

Innovative Programs

Provide Access
to Care

by MaryAnn Lando

With America's safety net hospitals struggling under the burden of uncompensated care, federal and state healthcare dollars being squeezed by budget deficits, and employers dropping coverage due to cost increases, the problem of providing healthcare to America's uninsured seems intractable. But some communities have found innovative ways to provide care for this growing population. This article profiles three such efforts. They differ in the populations they serve, the services they provide, and the ways they finance their operations. But what they share is creativity in leveraging existing funding, leadership, and administrative resources—and commitment to the belief that providing access to basic healthcare benefits the community as a whole.

Ingham Health Plan, Ingham County, Michigan

Dennis M. Litos, CHE, president and chief executive officer of Ingham Regional Medical Center in Lansing, MI, was part of the coalition that developed Ingham Health Plan. "In 1994, I had a meeting with the director and deputy director of the county health department, and we began talking about indigent care in the county. Our biggest concern was that our emergency rooms had become the first line of care." The group agreed that a managed system of care was needed, but they struggled with how to find funding.

They brought the matter to a community organization, the Access to

Health Committee, which secured grants from the Robert Wood Johnson Foundation and the W. K. Kellogg Foundation to assess the community's needs. The question of how to pay for services remained unresolved until late 1996, when consultant Jay Rosen of Health Management Associates proposed a funding structure. As IHP Executive Director and Ingham County Health Department Deputy Director Bruce Miller explains, "The county and state would each put up money, which would be eligible for Medicaid matching. The matching funds would be returned to a local hospital in the form of a special Disproportionate Share Hospital payment. The funds would only be available if the hospital agreed to use them to organize and manage care for low-income uninsured people through a nonprofit corporation set up to operate the program."

The approach was innovative but required buy-in from three separate entities. Health Management Associates approached state officials to see if they would support the initiative. The director of the Ingham County Health Department, Bruce Bragg, went to the county controller and board of commissioners to explain how county funds could be one element in financing an organized system of care for the uninsured. "The board was very supportive of the goal of covering uninsured people," says Miller. "Once they understood the funding mechanism, they were prepared to release the funds." Finally, a

local hospital had to agree to receive the DSH payments and turn them over to the not-for-profit corporation. Ingham Regional Medical Center, under Litos's leadership, agreed to fulfill that role, and Ingham Health Plan Corporation was created.

The program began operating in 1998 by covering about 8,000 patients from the Ingham County Health Department. Today, some 14,000 patients receive primary care, specialty care, outpatient lab, X-ray, and prescription drugs. The primary care network comprises 31 offices, including county Health Department-operated clinics and IRMC-employed physicians. Sparrow Health System has also begun participating, providing hospital-related outpatient services and laboratory services; it also has signed an agreement to pass along DSH funds to IHP. "Being able to present a card at the doctor's office allows patients to have dignity about seeking healthcare," says Litos. "And physicians are pleased that some payment is coming in, versus having uninsured patients simply show up at the office."

The program has been a success but is not without its pitfalls. "We've mandated a benefit for the uninsured, but we can't mandate ongoing funding," notes Litos. "Federal and state dollars can be pulled out at any time." Indeed, IHP had begun providing scheduled outpatient hospital services, along with small grants to hospitals for inpatient services, but can no longer afford to do so.

Innovative Programs Provide Access to Care

As for whether IHP has reduced use of the emergency room as a first line of care, the plan recently began processing patient claims in a way that will enable it to collect that data. Meanwhile, other counties in Michigan and around the country have looked to IHP as a model; similar programs are now operating in 31 Michigan counties, providing nearly 100,000 uninsured people with healthcare services. And IHP itself is branching out with Ingham Advantage, a subsidized insurance program targeting small employers who do not already sponsor health insurance for employees. IHPC has also leveraged its relationship with a pharmacy benefits manager to develop the Capitol Area Prescription Program, a discount card program that provides an average 25 percent discount on prescriptions for more than 20,000 people in 28 Michigan counties who lack prescription drug coverage.

“What we’ve learned is that you can, with not a lot of money, provide a thin benefit for people who will otherwise be forced to choose between healthcare, food, or housing,” says IHP’s Miller.

