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Genesee Health Plan: Improving Access to Care and the Health of Uninsured Residents Through a County Health Plan

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ABSTRACT: Genesee Health Plan (GHP) is a community-based nonprofit that provides primary care and other basic health care services to 27,000 low-income, uninsured adults in Genesee County, Michigan—one of the most economically challenged areas of the United States. Its annual budget of $24 million is funded through a dedicated local property tax and charitable support, supplemented by some state and federal financing. By increasing access to physician services and supporting patients to adopt healthy behaviors and manage chronic disease, the plan reduced its enrollees' use of emergency department services by 51 percent between 2004 and 2007 and hospital admissions by 15 percent between 2006 and 2007. GHP relies on independent physicians, clinics, and hospitals to provide services to its members and on collaboration among its community stakeholders—including local government, hospitals, faith-based organizations, universities, and community groups—to identify gaps in regional coverage and allocate resources accordingly.

OVERVIEW

Many counties in Michigan have created health plans to provide basic ambulatory care services to "medically indigent," uninsured, nonelderly adults who earn less than 35 percent of the federal poverty level and who are ineligible for Medicaid.[1] The state determines eligibility criteria and provides funding for these health plans through an Adult Benefits Waiver program, which reallocates unspent federal funds from the state's Medicaid program.[2]

Some counties have built on this infrastructure to develop innovative programs serving a broader population of low-income uninsured residents. Genesee County is unique among them because it does so using a dedicated property tax. By raising funds this way, the health plan was able to expand the population it serves to include low-income, uninsured county residents with incomes up to 175 percent of the federal poverty level.[3] "We took the county health plan concept and really put some thought and planning into making it a model that could be an example and one that could be replicated," says Linda Hamacher, Genesee Health Plan's CEO.

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Incorporated as a nonprofit 501(c)(3) organization in 2001, Genesee Health Plan (GHP) operates two plans with a staff of 17 people.[4] Plan A serves the medically indigent with an annual budget of approximately $7 million provided by the state. Plan B serves the expansion population of low-income, uninsured residents on a budget of $16 million, or about $600 per member, financed through both public and private sources.[5] This case study focuses on the Plan B population.

The property tax, which Genesee County voters approved in November 2006 by a vote of 54 percent, provides $11.3 million per year through 2013, most of which supports GHP.[6] The Charles Stewart Mott Foundation and the state of Michigan provided start-up funds. Several local foundations (the Ruth Mott Foundation, the Community Foundation of Greater Flint, and the Charles Stewart Mott Foundation) together contributed another $1.7 million between 2005 and 2007. GHP also partners with local hospital and health systems including Genesys Health System, Hurley Medical Center, and McLaren Regional Medical Center, which participate in the GHP provider network, serve on the GHP board and its committees, provide data on compensated and uncompensated services delivered to GHP members, and provide financial support.[7]

The health plan's leaders and providers believe GHP plays an important role in improving community health. Local hospitals see the health plan as an effective way to invest money in primary and preventive health care, keep uninsured county residents healthier, and reduce unnecessary or preventable emergency department (ED) visits and hospitalizations.

In 2008, GHP became involved in the Institute for Healthcare Improvement's Triple Aim program, which fosters innovative approaches to improving population health and patients' experiences of care while reducing or controlling the per capita cost of care. This involvement came about through a community partnership with Genesys Health System, which was one of several organizations that served as prototypes for the Triple Aim. The Commonwealth Fund studied GHP as part of a series of case studies on the Triple Aim.

SERVICES

Genesee Health Plan members enrolled in Plan B receive primary and preventive care and other basic ambulatory health care services including specialty care, outpatient laboratory and radiology services, and limited prescription drug coverage from a narrow formulary of generic drugs. The health plan also supports its members in adopting healthy behaviors, through a health navigator program it implemented in partnership with Genesys Health System.

There are no premiums or enrollment fees in Plan B, but $3 copayments are charged for physician visits and prescription drugs. No copayment is required for diabetes medications. For nonformulary medications, GHP's Prescription Assistance Program coordinators help members apply for free drugs through manufacturers' prescription drug assistance programs.

Plan B does not cover ED visits or hospitalizations, but it does cover physician services for outpatient surgeries and provides an annual lump-sum payment to local hospitals to defray the institutions' uncompensated costs. GHP made more than $3.1 million in payments, including the annual lump sum payment, to health systems in 2007 to subsidize a portion of uncompensated services.

