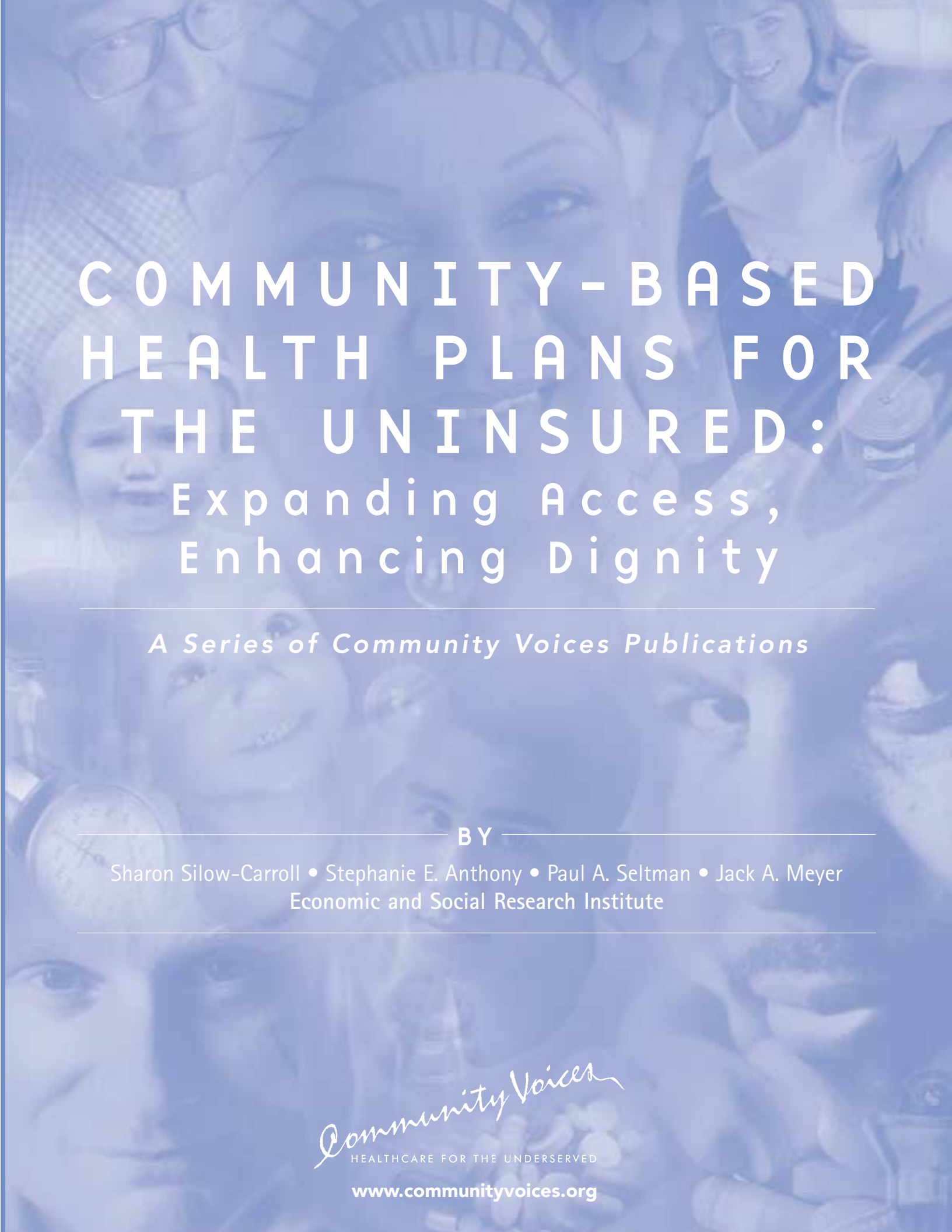

COMMUNITY-BASED HEALTH PLANS FOR THE UNINSURED:
Expanding Access, Enhancing Dignity

A Series of Community Voices Publications

BY

Sharon Silow-Carroll • Stephanie E. Anthony • Paul A. Seltman • Jack A. Meyer

Economic and Social Research Institute

Community Voices

HEALTHCARE FOR THE UNDERSERVED

www.communityvoices.org

COMMUNITY-BASED HEALTH PLANS FOR THE UNINSURED:

Expanding Access, Enhancing Dignity

A Series of Community Voices Publications

NOVEMBER 2001

BY

Sharon Silow-Carroll • Stephanie E. Anthony • Paul A. Seltman • Jack A. Meyer

Economic and Social Research Institute

Prepared for

W.K. KELLOGG FOUNDATION

Table of Contents

Acknowledgments

The authors gratefully acknowledge the support of the W.K. Kellogg Foundation. We also thank the leaders of Community Voices programs who provided information about their health plans. We appreciate the wealth of information gained from Dennis Andrulis and Michael Gusmano in Community Initiatives for the Uninsured: How Far Can Innovative Partnerships Take Us? (The New York Academy of Medicine, August 2000). In addition, we appreciate the willingness of Jim Burnosky to share his knowledge about community initiatives in Florida.

About the Economic and Social Research Institute

The Economic and Social Research Institute (ESRI) is a nonprofit organization that conducts research and policy analysis in health care and in the reform of social services. ESRI specializes in studies aimed at enhancing the effectiveness of social programs, improving the way health care services are organized and delivered, and making quality health care accessible and affordable.

About the Authors

Sharon Silow-Carroll, M.B.A., M.S.W. is a Senior Research Manager at ESRI. Ms. Silow-Carroll's areas of expertise include analyzing health care reform strategies and reviewing programs aimed at meeting the needs of vulnerable populations. Her recent projects include: a review and analysis of state and community-based initiatives to expand employment-based health insurance; a survey on employers' attitudes toward their role in financing and managing health coverage and their reactions to health reform proposals; and the development of a comprehensive strategy to address insurance and non-insurance barriers to health care. She is author of an ESRI book analyzing business' role in providing health care coverage to workers and families from economic, social, and cultural perspectives. She is co-author of numerous reports and articles reviewing public and private sector initiatives geared to expand access, contain costs, and improve quality of health care.

Stephanie E. Anthony, J.D., M.P.H. is a Senior Policy Analyst at ESRI. Ms. Anthony has conducted extensive research and policy analysis on federal, state, and local programs that improve the health of children and families. Her areas of expertise include children's health and the State Children's Health Insurance Program (S-CHIP), state and local initiatives to improve access to health coverage, Medicare fraud and abuse, Medicaid managed care for vulnerable populations, hospital governance, and youth violence. She is co-author of numerous reports, including recent studies on Medicaid managed programs for individuals dually eligible for Medicaid and Medicare and the impact of the False Claims Act in reducing health care fraud.

Paul A. Seltman, J.D., is a Policy Analyst at ESRI. He has been accepted for a one-year fellowship with the Bosch Foundation in Germany. Mr. Seltman most recently served as a Special Assistant in the Office of the Assistant Secretary for Legislation at the Department of Health and Human Services, where he was a legislative advisor and liaison with Congress on Medicare issues, including Medicare+Choice and access to prescription drugs. Previously, Mr. Seltman served as Minority Counsel for the U.S. Senate Budget Committee and Minority Counsel for the U.S. House of Representatives Budget Committee, where he primarily focused on matters related to health care and social welfare policy. Mr. Seltman's other professional experience includes working as Deputy Chief of Staff for U.S. Representative Major R. Owens (D-NY).

Jack A. Meyer, Ph.D. is the founder and President of ESRI. He is also an Adjunct Associate of the Center for Health Policy at Stanford University. Dr. Meyer conducts policy analysis and directs research projects in health care and social policy. He is the author of numerous books, reports, and articles on topics including health care, labor market and demographic trends, and policies to reduce poverty. Dr. Meyer has directed a series of studies on policy reforms to broaden health coverage, with special emphasis on new models to assist the working uninsured. He has also studied the role of employers in health care quality improvement and innovative private sector cost management initiatives.

Economic and Social Research Institute Board of Directors

Mickey Levy, Chief Economist, Bank of America

William Lilley III, President and CEO, Policy Communications Inc.

Kenneth McLennan, Retired President and Senior Consultant, Manufacturers' Alliance for Productivity and Innovation

Jack A. Meyer, President, Economic and Social Research Institute

Beth Shulman, Special Assistant to the President, United Food and Commercial Workers Union

Sheila Zedlewski, Program Director, Urban Institute

SUMMARY

National reforms to significantly reduce the ranks of the uninsured are not on the near-term political agenda. While many states are active in expanding health coverage among certain populations (e.g., low-income children and parents) certain populations such as lower-income working families, adults without dependent children, and undocumented immigrants and their children remain disenfranchised from the health care system. Lacking a "medical home," many uninsured people forgo basic primary and preventive care, leading to high-cost inpatient and emergency room services.

Meanwhile, the traditional safety net has been undergoing enormous stresses that threaten its ability to continue serving vulnerable populations. These stresses include government funding cutbacks, volatility in the Medicaid managed care market, welfare reform, and competition for tobacco settlement funds.

Some counties and safety net providers are responding by experimenting with ways to promote better patterns of care for the uninsured in their communities. This report focuses on community-based initiatives that enroll uninsured individuals and families into organized health plans that provide a designated set of benefits. These programs differ across communities in key features such as eligibility criteria, services covered, financing sources, and administrative entities. Yet many of the programs have the following common elements:

- provides enrollees with a "medical home";
- offers some form of care management that enhances early detection of medical problems, promotes preventive care, and reduces inappropriate utilization of emergency and inpatient services;
- gives providers some incentives to serve patients who cannot pay for services; and
- promotes the dignity of enrollees.

These programs aim to improve health and lower costs by reducing care in inappropriate settings and eliminating avoidable illnesses and hospitalizations.

A small but growing number of communities are developing these kinds of coverage programs, including several grantees of the W.K. Kellogg Foundation's Community Voices: HealthCare for the Underserved initiative. Health plans supported by this initiative and described in detail in this report include:

- UNM Care Plan, Bernalillo County, New Mexico;
- Ingham Health Plan, Ingham County, Michigan;
- Primary Care Plan, El Paso County, Texas;
- FirstConnection, Moore and Montgomery Counties, North Carolina; and
- Family Care, Alameda County, California.

LESSONS FOR PROGRAM PLANNERS AND POLICYMAKERS

These five communities are providing excellent opportunities for learning about promising strategies to help vulnerable residents gain access to health and social services, as well as how to overcome a range of barriers to successful outcomes. They are yielding interesting insights that could benefit other communities as well as state and federal policymakers. The following lessons emerge from their experiences and from a review of similar programs across the country:

1. Stable and Sufficient Funding is Critical but Elusive

Health plans for the uninsured rarely have sufficient funds to serve the entire target population, nor do they have money to expand. Without a regular financing source such as Medicaid reimbursement or private premium payments, these programs often depend on temporary, precarious, and/or limited funding streams.

Many factors exacerbate the financial pressure on the health plans. Older programs faced increased financial stress when their enrollments rose because of the "de-linking" of Medicaid and cash assistance as well as other factors related to welfare reform. Health care cost escalation and "adverse selection" can cause programs' costs to exceed their budgets. Programs that predominantly rely on medical service contributions are particularly vulnerable, and find it difficult to plan a budget and deliver a standard and stable package of benefits. Increased competition, payment cuts imposed by managed care organizations, and more frequent hospital mergers often result in cost-cutting changes in hospital policies that squeeze programs for the uninsured.

For health plans for the uninsured to truly flourish, more support from the state and federal governments is needed. Additional strategies could be targeted to the business sector since many uninsured people are working but not receiving employer-sponsored health coverage. Also, program planners need to be creative in iden-

tifying sources of financing for programs, and can benefit from partnering with organizations that have greater access to capital. Officials in Ingham County created a "special Medicaid payment" by using county and state funds dedicated to indigent care as a portion of the non-federal (i.e., state) share of Disproportionate Share Hospital (DSH) payments to the local hospitals, and used this to capture additional matching federal DSH dollars.

2. A Medical Home Can Bring Psychological, Medical, and Financial Benefits

Providing uninsured people with a "medical home" through assignment of a primary care provider and a membership card offers them a sense of belonging and dignity, and expanded access to mainstream primary care providers. Some programs have also demonstrated measurable improvements in the cost-effectiveness of health care delivery, with financial savings in the long run. The UNM Care Plan, for example, has resulted in reduced hospitalizations, hospital days, and (after an initial increase due to pent-up demand) ambulatory care utilization, saving $148 per member in inpatient and outpatient costs in FY 1999.

3. Collaboration Helps Ensure Success

Establishing relationships among community-based safety net organizations and ensuring commitments to work toward the same goal is a long and labor-intensive process, yet in many cases critical. Partnerships and alliances help to raise needed capital, reduce duplication of services, increase the pool of potential enrollees, and allow for efficiencies of scale. Safety net organizations in El Paso, for example, realized that with rising numbers of uninsured and declining financial resources, they needed to "survive together" as an integrated health care delivery system to effectively serve the county's underserved populations.

There are risks to collaboration, however, such as potential conflicts of interest among the different sponsors or between the sponsors and the health plan. To address these risks, the health plan should, with the help of skillful leadership, forge its own identity and mission and secure sufficient independence from its sponsoring organizations.

4. Adequate Provider Supply and "Buy-In" are Crucial

Adequate reimbursement rates and positive financial incentives are important both to encourage physicians to participate in the network (if participation is voluntary) and to discourage them from avoiding serving plan members (if participation is mandatory). An adequate supply of primary care providers (PCPs) is particularly important, since these practitioners are the entry point into the health system for enrollees. A shortage of PCPs leads to overburdened providers and long waits at clinics or for appointments, resulting in patient frustration and potentially undermining the goals of the program.

5. Take a Broader View of "Health Professionals"

Community-based health plans can and should utilize a broad range of individuals such as community health representatives, social workers, case managers, behavioral health workers, nurse practitioners, physician assistants, dental hygienists, and interpreters–depending on the specific population needs. For many functions, these workers serve as less costly, and in some cases, more effective alternatives to "higher professionals" in reaching the target population, gaining trust, teaching health promotion, and communicating with enrollees. An interdisciplinary approach in which the various services are linked and there is ongoing communication among providers is also important.

6. Communication, Education, and Respect are a Must

Programs are more likely to succeed if they communicate effectively with patients and prospective patients. Before conducting outreach to prospective enrollees, programs must make sure they understand the cultural and ethnic composition of the target group and conduct basic market research. Planners need to seek potential enrollees' advice on program design and be prepared to adapt the program to patients' needs. The health plans must educate new members at the time of enrollment about the appropriate utilization of the PCPs and specialists, the importance and benefits of preventive health care, and other plan rules.

Particularly in areas with large immigrant populations, plans must overcome language barriers with translators, bilingual practitioners, and written material

in multiple languages. For health plans that include undocumented individuals, program planners should consult with community representatives about how to most effectively communicate with these people so that they feel more comfortable enrolling. Family Care in Alameda County, for example, is enrolling people through one of the few channels that are trusted by immigrants–community health centers. Programs also should make sure that they treat their patients with dignity; if enrollees are not comfortable with how they are being treated by a program and its staff, they are less likely to seek medical attention from the program.

7. Health Plans Must Be Prepared to Address Multiple Needs

Targeting uninsured populations often means enrolling vulnerable individuals and families with an array of medical, social, behavioral, and financial needs. Social supports should be included to the extent that financing permits, and case management should be an integral part of the programs. Case managers must be prepared to arrange or make referrals for services such as transportation, child care, literacy programs, job placement, substance abuse services, and others. The case manager of the FirstConnection health plan, for example, has helped enrollees qualify for various health services and social supports that fall outside of the standard medical package, such as home heating subsidies, car seats, eyeglasses, home safety, and others as needed.

8. Planners Face Tradeoffs Between Scope of Benefits and Cost

With limited budgets, program planners are faced with a difficult decision of whether to offer a comprehensive set of services to a smaller number of people, or offer limited coverage and reach a larger number of people. Regardless of which choice is made, benefit packages should be stable and adequate to meet the most important needs of the programs' target populations. The Ingham Health Plan chose to offer outpatient services only, allowing it to serve more people. Other plans offer comprehensive benefits so members can enjoy "seamless" coverage so that shifting between the health plan and Medicaid/S-CHIP does not disrupt relationships with PCPs or significantly change covered services. Similarly, it allows families with multiple sources of coverage to deal with one set of providers and benefits.

9. Targeting Small Businesses Poses Many Challenges

Health care access programs established to help small businesses and their employees face their own unique challenges. Yet, it is important to continue to seek ways to encourage employers to provide health coverage to low-income workers. Most of the health plans explored in this report serve the working poor, who are not offered job-based coverage and cannot afford to purchase insurance on their own. A few pilot programs that subsidize small businesses that begin offering health benefits are showing signs of success and could be expanded.

Political Lessons and Recommendations

Factors that Influence Political Support for Community-Based Health Plans

Program planners can use lessons from others' experiences to help build essential support from local and state policymakers:

1. Keep State Officials and Legislators Informed

Programs have a stronger foundation if there is a long history of cooperation and consultation between the community-based organizations delivering the services and the local and state government entities. The extra time spent educating state officials about the program and its merits is worth the effort, especially given their need to balance and weigh many different interests. Even when a program shows success, ongoing communication is important to avoid a false impression among public officials that the uninsured problem is solved. In some cases, a quid pro quo is helpful; to help gain state approval for the establishment of "special" Medicaid payments to fund the Ingham Health Plan, the program agreed to provide care for the county's medically indigent population.

2. Source of Funding Matters

While taxes can be a steady source of funding, they are almost always unpopular and politically vulnerable. However, tax financing for health care programs may be easier to sell politically if the tax source already exists. Other public funding mechanisms have political problems as well, with various interests competing for the scarce dollars.

3. Promote as High Budget Priority

Financial support is based in part on the importance that government officials attribute to the programs relative to other budget priorities. If there were a significant economic downturn, state and county revenues would likely fall, putting a squeeze on government budgets. At the same time, the number of uninsured and those eligible for the programs would likely grow, potentially swelling the programs' enrollments.

4. Enlist Support of Large Health Systems

It is often helpful to enlist the support of politically powerful health care systems. One approach is to convince these key providers that funding for the program would work to their benefit because they would not have to absorb as much of the cost of serving this target population. This may require establishing the linkage between sound front-end investments in primary and preventive care and reduced emergency room and inpatient hospital use. Planners should be careful, however, that forming such a political alliance does not result in the larger health systems garnering the program's funding for their own use.

5. Court Consumer Groups and Labor Unions

Another factor that affects programs' political support is the extent to which consumer groups and labor unions have "bought in." If local or state governments partner with private clinics to provide indigent care, programs may find themselves battling labor unions concerned about the loss of union jobs and consumer advocates concerned about adequate patient access to care. Including these groups in the planning process and pointing out the benefits in terms of improved access and reductions in uncompensated care can help win their support and involvement.

6. Seek and Emphasize Measurable Outcomes

A final factor that can affect political support for indigent care programs is evidence of success in improving quality, health outcomes, and cost-effectiveness. Some of the programs that are the most highly regarded in their communities are ones that have strong quality control mechanisms in place, with reviews conducted by independent third parties. Strong quality control with positive, measurable outcomes can help provide solid insulation from political attack if a program's effectiveness is ever questioned.

County, State, and Federal Efforts to Promote Health Plans for the Uninsured

Legislators at the federal, state, and county levels can help promote or expand health plans for the uninsured, primarily by providing a stable funding source. Without such long-term financial commitments (through legislation and appropriations), there is no guarantee that these programs will not be abandoned or eliminated if the economy takes a downturn or once start-up funds run out.

Federal level support could take the following forms:

- enable states to pool indigent care funding (including DSH funds) and direct them toward community-based programs;
- ease up on prohibitions against using federal Medicaid matching funds for undocumented residents;
- make it easier for states to apply for Medicaid waivers for demonstration projects and to extend eligibility;
- tap the budget surplus or other sources to provide demonstration grants directly to states and communities to create health plans, insurance infrastructures, and premium subsidies for low-income people, or to replicate successful community-based models; and
- expand activities under the Health Resources and Services Administration's (HRSA) Office of Managed Care (which provides technical support to safety net providers to help them participate in the networks of Medicaid managed care plans) to include education and assistance in implementing health plans for the uninsured.

State level support could include the following:

- devote a portion of state budgets toward seed money or ongoing support for community-based health plans, or toward expanding existing successful programs to a broader geographic area; this could include a portion of tobacco settlement funds;
- allow flexibility in using existing state and local money to foster "creative" arrangements that leverage federal funds;
- expand eligibility for Medicaid and S-CHIP programs, opening slots in community-based health plans for additional uninsured people who remain ineligible for the public insurance programs;

- consider ways to allow currently undocumented residents to benefit from public programs;
- involve state Medicaid departments in education, outreach, and enrollment for health plans for the uninsured; and
- encourage state insurance departments to allow more flexibility and to expedite the authorization process for access-expansion plans without compromising the integrity and stability of the new insurance entity, and consider waiving some state-mandated benefits to allow community-based insurance plans to provide more basic coverage at a lower cost.

County health departments could provide direct or indirect support:

- take the lead in implementing health plans for the uninsured; or
- help finance health plans administered by other organizations, by earmarking a local tax (e.g., property, sales) for this purpose, and petitioning the state to devote a portion of tobacco settlement funds toward such programs; and
- provide a leadership role in organizing and nurturing collaboratives among the county health department and safety net organizations.

Conclusion

Community-based health plans for uninsured populations have the potential to expand access to care, enhance dignity among enrollees, improve health outcomes and productivity, and even reduce health costs over the long run. Such a strategy, however, requires an expanded and stable source of funding to move these programs beyond the demonstration or pilot stage. In addition, it must be part of a broader solution to the problem of the uninsured that includes: encouraging employment-sponsored coverage through tax credits and health insurance purchasing cooperatives for small businesses and individuals; expanding public coverage programs such as Medicaid and S-CHIP; improving outreach and education to undocumented and low-income communities; and expanding safety net, community-based programs for the uninsured who remain outside the system.

