PIHN enrollees have at least one chronic condition that is addressed through care management. PIHN emphasizes enhanced care and case management for patients with asthma, diabetes, hypertension, and depression. Patients identified as high risk receive home visits to identify opportunities for improved care. PIHN has developed clinical measures and standards for certain chronic conditions, and provides training, a data base, tools, and problem-solving assistance on how the clinics can implement the standards in practice. The program reimburses primary care sites $3 per member per month for care management work, which may be performed by persons ranging from clerical staff (who track the patient) to nurse practitioners.

The program has designed creative strategies to efficiently provide education and medical services included in CAP standards of care. They include home visits by lay health educators, group medical visits, improved availability of computer patient registries, and patient tracking information that assists providers in meeting patient care standards. Education of patients in self-care management is an important component.

Supported by Community Voices funding, the New River Health Association has developed an advanced care management strategy for chronic conditions called "The Community Health Outreach Worker (CHOW) Project." CHOW targets PIHN patients with home visits and group interventions. Under the model, patients and their families are partners with the care manager in assessing needs and strengths; establishing goals;

obtaining services, treatments, and support; and preventing and managing crisis.

PIHN is testing "shared medical appointments," a cost-effective mechanism to deliver health care in a supportive group setting with patients sharing similar medical and psychosocial issues. These group visits have the potential to increase the quality of care, enhance the patient-physician relationship, reduce waiting lists, reduce physician phone call burden, and enable physicians to better manage patients with chronic diseases. PIHN is also evaluating telemedicine for specialized ophthalmology, which can reduce difficult travel requirements for patients in rural communities and could increase the number of diabetic patients receiving retinal exams.

Financing

The development, administration, and care management components of PIHN are financed by federal CAP grants; a two-year grant followed by a one-year extension. Administrators hope to secure funding from private or public sources to continue beyond 2004. A grant from the W.K. Kellogg Community Voices Initiative provided educational opportunities for medical professionals (physicians, nurse practitioners, physician assistants, and other medical professionals) within the PIHN system to learn the benefits of shared medical visits, and to learn how to conduct such group medical visits. Additionally W.K. Kellogg Community Voices Initiative, supported the development of the care management model that is being instituted in participating primary care sites. The actual health care services provided by the hospitals and clinics are not reimbursed through the program, but continue to be treated by providers as uncompensated care. Some are written off as charity care, covered by grant funds, or sponsored by a local hospital.

Employers-Community Access Program (E-CAP)

Target Population and Eligibility

E-CAP targets low-income, uninsured workers and their spouses (children are generally covered by the state's SCHIP program). Employees are eligible to enroll if they meet the following requirements:

- Employed at least 16 hours per week with an employer that has entered into a participation agreement with PIHN (also, employers may require a waiting period before employees are eligible to apply);
- Family income is below 185 percent of FPL;
- Have not been covered by health insurance for at least the previous six months or have involuntarily lost coverage within the previous six months; and
- Between 19 to 64 years old.

No more than a total 500 people may be enrolled in the program at one time.

Outreach and Enrollment

Initially, staff plan to approach employers of working beneficiaries of the PIHN CAP program and ask them to join E-CAP. In general, members will be enrolled through participating employers during an initial enrollment period and at annual enrollment periods thereafter (new employees may apply for enrollment upon completion of the waiting period). PIHN determines eligibility based on a completed application that includes demographic and financial information, a brief health history, medical information released to PIHN, an assurance of no health insurance coverage, and selection of a primary care provider. At the beginning of each year, participating employers will provide PIHN with a list of all enrolled employees, and inform PIHN of changes during the year.

Covered Services

Covered services are provided through the Partners' network of participating health service providers, and include comprehensive primary care and basic preventive care services, care management, most hospital outpatient and inpatient services offered by the participating hospitals, and only those specialist services offered by participating specialists (securing specialist participation has been a challenge). Although pharmaceuticals are not covered, many enrollees are eligible for free pharmaceuticals for chronic conditions through state pharmacy assistance programs. Copays include $5 per provider visit, $100 per inpatient admission, and $25 per emergency department visit for a verified emergency.