In 2006, GHP began a pilot program to provide limited physical therapy benefits through an agreement with the University of Michigan–Flint's Urban Health and Wellness Center. Physical therapy faculty and students work with GHP members to provide therapy for surgical and chronic care pain patients. The Urban Health and Wellness Center's nurse practitioner-managed primary care clinic also provides primary care to 4,000 plan members.

In 2007, the plan began to provide a limited outpatient mental health benefit, which permits 20 sessions of mental health services per year. This program was developed in partnership with Genesee County Community Mental Health, a county agency, using $580,000 in funding from the agency.

Exhibit 1. Health Insurance Coverage Among Nonelderly Residents, 2006–2008

	Employer-based coverage	Individually purchased coverage	Medicaid coverage	Uninsured
Flint metropolitan area	53.4%	2.7%	19.4%	22.8%
Michigan	67.5%	4.9%	14.7%	12.7%

Source: Employee Benefit Research Institute analysis of Current Population Survey, March 2007–2009.

POPULATION

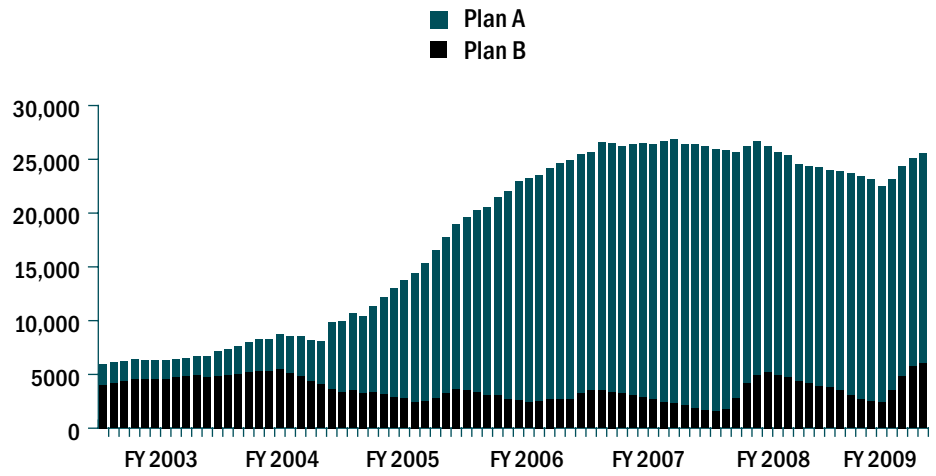
Genesee County struggles not only with serious economic challenges, but also with health risk. Both Genesee County and its largest city, Flint, have undergone a substantial decline in population and employment in the last three decades, reflecting the changing fortunes of the U.S. auto industry on which the community relied. Flint had an unemployment rate of 26.6 percent as of December 2009; Genesee County's rate was 16.0 percent.[8] At the same time, Genesee County ranks last out 82 counties in Michigan on measures of unhealthy behavior, which include smoking, adult obesity, binge drinking, and teen birthrates.

Almost one of four nonelderly residents lacked health insurance in the Flint metropolitan area during 2006–2008 (Exhibit 1).

When GHP began Plan B enrollment in 2002, it set the income cap at 150 percent of the federal poverty level. In 2006, GHP increased the income limit to 175 percent of the federal poverty level. As a result, enrollment increased rapidly through 2007 (Exhibit 2). Plan B also gained members when Plan A reached a statewide limit in 2004 and those who qualified for Plan A were added to Plan B. GHP now covers 78 percent of uninsured adults in the Flint metropolitan area with incomes at or below 200 percent of the federal poverty level.

According to recent data from the health plan, 59 percent of newly enrolled GHP members are unemployed, 27 percent say their employer does not offer health care coverage, and 11 percent say they could not afford employer-offered coverage.

Exhibit 2. Enrollment in Genesee Health Plan, 2003–2009



Source: Health Management Associates.

As a population, uninsured adults are more likely to go without prescription medication, have lower annual earnings, are less likely to receive basic health screenings, and have worse outcomes for chronic conditions.[9] GHP found that in the six months prior to enrolling in the plan, 7 percent of members were admitted to the hospital, 29 percent had used a hospital ED, and 22 percent of those had used the ED more than once. At the time of enrollment, approximately 26 percent of new GHP members reported one or more chronic diseases including chronic pain (31%), hypertension (15%), asthma (10%), high cholesterol (8%), diabetes (5%), and heart disease (2%).

IMPLEMENTATION

From the beginning, GHP's board was committed to creating a program of care for the uninsured that was delivered through the same health care systems and providers used by the insured population. "It might have been easier to create a dedicated clinic for the uninsured and there was some support for that within the medical community, but we felt that it had to work in the regular health care system," Hamacher says. "Many uninsured patients already had a community physician and continuity of care is important. We also wanted to demonstrate how support for this population and their physicians could be done through a network of independent physicians, the way care in most communities is organized."