Hillsborough HealthCare, Hillsborough County, FL

The state of Florida mandates that its counties provide a minimal level of healthcare funding for residents living at the poverty level. In the late 1980s, Hillsborough County’s indigent care costs were increasing an average of 17 percent a year, and many hospital admissions among the uninsured were for avoidable reasons. In 1991, the board of county commissioners

Programs at a Glance

Program Name	Hillsborough HealthCare
Region Covered	Hillsborough County, FL
Established	1992
Enrollment	31,000
Financing	1/2 percent county sales tax
Administration	Hillsborough County Department of Health and Social Services
Services	Primary care, specialty care, outpatient and inpatient hospital care, pharmacy, dental, vision
Cost to Participants	HHC: No cost for basic services, moderate copayments for dental care and eyeglasses. Medical Crisis Intervention: Sliding-scale copayments based on income for all services.
Eligibility	Adult residents earning up to 100 percent of FPL. Uninsured adults earning 101 percent to 150 percent of FPL may qualify for MCI program for severe or chronic conditions. Low-income Medicare recipients eligible for pharmacy, vision, and dental.
Providers	4 regional networks of primary care physicians, specialists, and hospitals. Includes 12 primary care clinics (5 operated by hospitals), 600+ physicians.

received approval from the Florida legislature to levy a 1/2 percent sales tax to fund Hillsborough HealthCare, a new, managed system of care. The program also received \$26.8 million per year in property taxes. HHC began operations in 1992.

After four years, patterns of hospitalization among the uninsured looked

the same as those for the general population. After five years, HHC had saved an estimated \$90 million the county would have spent providing mandated care. To date, HHC has reduced direct healthcare costs by an average of more than \$44 million a year and has helped strengthen local hospitals and provider practices by reducing unpaid bills.

Ingham Health Plan	WellPlan of New Mexico
Ingham County, MI	Statewide
1998	2004
14,000	40,000 (projected); capped based on available financing
County and state budget appropriations matched by Disproportionate Share Hospital payment	Unused SCHIP funds (82 percent federal match), Medicaid funds (75 percent federal match), existing state funds not currently receiving federal match
Nonprofit Ingham Health Plan Corporation	Developed by New Mexico Human Services Department, New Mexico Hospitals and Health Systems Association and statewide coalition; managed care organizations will administer coverage
Primary care, specialty care, outpatient laboratory and X-ray, pharmacy	Primary and specialty care; inpatient and outpatient hospitalization; pharmacy; laboratory and X-ray; physical, occupational, and speech therapy; behavioral health and substance-abuse services
No cost to enroll; modest copayments for all services	Employer: \$75 premium/enrolled employee/month. Employee: \$0-\$35 premium/month based on family income; income-based sliding-scale copayments for services. Those not associated with an employer may pay both premiums to receive coverage. Employers may also purchase spousal coverage.
Adult residents earning up to 150 percent of FPL who do not qualify for Medicare or Medicaid	Adult residents earning up to 200 percent of FPL
Two local hospitals, 31 primary care practices, 100+ specialty care practices	Affiliates of participating MCOs: Presbyterian, Lovelace, Cimarron, and Blue Cross/Blue Shield

“The program has helped ensure that we receive some reimbursement for patients we were already seeing,” says Ronald Hytoff, CHE, president and chief executive officer of Tampa General Hospital. Now a private, not-for-profit hospital and still a primary safety net provider for the region, Tampa General was once the county hospital. “The plan pays about two-

thirds of what it costs us to see each patient. By using that money for matching funds, we’re able to reduce the loss a bit further. And our patients have better access to care.”

Sales tax financing was chosen because Hillsborough County is in the Tampa Bay area, which is a destination for tourists and seasonal res-

idents. But this method of financing is not without its drawbacks: In tough economic times, consumers may curtail spending just as greater numbers of residents become eligible for services. However, HHC has a financial plan in place that calls for building and maintaining a reserve equal to 33 percent of the prior year’s plan expenditures.

Innovative Programs Provide Access to Care

“People think the sales tax is our golden egg,” notes HHC Director David Rogoff, “but we also have four very strong provider networks that provide services to HHC at substantial discounts to established Medicare/Medicaid fee schedules.” HHC also leverages its funds by sending provider invoices to the state, which adds 17.5 percent in Upper Payment Limit dollars before distributing the money to the three participating Disproportionate Share Hospitals. “Last year, we sent nearly \$31 million of our expenses to the state,” says Rogoff. “Upper Payment Limit funds added \$4.7 million to that, and an estimated \$500,000 was added through the Disproportionate Share program.”

Enrollment records show that 70 percent of participants are working or seeking work; HHC also seeks to help them obtain or maintain employment. “We try to remove health barriers to their remaining employed,” says Rogoff. “People have come in for healthcare, and we’ve helped them get involved with other county social service programs and receive job training.” Rogoff estimates that helping program participants maintain employment adds a productivity value of \$15 million per year to the economy.