Section 1. Introduction & Background

Lack of health insurance takes a significant toll on both individuals and society. Being uninsured not only deprives people of having a regular source of care, but also deprives them of dignity when they must approach health care practitioners and institutions that regard them as "freeloaders." When care is provided, it is often in an inefficient way, in the form of high-cost emergency or hospital inpatient services that could have been avoided with proper preventive and primary care. That is, uninsurance leads to inefficient patterns of care, which contribute to poor health outcomes, lower productivity, and high costs in the long run. Further, the "safety net" providers that have traditionally provided health care to people without coverage are facing growing financial pressures, threatening their ability to perform this function in the future.

Achieving universal health coverage is not currently on the public policy agenda at the national level, and while existing public programs (Medicaid, S-CHIP) may be expanded on a state-by-state basis, there are some vulnerable groups that are consistently left out of these programs. Low-income working families, adults without dependent children, and undocumented immigrants are among those who often cannot afford private insurance and are not eligible for public coverage. Millions of low-income people are eligible for government programs but not enrolled. Meanwhile, county health departments and safety net providers are facing pressures to stretch their dollars and provide care to the uninsured more efficiently.

In response to these factors, communities around the country are trying to address and alleviate the problem of the uninsured. Some are experimenting with innovative ways to improve access to appropriate care, hoping to improve the health of their most vulnerable residents and save money in the long run.

This report focuses on one such strategy that involves enrolling uninsured individuals and families in a health plan that:

- provides them with a "medical home";
- offers some form of care management that enhances early detection of medical problems, promotes preventive care, and reduces inappropriate utilization of emergency and inpatient services;

- gives providers some incentives to serve patients who cannot pay for services; and
- promotes the dignity of enrollees.

A small but growing number of communities are developing these kinds of coverage programs, including several grantees of the W.K. Kellogg Foundation's Community Voices: HealthCare for the Underserved initiative. These communities are providing excellent opportunities for learning about promising strategies to help vulnerable residents gain access to health and social services, as well as how to overcome a range of barriers to successful outcomes. They are yielding insights that could benefit other communities as well as state and federal policymakers.

This report presents detailed profiles of five such community-based health plans for the uninsured, documents similar models and evidence about related efforts, and draws lessons for program planners and policymakers hoping to expand and replicate successful programs around the country.

In the remainder of this section, we describe the stresses on the safety net and outline the health plan approach communities are undertaking to expand access to uninsured residents. Section 2 contains profiles of five community-based programs, including (in order of the oldest to the newest):

- UNM Care Plan, Bernalillo County, New Mexico;
- Ingham Health Plan, Ingham County, Michigan;
- Primary Care Plan, El Paso County, Texas;
- FirstConnection, Moore and Montgomery Counties, North Carolina; and
- Family Care, Alameda County, California.

Each profile describes how the program was developed, eligibility criteria, services provided, care management activities, outreach efforts, the enrollment process, funding sources, obstacles faced and addressed, and lessons learned to date. We also provide a contact source if readers would like to obtain additional information about the program.

Section 3 presents a review of other community-based models for expanding access to care to the uninsured and summarizes evidence about health plans (including Medicaid managed care plans) developed by safety net providers and alliances that include safety net institutions.

Section 4 offers lessons for program planners and policymakers, based on the experiences of the five programs profiled and our review of the literature. These lessons are intended to assist administrators and legislators at the local, state, and federal levels who are interested in promoting and expanding successful community-based health plans for the uninsured.

Stresses on the Safety Net

The fallback source of care for people without health coverage has been safety net providers–community health centers, public health centers, hospital clinics, and inpatient facilities that serve large numbers of uninsured, disenfranchised patients. These patients often seek care in emergency rooms, either for primary care needs that could be more efficiently provided in other settings, or for illnesses that could have been avoided had the problem been addressed earlier.

But the traditional safety net has been undergoing enormous stresses that threaten its ability to continue serving vulnerable populations. These stresses include government funding cutbacks, volatility in the Medicaid managed care market, welfare reform, and competition for tobacco settlement funds.

Government Funding Cutbacks

After an increase in Medicaid reimbursement in the late 1980s, safety net providers faced major cutbacks a decade later. The Balanced Budget Act of 1997 (BBA) called for cuts in federal dollars for disproportionate share hospital (DSH) payments to hospitals that serve a large portion of poor and uninsured patients. Congress believed that these reductions, which were to be phased in, would be offset by the positive impact on providers of the new State Children's Health Insurance (S-CHIP) program. The BBA also began to phase out a requirement that paid federally-licensed community health centers (CHCs) the actual cost of patient care, resulting in reduced reimbursement payments to CHCs. In addition, the BBA repealed the Boren Amendment, which allowed hospitals to challenge the adequacy of Medicaid payments.

Finally, the BBA cut Medicare reimbursement rates and funding for graduate medical education. Although Congress restored some of the money in late 1999 and 2000, the overall impact of the BBA has been to add to the financial stress on safety net hospitals.

Volatility in the Medicaid Managed Care Market

State efforts to shift Medicaid enrollees into managed care plans over the past decade have resulted in a broader range of choice of providers for this population. But this improvement for patients also translated into a loss of paying patients for many traditional safety net providers.

Under fee-for-service Medicaid arrangements, payments to safety net providers, particularly if they were cost-based, helped them cover a portion of the cost of serving indigent patients. But the lack of case management and timely preventive and primary care were contributing to poor health outcomes for Medicaid patients and sharply increasing program costs. In response, states contracted with managed care organizations, both commercial plans and Medicaid-only plans, to enroll Medicaid patients who could then select from a list of primary care providers, who in turn directed patients to a wider range of diagnostic centers and hospitals.

This shift has, in many ways, improved the actual range of choices for patients, increased early detection of medical problems, and reduced inappropriate care. Yet, this shift in the way Medicaid patients use the health care system has also brought some adverse consequences as well. Safety net providers have had to learn how to negotiate with managed care plans to be included in their networks and to obtain adequate payments rather than receiving full Medicaid reimbursement directly from the government. In many cases, Medicaid patients began to use other providers in the community. While this had the positive effect of giving them better access to a broader range of health care providers, it also resulted in a reduction in an important source of revenue for many safety net institutions.

Recently, some large commercial health plans exited the Medicaid market, citing inadequate capitation payments from Medicaid and significant losses. This has disrupted the channels of patient care. Many safety net providers have tried to adapt to the new environment by forming their own managed care organizations, often in partnership with other safety net organizations in the community. The intent is to retain, recapture, or expand their market share of Medicaid patients, enhancing their ability to serve uninsured, poor individuals. But the majority of such plans have lost money, and face uphill battles for their survival.[1]

Welfare Reform

Welfare rules instituted under the Professional Responsibility and Work Opportunity Reconciliation Act of 1996 ("welfare reform") have led to a movement of people from cash assistance rolls–which had been linked to Medicaid coverage–into the workforce. But reports suggest that a majority of former welfare recipients are entering jobs that do not provide health coverage, or they are declining work-based coverage because their share of the premium is too high.[2] Many are not aware that they can continue Medicaid coverage for a period after losing cash assistance. One study found that among women who had been off welfare for more than one year, only 28 percent had private employer-based coverage, 22 percent had Medicaid coverage, and 49 percent were uninsured.[3] This shift has put additional pressure on safety net institutions, as patients who were previously tied to a secure funding stream turned into sources of uncompensated care.

Competition for Tobacco Settlement Funds

Safety net institutions that have expected tobacco settlement funds to strengthen their ability to serve the uninsured are now bracing for the possibility that they may receive a smaller piece of the pie.

In 1998, an agreement between the 5 major tobacco companies and the attorneys general of 46 states, 5 commonwealths and territories, and the District of Columbia stipulates payments of $206 billion to the states over 26 years. Four other states settled individually with the tobacco industry for more than $40 billion. The settlement calls for certain public health provisions, and there is potential to use a portion of the funds to buttress safety net providers and help meet the basic health care needs of vulnerable populations. But already there is fierce competition for the money to meet other needs, and many safety net institutions are receiving less than they had counted on.

[1] See Section 3 for a summary of the evidence regarding Medicaid managed care plans sponsored by safety net providers, including reviews of articles by Bradford Gray and Catherine Rowe, and Michael Sparer and Lawrence Brown.

[2] Findlay, S. and J. Miller. Down a Dangerous Path: The Erosion of Health Insurance Coverage in the United States. National Coalition on Health Care, May 1999.

[3] Garret, B., and J. Holohan. "Health Insurance Coverage After Welfare." Health Affairs, 19 (1), Jan/Feb 2000.

Communities Experiment with Access Expansion

National reforms to significantly reduce the ranks of the uninsured are not on the near-term political agenda. While many states are active in expanding coverage among certain populations, particularly low-income children (through S-CHIP) and parents (through S-CHIP and Medicaid expansions), certain populations remain outside these systems, especially lower-income working families, adults without dependent children, and undocumented immigrants and their children. The precise profile of the uninsured population varies from community to community.

Some counties and safety net providers are responding by experimenting with ways to promote better patterns of care for the uninsured in their communities. The type of initiative on which we are focusing involves enrolling uninsured individuals and families into organized health plans that provide a designated set of benefits. These programs differ across communities in key features such as eligibility criteria, services covered, financing sources, and administrative entities. Yet many of the programs have common elements, such as membership cards, assignment of a medical home, some method of "managing" enrollees' care, and other features that distinguish them as "health plans" rather than as entities that provide last-resort, free care to the uninsured.

These programs aim to improve health and lower costs by reducing care in inappropriate settings and eliminating avoidable illnesses and hospitalizations. They also promote dignity for individuals who previously had been disenfranchised from the health care system, or treated poorly when they try to obtain care.

Health plans for the uninsured address three critical problems faced by uninsured people:

1. ***Lack of a medical home for regular primary and preventive care.*** The health plans that enroll uninsured people generally assign the enrollee to a primary care provider (PCP) who establishes a relationship with the individual and oversees their care.

2. ***Lack of care management.*** The health plans often provide an assessment by a case manager of the health, behavioral, and socioeconomic problems facing the enrollee and his/her family. The case manager helps arrange and/or makes referrals to social support services. Other efforts to improve patterns of care include the development of a care plan, and requiring referrals to specialists.

3. ***Discrimination against "charity care" patients.*** The health plans generally provide an enrollment card that puts enrollees on comparable footing with "insured" patients. The plans often reimburse individual providers for treating enrollees, which diminishes reluctance by providers to serve these individuals and promotes a sense of enfranchisement and dignity among enrollees.

These community-based health plans for *uninsured individuals* are the focus of this report, but they are not the only strategy being pursued to improve access. A few communities are trying to address the lack of practical, affordable coverage options for small businesses by developing low-cost or subsidized insurance products for small firms.[4] To maximize access expansion, these two approaches should not be viewed as opposing techniques, but rather as two *complementary* strategies that could be pursued in tandem. Indeed, the current lack of community initiatives that expand employer-based coverage adds pressure on the individual-based health plans to enroll and subsidize care for uninsured workers who otherwise might be able to get coverage through their workplace.

Finally, it must be emphasized that communities do not operate in a vacuum. Success of a local program often depends on cooperation and backing at the county, state, and sometimes federal levels. Such cooperation may take the form of funding, outreach/education, special legislation, or waivers. Similarly, expansion of community-based programs to a larger scale requires ongoing, adequate financial and political support from state and federal governments (discussed further in Section 4).

[4] See Table 4 in Section 3 for examples of community programs to expand employment-based health insurance in small firms.

SECTION 2. COMMUNITY PROFILES

METHODOLOGY

The following profiles are based on telephone interviews over the December 2000 to March 2001 period with program directors and/or other representatives knowledgeable about the history and current operation of the health plans. The profiles are also based on reviews of progress reports, articles, web sites, promotional literature, and other material providing relevant information.

The five health plans were selected from the programs associated with the W.K. Kellogg Foundation's Community Voices: HealthCare for the Underserved initiative if they met the following criteria:

- targets uninsured individuals;
- has an enrollment process and membership card;
- provides a defined set of benefits for a designated time period;
- assigns enrollees to a medical home;
- includes some method of managing enrollees' care;
- has a defined method of payment; and
- has been operating for at least six months.

Though the five health plans have the above features in common, there are important differences in terms of longevity and size of program, services covered (such as oral and mental health care), financing, challenges faced, and lessons learned. For example, the plans range in size from under 200 enrollees in one of the newer programs (FirstConnection began in May 2000) to approximately 14,000 enrollees in the oldest program (UNM Care Plan began in April 1997). The newer health plans (Family Care and FirstConnection) are still making adjustments to address implementation issues that arise, although even the older health plans are making modifications to address problems and improve their plans. (As noted earlier, the profiles are presented in order from oldest to newest.)

Other Community Voices grantees are involved in developing health plans for the uninsured, and a number are planning to implement insurance plans for small businesses. (Information about all Community Voices sites can be obtained at www.communityvoices.org.)

UNM CARE PLAN BERNALILLO COUNTY, NM

OVERVIEW

In April 1997, the University of New Mexico Health Sciences Center (the Center) began the UNM Care Plan (the Plan), a managed care program for uninsured residents of Bernalillo County, New Mexico. The Plan pools county indigent care funds with resources of local safety net providers, and links uninsured patients with primary care providers at accessible, neighborhood-based clinics in Albuquerque. It features "one-stop shopping," including comprehensive medical services, social services, case management, community outreach, and in some sites, behavioral health. The management of care has increased use of primary and preventive care, while reducing inpatient hospital stays and overall costs. The membership and payment mechanisms foster dignity for enrollees and eliminate the stigma of "charity care." As of February 2001, there were approximately 14,000 enrollees.

BACKGROUND AND DEVELOPMENT OF THE PROGRAM

The Center is New Mexico's largest safety net provider and its only academic health center. In a state with the highest rate of non-elderly uninsured (25.6 percent) and the lowest per capita income in the country, the Center has seen its uninsured patient population increase while revenue sources declined during the 1990s. Specifically, disproportionate share hospital (DSH) and graduate medical education payments from the federal and state governments have been declining, and competing managed care organizations are increasingly attracting Medicare, Medicaid, and CHAMPUS patients who had traditionally provided revenues for the Center.[5] Further, among the 30 percent of the Center's patients who were uninsured (about 30,000 patients per year during the mid- to late-1990s), many were receiving care at emergency departments and other settings that were both costly and inappropriate for the presenting problem.

The Center's primary revenue sources for serving the uninsured were federal DSH funds and, for county residents deemed "medically indigent," a local indigent

[5] CHAMPUS, which stands for the Civilian Health and Medical Program of the Uniformed Services, is the military health program.

care fund. These two sources did not meet the Center's uncompensated care costs, however, and the hospital was losing $1 million per month in 1997, threatening the Center's service and academic missions.

The Center responded by developing a managed care plan for uninsured county residents designed to contain costs while improving access to and quality of care. The "UNM Care Plan" was developed in partnership with county government, First Choice Community Health (a local network of community health centers), and the New Mexico Department of Health.

Obstacles Faced and Addressed

The Center faced many obstacles that needed to be addressed before implementing the UNM Care Plan in April 1997. Program planners addressed these barriers through a two-year planning process in which providers and administrators from the Center and other safety net institutions came together to learn about the needs and characteristics of the target population, and to design and develop the Plan. This process helped to eliminate misconceptions and fears, establish relationships, and build consensus on key strategies and plan features.

Among the barriers were the following:

- ***Inappropriate utilization of high-cost settings.*** With a minority of uninsured individuals able to identify their own primary care provider, many potential enrollees were accustomed to seeking care at emergency departments, urgent care centers, and specialist offices. UNM Care Plan creators needed to educate new enrollees about the role of PCPs and to strongly encourage their use except for true emergencies.

- ***Shortage of PCPs.*** With easy access to primary care providers as the cornerstone of the UNM Care Plan model, program planners had to deal with a severe shortage of neighborhood-based PCPs in the local service area. The Center addressed this problem by hiring 12 new primary care provider faculty and five family nurse practitioners, extending hours in two clinics, and increasing the number of clinical sessions for most primary care faculty.

- ***Resentment by providers.*** Under the "unmanaged" system, providers received very little compensation for serving uninsured patients. This contributed to resentment among providers and an incentive for some to create a two-tiered system of care that favored "paying" patients. The UNM Care Plan tried to address this problem by offering UNM PCPs a $4 per member per month (PMPM) "add on" to their salaries (as employees of a state institution) as an incentive to serve Plan members. This was less than the $6 PMPM rate among Medicaid enrollees, but on average, significantly more than prior compensation for serving the uninsured. (See Financing section, below, for current reimbursement policies.)

- ***Information system and infrastructure ill-equipped for managed care.*** The Center's patient information system, originally structured to conduct billing for physicians and hospital services, was not designed for "managed care" functions under the new Plan. New systems had to be expanded or developed including:
  - Quality programs–specialty referral guidelines, expanded disease management;
  - Member services–panel management, complaint procedures, satisfaction surveys;
  - Medical information systems–relational databases, practice-support reports;
  - Utilization management–prior approval/prospective and concurrent reviews, patient grievances;
  - Pharmacy management–plan-specific formulary; and
  - Primary care management–management team, oversight body, addressing of operational issues and creating consistency across sights.

  To help implement and monitor the Plan, the Center contracted with a state-licensed managed care organization to educate providers about the UNM Care Plan, track enrollment, monitor performance measures, and compile financial and resource utilization data.

- ***Fragmented coverage and frequent changes in Medicaid eligibility.*** Among a target population in which individuals frequently move on and off Medicaid, and in which children are often Medicaid-eligible but parents are not, program planners faced a challenge to provide continuity and consistency in coverage. They achieved this by designing a comprehensive benefit package and a "seamless" system in which relationships with PCPs

can be maintained as a patient moves from the UNM Care Plan to Medicaid and back. These features greatly reduce the fragmentation and disruption in provider-patient relationships usually faced by medically indigent families.

- ***Competition among safety-net providers.*** Declining funding for uncompensated care had led to severe competition and conflicts among previously "allied" safety net providers. Yet program planners were convinced that for the Plan to be successful, competing provider groups would need to pool resources and collaborate more closely. The two-year planning process that included the major stakeholders helped to break down rivalries and build up positive working relationships among groups within the Center, the local network of community health centers (First Choice Community Health, Inc.), and the Department of Health.

Program Description

Target Population & Eligibility

The UNM Care Plan targets the 15,000 to 20,000 uninsured residents of Bernalillo County who are considered "medically indigent" or "working poor." Eligibility is based on criteria for the Bernalillo County Indigent Fund, which includes:

- family income less than 235 percent of the federal poverty level (FPL);
- not eligible for Medicaid or other public insurance programs; and
- resident of Bernalillo County.

Those groups ineligible for the program include out-of-county indigents and residents who are not legal citizens.

Covered Services

The benefit package includes:

- services comparable to Medicaid benefits (except for the addition of co-payments and the absence of guaranteed behavioral health, see below), including outpatient and inpatient care, physician services, laboratory, and x-ray;
- choice of primary care provider (PCP) and a primary care clinic near home;
- reduced out-of-pocket medication cost using the Plan's formulary; and
- access to a 24-hour telephone triage system.

Enrollees do not pay a monthly premium. Unlike Medicaid coverage, there are co-payments, which are based on a sliding scale according to income. The co-payments are designed to encourage the use of primary care and discourage the inappropriate use of costly settings. The co-payments are: $5 per primary care visit if income is below 185 percent of the FPL, or $10 if income is between 185-235 percent of the FPL; $0 for prenatal and postnatal care; $15 per urgent care visit; and $25 per emergency room visit. Referrals are required for specialist visits, and prior authorization is needed for high-cost diagnostic and medical procedures.

Oral and Mental Health

The UNM Care Plan does not include dental services; UNM Hospital has chosen instead to contract out oral health care for the uninsured, although access has been severely limited under this arrangement.[6] In an effort to improve dental services for the uninsured and UNM Care enrollees, the UNM School of Medicine, Department of Surgery, Division of Dental Services, in collaboration with the Department of Health, the Kellogg Community Voices initiative, and local provider organizations, has developed an oral health program for the county's underserved. Utilizing contract and grant funding for services, eligibility is determined based on the same criteria as the UNM Care program. Currently, funds are used to guarantee access of enrollees and low-income undocumented adults to emergency dental services regardless of ability to pay. Funds are used to provide free preventive and simple restorative care for uninsured children and pregnant women. With the expansion of participating sites, recruitment of new dentist faculty has been successful. Collaboration with safety net providers will increase the availability of dental care (preventive and restorative).

The goal is to have a system operating by Spring 2002 that will meet the staffing needs of the safety net providers on behalf of their patients. Through the development of

[6] The University of New Mexico (UNM) Division of Dental Hygiene provides hygienist training at UNM Health Sciences Center Hygiene School facilities. In addition, UNM Hospital manages the County's Community Health Partnerships (CHP) grant program and purchases dental services for some of the County's uninsured through the local not-for-profit Community Dental, Inc. The CHP fund is a separate County Commission appropriation from the Bernalillo County Indigent Fund, though both go to UNM Hospital. Although the County Indigent Fund does not specifically fund dental care, improving the status of the oral health of Bernalillo County's uninsured continues as a high priority.

coordinated intake, assessment and referrals, utilizing the Community Access Program, it is anticipated that the uninsured and the underserved in Bernalillo County will have reliable access to a comprehensive oral health program. The efforts have increased the number of dentists from zero before the program, to its eighth faculty dentist.