To meet this need, GHP established a network of 192 primary care physicians, most of whom are affiliated with one of the three participating hospital systems. These physicians, who provide medical homes for the patients, coordinate referrals for specialty care using a network of 289 specialists. Primary care providers are reimbursed on a fee-for-service basis using the Medicaid rates plus 14 percent. Specialty physicians are paid Medicaid rates plus 4 percent. Medicaid fees in Michigan are 90 percent of the national average and 63 percent of Medicare fees, according to the Urban Institute.[10]

GHP also provided cultural sensitivity training to prepare physicians and office staff—many of whom were accustomed to treating patients with generous health insurance benefits—for caring for patients who had been without any health insurance coverage for years. "These physicians needed to have a clear understanding of the social, cultural, and economic barriers this population faces," Hamacher says. "Physicians had to learn that this population has multiple needs and in some cases, chronic conditions that have never been treated. For many physicians, GHP members are different from the types of patients they may be used to," she says.

GHP's board of directors includes representatives from the county health department, hospitals, physician groups, a children's health center, a university, the health plan, pharmacies, community groups, and faith-based organizations. The collaboration among these different stakeholders has helped to identify barriers to care and gaps in coverage, while also fostering broad-based community support for the plan. To identify pressing needs in the community, GHP also relies on input from its members solicited through focus groups and feedback from staff, who have frequent contact with members.

PATIENT SELF-MANAGEMENT SUPPORT

To help patients develop healthy behaviors and enhance self-management skills, the plan partnered with Genesys Health System to adopt its health navigator intervention, which the health system modified to address the needs of an indigent population. Behaviors common among this group include physical inactivity and smoking, which are the lead determinants of morbidity and mortality. For more details on the health navigator program, read the separate Genesys HealthWorks case study report.[11]

RESULTS

After adopting the Triple Aim in its strategic planning, Genesee Health Plan has organized its results in the program's three areas: population health, patient experience of care, and cost and resource use. GHP is also encouraging its key stakeholder organizations to organize around the goals of the Triple Aim.[12]

Population health

After instituting the health navigator program, GHP saw improvements in healthy behaviors, which are lead determinants of health and longevity. For example, exercise and healthy eating have increased by 53 percent among health plan members who have engaged with the navigators. About 82 percent of diabetes patients engaged with health navigators have improved their self-management.

By engaging patients in self-management support, the health navigator program has contributed to the reduction in ED use and hospital admissions.

Patient experience of care

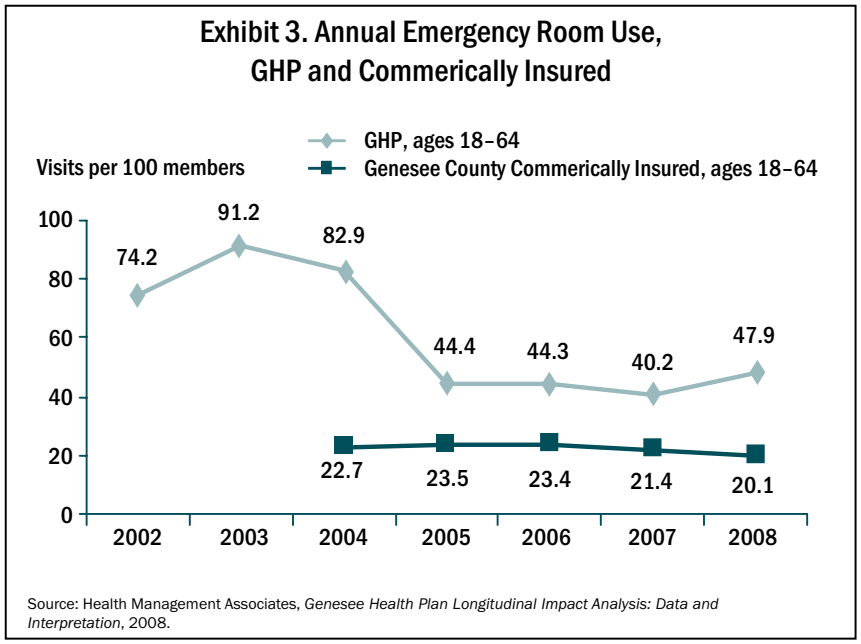
Access to care is an essential measure of patient experience, especially for the low-income, uninsured population; without access, there is no patient experience of care. GHP has been monitoring access through a variety of measures, including the use of physician services and prescription drugs. GHP has found its members see primary care physicians at almost the same rate that enrollees of local commercial health plans do (2.1 times per year versus 2.4). For well-care visits (i.e., annual physicals), GHP members see physicians at the same rate as their counterparts in commercial health plans. Likewise, as membership in the plan has increased, so has the total number of mammograms received by the community's low-income women. That number has increased from 400 in 2003 to 2,800 in 2007.