Management of Care

Enrollees select a primary care provider (PCP) among participating providers; the PCP takes responsibility for basic care management. E-CAP utilizes the enrollment, care management, and information/reporting systems

that have been developed for the PIHN CAP program, described above. Enrollees with chronic conditions (asthma, diabetes, depression, and hypertension) and other high-risk patients receive care management services to promote compliance with standards of care and to activate patient involvement with their own care.

Financing

This model relies on health care providers to deliver heavily discounted services – though they will receive some steady payments for previously uncompensated care. Under the E-CAP model, participating employers and/or enrollees pay a monthly prepayment fee of $49 for each enrollee (there is no required employer contribution), plus copayments at the time of service. Reimbursement to hospitals, primary care providers, and specialists are based on these payments.[8] Primary care and hospital providers receive a monthly capitation of $9 and $24 per member, respectively. Another $15 per member per month is allocated to specialty care (to be distributed using relative value units), and $1 for administration. Thus, the CAP grant dollars have helped to develop E-CAP and the resource center, but the services will be supported by employer/employee cost-sharing and discounted care from providers.

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Primary Care Plan

EL PASO COUNTY, TEXAS

Overview

The Primary Care Plan (PCP) is a coverage program that provides a medical home to low-income, uninsured residents of El Paso County. It is administered by the El Paso First Health Network (EPFHN). EPFHN also administers plans that serve Medicaid and SCHIP populations and is owned by the El Paso County Hospital District. Developed by a collaborative of safety net organizations with support from the W.K. Kellogg Foundation, PCP was recently (July 1, 2003) integrated into the El Paso County Hospital District and is now included in the Hospital District's overall budget where it will continue to remain a distinct program. The 7,000 enrollees in the program receive comprehensive benefits, with an emphasis on primary care and care management.

Value and Contribution

El Paso County, Texas, faces many challenges: it is a border community; approximately 40 percent of the county's adult population (ages 19-64) lacks health insurance;[9] there is a large population of undocumented individuals; there is a shortage of health care providers; and it has a low tax base. Instead of competing for very limited resources, community and federally qualified health centers, the city/county health department, the non-profit teaching hospital (Thomason Hospital), and other safety net providers formed a collaborative to identify the community's health and social service needs, and to discuss ways to avoid the duplication of services. PCP grew out of this collaboration. It was intended to improve health status among the indigent, reduce emergency room visits, and reduce overall medical expenditures.

A comprehensive member survey was administered in 2000 to gauge the impact of the program. Seventy percent of PCP enrollees visited their primary care provider, whereas only 29 percent of enrollees had a primary care provider before enrolling in the plan. Sixty-five percent of enrollees reported being very satisfied or satisfied with the services received; 98 percent indicated that they would recommend enrolling to a friend. Additionally, El Paso Community Voices was able to track emergency room use per diagnosis and conclude that members, for the most part, are using the emergency room appropriately. There will be continued monitoring and assessment of cost-effectiveness in the future.

PCP has the potential to be replicated in other communities faced with similar challenges, as long as there are a hospital district, safety net, and community providers that are committed to formulating and administering a coverage program based on managed care and shared responsibility.[10] The role of collaboration cannot be overes-

8 E-CAP is not "insurance" subject to insurance department regulations, but rather a program of pre-payment for defined health benefits provided by a limited number of health care providers.

9 Texas Health and Human Services Commission. Research and Forecasting Department. Monthly Program Statistics Report. August 2003.

10 San Antonio has a similar program for its underserved community.

timated. Bringing together safety net providers, patient advocacy groups, community-based organizations, and nearby universities was and continues to be seen as an important factor in the development and sustainability of the Primary Care Plan. It has opened up the lines of communication, and through the feedback of providers and advocates, ensures that the community is better served.

Target Population and Eligibility

Adults over age 19 with incomes below 100 percent of the FPL who are residents of El Paso County and not eligible for other publicly supported programs are eligible for PCP. Enrollees are eligible for one year, provided their eligibility status does not change due to economic conditions, residence, or qualification for another publicly supported program. They may be recertified after the year. Individuals are issued membership cards which list their primary care provider.

Outreach and Enrollment

The Primary Care Plan began enrolling individuals in April 1999. Initially, children were eligible and comprised the largest group of enrollees. However, when the state's SCHIP program began in June 2000, the children were transitioned into SCHIP during the PCP recertification process.