Mental health services have not to this point been included in the UNM Care Program. Funding streams for the Bernalillo County Mental Health Center (BCMHC) and the UNM Hospital facilities have been separate. However, the BCMHC continues to annually exceed the county "mil levy" allocation for the value of services delivered in comparison to funds received. At this point, patients who do not have coverage are treated either through the Regional Care Coordination, a state funded network, or under the broader agreement with the county to provide indigent care. While not structured as a covered Behavioral Health program, benefits for indigent populations include the spectrum of services offered by Bernalillo County Mental Health Center: acute inpatient, routine outpatient, intensive outpatient, partial hospital, psych-social rehab psychotherapy, and case management. As indicated earlier, while these programs are not combined with the UNM Care Program due to the separation of the funding streams, the same financial qualifying criteria are used and the clients are essentially placed in a "Care Program" at BCMHC. UNM's strategic plan does include provision of behavioral health services within some primary care clinics. The BCMHC is in the process of recruiting two full-time staff positions, one for the South Valley First Choice Healthcare clinic and one for the UNM Family Practice Clinic. In addition, the BCMHC has hired a Nurse Practitioner to provide primary care.

Management of Care

Establishing a "medical home" for UNM Care Plan enrollees through assigned PCPs encourages primary and preventive care. The PCP manages the enrollee's care and helps avoid duplication of services or medications. In addition, case managers and social workers have been re-deployed from inpatient settings to neighborhood clinics, where they help patients and families deal with social and economic factors related to health in a "one-stop shopping" setting. Plan administrators understand that a commitment to addressing non-medical issues through social support services at the front-end can be cost-effective, reducing inpatient and costly care later on.

Financing

The $4 PMPM "add on" to reimbursement for UNM PCPs serving Plan enrollees (noted above) continued for about a year and a half after the program's start date. The Plan currently is modifying its reimbursement formula to disburse indigent care funds to UNM practitioners, over and above the base salary faculty receive as employees of a state institution.

First Choice practitioners have a different arrangement; in addition to federal funds and co-payments, they receive a portion of the County's $2 million annual "Partners in Health" fund for safety net provider organizations (CHCs, dental providers, etc.), which defrays some UNM Care costs. When that fund is expended, they then are paid approximately $60 per visit from UNM Care Plan funds. While this is costly to the Plan, it is less expensive than UNM hiring more primary care faculty to see these patients.

Specialists are paid on a reduced fee-for-service basis at rates far below those received for the uninsured prior to the Plan. This is acknowledged as a "disincentive" to serve Plan enrollees, and alternative mechanisms are being examined.

The primary source of revenue to the Center to defray the costs of uncompensated inpatient and outpatient care of indigent individuals is the local "mil levy" (county property tax). This fund contributed approximately $24 million in 2000, and after citizens recently voted to increase the levy, it is expected to increase to over $50 million by 2002. In addition, the University Hospital expects to receive about $12 million in federal DSH funds in 2001. A portion of these two sources of revenue funds the UNM Care Plan. In addition, the Center and the New Mexico Department of Health received a $3.7 million grant from the W.K. Kellogg Foundation's Community Voices: HealthCare for the Underserved initiative. The grant is being used to expand upon the model of improved health care quality and access; enhance interdisciplinary services such as behavioral health, social services, and dental care; expand the provider network; and adapt the model to the needs of other counties across the state.

The Center will participate with six other safety net provider systems in the four-county, Central New Mexico region in receiving additional funding from the Health Resources and Services Administration (HRSA) as a Community Access Program (CAP) grantee. This safety net partnership will collaborate in the integration of medical information systems, registration, eligibility,

sharing best practices, and training and deployment of community health workers. The goal is to increase efficiency and capacity by collaboratively enrolling all uninsured residents with their own PCPs.

Enrollment & Outreach

Uninsured people apply for UNM Care Plan enrollment at the University Hospital Business and Eligibility Office. New patients who meet eligibility criteria, and patients renewing their eligibility for the county Indigent Fund, are enrolled in the Plan. Currently there is no active advertising or marketing for the Plan, because the Center does not have sufficient primary care capacity to absorb a substantial increase in enrollment. Thus, the focus is on enrolling people who are already using UNM services and for whom the Plan can improve efficiency of care. It is hoped that through the CAP initiative, significant increased capacity will emerge throughout the seven safety net partners' systems and will allow increased enrollment in a UNM Care Plan-like program.

After eligibility is verified, new enrollees are educated by a Plan representative about benefits, enrollee responsibilities regarding co-payments, and other Plan elements. Finally, the new enrollee selects a PCP at a participating primary care clinic. The enrollee may choose among UNM primary care faculty, residents, nurse practitioners, or physician assistants in one of seven UNM-run clinics or among PCPs in one of five First Choice Community Health clinics. Women may receive primary care from an obstetrician-gynecologist or nurse midwife. Most enrollees select a PCP or clinic based on past relationships or proximity to their home. New enrollees receive a UNM Care Plan identification card listing their PCP.

Enrollment in the Plan averaged about 1,000 new patients per month during the first year, then about 350 per month during the second year. With some disenrollment due to movement in and out of Medicaid or the county equaling new enrollments, total membership has remained steady at about 14,000. The typical enrollee is a young adult woman (70 percent are between ages 19-49; 69 percent are female), and the largest ethnic group represented is Hispanic (56 percent).

Lessons Learned

Accomplishments

An analysis of the UNM Care Plan after its first two years of operation showed very promising results (see Table 1). Initially, the pent-up demand among the uninsured led to a large increase in primary care services soon after enrollment. However, by the end of two years, there were significant declines among Plan enrollees in utilization of ambulatory care services (primary care and specialty), ER visits, number of hospitalizations, and number of hospital days per 1,000 enrollees. These declines can be attributed to the early intervention by PCPs, incentives to avoid inappropriate costly hospitalizations, management of care through gate-keeping (prior approvals, referrals for specialty care), and provision of social support services.

The Plan saved an estimated $148 per member in inpatient and outpatient care in FY 1999. Nearly $2 million per year in savings to University Hospital is attributed to the UNM Care Plan, and the replacement of unpaid hospital days with paying patients is estimated to yield nearly $700,000 in additional revenues per year.

In 2000, the Center was awarded the "21st Century Award" from the National Association of Public Hospitals and Health Systems in recognition of its effort to extend health care services to large numbers of uninsured people through its UNM Care Plan.

Table 1: Performance Indicators of the UNM Care Plan

INDICATOR	FY 1998	FY 1999 (a)
Specialty care visits per member year (b)	**0.85**	**0.68**
Emergency department & urgent care visits per member year	**0.38**	**0.35**
Hospital days per 1,000 member years	**331.80**	**278.80**

(a) All differences are significant at the p<.0001 level.

(b) Member years are the aggregate number of months plan members are enrolled each year divided by 12.

Source: Kaufman, Arthur, Daniel Derksen, Stephen McKernan, Pamela Galbraith, Saverio Sava, John Wills, and Elizabeth Fingado. "Managed Care for Uninsured Patients at an Academic Health Center: A Case Study." Academic Medicine, Vol. 75, No. 4/April 2000, pp. 323-330.

Challenges to Program Planners

According to UNM Care Plan administrators, managing the care of uninsured patients can reduce utilization and costs if the plan addresses the specific characteristics and needs of the target population. For example, when serving a low-income population, a significant investment may be required in social support services such as translators, transportation assistance, and referrals for job training and literacy programs. Administrators also emphasize the importance of easy access to primary care; through adequate numbers of practitioners; reasonable waiting times; and convenient, neighborhood clinics. With a large portion of enrollees working or in a family with a working single parent, evening clinic hours are especially important, as well as 24-hour telephone triage as an alternative to seeking care in emergency rooms.

Plan officials also alert others who begin managed care coverage programs for the uninsured to expect an initial increase in demand for health services as enrollees seek care for problems they had previously neglected. This upsurge in outpatient care is temporary, however, and more than offset by a long-term reduction in avoidable hospitalizations.

While the UNM Care Plan model has many features that contribute toward its success, Plan officials point out some limitations that other program planners should avoid or address. One recommendation is to provide financial incentives (such as capitation rather than reduced fee-for-service) to specialists as well as PCPs. While referral and prior approval requirements led to reductions in specialty care, Plan administrators suggest better alignment of incentives and coordination between primary and specialty care.

A second limitation of the UNM Care Plan is the separation of the majority of behavioral health services at a separate facility, the UNM Mental Health Center. Program planners should attempt to integrate behavioral health into community-based, primary care settings. In 2000, the UNM Mental Health Center implemented a parallel, managed system for the uninsured tied to the UNM Care Plan model, and is planning to integrate and co-locate some of these services in the near future.

Finally, there should be greater efforts to enroll the approximately 10,000 people who are eligible but not enrolled, along with efforts to expand primary care capacity. Further, consideration should be given to expanding the Plan or creating a modification of the Plan to serve undocumented immigrants and uninsured patients who do not reside in the county. Without such access to enhanced primary care, the Center faces substantial, avoidable emergency and specialty visits and hospitalizations.

In sum, with declining funding streams, a managed care model that pools resources among safety net providers appears to hold much potential. These health plans enfranchise the uninsured, enhancing personal dignity, improving care-seeking practices, and improving patient status (and thereby access) in the eyes of providers. The safety net providers need to overcome rivalries and join as natural allies to better manage the care of the uninsured. Such a collaborative design brings challenges in terms of achieving consensus and cooperation, but also allows for greater access to resources and economies of scale.

Public policies that enable states to pool indigent funding (including federal Medicaid matching funds) and direct them toward such community-based efforts could help replicate and expand this model. Easing up on prohibitions against federal funding for undocumented immigrants could also enable community planners to better meet needs of local, vulnerable populations.

Contact for More Information

Arthur Kaufman, M.D., Professor and Chair, Department of Family and Community Medicine, University of New Mexico, (505) 272-2165; e-mail: Akaufman@salud.unm.edu.

Sources:

Kaufman, Arthur, Daniel Derksen, Stephen McKernan, Pamela Galbraith, Saverio Sava, John Wills, and Elizabeth Fingado. "Managed Care for Uninsured Patients at an Academic Health Center: A Case Study." Academic Medicine, Vol. 75, No. 4/April 2000, pp. 323-330.

Personal communication with Arthur Kaufman, M.D., Professor and Chair, Department of Family and Community Medicine, University of New Mexico, January-February 2001; and Wayne Powell, Director of Community Outreach/Development, UNMHSC Office of Health Services, May 2001.

Press Release: HSC News Release: UNM Health Services Center Recognized for Efforts to Expand Access to Health Care, August 29, 2000.

INGHAM HEALTH PLAN
INGHAM COUNTY, MI

OVERVIEW

Ingham Health Plan (IHP) is a health coverage program for uninsured residents of Ingham County, Michigan with incomes below 250 percent of the federal poverty level (FPL) who are not eligible for Medicaid or other public coverage programs, and for former enrollees in the State Medical Plan (SMP) program.[7] The Ingham Health Plan Corporation (the Corporation) is a non-profit organization that was created to administer the IHP program through a nine-member, community-based board of directors. IHP is not an insurance product, but provides a defined set of outpatient services to enrollees. Services must be provided at participating locations and by participating providers (unless otherwise authorized), and, for most enrollees (excepting SMP enrollees), services may be limited if funds are not available to pay for them. The program links enrollees to a medical home, or a regular and consistent source and site of primary care, and uses managed care principles (e.g., prior authorization for specialty care) to promote preventive care and appropriate utilization of services. The program was launched on October 1, 1998, and as of February 2001 enrolls 11,500 individuals, including roughly 1,200 former SMP enrollees.

BACKGROUND AND DEVELOPMENT OF THE PROGRAM

In the aftermath of the Clinton Administration's failed efforts to pass a national health reform plan in the mid-1990s, policy experts from around the country predicted "dire consequences" for safety net providers struggling to provide care to low-income populations and to survive in an expanding Medicaid managed care climate. Ingham County Health Department, which operated nine health clinics at the time, realized that it needed to start aggressively planning ways to address the health issues confronting the county's uninsured residents at the local level. The county already was dedicating a significant amount of financial resources to its primary care clinics (about $2 million in local funds), and it anticipated an increasing number of uninsured. At the time, estimates of the uninsured in Ingham County, which includes the state capital of Lansing, were 25,000-30,000, or 10 percent of the county's population.

County officials considered several options to improve access to care for uninsured residents. One option was to devote additional money to expanding Medicaid; another was to focus on increasing access to much needed services for the lower-income uninsured population. The county chose the latter option, believing that improving access to primary care, specialty care, diagnostic services, and prescription drugs would be the best investment of limited financial resources.

The decision to create the IHP program appears to reduce the number of people who identify themselves as uninsured. The people covered by the IHP carry a membership card, are assigned to a medical home, have benefits that are set forth in a membership booklet, obtain medicine from virtually any pharmacy in the community, and are referred for specialty care and diagnostic services. In a recent Health Assessment Survey performed by the Health Department, some IHP-covered respondents did not identify themselves as being uninsured, mentioning they had coverage through the IHP.

To develop IHP, Ingham County first received a small grant from the Robert Wood Johnson Foundation to fund health-based community development programs. Ingham County also received a grant from the W.K. Kellogg Foundation's Community Voices: HealthCare for the Underserved initiative, which was used to increase community awareness and support for the development of Ingham County's Community Voices initiatives and for marketing materials for the IHP program. As a Community Voices grantee, the county developed a multi-pronged approach to improving access to care for its low-income uninsured and underserved residents. IHP is one component of the Ingham County Community Voices initiative.[8]

The county has been approved and funded by the Health Resources and Services Administration (HRSA)

[7] The State Medical Plan is a state program for individuals with very low incomes (< $263/month) who do not qualify for Medicaid. Many of these individuals have chronic health conditions, particularly mental health and substance abuse problems.

[8] Other initiatives include Access to Health (community input process to develop recommendations for an organized system of care for the uninsured in Ingham County); Democratized Data (web-based information and referral mechanism allowing providers and individuals to identify community resources for meeting health and human service needs); Leadership Institutes and Health Summits; and Health Realization (educational effort to help residents understand how their daily lives impact their health). New initiatives of the Community Voices initiative include an Oral Health Task Force and an African-American Health Institute.

as a Community Access Program (CAP) grant recipient. The CAP grant will allow the IHP Corporation to: 1) recruit more primary and specialty care providers and offices, 2) implement a program to help providers render age and sex appropriate preventive and disease-management services and document the number of people who receive recommended services, 3) undertake a patient visit redesign process intended to improve patient and provider satisfaction, and 4) increase member participation in their own care through the creation of advisory committees at certain health centers.

Obstacles Faced and Addressed

The major obstacles the county addressed in implementing IHP were determining the basic design of the program, developing a stable source of financing, and obtaining provider acceptance.

- ***Coverage product versus insurance plan.*** The primary reason the county created a "benefit product" rather than an "insurance product" was limited funding. Insurance products in Michigan are subject to a variety of insurance regulations, including a state-mandated minimum set of benefits, and, therefore, are significantly more expensive to maintain. The county believed its goal of providing access to primary and preventive care services to a large portion of its uninsured population would be best met by offering a benefit product with a limited, structured set of benefits (see Covered Services, below). In this way, the county felt it would not "over-promise" on the services it could provide and could serve more people with a given budget. According to a county official, the county currently is paying one-third or less of what it would be paying had it decided to develop an insurance product.

- ***Developing a financing mechanism.*** Once the county decided on a program focus and basic design, it was confronted with the task of developing a stable and sufficient source of financing. The primary goal of IHP was to cover 14,000 uninsured individuals in the county with incomes below 250 percent of the FPL, and over time to develop coverage strategies for all other uninsured people, linking them with organized systems of care. Cost estimates for the program at full implementation were roughly $6 million. County officials identified several sources of funding that could be used, but knew that state officials would need to be convinced to use the funds. The county wanted to combine the money it already designated to fund indigent care at its health clinics ($2 million) with the money the state used to fund the SMP program for SMP-eligibles in Ingham County ($1.2 million).[9] These two sources would serve as an "add-on" to the state's share of the Medicaid disproportionate share hospital (DSH) payment going to the county's two hospitals (Sparrow Health System and Ingham Regional Medical Center), and would be used to draw down additional federal DSH matching funds of $3.4 million.[10] This special DSH payment would be entirely separate from the DSH money already going to the hospitals, and it would be "passed through" to the IHP Corporation.[11] (That is, the hospitals would not lose their portion of the DSH payment.) With the help of Health Management Associates, a private consulting firm based in Lansing, the county developed the funding mechanism and convinced the state that this would be an appropriate use of funds and would be sufficient to fund the IHP program. (State Medicaid approval was necessary because this money constituted a "special" Medicaid DSH payment.) In addition, the IHP Corporation agreed to provide care for the SMP population in Ingham County and to maintain for this population, at a minimum, the benefit level of the SMP program.

- ***Provider acceptance.*** By law, DSH payments must be made to hospitals. In addition, total DSH payments to a hospital (from both state and federal sources) are capped according to the level of the hospital's

[9] In most other counties in the state, SMP-eligibles are still enrolled in the SMP program.

[10] The Medicaid DSH program provides a special Medicaid payment (comprised of a non-federal or state portion and a federal match) to hospitals that serve large numbers of low-income uninsured and Medicaid patients. The payment is "designed to strengthen the financial situation of hospitals in light of their disproportionate burden." States generate their portion of the DSH payment to local hospitals through a variety of sources, including provider taxes and general revenues. This amount, which is determined based on the state's DSH formula, is used to drawn down a federal DSH match, which ranges in percentage based on the state' Medicaid federal matching rate. In Michigan, the federal match is 56 percent and the state portion is 44 percent.

[11] There is a cap on the amount of DSH money each hospital can receive, but there is sufficient room in the available hospital DSH caps to accommodate what the hospitals receive and what IHP draws down.

provision of care to low-income populations. Ingham Regional Medical Center's (IRMC) total DSH payment is capped at $3.6 million, and Sparrow's is capped at roughly $7 million. Therefore, the county would at least need the approval of Sparrow to fund the program at its full implementation cost of $6.6 million. Sparrow, however, initially was skeptical of the program and did not sign an agreement to actively participate until 2000. At the time, the hospital believed that the county should fund more comprehensive care (including inpatient hospital care which IHP does not currently cover) for a smaller number of uninsured individuals, rather than a less comprehensive benefit (outpatient plus prescription drugs) for a larger number of people. The hospital's argument was somewhat self-protective, as they, like other providers, were adversely affected by cuts in reimbursements under the Balanced Budget Act of 1997 and increased competition for managed care patients and funds. IRMC had similar concerns, but overall felt that IHP would be a beneficial program for the community. According to one IHP Corporation official, the "hard feelings" that were evident at the outset have since been overcome. The County has addressed the hospitals' concern, in part, by setting aside $500,000 annually to give to the hospitals to help pay the costs of non-covered services, including inpatient hospital care.

Program Description

Target Population & Eligibility

The initial goal of the program was to enroll 14,000 uninsured residents of Ingham County with incomes up to 250 percent of the FPL, including 1,400 former enrollees in the State Medical Plan. As noted earlier, SMP is state-run coverage program for very low-income individuals, often with special health needs, who are ineligible for Medicaid. According to program officials, "immigration status is not an issue for program eligibility," so undocumented individuals who reside in Ingham County and meet the income eligibility criteria can and do enroll in the program. The enrollment staff at IHP determines eligibility for the uninsured population, while the state continues to determine eligibility for the SMP population.

Covered Services

IHP enrolls two groups of enrollees: former enrollees of the State Medical Plan program, and previously uninsured individuals with incomes below 250 percent of the FPL.

Both former SMP and uninsured enrollees receive coverage for:

- outpatient physician services, including outpatient primary and specialty care;
- outpatient laboratory and x-ray (radiology); and
- pharmacy services (prescription drugs) based on strict formulary.[12]

Former SMP enrollees also are covered for:

- outpatient hospital services;
- emergency services; and
- durable medical supplies.[13]

For formerly uninsured individuals, a copayment of $5 is required for primary care, x-ray, and generic pharmacy services, and a copayment of $10 is required for specialty care and brand-name drugs. There is no copayment for laboratory services. Former SMP enrollees do not have any copayments. Neither group is covered for inpatient hospital services, although most IHP enrollees are eligible for free or low-cost care through the hospitals' charity care programs. As noted above, the IHP Corporation also has set aside $500,000 per year in grants to the participating hospitals to help pay for non-covered services. IHP enrollees (both groups) also are not covered for organ transplants, blood transfusions, vision and hearing, dental care, mental health and substance abuse services, weight loss, and hospice, among other services.[14]

Oral and Mental Health

Although IHP currently does not cover oral health, data suggests that a large number of emergency room encounters by IHP enrollees are instigated by underlying oral health conditions. To address this issue, program officials have been in discussions with a local dental health provider network, which is submitting a proposal to IHP to provide a limited dental benefit for a subset of the IHP population. Because of limited financial resources, the

[12] Former SMP enrollees are not subject to a strict prescription drug formulary.

[13] As a condition for using the money formerly dedicated to the SMP program, IHP accepted the responsibility of providing coverage for the SMP population at its previous level.

[14] Although many SMP enrollees have mental health conditions, they are not guaranteed these services through the SMP program. However, many of these individuals receive mental health services through the Community Mental Health program.

proposal currently focuses on the SMP population and will cover preventive oral health care (e.g., extractions and fillings). It also may cover the preparation and fittings for crowns and dentures. Program officials hope to include this new preventive dental benefit in the FY 2002 IHP budget. IHP is aware, however, that oral health needs extend beyond preventive oral health services. The County Health Department, which operates an adult dental clinic, is overwhelmed with a demand for oral health services and is not accepting new patients. There currently is a one-month wait for emergency room oral health visits.

On a community-wide basis, the Ingham County Community Voices initiative has developed an oral health task force to improve and expand access to oral health care for county residents, particularly for Medicaid-eligible children through the creation of a children's dental clinic operated by the County Health Department.

Mental health services are not covered by IHP beyond certain prescription drugs (e.g., Prozac and various anti-anxiety drugs) covered under the program's formulary. These drugs represent a significant portion of IHP's pharmacy bill. For years, the Tri-County area (Ingham, Eaton, and Clinton counties) has operated the Adult Mental Health Program, which it is required to do by law. However, in an effort to "balance its budget," the program recently eliminated its outpatient mental health program, and is accepting only "the most seriously ill" and turning away others. According to IHP, this effectively is pushing people out of the Tri-County program and into IHP, which is "depleting [the program's] coffers." Unfortunately, IHP does not have the financial resources to fill in the gaps in mental health services for people who no longer qualify for the Tri-County program. According to IHP officials, these individuals have serious/chronic mental health conditions and require costly care.