However, visits to specialists are significantly less frequent (47.4 visits per 100 members of GHP plans versus 112.48 visits per 100 members of commercial health plans), according to Hamacher. Of the referrals made to specialists by GHP physicians, more than one-third do not result in visits. Hamacher says many factors could contribute to this problem, including misplaced fears that a specialist visit will result in a large medical bill; social, economic, or cultural barriers that prevent patients from scheduling or attending the visit; specialists being unwilling to accept low reimbursement rates or being intolerant of cancelled appointments or no-shows; and access problems caused by high demand and low capacity within certain specialties. GHP leaders continue to examine methods of alleviating members' and specialists' concerns.

The plan's analysis also found that while the rate of specialty care visits is increasing over time, the number of referrals is decreasing. Since 2004, specialist referral rates per member have decreased by 44 percent from 92 per 100 GHP members in 2004 to 51 per 100 members in 2007. Hamacher says this reflects effective management of earlier pent-up demand and the healthier status of recent enrollees.

The plan has seen a substantial increase in use of outpatient surgery services, after GHP agreed to pay physicians' fees for outpatient surgeries, such as hernia and gallbladder repair, carpal tunnel and cataract surgery, and others. The number of outpatient surgeries increased by 360 cases, or 61 percent, between 2006 and 2007. Because the plan covered physicians' fees and not hospital costs, the policy change imposed a cost on hospitals. However, GHP leaders deemed it necessary because many physicians (particularly specialists) felt frustrated that they could not adequately treat their patients without access to necessary surgeries; some threatened not to treat GHP patients at all. Hence, the GHP board determined that increased access to these services made sense and would help maintain access to specialty physician services, according to Trissa Torres, M.D., M.S.P.H., who represents Genesys Health System on the GHP board.

Prescription drug use also has increased. The average number of prescriptions filled per plan member in his or her first 12 months increased from 12.3 for members enrolled in 2003 to 12.5 for members enrolled in 2007. At the same time, the cost of the prescription drug benefit declined, from $22.13 to $13.98 per member per month from 2003 to 2007, because of



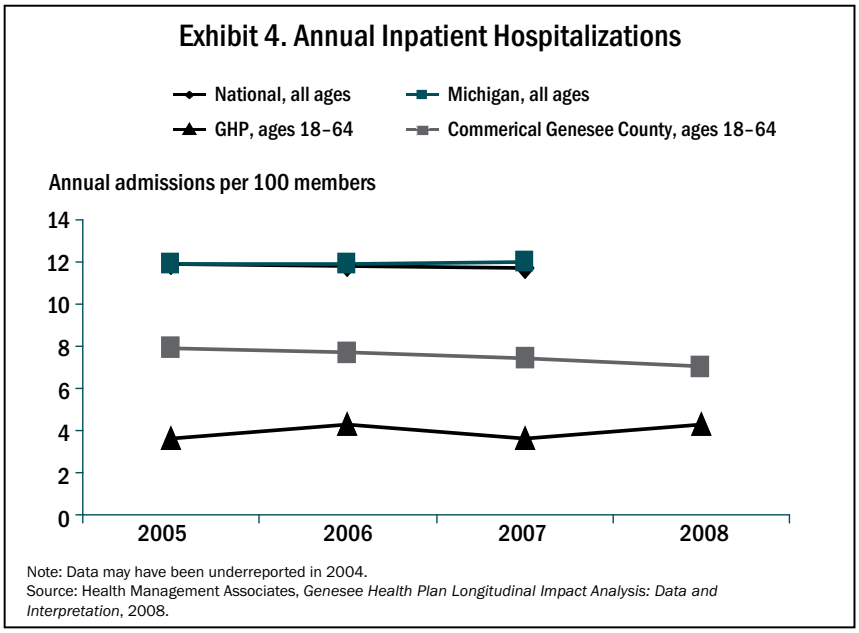
Source: Health Management Associates, *Genesee Health Plan Longitudinal Impact Analysis: Data and Interpretation*, 2008.

the efficient management of the benefit by the plan's third-party administrator, HealthPlus Options, Inc. Between 2004 and 2007, laboratory and radiology services per 100 GHP members decreased 30 percent and 36 percent, respectively, as pent-up demands were met and a healthier population was enrolled, Hamacher says.