At the very start of the program, enrollment numbers were low, so outreach workers and "promotoras" targeted neighborhood events, schools, community centers, and churches. Once enrollment reached its cap of 7,000, it has remained at that level. The Primary Care Plan operates a waiting list of well over 1,000 individuals who are enrolled as members leave the plan. In 2002, 73 percent of enrollees were female and between the ages of 20 and 55.

Covered Services

Initially, coverage included outpatient primary and preventive care, laboratories, x-rays, and limited in-network specialty care services.[11] Pharmaceutical coverage was provided through the indigent pharmacy plan for Thomason Hospital. Hospital care was not officially covered by PCP, but enrollees qualified for charity care at Thomason Hospital. The initial benefits package was determined through a collaboration among partner agencies, community groups, EPFHN, and consultants. Many trade-offs were discussed and deliberated. It was decided to: include hospice benefits in order to stretch dollars by preventing lengthy hospital stays; include children to ensure basic family coverage in the beginning (although children were later enrolled into S-CHIP); and to not provide mental health coverage due to its high costs.

Once PCP was integrated into the Hospital District, covered services were extended (particularly for specialty care, inpatient hospital, and other ancillary services) to match those provided through the county indigent care plan. PCP and the indigent care program initially differed because PCP was more focused on primary and preventive care, and the indigent care program, run through the Hospital District, was more focused on hospital-based services. The specific benefits extended to PCP enrollees included: case management services, most diagnostic tests, emergency room services, gynecological services, immunizations, prenatal care, and well patient annual exams. There is a $5 copay for physician office visits.

Dental care, while a pressing concern, was not a covered benefit originally due its high cost and the challenge of working with the dental community on any type of insurance product. However, it was recently integrated into the program as a means of preventive care for enrollees with diabetes.

Management of Care

PCP enrollees select a primary care provider, nurse practitioner, or primary care clinic from the EPFHN to serve as their medical home. Case management services are offered to enrollees with special health care needs. These services are particularly important for the program's high-risk population, such as patients with diabetes and hypertension.

Financing

Through its grant from the W.K. Kellogg Foundation, the Primary Care Plan was able to develop its infrastructure, staffing, and daily office operations. The El Paso County Hospital District contributed $2 million annually over five years to fund the health care services of the

11 Coverage was structured around specific CPT codes. (CPT codes describe medical or psychiatric procedures performed by physicians and other health providers; they were developed by the Health Care Financing Administration (HCFA) to assist in the assignment of reimbursement amounts to providers by Medicare carriers.)

enrollees including cost of care, physicians' fees, and laboratory costs. Since enrollment into the program was almost always on target, and due to the limited benefits, the costs were always within budget.

Currently, the program is under the direction of the Hospital District which assumes full responsibility of its financing under its annual budget. Its financing remains at $2 million annually, part of which comes from DSH funding. Enrollment remains capped at 7,000 individuals.

Reimbursement rates to providers under the Primary Care Plan equal Medicaid fee-for-service reimbursement rates plus 5 percent. Texas has particularly low Medicaid reimbursement rates, however, and this has made many local physicians reluctant to accept new PCP (and Medicaid and SCHIP) patients. Yet a relatively large number of facilities (8-10) have participated in the program, which has enabled provider and patient coverage to be widely distributed.

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Turtle Health Plan and Turtle Trust
California Rural Indian Health Board, Inc. (CRIHB)

SACRAMENTO, CALIFORNIA

Overview

The California Rural Indian Health Board, Inc. (CRIHB) helped create what will be the nation's first American Indian managed care organization, named the **Turtle Health Plan.** Over 63 tribal governments and 60 clinic sites from around the state have agreed to participate in the plan. The plan will offer three products: Medi-Cal (Medicaid); Healthy Families (SCHIP); and the **Turtle Trust,** a commercial product for employees of American Indian organizations such as clinics, casinos, and Indian Health Service-funded organizations. Once its license is approved by the state (due in winter of 2004), Turtle Health Plan would be the default Medi-Cal provider for all eligible Native Americans in California who have selected participating Indian health programs as their primary care provider. This would ensure the plan a large pool, reducing the risk assumed by the Turtle Health Plan. The plan is scheduled to begin in the first five of the state's eleven designated zones in July 2004.