To help address this issue, the Ingham County Mental Health Agency and Substance Abuse Agency are co-chairing a task force on mental health and substance abuse issues. The task force hopes to identify gaps in the provision of these services and determine the level of resources that are required to meet the needs.

Management of Care

IHP provides membership cards to all enrollees, and assigns enrollees to a primary site of care so individuals have a medical home. Access to specialty care, which is coordinated by case managers and IHP staff on an as-needed basis, requires prior authorization.

The provider network for IHP initially included only the nine health clinics associated with the County Health Department. Cristo Rey Community Center, which operates a community health center serving primarily Hispanic patients, was added in March 1999. Only recently, the program was expanded to include a tenth county health clinic and a variety of other providers. Today, IHP has 29 primary care sites, including 10 county health clinics, Cristo Rey Health Center, IRMC's Mid-State Physicians (14 physician group sites), Michigan State University (MSU) Health Team (3 sites), and Dr. Jon Cooper of South Cedar Osteopathic, P.C. The provider network also includes 30 pharmacies (coordinated by one pharmacy benefit manager), Sparrow Regional Laboratory, three Radiology groups, and various specialists. IHP has had difficulty in recruiting ENTs (ear, nose, and throat doctors), dermatologists, and neurosurgeons. To ensure quality care, IHP is selective in expanding the network; providers must demonstrate they have contracts with existing HMOs so the county knows they have appropriate credentials.

IHP has one full-time employee (FTE) case manager, a job that is split between two individuals. The case managers work with enrollees with special health needs (e.g., diabetes), their families, and providers to discuss care needs, develop an informal care plan, and select appropriate specialists. The case managers, like all IHP staff, are involved in authorizing specialty services, paying claims, and assessing eligibility for Medicaid and other public coverage programs. The case managers also help enrollees apply for free care under the hospitals' charity care policies.

Administration

IHP is managed by the Ingham Health Plan Corporation, which has a ten-member board of directors. All of the board members are from the local community and include current or former city, county, and state officials; physicians; representatives from the two participating hospitals/health systems; and, pursuant to IHP Corporation's charter, two enrollees of IHP. The board members' two- to three-year terms are staggered, and members are nominated and appointed by an IHP Corporation nominating committee. The County Health Department also is actively involved in the program's implementation. In addition, the

Table 2: Enrollment in IHP

DATE	TOTAL ENROLLMENT	SMP ENROLLEES
October 1998	1,463	1,463
January 1999	6,016	1,273
July 1999	8,362	1,481
October 1999	8,426	1,648
February 2000	9,482	1,769
October 2000	11,638	1,760
February 2001	11,500	1,200

Source: Ingham Health Plan Corporation, 2001.

IHP Corporation receives consulting and legal assistance from three local private firms.

Financing

As noted above, IHP is financed through a special disproportionate share hospital payment that was created from the combination of three funding sources. The funding sources are:

- local government health care funds of $2 million (generated from county tax revenues) used to support indigent care provided by the county health clinics;
- state funds designated for SMP enrollees, which are $1.2 million per year; and
- federal Medicaid DSH matching funds, which are $3.4 million per year.

This special DSH payment of about $6.6 million is made to the two local hospitals that participate in the program. The hospitals do not contribute any of their own revenues or DSH allotment for inpatient care, they simply "pass through" the local, state, and federal Medicaid combined payment to the IHP Corporation. The IHP Corporation, in turn, distributes the money to IHP providers who provide direct services; the County Health Department, which provides enrollment, data management, and case management services; and consultants to the Corporation.

IHP budgets an average of $40 per person per month (PMPM) to provide benefits to its enrollees. Participating providers are reimbursed $12 PMPM for providing primary care services to uninsured enrollees and $41 PMPM for SMP enrollees. (As noted earlier, the SMP population typically is a sicker population than the uninsured population and is covered for more services.) Specialty care, x-ray and pharmacy claims are paid on a Medicaid fee-for-service basis. The PMPM costs for pharmacy benefits are $25.81 for SMP enrollees and $1.68 for uninsured enrollees, which are both slightly below the budgeted amount. Lab and radiology rates are each capitated at $.50 PMPM. Specialty care is paid on a fee-for-services basis, and has cumulatively cost $5.93 PMPM to date.

Enrollment & Outreach

As of February 2001, there are over 11,500 enrollees in Ingham Health Plan, including roughly 1,200 former SMP enrollees. This represents one-third of the uninsured population in the county. The first group enrolled in IHP was the former SMP population, which included 1,463 individuals (see Table 2). IHP then enrolled uninsured individuals that were receiving care at the county's primary care centers. Uninsured individuals at Cristo Rey Health Clinic were enrolled in March 1999.

The racial makeup of the former SMP and uninsured population enrolled in IHP is fairly comparable. Over half (52 percent) of the SMP enrollees are white, while 26 percent are black, 6 percent are Hispanic, 2 percent are Asian, and 14 percent are of other races. Uninsured enrollees are 56 percent white, 22 percent black, 10 percent Hispanic, 3 percent Asian, and 9 percent of other races.

In general, IHP conducts only limited marketing of the program to avoid "overpromising" on the services it can provide with its current budget. Program officials feel it would not be fair to aggressively seek new enrollees until they are sure they have the provider capacity and funding to do so. Although IHP recently expanded the provider network, officials need time to train providers and gauge

their willingness to accept enrollees. Most providers are willing to accept "10 or 20 or 40" individuals, but not 100. In the first week of February 2001, IHP officials announced that they have the capacity to enroll an additional 900 individuals, bringing them closer to their enrollment goal of 14,000, which they had hoped to reach by December 2000.

Currently, social service agencies and the participating hospitals refer individuals to the program, and the program accepts "walk-ins" who hear about the program though word-of-mouth. The county has 4.5 FTE "enrollment specialists" who assess each individual's coverage status to determine if they are eligible for other coverage programs, including the state's Medicaid and S-CHIP programs and the Medical Access Program, a previous county effort to coordinate all free care services for uninsured residents of the county through the coordination of volunteer providers.

Future Plans

The IHP Corporation has the following plans for the Community Voices initiative:

- ***Capital Area Prescription Program (October 2000).*** While not part of IHP, this program was created by the IHP Corporation. This program initially was for individuals ages 60 and over without a prescription drug benefit. Eligibility was expanded in April 2001 to include any person of any age and income in Ingham, Clinton, and Eaton Counties who does not have a prescription benefit. Enrollees are required to pay a 100 percent co-payment on the drugs, but the co-payment applies to a discounted price the program receives from using the IHP network of pharmacies. Drug discounts range between 15-75 percent, but average roughly 20 percent of the retail price. The Corporation finances the administration of the program through manufacturer rebates on senior prescription drug claims. There currently are 1,300 enrollees in the program.
- ***Subsidized Health Insurance Program for Low-Wage Employers (developed, but not yet implemented).*** This is a product that was designed to cover 1,000-3,000 low-income workers through small businesses that do not offer health coverage. The product will be financed through a "three-way split" among the employer, employee, and an IHP Corporation subsidy to local HMOs, which would manage the product. Premiums are estimated to be $120 PMPM. This product will cover inpatient care.
- ***Community Access Program (CAP) Grant (approved and funded as of March 1, 2001).*** The CAP grant proposal, submitted to HRSA, seeks funding for a variety of initiatives, including to sustain IHP's capacity to enroll 14,000 formerly uninsured individuals in Ingham County; expand the IHP program to the "Tri-County" area by including Eaton and Clinton Counties; add new primary and specialty care providers to the network; increase the efficiency with which providers can access data on patients; improve enrollment and referral linkages to community sites; and increase access to mental health and substance abuse services. The proposal outlines a three-year phase-in process.
- ***Student Health Insurance Initiative (still in development).*** This program, which will be administered by the IHP Corporation, will provide access to health insurance or health coverage for 3,000-5,000 MSU students.
- ***IHP for Kids (still in development).*** This program would be a joint effort between the IHP Corporation and local schools to make the IHP program the "default" coverage for students enrolling in schools. If necessary, eligible children would then be linked to Medicaid or the state S-CHIP program (MIChild).

Lessons Learned

The main lesson IHP Corporation officials have learned is that a county can provide basic, but essential, health benefits to different segments of its uninsured population at an affordable cost. Counties do not necessarily have to limit their coverage initiatives to the "sickest" segments of the population (e.g., the SMP population). In fact, the majority of IHP's almost 12,000 enrollees are young, fairly healthy, and are not excessive users of health care resources. When a county targets a limited amount of funding to primary and preventive care, with wraparound social services, it can help a lot of people for the dollars invested. State and local funds can also be used to leverage additional support from the federal government, enhancing the impact on access to care.

According to program officials, they are providing a basic level of coverage for uninsured people for less than the cost of commercial insurance ($40 per person per month compared to $120-$200 per person per month).

This is important because one of the biggest obstacles to covering uninsured people is cost. While IHP coverage is limited, the program is applying this money toward providing prescription drugs, specialty care, and diagnostic services–and reimbursing providers for them–to individuals who rarely received these services before. In addition, the program is able to offer a prescription drug benefit for less than an average of $10 PMPM by offering a strict formulary of primarily generic drugs and a few brand-name alternatives. There have been very few complaints from enrollees about the strict formulary, as most enrollees did not have drug coverage at all prior to enrolling in the program. IHP officials point out that many drug formularies are the other way around, and, therefore, are very expensive.

Even though IHP is not an insurance product (and thus not bound by insurance regulations), it is often perceived as such. To patients, providers, and the community, IHP looks like a managed care plan and enrollees with membership cards and a primary care provider "feel" like they have health insurance. Program officials emphasize that IHP enrollees are treated with dignity and "get care in the same way that we get care." In addition, IHP can be evaluated in the same manner as an employer-sponsored insurance plan or Medicaid. In fact, Health Plan Employer Data and Information Set results will be generated for the program when it is evaluated as part of the Community Voices and CAP initiatives.

Finally, a key issue in developing any community-based program to improve access to care is identifying a viable source of financing. In Ingham County, officials and program consultants creatively leveraged county and SMP funds to attain federal Medicaid DSH matching funds.[15] That is, they knew they could draw down federal Medicaid matching dollars if they could identify funds to make up the state's portion (e.g., non-federal portion) of the Medicaid payment. Other communities in Michigan (Wayne and Muskegon County) had previously created similar financing mechanisms to support community-based health programs. While amendments to the state's Medicaid plan were necessary to direct Medicaid funds to these programs, federal approval was not necessary. Consequently, in most cases, communities, counties, and the state (primarily through the state budget office rather than the state Medicaid program) must "buy into" the program.

Contact for More Information

Bruce Miller, Ingham Health Plan Corporation, (517) 887-4311; e-mail: hamiller@ingham.org.

Sources:

Ingham Community Voices: Overheads/Handouts for Project Directors Meeting, November 27-29, 2000.

Ingham County Community Voices web site: www.communityvoices.org/LL-Lansing.asp

Notes from the Road: Ingham County Community Voices, Julie Pratt, December 4-6, 2000.

Personal communications with Bruce Miller, Ingham Health Plan Corporation, and Doak Bloss, Ingham County Health Department, February 2000.

W.K. Kellogg Foundation's Community Voices: HealthCare for the Underserved web site: www.communityvoices.org.

Primary Care Plan El Paso County, TX

Overview

The El Paso Community Voices Primary Care Plan for the Uninsured (Primary Care Plan) was developed by the El Paso Collaborative to provide health insurance coverage to some of the county's 70,000 uninsured individuals below 100 percent of the federal poverty level (FPL). The plan is administered by El Paso First Health Network (EPFHN), a managed care plan owned by the El Paso County Hospital District that was developed concurrently with the Primary Care Plan to serve the county's Medicaid, S-CHIP, and medically indigent managed care population. The program provides insurance coverage for a comprehensive set of benefits; links enrollees to a "medical home"; and uses managed care principles to promote prevention, continuity of care, and cost-efficient care. The program began enrolling people in April 1999. As of March 2001, EPFHN had roughly 2,500 Primary Care Plan; 15,000 S-CHIP; and 8,400 Medicaid enrollees. Enrollment is continuing to increase in each of the programs listed above.

Background and Development of the Program

El Paso County's demographic and geographic characteristics make it unique among American metropolitan areas. With a population of 700,000, El Paso has over 300,000 individuals with incomes below 200 percent of

[15] Officials note, however, that there are "non-Medicaid" potential sources of financing.

the FPL. El Paso has one of the highest uninsurance rates in the U.S., with 240,000 individuals–or 34 percent of the county's population–lacking health insurance. About 70,000 uninsured individuals (or 30 percent of the uninsured) have incomes below 100 percent of the FPL. In addition, over 300,000 individuals are underserved, meaning that even though they may have periodic access to health insurance, they are confronted with multiple barriers to receiving such care, including language and transportation barriers.

Located on the border between the U.S. and Mexico, the county has a large number of undocumented individuals (estimated to be between 80,000 and 100,000), and large bilingual and binational populations. In 1999, over 75 percent of the population was Hispanic. Many individuals go back-and-forth across the border to receive health care because, particularly for uninsured individuals, services are significantly cheaper in Mexico than they are in the U.S. Further, county officials cite a decreasing number of health care providers in the area; El Paso will soon become the largest city in the United States without a children's specialty surgeon. Additionally, the county has a growing number of unemployed individuals; with the current rate at 9.8 percent, the unemployment rate is almost double the national average.

To compound these problems, safety net providers have been losing patients and sources of funding due to cutbacks in federal and local funds for health care, the increase in managed care in the area, and the prevalence of commercial HMOs. The county's medically indigent program that helped fund services provided by the county's clinics and hospital has slowly cut back its budget in line with federal cuts in Medicare and Medicaid reimbursement.[16] Community-based health and social service organizations serving low-income and uninsured individuals have been competing for scarce funding and have all lost money in the process.

In addition, the last time the Hospital District increased taxes was in 1988. According to county officials, El Paso is a "property poor community." One recruiting tool to bring attractive jobs to the community has been to defer taxing companies in exchange for the creation of jobs. This has resulted in a lower tax base–or total pool of money from various taxing mechanisms–in the community. In addition, residents already are taxed at a higher rate than in many other parts of Texas. This situation creates limitations in the number of times (and the amount) the Hospital District can realistically raise taxes.

In response, a group of these organizations formed a collaborative in the late-1980s to address the array of problems facing their clients. The group was officially established by the El Paso County Commissioners Court and called the Lower Valley Health Task Force. The collaborative included most of the county's non-profit community health centers (CHCs), the Federally-Qualified Health Centers, the City/County Health Department, the county's non-profit teaching hospital (Thomason Hospital), and other safety net providers from around the community. The primary goal of the collaborative was to identify the community's health and social service needs and discuss ways to avoid duplication of services. In the early stages of the collaborative, the members mostly discussed "turf issues, geographic catchment areas, and our missions" to make sure they were "on the same wavelength." However, with rising numbers of uninsured and declining financial resources, the collaborative members soon realized that to survive, they needed to "survive together" as an integrated health care delivery system for the county's underserved population.

The W.K. Kellogg Foundation's Community Voices: HealthCare for the Underserved initiative gave the collaborative the means to achieve this goal. The El Paso County Hospital District applied for a grant from Kellogg and received $4.2 million for the five-year Community Voices initiative. The El Paso County Hospital District matched this amount and also provided a $10 million "rollover" of funds to pay for health care services for the medically indigent. The Kellogg grant primarily subsidized staffing to operationalize program goals and objectives, which included focus groups to identify needs, meetings, and infrastructure development.

The El Paso Community Voices initiative is a partnership between the El Paso Community Voices Collaborative, EPFHN, the El Paso County Hospital District, and other core partners in the El Paso community. Many of the member organizations have been a part of the collaborative since it was originally formed in the late 1980s.

[16] Medically indigent individuals have no medical insurance, have very low incomes, and often receive financial assistance through public-assistance programs, such as Temporary Assistance for Needy Families (TANF). These individuals often are at high-risk for diseases and adverse health conditions and typically receive health care services on an as-needed basis at hospital emergency departments.

The collaborative wanted to target "truly medically indigent" individuals; high-risk individuals who were not even casual users of the services provided by the collaborative members (the hospital, CHCs, and safety net providers). Faced with limited resources, the county "went where we thought we could have the most dramatic impact."

The Community Voices Primary Care Plan, administered by the EPFHN, is one of several projects of El Paso's multi-phase Community Voices initiative. The phases are:

- ***Phase I.*** The Community Voices Collaborative designed the Primary Care Plan for the medially indigent concurrently with the Medicaid managed care plan administered by EPFHN. EPFHN now serves Medicaid, S-CHIP, and Community Voices' Primary Care Plan enrollees.
- ***Phase II.*** The collaborative developed an enrollment strategy for the Primary Care Plan and began operating the plan.
- ***Phase III.*** The collaborative is in the process of evaluating data from the Primary Care Plan to identify new ways to expand enrollment or benefit options, such as oral and mental health benefits.
- ***Phase IV.*** The collaborative is in the early stages of developing a community-wide organized system of care that will entail sharing information among providers (in both El Paso and Juarez, Mexico) and improving continuity of care for consumers. The ultimate goal is to develop "cost-effective, efficient, and replicable models" for other parts of Texas and the Southwest.

The goals of the Primary Care Plan are to: 1) improve enrollees' health status, 2) reduce emergency room visits, and 3) reduce overall medical expenditures. It was modeled after the Hillsborough County (Florida) Health Plan for the Medically Indigent, which started in 1992. Hillsborough County officials visited El Paso Community Voices during the development of the Primary Care Plan and served as "outside experts" in an all-day seminar that drew over 90 participants. At the time, the Primary Care Plan did not generate significant opposition. The collaborative held a public hearing at which "all of the interest groups were represented." According to program officials, each interest group, including advocates for the elderly, oral health, and mental health, wanted the Community Voices grant to focus on their particular issue. However, the collaborative "went with where we thought we could get the biggest bang for the buck."

Obstacles Faced and Addressed

Because the county had formed a strong collaborative with common goals in the late 1980s, there were not many obstacles in developing the Community Voices Primary Care Plan. However, there were a few stumbling blocks.

- ***Should children be eligible for the program?*** There was a "philosophical debate" among collaborative members early on in the development of the Primary Care Plan as to whether children should be eligible. Children in the targeted income level were eligible for Medicaid (S-CHIP was not implemented yet), but many were not enrolled. There are still over 100,000 children eligible for Medicaid and S-CHIP in El Paso who are not enrolled in the programs. Initially, children were eligible for the program and comprised the largest percentage of program enrollees (almost 40 percent). Once the state's S-CHIP program was rolled-out in June 2000, children were transitioned into Medicaid and S-CHIP during the recertification process. Consequently, the program's enrollment numbers have dropped significantly (see Enrollment and Outreach below). Still, there are a number of children under 19 years of age who do not qualify for Medicaid or S-CHIP due to undocumented status or the too recent attainment (after the 1996 welfare reform) of legal permanent resident status. This issue is still under review, but currently only adults over 19 years of age are being enrolled into the plan.
- ***Very low early enrollment numbers.*** For several months after the program began, the enrollment numbers were very low (about 160 enrollees). Officials struggled with ways to increase enrollment before stepping up their outreach and enrollment efforts using 10 Community-Based Organizations (CBOs) that "went anywhere that people congregate," including neighborhood events, schools, community centers, and churches. This strategy proved quite successful; whereas program officials thought they could phase-in a "significant number" of new enrollees over a six-month period, they enrolled 7,000 individuals in six weeks.

PROGRAM DESCRIPTION

Target Population & Eligibility

The eligibility requirements for the Primary Care Plan are:

- Adults ages 19 and over;
- Incomes at or below 100 percent of the FPL;
- Residents of El Paso County; and
- Not eligible for government-funded programs.

Enrollees are eligible for one year, as long as their eligibility status does not change–e.g., due to a change in economic or resident status or they become eligible for other public programs. Individuals then go through a recertification process for another year of eligibility. Upon enrollment, individuals are issued membership cards on which their selected primary care provider is listed.

As noted earlier, children initially were eligible for the program. At one point, enrollees under age 20 (including children) comprised 40 percent of the total enrollment. Since S-CHIP became effective in June 2000, child enrollees have been transitioned into Medicaid or S-CHIP when they go through the recertification process each year. Because program administrators do not ask potential enrollees for their immigration status, they do not know how many, if any, undocumented individuals are enrolled in the program.

Covered Services

The Primary Care Plan covers all outpatient primary, preventive, and limited in-network specialty care services (physician office visits), and office-based laboratory and x-ray services. Inpatient hospital services are not covered under the plan itself. However, at 100 percent of poverty, all Community Voices members qualify for charity care from the El Paso County Hospital District.

Through focus groups with potential enrollees, the collaborative initially identified the target population's health needs. Provider feedback suggests that the benefit package is sufficient and is meeting the enrollees' needs. However, while program officials are always considering ways to expand the benefit package so it more closely resembles Medicaid, their first priority is increasing utilization of the benefits offered, as utilization rates are between 30-35 percent. Nonetheless a study of 1,900 Community Voices members found that 65 percent of the members had accessed the plan for at least one service encounter.

Oral and Mental Health

Oral health services currently are not covered by the Primary Care Plan. However, El Paso Community Voices has several oral health initiatives underway. The Primary Care Plan's enrollment committee is in the process of reviewing the program's scope of benefits to see how they can include oral health services, and at what level, as a covered benefit under the program's budget. Program officials indicate that, at a minimum, they likely will be able to cover preventive care for enrollees, but they do not know if restorative care will be feasible. Using data collected by EPFHN, program administrators have identified the adult oral health services that are most needed. These services currently are not covered by any program in the county.