"Overall patient experience is excellent, as reflected in high satisfaction rates and positive feedback from individuals we have helped" through the health navigator program, notes Torres, who as medical director of Genesys HealthWorks was responsible for developing and providing ongoing support to the Navigator program. "Access to health care is an important piece, but access to health is what we really want to achieve," she says.

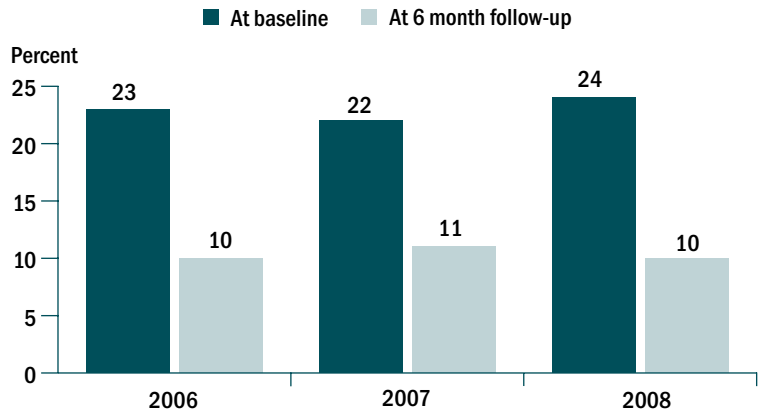
Cost and Resource Use

The rate of ED use among GHP enrollees fell by half, from 82 per 100 GHP members in 2004 to 40 per 100 GHP members in 2007. Hospital partners saved an estimated $1.5 million in 2006 and 2007 alone, compared



Note: Data may have been underreported in 2004.
Source: Health Management Associates, *Genesee Health Plan Longitudinal Impact Analysis: Data and Interpretation*, 2008.

Exhibit 5. Percent of Patients Engaged in Self-Management Support Who Report One or More Visits to the E.D. in the Past 3 Months



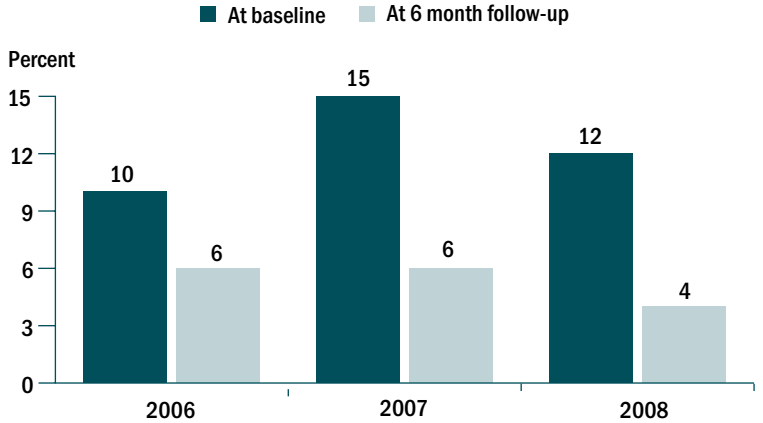
Source: Genesys HealthWorks and Genesee Health Plan.

with what costs would have been if the ED visits rate remained at the 2005 level, according to an analysis by Health Management Associates. However, the rate at which enrollees pursue care in EDs is still twice that of the local commercially insured population (Exhibit 3).

Hospital admissions fell from 4.26 per 100 members in 2006 to 3.62 per 100 members in 2007, a 15 percent decline, representing an estimated savings of $1 million for hospital partners, according to the analysis by Health Management Associates. Overall, the rate of rate of inpatient admissions for GHP patients remains at about half the rate of the local commercially insured population (Exhibit 4). (Hospitalization is not a covered benefit under the plan.)

The declines in ED use reached a plateau in 2008. The remaining ED visits were for dental, mental health, and substance abuse issues, which are not covered by the GHP benefit plan. The visits are not likely to decrease without communitywide interventions, Hamacher says. Likewise, many of the hospitalizations that occurred in 2008 were for serious conditions that could not be averted, such as cancer, heart attack, and emergency surgery.

Exhibit 6. Percent of Patients Engaged in Self-Management Support Who Report One or More Admissions in the Past 3 Months



Source: Genesys HealthWorks and Genesee Health Plan.