Value and Contribution

The creators of the Turtle Health Plan were motivated by the idea of establishing a managed care organization that would serve the health care needs of American Indians, with an understanding of the culture and the particular access problems that affect this population across the state. A parallel goal is to develop quality improvement systems for tribal and urban Indian health programs, and, through contracts, enhance patient treatment coordination and communication between primary care and specialty providers.

Native Americans who are either uninsured or covered under Medi-Cal or Healthy Families will likely benefit from the creation of the Turtle Health Plan. Currently, the uninsured – many of whom are employed but do not have access to employer-sponsored insurance, or may be eligible for Medi-Cal or Healthy Families but are not enrolled – rely entirely on Indian Health Service-funded clinics and have poor access to hospitals and specialists. Turtle Health Plan officials hope that the Turtle Trust will allow more American Indian organizations to offer affordable coverage to their employees, subsequently improving coverage rates and shifting individuals out of the safety net and into a managed provider network. At the same time, the Plan will address the spotty access to specialty care faced by American Indians enrolled in Medi-Cal and Healthy Families, by contracting with and establishing a network of clinics and a full range of specialists. Plan officials think it will succeed in this effort because it plans to reimburse providers 5 to 25 percent more than they previously received through Med-Cal; they estimate that between 2,000 and 3,000 specialty providers will eventually participate in the Plan.

In improving existing health coverage options and creating a new one, the Plan hopes to generate cost offsets in the Indian Health Service budgets that are the main revenue source for tribal clinics, and subsequently, expand the reach of the safety net for tribal communities. For example, by increased billing of Medi-Cal or Healthy Families for primary care services, clinics may be able to offer more dental health and mental health services.

Management of Care

All enrollees, whether they are Medi-Cal, Healthy Families, or Turtle Trust, will choose an Indian clinic site, and subsequently a physician at the site, as their primary care provider (PCP). PCPs will manage primary care services and make referrals to specialty care when necessary. Managing of chronic and expensive care is a central focus of the Plan; their actuarial analyses, which govern their reimbursement rates, are based on the philosophy that "appropriate care at the appropriate place" will lead to cost-efficient care. The Plan's administrators will use health status indicators and analyze utilization and referral patterns to assess preventive care usage and make adjustments to the management system as necessary. In addition, they will implement a computerized internet communication system – called "Dr. Referral Express" – in all participating sites, which will make provider-to-provider communications more efficient.

Financing

The Medi-Cal and Healthy Families products will be financed just as other Medicaid and SCHIP managed care organizations are in the state, through a combination of state and federal dollars. In terms of provider reimbursements, the Turtle Plan estimates that it will be able to pay a rate that is higher than the state's fee-for-service rates due to the overall efficiency of care provided by the total Turtle network. For example, the plan's prospective pharmacy management benefits organization has estimated that it will spend $3-4 million less per year compared to Medi-Cal paid claims over 2001 and 2002.

Development of the entire plan, to this point, has been funded through grants from the California Endowment, the W.K. Kellogg Foundation's Community Voices Initiative, and other private entities. Between the sheer size of the state, and the monumental task of putting together contracted primary, specialty, hospital, and ambulance networks in 11 California zones, current financing for the Turtle Trust is not adequate to reach the start of operation in April 2004. Plan officials estimate that at the very least, an additional $500,000 will be needed to start operations; both private and public sources are being pursued. Advocates for the plan are trying to raise interest among possible funders by explaining that providing health coverage through the Turtle Plan will serve to ease the pressure on the IHS, allowing the IHS to provide safety net services to more people who do not qualify for any types of coverage. In addition, they think the costs of running the Turtle Trust will be at least 10 percent lower than costs of commercial plans, because they will not be working with brokers or investors, and they will operate as a not-for-profit organization. With the 10 percent savings, the Turtle will actively encourage the Indian employers to subsidize the health insurance premiums of the families of their employees and hence reduce the numbers of uninsured.

Turtle Health Plan

Target Population and Eligibility

It is planned that Turtle Health Plan will, through a series of phases, target American Indians who are already enrolled in, or who newly qualify for, either Medi-Cal or Healthy Families. During its first year of operation, the Plan will enroll Medi-Cal members who obtain services at their participating tribal and urban Indian health clinics. The second and third years of operation will see enrollment opportunities expand to those in other counties, as well as Healthy Families enrollees. The choice of the Turtle Health Plan as one's Medi-Cal or Healthy Families managed care provider will be available not just to American Indians, but also to non-Indian California residents who meet the Medicaid and SCHIP eligibility requirements and choose a tribal or urban Indian clinic as their primary care provider.