Outside the Primary Care Plan, El Paso Community Voices has developed an Oral Health Advisory Committee that is looking at ways to address gaps in oral health care in the county. The Committee soon will submit a waiver request to the state Medicaid program to develop a demonstration project to include adult oral health services as a Medicaid–covered benefit for Medicaid recipients in El Paso County.

In addition, the El Paso Community Voices board of directors has approved a demonstration project, called Sonrisa La Familia, which is a two-phase oral health education (phase one) and preventive treatment (phase two) program targeted to young adult parents or guardians and at least one child (preschool to teenager) who are eligible for Medicaid and S-CHIP dental health services. Phase one entails multiple education sessions with oral health care professionals, after which participants will be referred for in-depth preventive treatment in phase two. The program, still in development, will have a two-year lifespan.

The Primary Care Plan also does not cover mental health services, although program officials indicate that they also will encourage the enrollment committee to begin to consider ways to cover this benefit at some level (as they will for oral health services). The level of dialogue on mental health is not as "far along" as oral health in El Paso. Interagency communications on mental and behavioral health issues are just beginning. El Paso Community Voices does have a Mental Health/Behavioral Health Advisory Committee that is actively seeking funding to support the development and implementation of different projects in this area.

Management of Care

Primary Care Plan enrollees select a primary care provider (PCP), a nurse practitioner, or a primary care clinic from the El Paso First Health Network to serve as their primary care provider and "medical home." The El Paso First Health Network includes 235 primary care providers and over 700 specialists. Enrollees need referrals from the primary care provider to receive specialty services, x-ray, and laboratory services.

Outpatient services are provided through the EPFHN, while inpatient services are only covered at Thomason Hospital. In addition, lab and radiology services are provided at Thomason Hospital, although preliminary lab and radiology work can be done at the primary care provider's office (or at the hospital). Prescriptions can only be filled at the Thomason Hospital Pharmacy.

Case management services are provided to enrollees with special health needs through the EPFHN. These services are particularly important for the program's high-risk population. During one month (July 1, 2000-July 31, 2000), 290 enrollees generated 389 "encounters" or claims. Encounters for diabetes and hypertension–the top two diagnoses for enrollees that month–together represented 23 percent of the total encounters.[17]

Enrollees pay a $5 copayment for physician office visits. Because utilization rates have been low (30-35 percent), program costs and costs per enrollee have been well within the budgeted amount. As of July 31, 2000 (just over one year after the program started), 6,801 claims have been processed, and provider payments totaled $226,512 (well within the $2 million budgeted per year). The lessons learned from the first year of the plan have made Community Voices take steps to ensure greater utilization of the medical services. In addition, EPFHN is paid $2 PMPM to manage the Primary Care Plan.

According to program officials, local physicians are beginning to balk at accepting new Medicaid, S-CHIP, or Community Voices enrollees because the reimbursement rates are drastically low. Reimbursement to providers under the Primary Care Plan equal Medicaid fee-for-service reimbursement rates plus five percent. However, El Paso has significantly lower Medicaid and S-CHIP reimbursement rates than other parts of Texas. For example, there is a $220 disparity for Medicaid reimbursement for births between Houston and El Paso.[18] Medicaid fee-for-service reimbursement rates are based on the historical utilization of medical services by people in a community. And people in El Paso have very low utilization rates due to the high uninsurance rate, large number of underserved individuals, and the high utilization of Mexican health care providers in Juarez, Mexico.

Several years ago, providers' patient bases were roughly 30 percent Medicaid and 70 percent commercial patients (with about 5 percent uninsured somewhere in the mix). Now, they are 70 percent Medicaid and S-CHIP (and Community Voices enrollees) and 30 percent commercial. Despite this fact, the EPFHN has so far continued to "take ownership" of the Primary Care Plan and is still committed to the program.

Administration

As of January 2000, the El Paso Community Voices board of directors had 23 community-based members, including representatives from several CHCs, the University of Texas-El Paso, El Paso Community College, Texas Department of Health, Thomason Hospital, Texas Nurses Association, Visiting Nurses Association, Hospice of El Paso, Texas Tech University Health Sciences Center, Kellogg Community Partnership clinics, and several disease-specific associations. To date, there is no Primary Care Plan enrollee on the board of directors, but program officials hope to mandate a minimum member representation requirement soon. EPFHN, which administers the Primary Care Plan, has its own board of directors. The executive director of El Paso Community Voices is an ex-officio member of this board.

Financing

The W.K Kellogg Foundation's Community Voices grant supported the program's infrastructure development. The El Paso County Hospital District is contributing $2 million per year for 5 years to fund the health care services provided to Primary Care Plan enrollees for a total five-year sum of $10 million.

Enrollment & Outreach

As of March 2001, the Primary Care Plan had roughly 2,500 enrollees. This is a decline from July 2000 enrollment numbers, which were over 6,500. At that time, 39 percent of enrollees were ages 0-20, 20 percent were

[17] El Paso First Health Network, August 8, 2000.

[18] Sharrer, Gary, "Voices vent over no health coverage," El Paso Times, June 28, 2000.

ages 21-34, 18 percent were ages 35-44, 12 percent were ages 45-54, and 8 percent were ages 55-64.[19] Most of the decline was due to a significant number of children transitioning into the state's S-CHIP program (and Medicaid if eligible). However, children still comprise a substantial percentage of the program enrollment (over 550 included in the membership).

Between April and July 2000, 85 individuals went through the recertification process; 63 individuals were terminated from the program primarily for not responding to "two mailings and multiple attempts at telephone follow-up." Others were not recertified because they no longer fit the program's eligibility criteria. At least 12 children in the month of July were transitioned into S-CHIP.[20]

The extreme drop in membership resulting from the recertification process has prompted changes in the approach to outreach and enrollment. Community Voices will be hiring an Enrollment Coordinator to ensure that every member of the program has contact with Community Voices. Also, each new member is signing "release of confidential information" forms. The lack of such a release prevented Community Voices from receiving important information about its own members from EPFHN. Community Voices also will undertake the task of calling all the former members that failed to return their recertification information and were then dropped from the program. During the first year, Community Voices delegated much of the member outreach and education efforts to EPFHN. This has now changed. Community Voices will now take the lead in efforts to reach, educate, and advocate for its own members. However, EPFHN will still necessarily play a major role in these matters.

Targeted outreach to potential enrollees is done through 10 CBOs specifically trained to conduct program enrollment (e.g., identify eligible individuals and enroll them in the program). The CBOs sent fliers to potential enrollees, organized enrollment sessions at local businesses and churches, and arranged for a public service announcement on a Spanish radio station.

In July 2000, 33 percent of calls to the member help-line were in Spanish. Help-line calls averaged 15.5 per day. Roughly 40 percent of the calls requested benefits/plan information (e.g., regarding medical benefits, pharmacy benefits, and general information). In addition, 15 percent of member calls were eligibility questions, and 15 percent were to verify a PCP. These were the top three question areas that month. There were also 47 provider calls that month, averaging 2.4 per day. Roughly 30 percent of these calls related to the status of a claims submission.[21]

Future Plans

The El Paso Community Voices Collaborative has the following future plans for the Primary Care Plan.

- ***Develop a relationship with the Mexican Consulate.*** The Community Voices Collaborative is in the process of developing a Binational Collaborative with the government; public health officials; and providers in Juarez, Mexico. The goal is to begin to discuss ways to develop a database and record data on the health habits and utilization patterns of the Community Voices enrollees, many of which cross the border to receive at least some health services. Such a collaborative is necessary for health promotion, continuity of care, and outreach. This is also important if a true regional system of health care is to be created.
- ***Enroll hospital discharges directly into the Community Voices Primary Care Plan.*** The Collaborative will initially enroll 1,000 "frequent fliers" of hospital inpatient services into the Primary Care Plan. Frequent fliers are individuals who use inpatient hospital services three or more times a year. Program officials emphasize that, for the first time, these individuals will have someone to manage their care post-discharge, and provide necessary follow-up services. In addition, this will drastically reduce health care costs if individuals do not have to enter the hospital again, especially if they can avoid using the emergency room to access hospital services.
- ***Build political support for continued funding of the Primary Care Plan.*** Program administrators have begun informal discussions with local, state, and federal elected officials in an effort to convince them that El Paso Community Voices deserves continued support and funding to ensure its sustainability

[19] El Paso First Health Network Memorandum, Status Report (July 2000), August 16, 2000.
[20] El Paso First Health Network Memorandum, Status Report (July 2000), August 16, 2000.
[21] El Paso First Health Network, August 8, 2000

beyond five years of the Kellogg Community Voices initiative. More formal presentations will occur in the next few months. A Town Hall meeting is being planned, and the Congressman for El Paso has already agreed to co-sponsor the event.

- ***Increase involvement of the business and faith-based communities.*** Program officials want the business (e.g., Chamber of Commerce and local business leaders) and religious communities to become more involved in the Community Voices program. They feel business leaders bring valuable experience and a valuable perspective to the table that they have not been able to tap into as much as they have wanted. The faith-based communities have an established relationship with community residents that is also vitally important.
- ***Develop an Oral Health Task Force.*** The Community Voices Collaborative has developed an Oral Health Task Force that started in January 2000. An Oral Health project has been established as a result of the Task Force activities (see the above section on Oral and Mental Health services). The Project will target family participation and will combine education and treatment to help improve the oral health status of the participants. For the next two years, the Task Force will increase enrollment in the program, will increase overall community awareness about the benefits of good oral health, and will encourage increased individual responsibility for one's oral health status.
- ***Identify other sources of funding for the community.*** El Paso County recently was awarded a $986,000 Community Access Project grant from the federal Health Resources and Services Administration. The community also was awarded a Robert Wood Johnson "Communities in Charge" grant and a grant for tobacco cessation from the American Legacy Foundation. Each of these sources of funding is dedicated to improving the health of the community and improving access for low-income individuals to preventive and primary care services.

LESSONS LEARNED

The Primary Care Plan has learned a number of important lessons from its experiences to date.

- ***You need committed individuals and organizations working toward the same goal.*** El Paso officials stress the importance of having the entire community "at the kitchen table," particularly when the community has scarce (and limited) financial resources. This includes the community doctors, the HMOs, the Hospital District, and other members of the collaborative. In addition, you must put the community first before the interests of the individual organizations. Most importantly, the county/public hospital in the area must see itself as a community asset and not as a stand-alone, separate entity from the rest of the community. These programs for the uninsured and underserved require significant institutional change–a reorganization and restructuring of the entire community-wide health system, including the hospital(s), clinics, and safety net providers. El Paso was fortunate that it had a long-standing collaborative of all of the safety net and community-based health organizations in the county already working together. A lot of work went into developing the collaborative and the Primary Care Plan; it did not happen overnight.
- ***Physicians must buy into the program.*** Having the support of the local County Medical Society was essential in El Paso. "You have to have the physicians buy into the program or you are doomed." In El Paso's case, EPFHN (the HMO) would not have sponsored the program if it did not have the support of the local physicians.
- ***Neither the state nor the federal government can do what can be done at the local level.*** State and federal governments are reluctant to fund primary care delivery systems (ambulatory, preventive care), and this has hindered the development of these types of programs. The community had to do it for themselves with nontraditional approaches including aggressive outreach, direct involvement of community leaders, and enrollment on a one-on-one basis.
- ***The best experts are from out of town.*** El Paso Community Voices used other communities from around the country as models and "outside experts" to generate support. Hillsborough County, Florida's Health Plan for the Medically Indigent, which has been in operation since 1992, served as the model for the Primary Care Plan. In addition, El Paso Community Voices has an active information-sharing relationship with officials at Buncombe County, North Carolina's Project Access, in which

several hundred physicians volunteer to provide health care services to uninsured patients. According to El Paso officials, "we share a lot of ideas with each other and incorporate them into our programs."

- ***The "return on the investment" is not always financial.*** The focus of the cost-benefit analysis of these programs needs to shift from financial concerns to human capital. In El Paso, one component of the Primary Care Plan's "added value" was the ability of program officials to learn more about the overall health needs, health utilization patterns, and health status of the community from the program's target population than they did from the health experts in the community.

Contact for More Information

Jose G. Moreno, Executive Director, El Paso Community Voices: HealthCare for the Underserved, (915) 545-4810; e-mail: cvoices1@elp.rr.com.

Sources:

El Paso First Health Network Memorandum: Status Report (July 2000), August 16, 2000.

El Paso Community Voices web site: www.communityvoices.org/LL-ElPaso.asp.

Personal communications with Jose G. Moreno, Executive Director, El Paso Community Voices, and Pete T. Duarte, CEO, Thomason Hospital, March 2001.

Sharrer, Gary, "Voices vent over no health coverage," El Paso Times, June 28, 2000.

W.K. Kellogg Foundation's Community Voices: HealthCare for the Underserved web site: www.communityvoices.org.

W.K. Kellogg Foundation Status Call, Report for July through December 2000.

FirstConnection Moore and Montgomery Counties, North Carolina

Overview

FirstConnection is a pilot case management and health care services program for uninsured children and adults in the rural mid-Carolinas (Moore and Montgomery Counties). It was developed and is operated by FirstHealth of the Carolinas, a not-for-profit health system providing care to 250,000 people in 15 counties. FirstConnection targets children who are ineligible for North Carolina's State Children's Health Insurance Program (S-CHIP) often due to residency issues, and low-income uninsured adults who are not eligible for public health coverage programs. The plan assigns enrollees to a primary care provider, and offers case management services and a comprehensive benefit package including prescription drugs, mental health care, and dental care for children. The project timeline is two years (May 1, 2000- April 31, 2002), although additional financing is being pursued to extend the program. As of February 2001, 84 adults and 101 children were enrolled.

Background and Development of the Program

FirstHealth of the Carolinas is the dominant health system in the rural mid-Carolinas. Its network includes three hospitals, 21 family care centers, school-based health centers, EMS and critical care transport, home care services, and dental care centers. As the safety net provider to uninsured residents in its service area, FirstHealth of the Carolinas was aware of the many gaps in public coverage programs. While enrolling children in Health Choice (North Carolina's S-CHIP), for example, it found many children met income requirements but not residency requirements. Its emergency rooms were receiving growing numbers of "working poor" individuals and families who did not have a regular source of care, and whose conditions worsened because they delayed treatment.

FirstHealth administrators decided to target these populations for a program that would provide a "medical home," and to measure changes in the way they seek health care. Using private foundation grants and FirstHealth resources, FirstHealth embarked on FirstConnection as a two-year pilot program.

The goals of the program are to:

- improve access to care;
- increase appropriate utilization of health care services;
- emphasize the benefit of wise lifestyle decisions;
- positively impact satisfaction with care and perceptions of access; and
- improve the health status of the enrolled population.

Obstacles Faced and Addressed

Program planners originally intended for FirstConnection to be an insurance product within FirstHealth's existing HMO, so that the administration

would be synchronized with FirstHealth's population of employees and their families. FirstHealth staff worked with the North Carolina Department of Insurance over several months, but concluded that meeting necessary reserve and other requirements would both restrict the types of services it could offer and delay implementation for at least a year. They decided to move ahead with the pilot as a health program rather than an insurance product, but may convert it to insurance in the future.

With limited funds, and without being certain of the resources that would be needed to maintain the program, program planners decided to start small. They chose to limit the program to 200 enrollees in two counties over a two-year time frame, making it possible to measure and study utilization and costs, while also exploring additional funding sources. Program administrators acknowledge that this is a learning period, and that this limited program alone will not have a large impact on the estimated 10,000 uninsured residents of Moore and Montgomery Counties alone.

As the only large health care system in the geographic area, FirstHealth already had in place the kinds of partnerships that any community-based health plan would require. Also, it already had a network of primary care and specialty providers on its HMO panel, who were willing to join the FirstConnection network because it compensated them for services they previously provided as "charity care."

Program Description

Target Population & Eligibility

FirstConnection targets uninsured, low-income children and adults.

- Children (through age 18) are eligible if they are uninsured, their family income is under 200 percent of the federal poverty level (FPL), and they are ineligible for the state's Medicaid or S-CHIP program (Health Choice) due to residency issues. Generally this means that either the children are not legal residents, or their parents are not legal residents and therefore cannot provide proof of income for Health Choice enrollment.
- Adults (ages 19-64) are eligible if they are uninsured, their family income is under 200 percent of the FPL, and they are ineligible for public insurance programs (Medicaid, Medicare, others).

Covered Services

Benefits include:

- preventive care and immunizations;
- primary care;
- specialty care;
- hospital care;
- dental care (for children);
- prescription drugs;
- mental health care; and
- case management and social support services.

FirstConnection enrollees do not pay monthly premiums. Co-payments are designed to encourage primary and preventive care and discourage inappropriate use of emergency rooms. The co-pay structure is: $0 co-pay for preventive visits, $10 co-pay for sick visits to primary care providers (PCPs), $50 co-pay for emergency visits, and $4/$8/$12 co-pays for prescription drugs based on a formulary. The plan's 250 participating primary and specialty providers are those that participate in FirstHealth's HMO.

Oral and Mental Health

Comprehensive dental services for children were included as a benefit in FirstConnection for a few reasons. Planners viewed prevention and education as the key to good oral health; it made sense to start with children, who can benefit greatly from preventative care and from learning good oral health habits. Also, FirstHealth had the capacity to provide these services through its three dental clinics for Medicaid and medically indigent children, which began in October 1998. These clinics, which had the trust of the "uninsurable" children it served, became a good entry point to the First Connection pilot program. All dental services for the children are covered, except procedures such as complicated root canal or oral surgery, for which the program seeks assistance from local specialists.

Dental care for adults is not currently covered. The program wanted to start with manageable number of covered lives, and with the clinics running at capacity serving children, they are unable to expand to adults at this time. Program officials acknowledge, however, that they will need to address dental needs of adults in the future.

Mental health services are included in First Connection. Enrollees with mental health needs are initially referred to the FirstHealth Employee Assistance Program (EAP), where they are evaluated by a clinical

social worker and seen for a maximum of two visits. If the evaluator sees the need for further treatment or a medication evaluation, enrollees are referred to outpatient behavioral health services, for which they are covered for a maximum of 20 visits per year and are responsible for a $10 copayment per visit.

Management of Care

Each new enrollee selects a PCP from a list of participating providers. After enrollment and initial screening and tests, a case manager develops a care plan with the PCP and follows up with the enrollee as needed. Care plans may involve attending smoking cessation class and other behavior-related interventions as well as medical care. If an enrollee does not comply with the care plan, he/she may be disqualified from FirstConnection. Referrals are needed from the PCP for specialty services.

Case-management and social-support services are currently being provided or arranged by two individuals including a Registered Nurse and an assistant. Support services include transportation, interpretation, and assistance with meeting other needs and/or qualifying for other support programs (such as home heating subsidies, car seats, eyeglasses, home safety, and others as needed). The case managers report that even when one family member enrolls in FirstConnection, the case managers must address various problems affecting the entire family. Each case has presented new kinds of needs, and the program administrators are trying to determine which support services should be included within the scope of the program.

Financing

Health providers submit claims for services rendered to FirstConnection enrollees and are reimbursed according to a negotiated rate scale similar to Medicaid reimbursement rates. Thus, there is no capitation or risk-sharing by providers; FirstConnection holds all risk for the utilization and cost of services, which is one reason it is keeping enrollment limited during the pilot stage. As a rough estimation for budgeting purposes, planners used North Carolina Medicaid and Health Choice average costs of approximately $100 per child per month, and $140 per adult per month.

Financing is provided by foundations and FirstHealth system resources. The hope is that an initial investment in expanding access to primary and preventive care and case management services will lead to a reduction in expensive hospitalization and inappropriate emergency care. Grants from the W.K. Kellogg Foundation under its Community Voices: HealthCare for the Underserved initiative and The Duke Endowment provide key support, including an evaluation conducted by the Cecil G. Sheps Center for Health Services Research. The evaluation will track the extent to which the use of preventive health care measures rises, and ambulatory-sensitive (avoidable) hospital admissions and emergency room use fall. It will also monitor trends in total costs.

Enrollment & Outreach

Outreach has been conducted through community service providers, both inside and outside the FirstHealth system. Children are identified and referred to FirstConnection by FirstHealth Dental Care Centers, School Nurse Program, and School-Based Health Centers, for example. Potential adult enrollees are identified when they access the FirstHealth system and are not eligible for public assistance programs. FirstHealth also conducted initial outreach through health fairs and received referrals from English as Second Language and migrant educators at local community colleges, pediatrician offices, health departments, and other community agencies. As enrollment grew, interest also spread through word-of-mouth.

The case manager oversees referral, screening, and enrollment. After eligibility is determined, she meets with an applicant at his/her home to complete an enrollment form, initial assessment, and Personal Wellness Profile. Enrollees receive identification cards and visit a doctor (children visit a dentist as well) where additional screening and diagnostic tests are performed as needed.

Canopy™, a web-based case management application, makes it possible for FirstHealth to monitor and manage this targeted patient population across the entire delivery network. This web-based application service provider enables FirstConnection case managers to identify, assess, and manage high-risk patients across a continuum of care. Canopy™ helps FirstHealth physicians to interact with case managers through the web using patient notes, e-mails, and faxes. Canopy™ helps case managers develop an individualized care plan for each patient following a home visit. It also aids in medication management, thereby identifying drug interactions. FirstHealth case managers tested Canopy™ to

facilitate case management of their congestive heart failure patients, and believe it can help reduce admissions and improve patients' health status.

New enrollees also sign a Participant Responsibility Agreement that outlines his/her responsibilities for taking an active role in health promotion. (If the enrollee is a child, then his/her parent signs the agreement.) The case manager clearly explains the rules up front, which include:

- choosing a PCP within the FirstHealth network;
- providing necessary information;
- making lifestyle changes to improve health–e.g., cease smoking and participate in a smoking cessation program; cease drinking alcohol in company of child or allowing child to drink alcohol (for parent of child enrollee);
- obtaining recommended vaccinations, physicals, screenings, dental care (for children), and other preventive measures;
- complying with other recommendations delineated in the individual's care management plan, such as treatment for asthma or diabetes;
- maintaining contact with case manager;
- adhering to drug coverage rules (e.g., obtaining drugs from designated pharmacies, paying required co-pays);
- keeping appointments;
- obtaining a referral from the PCP before visiting a specialist, clinic, or hospital; and
- enrolling in school (if school-age).