The health navigator intervention, which helps patients develop healthy behaviors and enhance their self-management skills, played a role in reducing ED visits and hospital use. Among a subset of patients engaged in self-management support for whom hospital utilization data were available at both baseline and six months after engagement, engagement was associated with reductions of approximately 50 percent in hospitalizations and ED visits (Exhibits 5 and 6).

LESSONS LEARNED

Genesee Health Plan demonstrates how a small county health plan can partner with community organizations to better meet the needs of its medically underserved population in a way that increases population health and patient access to care despite limited resources. By partnering with the largest health systems, local health agencies, and community organizations, GHP has built a model of care that provides regular access to primary care, emphasizes health promotion, and addresses many often-ignored health issues, including obesity, smoking, and lack of physical activity.

Winning the support of the public and of health care providers was crucial to its success. Through a recently approved property tax increase, the residents of Genesee County provide the majority of funding for expanded coverage of the population of low-income, uninsured county residents. In addition, health care providers from the participating health systems deliver care for reimbursement only marginally better than Medicaid rates.

It is unclear whether voters in other places would be willing to provide similar kinds of financial support. In Genesee County the unemployment rate is above 16 percent. "Michigan has been in a recession—really in a depression—for a lot longer than the rest of the country," Hamacher points out. Because of this, voters were amenable to the idea of the Genesee Health Plan. "They understood that they could be next. In this type of economy, no one's job is safe and no one's health care is a given."

Political support also helped. "This was possible due to the outstanding leadership of the health plan's board of directors and elected officials including the Genesee County board of commissioners, and Michigan Senator Robert Emerson. A series of broad partnerships and talented individuals within the state and county all contributed to the concept, implementation, and success of the GHP," Hamacher says.

The economy also may have helped to secure the cooperation of health care providers. Many of them viewed the burden of uncompensated care for the uninsured as a serious threat to their financial stability and were motivated to find a solution. "The health care community was getting really alarmed about the numbers of uninsured, about how needy they were, and how expensive it was to treat them," Hamacher says.

The health plan has been effective in maintaining the participation of the hospitals by demonstrating through data that the uninsured population would continue to seek care at the hospitals if they did not have access to routine primary care. Hence, partnering with the hospitals' affiliated physicians to provide a primary care-based alternative creates a "win–win" solution as patients and hospitals avoid unnecessary—and often uncompensated—emergency department visits and hospital admissions. "We have built a partnership mode for the future. Involvement breeds ownership," says Hamacher.

"They've done a good job at having organizations like the hospitals provide a lot of free care that [the hospitals] probably wouldn't have if it wasn't for the health plan pushing us," says Rick Wyles, chairman of GHP's board of directors and chief financial officer of McLaren Regional Medical Center, one of the health plan's partners. For example, hospitals agreed to cover facility costs for outpatient surgeries while GHP pays the surgeons' professional fees. Whether that can continue over the long term without another source of funding remains to be seen, says Wyles, speaking as a hospital finance officer.

GHP made more than $3.1 million in payments to health systems in 2007 to subsidize a portion of uncompensated services, but its continued ability to do so depends on the stability of the county's property tax revenue base. As property values decline because of

the housing crisis, the health plan's revenues also will decrease.

Moreover, meeting the needs of the uninsured on an annual budget of $600 per member is a challenge. The health plan is routinely forced to find ways to balance health outcomes, costs, and patient experience. GHP must look not only at how its coverage decisions affect patients, but also how those coverage decisions affect safety-net providers in the community.

One of the most difficult decisions for the plan involves the depth and breadth of coverage for its members. This issue is often taken up by GHP's Network and Quality Committee, which comprises board members, a pharmacist, GHP's third-party administrator, and representatives from provider groups, health systems, and local safety-net organizations. The committee must often exclude coverage for services and benefits that are valuable but unaffordable. Brand-name cholesterol-lowering drugs (i.e., statins) are one example. The group felt it could not justify the expense because its drug budget was small. "There was a lot of dissatisfaction from doctors who were saying time and time again, 'How can I treat my patient when I don't have a statin?'" says Trissa Torres, chair of the Network and Quality Committee. GHP forged a compromise by seeking assistance from the drug manufacturers. Once some statins were manufactured in generic form and the cost came down, they were added to the formulary.

GHP has fewer resources per patient for Plan B (the low-income uninsured population) than for Plan A (the medically indigent). Exhibit 7 illustrates how GHP allocates resources to meet the needs of patients in both plans.