Outreach and Enrollment

After it receives initial authority to automatically place American Indian Medi-Cal and Healthy Families enrollees into the Turtle Health Plan, the Plan and its participating clinics will aggressively develop an outreach strategy to educate potential enrollees. Best enrollment practices will be shared in detail among the member Indian health programs. In addition, the Plan's third party administrator will take on some outreach responsibilities by sending re-certification reminders to Medi-Cal enrollees, particularly those who have not used any services in the previous six months. The Plan expects to enroll 10,000 to 20,000 individuals in its first few years of operation. Administrators believe this would provide a solid enrollment base that should allow them to assess and spread the cost for conditions such as heart disease, cancer, and other high-cost and chronic illnesses. Outreach for Turtle Trust is described below.

Covered Services
Medi-Cal and Healthy Families enrolled in the Turtle Health Plan will receive their state-designated program benefits just as if they were in another managed care organization.

Turtle Trust

Target Population and Eligibility
As described above, the target population for the Turtle Trust plan comprises employees of Indian organizations, who would be offered the plan through their participating employer. The employee insurance will reduce the cost of health insurance by a minimum of 10 percent since the Turtle is not-for-profit, has no stated or hidden broker fees, and predicts minimal marketing costs.

Outreach and Enrollment
Turtle Trust will be a competitive health insurance plan for Indian organizations. Outreach representatives will work with employers and employees to educate them about the availability of coverage through the Turtle Trust. Even large Indian casinos with "self-insured" plans will be able to save substantial savings or increase the benefit packages for employees at the same cost. Turtle Trust hopes to enroll between 20,000 and 30,000 casino workers alone once it is operational. Program planners predict that enrollment under the different Turtle Trust packages will allow the Trust to have predictability, stability, and substantially lower re-insurance rates.

Covered Services
The Turtle Trust will offer two to three different benefit packages: economical, standard and luxury. Each will be comprehensive, including basic primary care, pharmacy, specialty care, and hospital services, but the luxury package will include vision, mental health, and substance abuse services. Copayments for services will vary.

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UNM Care Program
BERNALILLO, NEW MEXICO

Overview
In 1997, the University of New Mexico (UNM) joined forces with a Bernalillo county-based network of Federally Qualified Health Centers (FQHCs), First Choice Community Health, the New Mexico Department of Health, and the county government, to form the UNM Care Plan (now called the UNM Care Program). The University's objective was to establish a managed care plan to provide primary care and case management services for uninsured individuals who were not eligible for Medicaid, and who sought basic care through inappropriate venues such as the University hospital's emergency department and urgent care centers. The goals of the plan were to: 1) provide the uninsured with a consistent source of primary care – a medical home – and case management; and 2) create a more stable funding source for the UNM hospital, which is a major safety net hospital and health education center.[12] The plan quickly enrolled nearly 7,500 individuals, and six years later it serves approximately 15,000 enrollees.

Value and Contribution
The UNM Care Program provides primary care and coordinates health and social services for uninsured individuals, particularly those who heavily utilize UNM emergency department services (described in more detail below). The hospital has experienced cost savings stemming from less frequent ER use, shorter hospitalizations, greater rate of immunizations, and earlier screening for chronic conditions. Those involved in the program cite its mission of improving primary care as having a positive impact on care quality, and subsequently, on cost savings. In addition, providers participating through the First Health FQHC network report that they achieved savings after the first year of the plan's implementation.

More recently, there has been an increase in uncompensated care volume and a decrease in reimbursements overall. There is reason to suggest, however, that these

12 The hospital had predicted reductions in its revenue streams from CHAMPUS and Medicaid, due to CHAMPUS reforms and the implementation of Medicaid managed care across the state.

outcomes stem largely from the economic downturn, and that the negative effects would have been worse without the presence of the UNM Care Program.

The UNM Care Program has been recommended to state policymakers as a model that could possibly be replicated across the state. It has also received attention at the federal level, as some stakeholders discuss the potential for the program to make an even greater impact by integrating it with the Medicaid program; with COBRA coverage; and ultimately, into a national health insurance program.