The case manager monitors compliance with the agreement, and non-compliance can result in disenrollment from the program. An enrollee receives a written warning after a missed appointment, for example, and is disenrolled after four missed appointments. So far, however, no one has been disqualified for non-compliance, and the case manager is being flexible while trying to ascertain whether the requirements are realistic and what adjustments should be made.

Anticipating that addressing multiple, unmet needs of the enrollee population may be time and labor-intensive, the first year's goal is to limit enrollment to 200 persons. As of February 2001, nine months into the program, FirstConnection had nearly achieved this goal, with 101 children and 84 adults enrolled.

Lessons Learned

While FirstConnection is too new to measure indicators of success or sustainability, program administrators have drawn some valuable lessons from their experiences developing and implementing the program. Those lessons and some recommendations for program planners include the following:

- ***Lengthy enrollment time.*** The initial enrollment process–particularly coordinating the meeting, educating the applicant, and collecting the large amount of information–takes significantly longer than expected. An average of three hours is required to enroll a family with three children. Enrolling Spanish-speaking applicants requires an interpreter, which makes the process even longer. Eliminating home visits and reducing the amount of information collected would reduce the enrollment time, but would hamper case managers' ability to fully assess the family's needs and would curtail the program's ability to measure the impact of the program. Program planners may instead learn from FirstConnection's experience and build longer enrollment times into their schedules and budgets.
- ***Co-payments burdensome for large families.*** Despite relatively small co-payments for individual primary care visits, large families had difficulty paying when many siblings had medical or dental visits on the same day. This calls for considering "sibling discounts" either routinely or in conjunction with meeting other criteria.
- ***System-wide barriers to care.*** Case managers identified system-level barriers to care including transportation, illiteracy, trust, and language barriers. FirstHealth addressed communication problems by using bilingual staff and multi-language telephone lines. Case managers tap the FirstHealth transportation system and public transit when necessary and meet other needs (e.g., eyeglasses and car seats) through other organizations. Case managers need to be creative and prepared to "leverage" other community resources.
- ***Over-dependence on case manager.*** Despite the provision of case management and a number of non-medical support services, some enrollees become over-dependent on the caseworkers and request services well outside the scope of the program. Health coverage programs that target vulnerable, disenfranchised low-income people must prepare for an enrollee population with multiple medical, social, and economic needs. Social supports should be included to the extent that financing permits,

and case managers should be prepared to provide some basic information about how to access other community services, as described above. At the same time, applicants should be clearly informed about the limits of the benefit package.

- ***Communication difficult without telephones.*** FirstConnection experienced difficulties communicating with applicants and enrollees who did not have telephones. Messages were at times miscommunicated when sent through neighbors, for example. This type of problem is common with programs that target low-income people. Case managers are still working to address this problem.
- ***Need to broaden outreach to adults.*** Preliminary analysis indicated that nearly 40 percent of adults were referred from within the FirstHealth system, and one-third of adult enrollees had four or more physician visits the previous year. This suggests that the program should expand its outreach efforts to adults who are further removed from any sources of care, and improve targeting toward adults who use emergency rooms inappropriately and away from those already obtaining care from a regular source.

The difficulties that were initially faced when trying to establish FirstConnection as an insurance product exposes an obstacle that other community organizations would face if they tried to replicate a similar program. One response is to follow FirstConnection's lead in establishing the program as a health plan without insurance status. But their experience also presents a challenge to state insurance departments to look for ways to allow more flexibility and to expedite the authorization process for access-expansion plans without compromising the integrity and stability of the new insurance entity.

Finally, it should be noted that FirstConnection was made possible through the financing of a large, multifaceted hospital system that serves virtually the entire population in its geographic area. A small, community-based organization by itself would have had much difficulty obtaining adequate funding for such an endeavor and would have required partnering with other institutions with greater access to resources.

Contact for More Information

Lisa Hartsock, Administrative Director of Community Health Services, FirstHealth of the Carolinas, Inc. (910) 215-1925; e-mail: lhartsock@firsthealth.org.

Sources:

Evaluation Plan: FirstConnection Health Care Program Preliminary Results. Prepared by the Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill, December 6, 2000.

FirstConnection Program Fact Sheet, FirstHealth of the Carolinas, Fall 2000.

Personal communication with Lisa Hartsock, Administrative Director of Community Health Services, FirstHealth of the Carolinas, January 2001.

Family Care
Alameda County, CA

Overview

Family Care is a subsidized health plan designed to meet the needs of uninsured working families, including undocumented residents, in Alameda County, California. It was developed and is administered by the Alameda Alliance for Health, a nonprofit, public health plan serving more than 73,000 Alameda County residents. Safety net health care providers that have a stake in caring for vulnerable, uninsured people in the community are part of the provider network. Family Care offers a comprehensive set of services and tries to provide a "seamless" health care system for families with some members enrolled in public programs. The program began in July 2000, and has enrolled 1,400 people as of March 2001.

Background and Development of the Program

Alameda Alliance for Health (the "Alliance"), a health plan that serves primarily MediCal (California's Medicaid program) and Healthy Families (California's S-CHIP) enrollees in Alameda County, was established in 1996. Its members can choose from a network of more than 1,000 community physicians, 12 hospitals, 26 community health centers, and over 160 pharmacies throughout the county. An independent board comprised of physicians, community leaders, and health plan members oversees Alliance programs and policies.

In recent years, the Alliance saw the number of uninsured residents increasing, particularly among low-income and immigrant families. Local safety net providers' experience indicated that there were many parents and siblings of MediCal and Healthy Families enrollees who had no health coverage. Many of these uninsured family members are undocumented residents. And focus groups indicated that uninsured families were

interested in joining a health plan if it were affordable.

The Alliance recognized the need to offer a low-cost health care coverage option for the uninsured. Supported by an informal local collaborative of safety net providers, it developed the Family Care plan to further its mission to serve the uninsured and underserved populations in Alameda County. The Alliance committed a portion of its reserve funds to subsidize health coverage for low-income and immigrant families. At the same time, it developed a similar but unsubsidized health plan called First Care, which targets working uninsured who can afford to pay full premiums.[22]

With grant assistance from the W.K. Kellogg Foundation's Community Voices: HealthCare for the Underserved initiative, the Robert Wood Johnson Foundation's Communities in Charge program, HRSA's Community Access Program (CAP), and other sources, the safety net organizations formalized their relationship into the Access to Care Collaborative. This collaborative is composed of the Alliance, Alameda County Health Care Services Agency, Alameda Health Consortium, Alameda County Medical Center, and the Asian Health Services/La Clinica de la Raza Community Voices Project. One of the roles of the collaborative is to help in the planning, decision making, and direction of Family Care. The foundation grants also support an evaluation of the Family Care plan.

Obstacles Faced and Addressed

The Alliance was required to expand its HMO license with the state's Department of Managed Health Care in order to implement Family Care. This was not a major obstacle, although the process took nearly a year, which is a typical timeframe for approval of a health plan's request to add a new line of business.

Before designing the benefit package, the Alliance held focus groups and learned that the target population was interested in comprehensive benefits, not just primary care. Although a generous benefit package is more expensive, designers felt that it was important to offer a plan that was attractive to people, and that it was easier to establish comprehensive benefits from the start rather than try to add benefits later to a more restricted plan. Another advantage was that a comprehensive package would be more comparable to MediCal and Healthy Families benefits, reducing fragmentation of care within families with multiple coverage sources.

Program Description

Target Population & Eligibility

Family Care targets uninsured children, families of children enrolled in public health programs, and immigrant families. Eligibility criteria include:

- family income up to 300 percent of the federal poverty level (FPL);
- live within Alameda County;
- complete an application and statement of health;
- have a child enrolled in the Alliance through Healthy Families, MediCal or Family Care; and
- all children in the household without health coverage must be enrolled.

Undocumented children and their parents are eligible to apply for Family Care (although estimates indicate that fewer than half of enrollees are undocumented). It is not a prerequisite that another child of the parent or a sibling of the undocumented child be enrolled in the Alliance through MediCal or Healthy Families, but if there are other children in Healthy Families or MediCal, they must be enrolled in the Alliance. Enrollment of the undocumented child into Family Care is sufficient to make siblings and parents eligible for Family Care, if all of the children in the family are undocumented.

Covered Services

Family Care offers a comprehensive set of benefits that includes primary and preventive care, physician services, inpatient hospital care, lab/x-ray, emergency services, prescription drugs, mental health services, dental care, family planning, home health care, skilled nursing care, hospice care, acupuncture, chiropractic care, and other services. There are no co-payments for preventive care (check-ups, immunizations, well-baby care, etc.) or hospital care; there is a $10 co-payment for doctor visits, a $5 co-payment for prescription drugs, and a $15 co-payment for emergency room visits.

Enrollees pay subsidized monthly premiums based on age. Premiums are $10 per child through age 18 or

[22] First Care has no income criteria; applicants are enrolled if they pass a self-reported health screen. Program enrollment began in July 2000 with very little publicity. As of February 2001, 83 individuals are enrolled. The Alliance plans to begin an advertising campaign later in 2001. The unsubsidized premium is age-based; for a single adult under age 30, for example, the monthly premium is $118.

through age 23 if a full-time college student. The monthly rate for a parent is $20 (ages 19-39), $30 (ages 40-49), $40 (ages 50-54), $70 (ages 55-59), and $120 (ages 60-64). Approximately 75-90 percent of the costs are subsidized.

The Alliance contracts with community health centers (CHCs), county health centers, and private practitioners. Provider reimbursement involves a combination of capitation and fee-for-service rate schedules. Primary care providers are paid both a capitation rate per enrollee, plus fee-for-service payments for preventive care (to encourage prevention). Specialty care is reimbursed on a fee-for-service basis at rates that are higher than MediCal payment rates.

Oral and Mental Health

Comprehensive dental and mental health services were included in Family Care for a number of reasons. First, as mentioned above, planners wanted to offer a benefit package consistent with Healthy Families, so that families with children in the S-CHIP program would have comparable, seamless coverage. Second, from an operational and administrative perspective, it is easier for staff to deal with one set of benefits for people with different coverage sources. And third, planners did not want the appearance of a tiered system in which Family Care would be viewed as sub-par compared with other coverage programs.

Dental care is covered through a network of dentists. Mental health coverage includes 10 days of outpatient care with co-pays of $20 per visit, and 10 days of inpatient care with no co-pays.[23] Family Care's experience so far indicates that enrollees were prepared to utilize their dental and mental care benefits, and no additional education or outreach in this area was needed.

Management of Care

Family Care tries to provide a seamless system of care for families whose members are enrolled in MediCal, Healthy Families, and those who are not eligible for public programs. Case management is provided by participating CHCs, as the Alliance does not have a comprehensive individual case management program for members at this time. The plan includes patient education and health promotion such as asthma and diabetes management classes, a 24-hour advice nurse telephone line, safety classes (including provision of car seats and bicycle helmets), and interpreter services (there are about 120,000 uninsured Latinos and Asians in the county).

Financing

The Alliance has allocated $8.1 million to subsidize Family Care through 2005. An additional $400,000 from a grant from The California Endowment subsidizes the cost of care for undocumented children. Plan administrators are pursuing additional funding from foundations to continue Family Care beyond five years and to expand enrollment. The Alliance is also expected to receive tobacco settlement funds totaling $1 million per year for two years, to subsidize health care for more uninsured individuals through Family Care.

The W.K. Kellogg Foundation, Robert Wood Johnson Foundation, and CAP grants help to organize and sustain the Access to Care Collaborative. Community Voices and Communities in Charge are working with the Alliance to develop and implement an evaluation plan, which will provide information that can help administrators modify the product, determine funding needs, and revise the implementation plan.

Enrollment & Outreach

Enrollment began July 1, 2000 on a limited basis. Plan administrators decided to expand enrollment in September/October 2000, and by March 2001, enrollment reached about 1,400. Enrollment is expected to increase to 2,000 by the second year of operation. Unless additional funding is obtained, enrollment will be capped at about 2,000 for the remainder of the program. With the state's proposed expansion of Healthy Families to include parents up to 200 percent of the FPL, some Family Care enrollees would transition into Healthy Families and open up additional slots.

Outreach is conducted at CHCs where clinic staff determines eligibility and enrolls applicants, and at other community organizations. CHCs have served as an important outreach vehicle, in part because they are trusted by immigrant families. The Community Voices program developed an educational handout for coverage options available in Alameda County, including Family Care and First Care. Community health workers have

[23] Limits and co-pays do not apply to certain conditions.

conducted outreach at community events in the Asian and Latino communities and have distributed the coverage handout and other Family Care information.

Lessons Learned

It is too early to gauge Family Care's accomplishments. The Alliance and collaborative partners look forward to developing an evaluation of Family Care to learn about the members' perspectives of their coverage and determine whether any changes will be needed to improve Family Care.

Whereas immigrant families are often reluctant to sign up for any public program out of fear that they will be asked their residency status, Family Care is enrolling people through one of the few channels that are trusted by immigrants–CHCs. Thus, Family Care is proving that it is possible, though not easy, to reach undocumented populations who would otherwise be totally left out in the cold.

Replication of Family Care without an entity like the Alliance with adequate reserve funds may be difficult without other sources of funding. Even with the Alliance as a strong sponsor, Family Care is limited to 2,000 enrollees unless other funding is secured. As currently funded, it cannot hope to reach the majority of its target population, not to mention the uninsured adults without children and others who are ineligible for the program.

To help more people benefit from subsidized health plans such as Family Care, plan administrators suggest public policies that would expand eligibility criteria for MediCal and Healthy Families, which would open up additional slots in Family Care. Also, making MediCal enrollment easier and reducing the stigma of public health programs would make those eligible more likely to take advantage of these plans.

Contacts for More Information

Nina Maruyama, Director of Development and Government Relations, Alameda Alliance for Health, (510) 895-4506; e-mail: nmaru@alameda-alliance.com.

Tomiko Conner, Project Director for Community Voices, Oakland, (510) 633-6292; e-mail: tomikoc@chcneb.org.

Sources:

Personal communications with Deborah Zahn, Project Director, Communities in Charge; Nina Maruyama, Director of Development and Government Relations, Alameda Alliance for Health; and Tomiko Connor, Project Director for Community Voices, Oakland, January - March 2001.

Family Care brochures.

Section 3. Review of Other Community-Based Access Programs

Other Community-Based Access Programs for the Uninsured and Small Businesses

In addition to the communities profiled in Section 2, other counties, cities, safety net providers, and small businesses are responding to the health care needs of the uninsured by experimenting with ways to improve access to care. The tables below (Table 3 highlights community-based programs for uninsured individuals, and Table 4 highlights programs for small businesses) describe some of the programs across the country that have been implemented to broaden health coverage, improve access to care, and help fill in gaps in the health care system. The programs differ across communities by program structure and administration; target population, eligibility criteria, and size of enrollment; scope of services; and financing sources. For example, while many programs function as insurance plans and even issue enrollees membership cards, others are strictly service plans that serve only those with a demonstrated medical need. The programs also vary in the benefits they offer; for instance, dental, mental health, and substance abuse services are not uniformly provided.[24] At the same time, these programs also share many common features. Most of them are county-administered and deliver a generous package of services to populations that otherwise might receive no care at all.

[24] In general, if Tables 3 and 4 do not specifically list dental, mental health, or substance abuse services as covered benefits under a program, then those services likely were not covered at the time the program was reviewed.

Table 3: Community-Based Programs to Improve Access for Uninsured Individuals [25]

Location	Name of Program	Program Structure & Administration	Target Population, Eligibility & Enrollment	Scope of Services	Financing
Alameda County, California	**County Medically Indigent Services Plan**	Alameda County Health Service Agency administers the program using a limited provider network for those with a medical need. The agency has exclusive contracts with Alameda County Medical Center and a network of CBOs. This is not an insurance program.	Target population is 120,000 county residents in need of medical attention with incomes below 200% of FPL and who are ineligible for Medi-Cal or any other health insurance. 51,686 patients served between July 1, 1998, and June 30, 1999.	Covers inpatient, outpatient, and specialty care, prescription drugs, and lab services.	The $60 million annual budget is financed through the county general fund, an increase in state sales tax, and an earmarked portion of state vehicle license fees. No cost-sharing for individuals with incomes below 100% of FPL. Sliding scale fee schedule for individuals with incomes between 100-200% of FPL.
Birmingham, Alabama	**Community Care Plan**	Jefferson County Health System administers the managed care plan using four primary care clinics and four network hospitals for inpatient care.	Target population is 250,000 uninsured county residents. 3,000 individuals enrolled in 1999.	Covers inpatient, outpatient, specialty care, prescription drugs, and lab services. Dental care is limited to oral surgery.	One of the network hospitals receives $37.5 million annually from the county for indigent care. The county also has a one-cent sales tax that finances indigent care. Program also receives Foundation grant money and $150,000 in annual sliding scale premiums (based on income) and co-payments at the four clinics.
Boston, Massachusetts	**Boston HealthNet (Pilot) Plan**	Boston Medical Center administers the program using its own facilities and 14 affiliated CHCs. The program does not have a formal managed care structure, but it is an insurance plan.	Target population is roughly 100,000 individuals in the Boston area who meet the residential and income guidelines of the state's uncompensated care pool. Eligible for full free care if family income is under 200% of FPL, subsidized care if between 200-400% of FPL. 68,565 individuals enrolled in May 2000.	Covers inpatient, outpatient, specialty care, prescription drugs, lab services, dental care, mental health and substance abuse services, and case management for the homeless.	Amount to cover receipt of care drawn from state uncompensated care pool; amount varies according to demand for services. Annual budget in 1999 was $94 million. Individuals with incomes between 200-400% of FPL pay based on a sliding scale fee schedule.
Buncombe County, North Carolina	**Buncombe County Medical Society Project Access**	Buncombe County Medical Society administers the program under a contract with Buncombe County. Mountain Health Care processes claims and provides data on physician services. The program relies on 500 volunteer physicians (85% of county physicians) to provide services. All county pharmacies participate, as well as two hospitals. This is not an insurance program.	Target population is 15,000 uninsured county residents with incomes below 200% of FPL with a need for medical attention. Roughly 13,000 patients a year receive care.	Covers inpatient, outpatient, specialty care, prescription drugs, and lab services.	Predominantly financed through medical service contributions, estimated to be $4.8 million in FY 1999: 60% from physicians, 40% from hospitals. Also financed through the county, which contributed $250,000 in FY 1999 and $350,000 in FY 2000. Most of these funds are used to pay for prescription drugs. The only patient cost-sharing is $4 per prescription.

[25] In this table, we indicate whether each program covers the following services: inpatient, outpatient, specialty care, prescription drugs, lab services, dental care, mental health and substance abuse services, and case management. Some programs also cover additional services, including (but not limited to) emergency room services, ambulance services, transportation services, and vision care. For more detailed information on these or other services, see the table's sources cited below.

Table 3: Community-Based Programs to Improve Access for Uninsured Individuals (Continued)

Location	Name of Program	Program Structure & Administration	Target Population, Eligibility & Enrollment	Scope of Services	Financing
Contra Costa, California	**Contra Costa Health Plan's Basic Adult Care (BAC)**	County-run HMO, Contra Costa Health Plan, administers BAC using a limited provider network of five county-operated health centers (outpatient) and one medical center (inpatient). Referrals for specialty care by primary care provider are permitted to an additional network of community providers. This is not an insurance plan.	Target population is county residents ages 19-64 ineligible for Medi-Cal or any other health insurance. Eligible only if there is a medical need, for six-month enrollment period. Individuals eligible up to $2,061 in monthly income; married couples up to $2,766. 4,000 patients enrolled in any given month.	Covers inpatient, outpatient, specialty care, prescription drugs, lab services, mental health services, and case management.	The $29 million program is financed with $19 million from the state and $9.5 million from the county (1999). Funding sources include county general fund, an increase in state sales tax, an earmarked portion of state vehicle license fees, tobacco funds, and some federal DSH money. There are sliding scale premiums based on income, although 88% of enrollees pay no premium.
Denver, Colorado	**CU Care**	Denver's University Hospital, University Health Sciences Center, and Kaiser Permanente of Colorado administered the managed care demonstration project from 1995-1998. Patients were treated at a primary care clinic (outpatient) and University Hospital (inpatient). Program's primary care clinic now continues to operate without a formal managed care component.	Target population was all uninsured Colorado residents who sought care at University Hospital with incomes under 185% of FPL. At its peak, the program had 12,000 enrollees. When funding was cut by 50% in final year, clinic limited care to patients referred by the emergency room.	Covered inpatient, outpatient, specialty care, prescription drugs, lab services, mental health services, and case management.	Funding was reduced by 50% in final year of operation. State uncompensated care block grant covered 30% of care costs, with balance financed through in-kind contributions from University Hospital, University Health Sciences Center, and Kaiser Permanente. Sliding scale co-payments, based on income, for outpatient and inpatient services and prescription drugs.
Hillsborough County, Florida	**Hillsborough County HealthCare Plan for the Medically Indigent**	County's Department of Health and Social Services administers the managed care plan using preferred provider networks consisting of hospitals, primary care physicians, and specialty physicians.	Target population is 28,000 county residents with incomes up to 100% of FPL who have no other health insurance coverage. Also eligible if medical expenses reduce an individual's income to 100% of FPL. 15,469 enrollees in January 2000.	Covers inpatient, outpatient, specialty care, prescription drugs, lab services, mental health services, dental care, and case management.	Financed through a $0.25 county sales tax and interest from a related trust fund. Enrollees with incomes up to 100% of FPL have co-payments for dental care only. Co-payments for other enrollees are on a sliding scale based on income.
Jacksonville, Florida	**WE CARE Jacksonville, Inc.**	A nurse employed by the city administers the program on behalf of WE CARE, a non-profit corporation. The nurse coordinates referrals from volunteer physicians and 10 primary care clinics to specialty and inpatient hospital care. All area hospitals participate. This is not an insurance program.	Target population is 148,000 uninsured county residents. Individuals with incomes up to 100% of FPL are referred to the University Medical Center for care, as it receives funds from the city to care for the poor. Individuals with incomes between 100-150% of FPL can obtain referrals for specialty care. Program does not estimate how many individuals receive care.	There is no formal benefits package since available services depend on physician and hospital donations.	Financed primarily through donations of medical supplies and approximately 9,000 hours of physician time valued at $1.9 million. The city covers $70,000 in administrative costs. An annual physician talent show also raises $15,000 to $20,000. There is no patient cost-sharing.
Los Angeles, California	**Public Private Partnerships**	County's Department of Health Services administers the program using 150 community clinics, of which 12 provide about half of all services. Most inpatient care provided at county facilities. This is not an insurance plan.	Target population is county residents without health insurance with incomes at or below 133% of FPL. Enrollment not provided by program.	Covers inpatient, outpatient, specialty care, and prescription drugs. (Services vary by clinic.)	The county spent roughly $42 million on the program in 1999, predominantly financed through the county's Medicaid 1115 waiver. The county also contributes money from general revenues. Cost-sharing is not required and varies from clinic to clinic.