GHP also recognizes it must not crowd out traditional insurers. "You don't want employers scrapping

Exhibit 7. Funds Spent on Genesee Health Plan from 2003–2008, Per Member

	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008
	Oct. 2002–Sept. 2003	Oct. 2003–Sept. 2004	Oct. 2004–Sept. 2005	Oct. 2005–Sept. 2006	Oct. 2006–Sept. 2007	Oct 2007–Aug. 2008
Plan A						
Primary care	$10.60	$9.36	$9.80	$9.28	$8.85	$8.08
Specialty care	$36.93	$36.89	$35.32	$34.58	$35.98	$29.57
Prescription drugs	$37.29	$16.94	$13.10	$20.68	$24.68	$21.40
Radiology	$12.51	$12.87	$14.39	$13.76	$10.70	$10.51
Laboratory	$4.93	$6.20	$5.66	$6.03	$4.59	$3.08
Outpatient hospital	$19.18	$17.16	$14.07	$13.59	$19.27	$32.09
Overall Plan A, per member per month	**$121.44**	**$99.42**	**$92.34**	**$97.92**	**$104.07**	**$104.72**
Plan B						
Primary care	$7.23	$9.36	$9.80	$8.46	$10.03	$10.65
Specialty care	$8.30	$17.33	$14.25	$13.44	$15.99	$16.86
Prescription drugs	$14.91	$12.41	$12.19	$12.45	$13.98	$13.23
Radiology	$6.21	$6.54	$8.90	$5.09	$4.61	$4.69
Laboratory	$3.88	$4.17	$4.93	$4.40	$3.62	$2.79
Outpatient hospital	$0.00	$0.00	$0.00	$0.00	$0.30	$0.74
Overall Plan B, per member per month	**$40.53**	**$49.81**	**$50.07**	**$43.84**	**$48.54**	**$49.90**

Source: Health Management Associates. *Genesee Health Plan Longitudinal Impact Analysis: Data and Interpretation*, Oct. 2008.

their coverage plans and relying on GHP to cover their employees," Hamacher says.

Through focus groups with members, GHP has been able to work out a compromise on another controversial issue—the decision not to cover urgent or emergency care. "Members of the focus group said they would be willing to pay $50 for urgent visits. They would rather pay for urgent care than end up with getting an emergency room bill," Hamacher says. As a result of this feedback, GHP is pursuing a deeply discounted urgent care rate that is affordable to members.

To keep the plan affordable for members without sacrificing quality, GHP places an emphasis on building partnerships and reducing redundancies in services. For example, GHP partnered with the University of Michigan–Flint to develop a clinic staffed by nurse practitioners that would operate as a primary care site. The university "happened to have a clinic that was just sitting there vacant and now it provides primary care and physical therapy services for 5,000 patients, using nurse practitioners, nursing students, and physical therapists. This is one area that communities and the health system overlook: the ability to partner with the educational system to help cover and provide services for the uninsured," Hamacher says.

GHP's participation in the HealthNet Collaborative, a consortium that includes the local health department, health advocacy organizations, and safety-net providers, has helped to identify areas of duplication or gaps in care. For example, GHP discovered it should not be trying to meet the needs of the homeless population, because better-equipped community resources already existed. "Regular communication between these organizations helped break down barriers and streamline services," Hamacher says.

From the start, GHP also has strived to ensure that its services complement related work by hospitals, clinics, and providers caring for the uninsured. To that end, the health plan works closely with other nonprofits such as the Genesee County Free Medical Clinic, the Center for Civil Justice, the Genesee County Health Department, Hamilton Community Health Network, and Genesee County Community Mental Health to ensure there is no duplication of services provided or populations served.

For example, GHP's existence has enabled the Genesee County Free Medical Clinic to raise its income threshold for eligibility from 200 percent to 250 percent of the federal poverty level, allowing the clinic to treat additional adults who do not qualify for GHP. Through such coordination, a critical uninsured population has access to needed services. In another example, GHP's provision of testing for sexually transmitted diseases has allowed the Genesee County Health Department to put roughly $340,000 to other uses.

CONCLUSION

National health care reform may change the role that Genesee Health Plan plays, as more of the uninsured gain Medicaid coverage. Until then, county health plans such as GHP are addressing those needs. "There's very much a role for local public funding and participation in the gap between where Medicaid eligibility ends and affordability—either through employment or purchasing on one's own—begins," says Kevin Murphy, senior vice president and chief financial officer of Hurley Medical Center, who serves on GHP's board and executive committee.

"The methods we have developed to coordinate care and support physicians and patients would be very important to any entity seeking to expand coverage in the future," says Hamacher. "These methods would help any community or organization to better support patients, especially those with chronic disease."