Target Population and Eligibility

The program targets individuals in Bernalillo County who are uninsured and considered either medically indigent or working poor. Income eligibility is set at 235 percent of the FPL. Individuals who are either eligible for Medicaid or any other public insurance program, and/or are not legal citizens do not qualify for coverage under the program.

Originally, the program targeted people who frequently used emergency room services, given that they might reap the most benefit from primary care and case management. Out of the first 7,500 enrollees, approximately half were considered "major" users, and the other half considered "relative" (i.e., moderate) users of the ER.

Outreach and Enrollment

The UNM Care Program's original design did not include a formal outreach strategy for enrollment purposes. Instead, the program focused on making contact with potential enrollees when they used the emergency room, since it was this population that it wanted to manage. As the program grew, knowledge of it spread by word of mouth. The enrollment process is conducted at the University Hospital, where eligibility is reviewed and verified by the Business and Eligibility Office. Qualifying individuals then receive information from a program representative about how to choose a primary care provider, copayments, benefits, and other plan details.

When the program was first implemented, there was evidence of significant pent-up demand among the newly enrolled. Enrollment quickly rose from 7,500 in the first month, to 9,000, and ultimately to a high of 15,000, which is where it remains in 2003. The program's administrators prefer to keep enrollment at this level due to the limited supply of primary care providers. While funding may be available, additional enrollees would likely have difficulty accessing the primary care services that are at the heart of the program. However, it is interesting to note that there has never been a cap placed on enrollment; the program has naturally sustained a level of 15,000 enrollees, which suggests that the University is reaching its target population.

Covered Services

UNM Care Program tried to create a benefit package similar in scope to the state's Medicaid benefit package so that families with members in both programs would have access to similar services and potentially the same providers. The benefit package includes physician services, inpatient and outpatient hospital care, laboratory and x-ray services, limited dental care (described below), and discounted pharmaceuticals. Enrollees choose a primary care provider – either at the hospital or at one of the First Choice clinics – through which they receive primary care services as well as specialty care referrals.

Behavioral health and oral health were originally considered for the UNM Care Program benefit package, but have not been implemented except in certain circumstances. For example, if oral health services are needed in order to complete covered medical care services, then they are provided (e.g., treatment for a cranio-facial injury that requires oral surgery prior to other reconstructive surgery). In recognition of the need for greater access to oral health among UNM Care Program enrollees, the program is working on stationing oral health practitioners at primary care sites, though services are not automatically covered under the program. In terms of behavioral health, while some of the clinics affiliated with the UNM Care Program do offer behavioral health services, again, they are not automatically covered under the program. Enrollees are more likely to be referred to the Bernalillo County Mental Health Center for subsidized care.[13]

13 Access to oral health and behavioral health has been facilitated, when possible, through interdepartmental referral. The Central New Mexico Community Access Program (CAP) has instituted a "Status One" patient appointment process and is implementing care management for some of the more complex behavioral health cases. In addition, oral health services at UNM have grown tremendously, with eight dentists on staff addressing oral health needs in the county and statewide.

Other specialty care is coordinated through referrals from the primary care provider to the Specialty Departments of UNM School of Medicine. Compensation for such services is provided to the extent available from the county indigent fund to cover at least hospitalization and related specialty care.

Management of Care

As described above, the enrollees' primary care provider manages care. The program provides its enrollees with access to a variety of social services and non-health related case management, and in some cases, behavioral health care, so as to offer a "one-stop shopping" environment in its provider sites.

Financing

The UNM Health Care Program is funded by county-level indigent care funds. A fee-for-service contract with the First Choice FQHC network assures a broader selection of providers and is also supported out of the county indigent fund. An additional $1 million is appropriated by the county for the Partners in Health Program, which provides services for populations that are otherwise not eligible for entitlement programs or the county indigent fund. The W.K. Kellogg Foundation's Community Voices program supported the development of the "Health Commons" delivery model for UNM and First Choice clinical sites. "Health Commons" connotes a primary care practice where a variety of medical, behavioral, social, and oral health services are made available to clients via a team of practitioners who assess the client's needs. The co-location strategy was developed to eliminate the barriers to accessing care beyond the primary care realm.

Primary care providers receive a capitated rate for health care services and care management. When it comes to specialty care, each case is reviewed individually by the hospital before determining the course of delivery and the payment rate.

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