Table 3: Community-Based Programs to Improve Access for Uninsured Individuals (Continued)

Location	Name of Program	Program Structure & Administration	Target Population, Eligibility & Enrollment	Scope of Services	Financing
Marion County, Indiana	**Wishard Advantage**	The County's Health and Hospital Corporation administers the managed care plan using one public hospital and seven CHCs (managed by Indiana University Medical Group). Does not use "gatekeeper" model but does require referrals for most specialty care.	Target population is 40,000 adult county residents with incomes up to 200% of FPL not eligible for any other type of assistance program. 22,000 enrollees in June 2000.	Covers inpatient, outpatient, specialty care, prescription drugs, lab services, and mental health services.	Roughly $76 million budget financed through $20 million in federal DSH matching funds and $56 million in city and county property taxes. No cost-sharing for enrollees up to 150% of FPL. Enrollees between 150-200% of FPL are charged for services on a sliding scale based on income.
Milwaukee County, Wisconsin	**General Assistance Medical Program**	The county's Department of Health administers this program using a third-party administrator for billing. Program uses 14 CHCs to provide primary care (acting as gatekeepers) and 22 clinics overall. Each clinic must affiliate with at least one hospital and pharmacy. This is not an insurance plan.	Target population is 130,000 county residents who are not eligible for any other health insurance coverage, earn a gross income of no more than $800 per month (individual), and have a medical need. Roughly 18,000 enrollees annually.	Covers inpatient, outpatient, specialty care, prescription drugs, lab services, mental health and substance abuse services, dental care, and case management.	Annual budget of $38 million financed through a county property tax levy that was dedicated to a now-closed county hospital (55% of budget) and a state block grant that includes federal DSH money (45% of budget). There is no patient cost-sharing.
St. Louis, Missouri	**Saint Louis ConnectCare Health System**	A nonprofit public-private partnership, headed by 17-member board of directors, administers the managed care plan using a third-party administrator for daily management of operations. The program operates a network of clinics and partners with four hospital systems for specialty and inpatient care.	Target population is all uninsured residents of St. Louis city and county with incomes up to 100% of FPL (free care), or above 100% of FPL on a sliding fee scale basis. Serves 30,000 annually.	Covers inpatient, outpatient, specialty care, prescription drugs, lab services, and dental care.	Annual budget of $38 million financed through the state ($21-26 million, including $8 million in federal DSH money), the city ($5 million), the county ($2 million), and operating revenues. Patients with incomes above 100% of FPL pay on a sliding fee scale basis.
San Antonio, Texas	**Carelink**	The University Health System (UHS) administers this program, which subsidizes the cost of medical care. The program uses a "closed" system, relying on UHS's hospital and its six ambulatory care centers. The program's extended network also includes five FQHCs and one private physician. This is not an insurance program.	Target population is 250,000-300,000 county residents who are low-income and uninsured, but program is available to all county residents regardless of income or insurance status (e.g., Medicare enrollees who lack drug coverage). The program also provides a 90-day membership for individuals who become unemployed. 62,621 enrollees in October 1999.	Covers inpatient, outpatient, specialty care, prescription drugs, lab services, and case management.	Program financed through a county hospital district property tax ($0.25 per $100 property valuation). In 1999, some federal DSH money also helped fund the program. There is no cost-sharing for patients with incomes below 75% of FPL. Above 75% of FPL, monthly payments vary. For prescriptions, there are no co-pays for those with incomes below 75% of FPL; $2 co-pays for those with incomes 75-150% of FPL; and $4 co-pays for those with incomes above 150% of FPL.
Shelby County, Tennessee	**Shelby County Health Care Network**	Under contract with the county, the Shelby County Health Care Corporation administers this program, which uses 10 primary care clinics and one urgent care clinic to deliver services. This is not an insurance program.	Target population is all residents of the county, with the goal of developing a more diverse payer mix. There is no enrollment process per se.	Covers outpatient, specialty care, prescription drugs, dental care, and case management.	Program financed from the county's general revenue, capped at $4.1 million annually. No information provided about cost-sharing.

Table 3: Community-Based Programs to Improve Access for Uninsured Individuals (Continued)

Location	Name of Program	Program Structure & Administration	Target Population, Eligibility & Enrollment	Scope of Services	Financing
Wayne County, Michigan	**PlusCare**	The Patient Care Management System, created by the county, administers this program, which contracts with three health plans and one dental plan.	Target population is 50,000-55,000 county residents ages 21-64 who are not eligible for any other health insurance coverage and have monthly household income of no more than $250 (excluding child support and Social Security payments). Enrollment is roughly 31,000-35,000.	Covers inpatient, outpatient, specialty care, prescription drugs, lab services. Dental care is limited to dentures and extractions. Does NOT cover mental health and substance abuse services, but plans are required to establish a system of referrals for these services.	The $44 million annual budget is funded by a hospital indigent care pool financed by state Medicaid, federal Medicaid matching, and county general funds. There is no patient cost-sharing for most health care services. There is a $0.50 co-pay for prescription drugs and a $3.00 co-pay for hearing aids.

Sources: Andrulis, D. and Gusmano, M. Community Initiatives for the Uninsured: How Far Can Innovative Partnerships Take Us? (The New York Academy of Medicine, August 2000); Silow-Carroll, S., Anthony S., and Meyer J., State and Local Initiatives to Enhance Health Coverage for the Working Uninsured (Economic and Social Research Institute, Washington, DC, October 2000).

Table 4: Community-Based Programs to Improve Access for Small Businesses and Uninsured Employers [26]

Location	Name of Program	Program Structure & Administration	Target Population, Eligibility & Enrollment	Scope of Services	Financing
Denver, Colorado	**Denver Health Medical Plan—Small Business Premium Subsidy Program**	Denver Health, an independent governmental authority that runs Denver's public health care system, administers this premium subsidy program for employers with 2-50 employees. The program offers three different health plans to the small businesses: a basic plan, a standard plan, and a premier plan.	Target population is employers and employees of small, low-income businesses without health insurance coverage. Firms must have 2-50 workers; must not have offered coverage in prior 90 days; and must have net income of $50,000 or less during the previous year. As of December 2000, 20 businesses were receiving the subsidy.	Covers inpatient, outpatient, lab services, and mental health and substance abuse services.	The program is financed through a 5-year, $5 million grant from The Colorado Trust and the W.K. Kellogg Foundation. This amount pays for a subsidy worth 20-50% of the total premium, determined on a sliding scale based on the firm's net income during the previous year. The employer and employee must pay the balance. The subsidy is available in years one, two, four, and five, with no subsidy in year three to determine the extent of retention of coverage without assistance.
Wayne County, Michigan	**HealthChoice**	The Patient Care Management System (PCMS), created by the county, administers this subsidized managed care program for businesses with three or more employees. PCMS contracts with a third-party administrator for collections and billings. The program contracts with five different health care networks from which enrollees may choose. Enrollees are assigned to primary care providers, who function as gatekeepers.	Target population is 9,000 county businesses with three or more employees. 50% or more of the employees must average an hourly wage of $10 or less; and employees must work at least 20 hours a week for an anticipated period of at least five months and be ineligible for other health insurance coverage. In June 2000, there were 19,019 employees and 1,977 small businesses enrolled.	Basic coverage includes inpatient, outpatient, specialty care, prescription drugs, and lab services. For additional premium charges, employers can receive optional benefits, including unlimited inpatient hospital days, mental health and substance abuse services, and dental care.	The $16.8 million annual budget is partially financed through premiums for health coverage. Premium costs are divided in thirds among employer, employee, and the program. The program obtains its funds from a hospital indigent care pool financed by state Medicaid, federal Medicaid matching, and county general funds. $5 co-pays are required for prescription drugs and physician visits. There are separate surcharges for dental benefits.

[26] In this table, we indicate whether each program covers the following services: inpatient, outpatient, specialty care, prescription drugs, lab services, dental care, mental health and substance abuse services, and case management. Some programs also cover additional services, including (but not limited to) emergency room services, ambulance services, transportation services, and vision care. For more detailed information on these or other services, see the table's sources cited below.

Table 4: Community-Based Programs to Improve Access for Small Businesses and Uninsured Employers (Continued)

Location	Name of Program	Program Structure & Administration	Target Population, Eligibility & Enrollment	Scope of Services	Financing
San Diego, California	**FOCUS (Financially Obtainable Coverage for Uninsured San Diegans), Sharp Health Plan**	Sharp Health Plan administers the premium assistance program for small employers and low- to moderate-income employees. The program is a partnership between Sharp Health Plan and Alliance Healthcare Foundation in which Sharp Health Plan offers insurance coverage and the foundation subsidizes premiums. The insurance is a "no frills," standard commercial plan.	Target population is more than 150 small businesses with 50 or fewer employees, and up to 2,000 full-time employees with incomes up to 300% of FPL. To be eligible, small businesses cannot have provided coverage in the past year, and employees cannot have been insured in the past year. As of June 2000, 1,699 employees and 216 businesses were participating.	Covers inpatient, outpatient, and prescription drugs. Mental health and substance abuse services are limited to outpatient services.	Premiums are subsidized through a $1.2 million grant from Alliance Health Foundation and a portion of a $400,000 grant from The California Endowment. Employer contributions to premiums are fixed, and employees pay according to a sliding scale based on income and family size. There are $5 co-pays for physician office visits and $5 generic/$15 brand co-pays for prescription drugs.
Muskegon County, Michigan	**Access Health**	The nonprofit Muskegon Community Health Project (MCHP) administers this program, which targets uninsured individuals who work for small to medium-sized businesses. The program is not an insurance plan. It has a network of providers with which it contracts directly. MCHP is a Comprehensive Community Health Models partnership of the W.K. Kellogg Foundation.	Target population is up to 3,000 full- or part-time (not seasonal or temporary) working, uninsured individuals in small to medium-sized businesses in Muskegon County. To be eligible, businesses can have up to 150 full- or part-time employees; must not have provided insurance for the last 12 months; and must have a maximum median wage of eligible employees of $10 per hour or less. As of June 2000, 155 small to medium-sized businesses were participating.	Covers inpatient, outpatient, specialty care, prescription drugs, and lab services.	The $4 million annual budget is financed through a shared buy-in among employer (30%), employee (30%) and community match (40%). Community match is comprised of federal DSH, local government, community, and foundation funds. Co-payments are required for most services (e.g., $5 for primary care provider office visit and $20 for specialist visits).

Sources: Andrulis, D. and Gusmano, M. Community Initiatives for the Uninsured: How Far Can Innovative Partnerships Take Us? (The New York Academy of Medicine, August 2000); Silow-Carroll, S., Anthony S., and Meyer J., State and Local Initiatives to Enhance Health Coverage for the Working Uninsured (Economic and Social Research Institute, Washington, DC, October 2000).

Safety Net-Sponsored Medicaid Managed Care Plans

Our literature review confirmed our findings from the profiles in Section 2 that safety net organizations sponsoring health plans are showing some successes but face significant challenges. Such challenges are not confined to health plans for uninsured populations. Reviews of safety net-sponsored managed care plans serving the Medicaid population reveal, despite a more stable funding source (e.g., federal/state Medicaid reimbursement), many similar obstacles and opportunities. Also, a review of safety net and community-based organizations that have formed alliances to develop Medicaid managed care plans reveals many important benefits of collaboration (similar to those experienced by the Community Voices collaboratives profiled), but also warns of potential conflicts and risks.

A recent study by Gray and Rowe reported the results of a national survey of Medicaid managed care plans sponsored by safety net organizations that have a mission to serve low-income populations.[27] Sponsors of the 80 health plans surveyed included community health centers, public and private hospitals, academic medical centers, government, physicians, insurers, or some consortia of these entities. The organizations experienced challenges in securing funding, building partnerships, reaching local low-income populations, and forging a new role in the community. The study found poor overall financial performance among the health plans, with 60 percent of the plans surveyed reporting a loss in 1997. Even the more successful plans "live on the edge," and are vulnerable to political, organizational, or fiscal changes. The authors concluded that the future of the safety net plans will depend largely on favorable state policies and access to capital (discussed further in Section 4).

A second study, by Sparer and Brown, looked specifically at the alliances formed by safety net providers that sponsor Medicaid health plans.[28] For these safety net providers, as well as for other organizations developing community-based health plans, alliance-building helps to raise needed capital, increases the pool of potential enrollees, and allows for efficiencies of scale. Alliances are subject, however, to conflicts of interest among the different sponsors and among the sponsors and the plan. Conflicts often occur, for example, between the mission to serve vulnerable groups and the desire to maximize revenues. These conflicts may be significant and can undermine the success of the health plan.

Section 4. Lessons for Program Planners and Policymakers

The five programs examined in detail in this report (Section 2) and similar programs across the country (Section 3) have all experienced the satisfaction and frustration that come with trying to launch successful health plans for uninsured populations. Below, we attempt to summarize the lessons from both their achievements and the stumbling blocks they continue to encounter.

1. Stable and Sufficient Funding is Critical but Elusive

Health plans for the uninsured rarely have sufficient funds to serve the entire target population, nor do they have money to expand. Without a regular financing source such as Medicaid reimbursement or private premium payments, these programs often depend on temporary, precarious, and/or limited funding streams.

Program administrators need to be creative in identifying sources of financing for programs, and may need to partner with organizations that have access to capital, ***in addition*** to an interest in promoting the goals of the program.

Some programs (UNM Care Plan, El Paso Primary Care Plan, FirstConnection, Family Care) are made possible through financing from a large hospital system or health plan able to "donate" a portion of their reserves. But this funding source is often inadequate to serve the entire target population, and it is vulnerable to changes in the supporting institution's financial circumstances. A small, community-based organization by itself would have even greater difficulty obtaining adequate funding for such an endeavor and would require partnering with other institutions with greater access to resources.

In some cases, programs have been the victims of their own success. The longer a program has been operating, and the happier its patients are with its services, the faster that word spreads among the uninsured about

[27] Gray, Bradford H. and Catherine Rowe. "Safety-Net Health Plans: A Status Report." ***Health Affairs***, January/February 2000, pp. 185-193.
[28] Sparer, Michael S. and Lawrence D. Brown. "Uneasy Alliances: Managed Care Plans Formed by Safety-Net Providers." ***Health Affairs***, July/August 2000, pp. 23-35.

the program's existence. This is a double-edged sword: on one hand, the programs exist to serve the uninsured; on the other hand, programs rarely have sufficient funds to serve the entire target population. Consequently, program administrators or elected officials often limit the amount of marketing and outreach that programs can do so that budgets are met and pressure to expand programs does not become too great.

The Ingham Health Plan, for example, recently limited marketing to new enrollees to avoid "overpromising" on the services it can provide with its current budget. Program officials feel it would be unfair to aggressively seek new enrollees until they are sure they have the provider capacity and funding to do so.

In Milwaukee's program, large numbers of uninsured patients in addition to those who were enrolled became aware of the program's benefits and started showing up for treatment at participating clinics. Concerns about being overwhelmed have caused many private hospitals in Milwaukee to choose not to participate in the program. These hospitals feel they already have tight budgets that have been buckling under the weight of federal reductions in DSH payments and ongoing increases in uncompensated care.[29]

Programs face increased financial pressure if their enrollments rise. Many of the older programs saw their numbers swell after the 1996 federal welfare reform law, which de-linked Medicaid and welfare eligibility, and led to a reduction in "welfare rolls." Many beneficiaries' perception of the loss of Medicaid coverage (despite rules that allowed continuation of coverage in many cases) is a major contributing factor to lower Medicaid enrollments and rising uninsured in almost every state.

In addition, health care cost escalation and "adverse selection" can cause programs' costs to exceed their budgets. While it was held in check in the mid- to late-1990s, health cost inflation has begun to reappear, fueled by diminishing returns on managed care savings and the high cost of prescription drugs. Before the program ended, Denver, Colorado's CU Care experienced serious adverse selection problems and corresponding cost increases from offering prescription drug coverage to its patients. As more uninsured individuals heard about the program, and its prescription drug benefit in particular, they found the program to be very attractive; and many of these patients ultimately required multiple prescription drugs. Shelby County, Tennessee's program also has experienced a similar adverse selection problem.[30]

Programs that predominantly rely on medical service contributions have an even higher risk of breaching financial constraints. Since the level of commitment may rise and fall, it is difficult to plan a budget and deliver a standard and stable package of benefits (e.g., Jacksonville, Florida's program). In Buncombe County, North Carolina's program, the value of donated services per patient has decreased significantly since the program began. The 1997 average value of monthly-donated services per patient was $600; in 1999, that fell to $300.[31] Moreover, the long-term success of programs like these depends heavily on their ability to recruit and retain physicians.

Like other actors in the health care system, community programs for the uninsured also have been squeezed financially by increased competition and payment cuts imposed by managed care organizations. Denver's CU Care program's budget was reduced by 50 percent in its final year of operation because University Hospital–one of the major in-kind contributors to the program's funding–had to significantly scale back its contribution due to competition and managed care. In Jacksonville, HMO growth has made it difficult to recruit more surgeons for the program since lower reimbursements have prodded them to see more patients, leaving less time and fewer resources for them to donate. In addition, increased competition has caused more frequent hospital mergers, often resulting in cost-cutting changes in hospital policies. In Jacksonville, one of the recently merged hospitals will provide only non-invasive procedures to the program's patients.[32]

Over time, as community programs grow, they will be in a better position to compete in the managed care marketplace. But moving toward full capitation and becoming a true managed care plan costs money and requires systems for income verification and patient utilization. The UNM Care Plan, for example, needed to build an infrastructure that included medical informa-

[29] Andrulis, D. and Gusmano, M. Community Initiatives for the Uninsured: How Far Can Innovative Partnerships Take Us? (The New York Academy of Medicine, August 2000).

[30] Andrulis and Gusmano, August 2000.

[31] Andrulis and Gusmano, August 2000.

[32] Andrulis and Gusmano, August 2000.

tion systems, quality control, utilization management, member services, and other systems to accommodate new managed care functions.

When possible, programs need to brainstorm for creative financing ideas. For example, the State of Michigan (Wayne County, Muskegon County, Ingham County) re-deployed some Medicaid funds to help pay for health coverage for the working and indigent uninsured, in addition to supporting indigent hospital care. Officials in Ingham County created a "special Medicaid payment" by using county and state funds dedicated to indigent care as non-federal (e.g., state) share of DSH payments to the local hospitals. This non-federal DSH payment was used to draw down federal DSH dollars over-and-above the DSH money already going to the hospitals for inpatient care.

Because most community programs find themselves financially stretched, however, they are admittedly only reaching a relatively small portion of the uninsured population, and they certainly do not have adequate funds to expand. For programs like these to truly flourish, more support from the state and federal governments is needed.

It should be noted, however, that additional reimbursement alone does not ensure success. As noted in Section 3, Medicaid managed care plans sponsored by safety net organizations also face challenges in securing initial funding, and due in part to low Medicaid reimbursement rates, many have been losing money in recent years.

2. A Medical Home Can Bring Psychological, Medical, and Financial Benefits

Many of the programs have succeeded in providing patients with a "medical home." These programs give patients a sense of belonging and offer them a feeling of dignity when they approach the health care system. All of the plans profiled in Section 2 give each enrollee a plan membership card and assign a participating primary care provider. In doing so, these programs and others (Boston, MA; Hillsborough County, FL; Contra Costa, CA; Marion County, IN; San Antonio, TX) provide the uninsured with access to mainstream, primary care providers, which helps to ensure they receive timely, quality care.

Indeed, some programs have demonstrated measurable improvements in both the quality and cost-effectiveness of health care delivery, with financial savings in the long run. The UNM Care Plan has resulted in reduced hospitalizations, hospital days, and (after an initial increase due to pent-up demand) ambulatory care utilization, saving $148 per member in inpatient and outpatient costs in FY 1999. In Buncombe County, North Carolina, the program has cut in half the number of patients receiving care in hospital emergency rooms. Likewise, Contra Costa, California's program has reduced emergency room use through patient education, particularly through nurse advice and case managers; and Marion County, Indiana's program has achieved similar reductions in emergency room use and inpatient admissions. In Hillsborough County, Florida, the program cut the county's costs for enrollees from $600 PMPM (in the year prior to implementation) to less than $200 PMPM.[33]

3. Collaboration Helps Ensure Success

Establishing relationships among community-based safety net organizations and ensuring commitments to work toward the same goal is a long and labor-intensive process, yet in many cases critical. Partnerships and alliances help to raise needed capital, reduce duplication of services, increase the pool of potential enrollees, and allow for efficiencies of scale. Safety net organizations in El Paso, for example, realized that with rising numbers of uninsured and declining financial resources, they needed to "survive together" as an integrated health care delivery system to effectively serve the county's underserved populations. The UNM Care Plan's strategy to overcome competition and improve financial stability by coordinating and pooling resources among many community-based safety net providers has been one of the key factors behind its success.