Notes

[1] Medically indigent is defined by the state as adults ages 19 to 64 with incomes less than 35 percent of the federal poverty level. Genesee Health Plan enrolls, manages, and provides services for this population under Plan A, which covers primary and specialty care services, outpatient laboratory and radiology services, outpatient surgery, and emergency department services. Inpatient hospital services are not covered.

[2] Michigan's Adult Basic Waiver program was authorized under Section 1115 waiver of the Social Security Act, approved on January 16, 2004; see T. McRae and R. D. Stampfly, *An Evaluation of the First 21 Months of Operation of Michigan's Adult Benefits Waiver* (East Lansing, Mich.: Michigan State University, Institute for Health Care Studies, Nov. 2005), http://www.ihcs.msu.edu/pdf/ABW_Evaluation.pdf.

[3] One hundred and seventy five percent of the federal poverty level translates to about $18,953 per year for an individual and $38,588 per year for a family of four.

[4] This number includes three health navigator team members who serve GHP under contract with Genesys Health System.

[5] Information on Genesee Health Plan was obtained from a site visit, from personal communications with the individuals listed in the acknowledgments, and from data and documents supplied by GHP including: L. Hamacher, *Yes You Can: Covering Your Community's Adult Uninsured* (Flint, Mich.: Genesee Health Plan, Jan. 2009); L. Hamacher, *Profile of the Uninsured in Genesee County: A Summary Report* (Flint, Mich.: Genesee Health Plan, 2008); and D. Strugar-Fritsch, J. Dalton, D. Roberts et al., *Genesee Health Plan Longitudinal Impact Analysis: Data and Interpretation* (Lansing, Mich.: Health Management Associates, Oct. 2008).

[6] The tax added $1 per $1,000 of taxable value to property owners' tax bills. This would translate to $75 per year for a property with a taxable value of $75,000.

[7] In addition, local hospitals can sign Indigent Care Agreements indicating that they have a cooperative relationship with the Genesee Health Plan. Hospitals that sign these agreements can potentially receive additional funding from a special component of Michigan's Medicaid Disproportionate Share Hospital program.

[8] U.S. Department of Labor, Bureau of Labor Statistics, Local Area Unemployment Statistics, Tables LAUCN26049003 (Genesee County) and LAUPA26100003 (Flint City), available at http://www.bls.gov/lau/data.htm.

[9] J. Hadley, "Sicker and Poorer—The Consequences of Being Uninsured: A Review of Research on the Relationship Between Health Insurance, Medical Care Use, Health, Work, and Income," *Medical Care Research and Review*, June 2003 60(2):3–75.

[10] S. Zuckerman, A. F. Williams, and K. E. Stockley, "Trends in Medicaid Physician Fees, 2003–2008," *Health Affairs*, May–June 2009 28(3):w510–w519.

[11] S. Klein and D. McCarthy, *Genesys HealthWorks: Pursuing the Triple Aim Through a Primary Care-Based Delivery System, Integrated Self-Management Support, and Community Partnerships* (New York: The Commonwealth Fund, July 2010).

[12] Results reported in this section were published in the following documents: L. Hamacher, *Yes You Can: Covering Your Community's Adult Uninsured* (Flint, Mich.: Genesee Health Plan, Jan. 2009); L. Hamacher, *Profile of the Uninsured in Genesee County: A Summary Report* (Flint, Mich.: Genesee Health Plan, 2008); and D. Strugar-Fritsch, J. Dalton, D. Roberts et al., *Genesee Health Plan Longitudinal Impact Analysis: Data and Interpretation* (Lansing, Mich.: Health Management Associates, Oct. 2008). More recent data suggest the number of primary care visits per 100 patients increased in 2008, as did well visits and specialty care visits. The number of ED visits per 100 members increased slightly in 2008.

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This study was based on publicly available information and self-reported data provided by the case study institution(s). The Commonwealth Fund is not an accreditor of health care organizations or systems, and the inclusion of an institution in the Fund's case studies series is not an endorsement by the Fund for receipt of health care from the institution.

The aim of Commonwealth Fund–sponsored case studies of this type is to identify institutions that have achieved results indicating high performance in a particular area of interest, have undertaken innovations designed to reach higher performance, or exemplify attributes that can foster high performance. The studies are intended to enable other institutions to draw lessons from the studied institutions' experience that will be helpful in their own efforts to become high performers. It is important to note, however, that even the best-performing organizations may fall short in some areas; doing well in one dimension of quality does not necessarily mean that the same level of quality will be achieved in other dimensions. Similarly, performance may vary from one year to the next. Thus, it is critical to adopt systematic approaches for improving quality and preventing harm to patients and staff.