Including community-based organizations (CBOs) in the alliances is important for many reasons. CBOs are generally more accessible and more trusted by local populations than large hospitals and institutions. They also play an essential role in outreach and enrollment. Also, by partnering with CBOs, programs for the uninsured may provide crucial economic support for small clinics or public hospitals that otherwise might not survive. In Milwaukee, Wisconsin's and Wayne County,

[33] Andrulis and Gusmano, August 2000.

Michigan's PlusCare programs, clinics have become a source of referrals for hospitals. This development has sparked hospitals' interest in cementing formal relationships with the clinics.

Moreover, some programs' use of third-party administrators for billing, standardization of medical records across program providers, and provision of software or other information technology assistance (Milwaukee County, WI; Shelby County, TN) have helped clinics to speed the billing and payment process, which is very important for small clinics on a tight budget.[34]

The advantages as well as a few ***risks*** of collaboration are evident in the experiences of safety net-sponsored health plans serving Medicaid enrollees.[35] As noted in Section 3, there are potential conflicts of interest among the different sponsors or between the sponsors and the health plan. Sparer and Brown underscore the importance of the health plan's board of directors, which–despite generally being made up of representatives of sponsoring institutions–should encourage the health plan to forge its own identity and mission and secure sufficient independence from its sponsoring organizations. This requires skillful leadership, whereby the director has the ability to: mediate conflicts among affiliated organizations and board members; lobby legislators and deal with regulators; understand principles of insurance and managed care; manage a complex organization in an evolving market; and address issues involved in working with low-income populations. This latter qualification includes having a knowledge of cultural differences, using providers from under-represented groups, and making other special efforts that reflect cultural sensitivity and respect for the target populations (see Lesson 6, following).

4. Adequate Physician Supply and "Buy-In" are Crucial

Programs' success also depends heavily on the willingness of physicians and hospitals to participate in the provider networks. Where physicians volunteer to participate in a program and can play a key role in its development, the program is more likely to succeed than if participation is imposed on them. Adequate reimbursement rates and positive financial incentives are important both to encourage physicians to participate in the network (if participation is voluntary) and to discourage them from avoiding serving plan members (if participation is mandatory). El Paso physicians are seeing higher and higher numbers of Medicaid and Primary Care Plan patients, causing some to balk at accepting new enrollees because the Primary Care Plan's reimbursement rates are based on very low Medicaid reimbursement rates plus five percent.

The UNM Care Plan found it helpful to hire a managed care organization to educate providers about the new plan. "Buy in" is also important in programs such as Buncombe County, North Carolina, which are primarily financed through in-kind medical service contributions. In El Paso, having the support of the local medical society was essential for the implementation of the program. The El Paso First Health Network managed care plan (a Medicaid managed care plan) would not have sponsored the Primary Care Plan (for the uninsured) if local physicians did not support the program.

One barrier to continuing the FOCUS plan for small businesses in San Diego is that providers have agreed to accept below-market rates for FOCUS enrollees. Accepting lower reimbursement may be tolerable for a project with 1,000 to 2,000 enrollees and limited duration, but program planners recognize that if the program expands, provider rates would have to increase to help secure providers' continued participation.[36]

An adequate supply of PCPs is particularly important, since these practitioners are the entry point into the health system for enrollees. A shortage of PCPs leads to overburdened providers and long waits at clinics or for appointments, resulting in patient frustration and potentially undermining the goals of the program.

5. Take a Broader View of "Health Professionals"

While physicians are critical, they comprise only one component of the potential "provider" pool. Community–based health plans can and should utilize a broad range of individuals such as community health representatives, social workers, case managers, behavioral health workers, nurse practitioners, physician assistants, dental hygienists, and interpreters–depending

[34] Andrulis and Gusmano, August 2000.

[35] Sparer and Brown, 2000.

[36] Silow-Carroll, S., Waldman E., and Meyer J., *Expanding Employment-Based Health Coverage: Lessons from Six State and Local Programs* (Economic and Social Research Institute, Washington, DC, February 2001).

on the specific community population needs. For many functions, these workers serve as less costly but highly capable alternatives to physicians and other "high professionals"–which is particularly important in programs with limited funds. These types of health workers may in fact be more effective in reaching the target population, gaining trust, teaching health promotion, and communicating with enrollees.

The community model also stresses the importance of the interdisciplinary approach, in which primary care, case management, social services, behavioral health, and other key services are linked, and there is ongoing communication among providers (see Lesson 7, below).

6. Communication, Education, and Respect are a Must

Programs are more likely to succeed if they communicate effectively with patients and prospective patients. Programs cannot merely provide access to health care services. The UNM Care Plan and others stress the importance of educating new members at the time of enrollment about the appropriate utilization of the PCP and specialists and other plan rules. After being clearly informed by enrollment workers, new members of FirstConnection (North Carolina) sign a Participant Responsibility Agreement that outlines their responsibilities for taking an active role in health promotion. The enrollment staff of El Paso Community Voices' plan sign a "Verification" form indicating that each applicant has received a detailed explanation of the application process and a summary of plan benefits.

If patients are used to going to a particular hospital and now must go to a clinic, the new arrangement must be clearly explained to patients to avoid confusion. Also, patients transitioning from acute care settings to managed care plans must be educated about the importance and benefits of preventive health care so they do not show up for treatment only when they are sick. Patient education and outreach can be a significant challenge in places where the population is very transient.

Many programs have identified language barriers. Particularly in areas with large immigrant populations, translators and written material in multiple languages are essential. FirstConnection and El Paso's Primary Care Plan address communication problems by using bilingual staff and multi-language telephone lines.

In places like Alameda County, California, with large numbers of undocumented individuals, many people do not seek medical attention from available services for fear that becoming a "public charge" could lead to deportation. The more vigorous the eligibility screening, the more nervous undocumented individuals become about filling out enrollment applications and providing information that could cause them problems with the Immigration and Naturalization Service (INS). This nervousness has not abated despite the INS's clarification that the use of public health care services does not affect the ability of individuals to qualify for green cards.

There is a need for programs serving areas with high concentrations of undocumented individuals to dedicate more time to consulting with community representatives about how to most effectively communicate with these individuals so that they feel more comfortable enrolling. Most of the enrollment in the Family Care plan in Alameda County, for example, takes place at community health centers that are more trusted by the immigrant population and where providers speak the languages of their constituents. Among the programs profiled in this report, Family Care and FirstConnection explicitly serve and target undocumented individuals. Others, such as El Paso's Primary Care Plan, employ a "don't ask" policy and do not discriminate in eligibility and enrollment determinations based on immigration status.

Before conducting outreach to prospective enrollees, programs must make sure they understand the target demographic group and conduct basic market research. In Muskegon County, Michigan, market research taught program administrators that programs viewed as "government entitlements" would not appeal to the uninsured workers in their community. Moreover, talking about "affordable insurance" did not resonate with people since many of the eligible employees were living right on the margin. So program planners decided to speak to the workers about coverage that "fits within their budget." [37]

Programs also should make sure that they treat their patients with dignity, from the perspective of their patients. Enrollees in San Antonio, Texas' program found the terms "educate," "indigent," and "homeless" used in the program's materials to be demeaning. If enrollees are not comfortable with how they are being

[37] Silow-Carroll, Waldman, and Meyer, February 2001.

treated by a program and its staff, they are less likely to seek medical attention from the program.[38]

In addition, programs need to seek their enrollees' advice on program design and be prepared to adapt the program to patients' needs. El Paso County conducted focus groups with potential enrollees to identify health needs and design the benefit package. In Marion County, Indiana, the program initially had a complicated enrollment process and was not sensitive to patients' scheduling needs. For example, the program mailed out cards with designated appointment times, not bothering to ask patients about times that would be convenient for them due to work schedules or child care arrangements.[39] In Muskegon County, Michigan, the program initially was limited to employers with 19 or fewer employees. However, the program found that day care centers, many of which had 20 or 21 employees, were particularly interested in participating. As a result, the program expanded the eligibility criteria to be responsive to community demand.[40]

Finally, programs should undertake serious patient education efforts about all aspects of health care delivery. In some areas, the proliferation of community and state programs for the uninsured has confused potential enrollees, who must figure out the programs for which they are eligible (e.g., St. Louis, Missouri). Programs should have staff who can help individuals sort through their options or at least be able to direct people to specific government offices that can help them.

7. Health Plans Must be Prepared to Address Multiple Needs

Targeting uninsured populations often means enrolling vulnerable individuals and families with an array of medical, social, behavioral, and financial needs. Social supports should be included to the extent that financing permits, and case management should be an integral part of the programs. Case managers must be prepared to arrange or make referrals for services such as transportation, child care, literacy programs, job placement, substance abuse services, and others. The case manager should also ensure/coordinate communication among the various disciplines involved in an enrollee's care. Coordination between mental health and social welfare services, for example, is critical.[41]

Access to case management services for enrollees in El Paso's Primary Care Plan has been particularly important, as the program's target population is very low-income, medically indigent individuals who often have chronic health conditions such as diabetes and hypertension. The UNM Care Plan offers "one-stop shopping" including primary care, social services, case management, and behavioral health services at neighborhood clinics. The FirstConnection (North Carolina) case manager has helped enrollees qualify for various health services and social supports that fall outside of the standard medical package, such as transportation services, home heating subsidies, car seats, eyeglasses, home safety, and others as needed. Health plans for the uninsured need to be creative and prepared to "leverage" other community resources. To avoid over-dependence on case managers, however, new enrollees should be clearly informed about the limits of the benefit package.

8. Planners Face Tradeoffs Between Scope of Benefits and Cost

With limited budgets, program planners are faced with a difficult decision of whether to offer a comprehensive set of services to a smaller number of people or offer limited coverage and reach a larger number of people. Regardless of which choice is made, benefit packages should be stable and adequate to meet the most important needs of the program's target population.

Program planners in Ingham County chose to provide a somewhat limited scope of services to more people, and are pleased with their results. They found that a county can provide basic, but essential, health benefits to a large portion of its uninsured population. They learned that they can provide basic primary and outpatient care to both the "sickest" segments of the uninsured population and to a large number of young, fairly healthy people who are not excessive users of health care resources.

Other programs (UNM Care Plan, FirstConnection, Family Care) have chosen to offer more comprehensive benefits (including inpatient care, dental care, and mental health care) for a number of reasons. Many unin-

[38] Andrulis and Gusmano, August 2000.

[39] Andrulis and Gusmano, August 2000.

[40] Silow-Carroll, Waldman, and Meyer, February 2001.

[41] Ro, Marguerite and Lucy Shun. *Forgotten Policy: An Examination of Mental Health in the US*, W.K. Kellogg Foundation Community Voices: HealthCare for the Underserved, April 2001.

sured individuals have family members (generally children) who are eligible for Medicaid or S-CHIP. Also, many people go in and out of Medicaid due to changes in work status and income. These factors have led some program planners to design their health plans with generous, Medicaid-like benefit packages and with provider networks overlapping with Medicaid providers. By doing so, members can enjoy "seamless" coverage so that shifting between the health plan and Medicaid/S-CHIP does not disrupt relationships with PCPs or significantly change covered services. Similarly, it allows families with multiple sources of coverage to deal with one set of providers and benefits. Not surprisingly, focus groups in Alameda County also have shown that comprehensive benefit packages are more attractive to the target population. Family Care planners additionally reasoned that it would be too difficult to expand a limited benefit package after the program was in operation.

9. Targeting Small Businesses Poses Many Challenges

Health care access programs established to help small businesses and their employees face their own unique challenges. The Denver Health Premium Subsidy Program, for example, had only 20 small businesses participating as of December 2000, after more than a year in operation. Wayne County, Michigan, businesses often find it hard to meet the county program's premium deadline because of tight finances.[42]

Despite these challenges, it is important to continue to seek ways to encourage employers to provide health coverage to low-income workers. Most of the health plans explored in this report serve the working poor, who are not offered job-based coverage and cannot afford to purchase insurance on their own. A few pilot programs that subsidize small businesses that begin offering health benefits are showing signs of success and could be expanded.

Political Lessons and Recommendations

Not only can program-level lessons be drawn from the health plans we have examined, distinct political lessons and recommendations also can be gleaned. Below we discuss factors that influence critical political support for these plans and suggest ways that local, state, and federal policymakers can promote such efforts.

Factors that Influence Political Support for Community-Based Health Plans

In general, state and local political support for the programs is solid but not overwhelming, and the level of support is affected by a number of factors. In some areas, program planners can make efforts to build support.

1. Keep State Officials and Legislators Informed

First, programs have a stronger foundation if there is a long history of cooperation and consultation between the community-based organizations delivering the services and the sponsoring government entity (e.g., County Medically Indigent Services Plan, Alameda County, CA). But even if there are strong ties between a program and its administering county (e.g., Marion County, IN), programs place themselves at risk if they do not keep state officials informed about the merits of their health plans. The extra time spent educating state officials is worth the effort, especially given their need to balance and weigh many different interests.

Ingham County used a private consulting firm to educate and convince state officials to approve "special" Medicaid DSH payments for the IHP program. Because the county used state money that previously funded medically indigent care to finance the program, part of the arrangement involved IHP agreeing to provide care for the SMP population in Ingham County.

In Florida, while they support Hillsborough County's program, both county and state officials are opposed to program expansion or any increase in taxes. This is partially due to the program's success, which has created the false impression that the uninsured problem is solved.

2. Source of Funding Matters

A second factor that influences programs' levels of political support is the source of funding. Because Hillsborough County, Florida's program's revenue exceeded its expenditures during the mid-1990s, state and county officials took action to reduce the size of the program's trust fund instead of allowing the program to expand. State officials eliminated a maintenance-of-effort property tax requirement, and county officials reduced a dedicated sales tax from one-half to one-quarter percent. That experience shows that while taxes can be a steady source of funding, they are almost always unpopular and politically vulnerable. However, tax financing for health care programs may be easier to

[42] However, the program's third-party administrator has permitted generous grace periods when needed. (Andrulis and Gusmano, August 2000.)

sell politically if the tax source already exists. For example, in Milwaukee County, Wisconsin, 55 percent of the program's budget comes from a county tax levy that used to be dedicated to a now-closed county hospital.[43]

Other funding mechanisms have political problems as well. Boston Medical Center and its Pilot Plan rely completely on the Massachusetts Free Care pool for funding. All hospitals in the state pay into the pool on the basis of their private sector care charges, and they view the pool as a redistribution of funds from the suburbs into Boston. While the pool is in good shape financially, there is the danger that hospitals outside of Boston could successfully push to have funds moved out of the Free Care Pool and distributed differently.[44]

3. Promote as High Budget Priority

A third factor that affects programs' political support is the importance that government officials attribute to the programs relative to other budget priorities. If there were a significant economic downturn, state and county revenues would likely fall, putting a squeeze on government budgets. At the same time, the number of uninsured and those eligible for the programs would likely grow, potentially swelling the programs' enrollments. How would these programs fare in a more competitive budgetary environment?

There are definite signs that local and state government officials might not be willing to expand the programs' financing to meet such an increase in demand. In Birmingham, Alabama, while the county is supportive of the program, it only allows limited outreach and marketing for fear of increased enrollment and expenses. The situation is similar in Milwaukee, Wisconsin, where neither the county nor state seem inclined to support additional funds for the program. Moreover, it seems that special access programs for the indigent are too often viewed by politicians as a "nice thing to do" rather than as a partial solution to a serious problem that has cost implications for the rest of the health care system. In Jacksonville, Florida, one community representative claimed that city officials rank the program on the same level as "'endeavors in the arts and humanities." And one program board member "complained that the city did not contribute nearly as much money to the program as it saved by avoiding unnecessary complications."[45]

4. Enlist Support of Large Health Systems

Programs' ability to enlist the support of politically powerful health care systems is a fourth factor that influences political support for programs for the uninsured. One approach is to convince these key providers that funding for the program would work to their benefit because they would not have to absorb as much of the cost of serving this target population. This may require establishing the linkage between sound front-end investments in primary and preventive care and reduced emergency room and inpatient hospital use. Planners should be careful, however, that forming such a political alliance does not result in the larger health systems garnering the program's funding for their own use.

Hillsborough County officials, for example, avoided this potential pitfall by dedicating its sales tax to a county insurance plan for the uninsured. But officials in Dade County, Miami, used a similar sales tax to subsidize predominantly one public hospital–Jackson Memorial–instead of establishing an indigent care program. That move is now being contested by other private hospitals in the area that also care for many uninsured patients. In addition, San Antonio, Texas' program is administered by the University Health System, but that major health system has resisted partnering with a larger portion of community providers because "the program's reimbursement rates are quite generous."[46]

5. Court Consumer Groups and Labor Unions

A fifth factor affecting programs' political support is the extent to which consumer groups and labor unions have "bought in." If local or state governments partner with private clinics to provide indigent care, programs can find themselves battling labor unions concerned about the loss of union jobs and consumer advocates concerned about adequate patient access to care (e.g., Los Angeles County, CA). However, in Shelby County, Tennessee, where unions and consumer groups do not have the same political muscle as they do in California, the program's use of private clinics has not met resistance.

[43] Andrulis and Gusmano, August 2000.
[44] Andrulis and Gusmano, August 2000.
[45] Andrulis and Gusmano, August 2000.
[46] Andrulis and Gusmano, August 2000.

County officials believe that their former Health Department clinics–now part of a 501(c)(3) nonprofit organization–have more tools they can use to improve the cost-effectiveness of care, such as hiring staff and using performance incentives. The county is willing to monitor the clinics' performance, but it has had to seek outside help to monitor contract performance and outcomes.[47]

6. Seek and Emphasize Measurable Outcomes

A final factor that can affect political support for indigent care programs is evidence of success in improving quality, health outcomes, and cost-effectiveness. Some of the programs that are the most highly regarded in their communities are ones that have strong quality control mechanisms in place, with reviews conducted by independent third parties (e.g., Buncombe County, NC; Tampa, FL). Strong quality control with positive, measurable outcomes can help provide solid insulation from political attack if a program's effectiveness is ever questioned.

County, State, and Federal Efforts to Promote Health Plans for the Uninsured

As mentioned earlier, most community-based health plans for the uninsured are only reaching a portion of their target population, let alone the total number of uninsured in the communities in which they are located. Legislators at the federal, state, and county levels can help promote or expand health plans for the uninsured, primarily by providing a stable funding source. Without such long-term financial commitments (through legislation and appropriations), there is no guarantee that these programs will not be abandoned or eliminated if the economy takes a downturn or once start-up funds run out.

To start, the federal government could enable states to pool indigent care funding (including DSH funds) and direct this funding toward community-based programs. It also could ease up on prohibitions against using federal Medicaid matching funds for undocumented residents and make it easier to apply for Medicaid waivers for demonstration projects and to extend eligibility. [This may require legislative and regulatory changes.] The federal government could tap the budget surplus or other sources to provide demonstration grants directly to states and communities to create health plans, insurance infrastructures, and premium subsidies for low-income people, or to replicate successful community-based models.

The U.S. Department of Health and Human Services' Health Resources and Services Administration (HRSA) includes an Office of Managed Care, which provides technical support to safety net providers to help them participate in the networks of Medicaid managed care plans, could expand its activities to include education and assistance in implementing health plans for the uninsured.

Similarly, states could devote a portion of their budgets toward seed money or ongoing support for community-based health plans, or toward expanding existing successful programs to a broader geographic area. This could include a portion of tobacco settlement funds. State policymakers could allow flexibility in using existing state and local money to foster "creative" arrangements that leverage federal funds (e.g., DSH).

Also, if they expand eligibility for their Medicaid and S-CHIP programs, states would open slots in community-based health plans for additional uninsured people who remain ineligible for the public insurance programs. In addition, they could consider ways to allow currently undocumented residents to benefit from public programs.

State Medicaid departments could help in education, outreach, and enrollment. Medicaid enrollment workers, for example, should be educated about and able to provide applicants with information on health plans for uninsured people who are ineligible for Medicaid or S-CHIP.

For programs that request insurance designation, state insurance departments could look for ways to allow more flexibility and to expedite the authorization process without compromising the integrity and stability of the new insurance entity. They also may consider waiving some state-mandated benefits to allow community-based insurance plans to provide more basic coverage at a lower cost.

County health departments could become involved directly in implementing health plans for the uninsured (e.g., Ingham County, MI; El Paso County, TX), or indirectly by helping to finance health plans administered by other organizations. They can earmark a local tax (e.g., property, sales) for this purpose, and can petition the state to devote a portion of tobacco settlement funds toward such programs. County officials could also provide a leadership role in organizing and nurturing collaboratives among the county health department and safety net CBOs.

[47] Andrulis and Gusmano, August 2000.

Conclusion

One of the most important lessons learned from our examination of community-based health plans for uninsured populations is that these initiatives have the potential to expand access to care, enhance dignity among enrollees, improve health outcomes and productivity, and even reduce health costs over the long run. Such a strategy, however, requires an expanded and stable source of funding to move these programs beyond the demonstration or pilot stage.

It is also clear that such a strategy must be part of a larger solution to the problem of the uninsured. Policymakers at all levels of government should promote a variety of ways to improve access to health coverage and health services for vulnerable populations. A comprehensive approach may include: encouraging employment-sponsored coverage through tax credits and health insurance purchasing cooperatives for small businesses and individuals; expanding public coverage programs such as Medicaid and S-CHIP; improving outreach and education to undocumented and low-income communities; and expanding safety net, community-based programs for the uninsured who remain outside the system.

W.K. KELLOGG
FOUNDATION

One Michigan
Avenue East
Battle Creek, MI
49017-4058
USA
616-968-1611
TDD on site
Telex: 4953028
Facsimile: 616-968-0413
Internet: http://www.wkkf.org

CV:HCU3977
Item #478
11-013MHP

Union Bug FPO