The goal is to enable participants to move on to jobs that provide healthcare coverage. That may be what happens to some of the 70 percent of enrollees who leave the program after less than a year. Others may join the growing ranks of working Americans

Cover The Uninsured Week 2004 to Promote Discussion of Potential Solutions

Following the success of last year’s weeklong series of events, the Robert Wood Johnson Foundation and other corporate and philanthropic organizations will sponsor Cover The Uninsured Week 2004, May 10 through 16. This year, as last, organizers will seek to promote a broader understanding of the problem of the uninsured. “Last year’s effort helped get the issue back on the national policy agenda,” says Stuart Schear, who manages the campaign for RWJF. “But just because something’s on our national agenda, it won’t necessarily stay there. We need to keep beating the drum until there’s a solution.”

The 2004 campaign will place added emphasis on sharing information about and fostering nonpartisan discussion of the wide array of potential solutions. “Everything from tax credits to the expansion of existing public programs has been proposed,” notes Schear. “The potential solutions span a broad range of ideological choices.” The nonpartisan aspect of the effort is evidenced by the public leaders who are supporting it: former Presidents Gerald Ford and Jimmy Carter will once again serve as honorary co-chairs, this year backed by nine former U.S. Surgeons General and former U.S. Secretaries of Health and Human Services from both Republican and Democratic administrations.

Because more than 175 million Americans get their health insurance coverage from their employers, this year’s campaign will also feature special workshops and events for the business community. “Owners of small- and medium-sized businesses don’t always know all of the steps they can take to obtain or keep healthcare coverage in the current insurance market,” says Schear. “Making employers aware of what they can do is an essential part of addressing the problem.”

The 2004 campaign will begin with a national kickoff event, followed by more than 1,000 community activities across the nation. Events will include community health fairs offering information, screenings, and other direct service to the uninsured; educational forums; and opportunities to enroll children and adults in the State Child Health Insurance Program and Medicaid. A national and local advertising campaign will promote the campaign, which organizers say will be the largest mobilization around the issue in American history.

For more information, visit www.CoverTheUninsuredWeek.org.

ML

who earn too much to qualify for programs such as HHC but still don't have access to coverage. "We're looking for ways to address the healthcare needs of adults at the next income levels," says Rogoff. "We have this investment in a program, and we're looking at ways to leverage that investment by working with the private sector, developing community partnerships."

WellPlan of New Mexico

WellPlan of New Mexico, which is expected to begin operations later in 2004, evolved out of work begun in 2000 through the Robert Wood Johnson Foundation's Communities in Charge initiative. "The central New Mexico area received a planning grant to assess who the uninsured in the region were and what their needs were," says Maureen L. Boshier, CHE, president and chief executive officer of New Mexico Hospitals & Health Systems, Inc., and a member of the coalition that developed WellPlan. "When we weren't selected for the implementation phase of that initiative, we expanded our scope and our coalition and began working with RWJF's State Coverage Initiative to develop a statewide program."

The need was great: About 25 percent of New Mexico's population aged 19 to 64 is uninsured, one of the highest rates in the nation. "Everyone was willing to work on this problem," Boshier recalls. "Providers were having significant proportions of their services paid below cost by Medicare and Medicaid. The commercial market was concerned about escalating costs

and knew it couldn't continue cost shifting." But the coalition faced a major constraint—it could not add any new costs to the state budget.

The solution the coalition came up with was to make use of State Child Health Insurance Program funds that would otherwise be lost to other states—New Mexico provides Medicaid to children whose families earn up to 235 percent of the federal poverty level, so it has comparatively fewer children to cover under SCHIP—as well as regular Medicaid funds and employer and enrollee contributions. This unique financing structure is made possible through a federal Health Insurance Flexibility and Accountability waiver, which allows states more flexibility in developing healthcare coverage, including cost-sharing and benefit design.

"We had pushback from advocates in our state who favored Medicaid expansion," notes Boshier. "But the difference in cost per beneficiary is enormous." She estimates that WellPlan will cost the state \$21 per member per month versus \$85 for Medicaid, thanks to premium sharing, copayments, benefit design, and a higher federal match rate.

As for benefit design, the coalition worked with insurance companies in the state to craft a package that emulates commercial coverage. It also conducted focus groups of employers and employees to test price points for its services. To address insurance companies' concerns about

unfair competition, employers who have dropped commercial coverage within the prior 12 months will not be eligible to participate. "We don't want employers who have commercial coverage to cancel it to get into this plan because it's less expensive," says Boshier. Enrollees must have been without coverage for the prior six months; there are no preexisting condition limitations.

Creating a Program in Your Community

While the financing structures, benefit designs, and administrative arrangements described here aren't appropriate for all communities, these programs demonstrate that innovative approaches can make it possible to provide good, basic care for the uninsured. (See "Programs at a Glance" sidebar.) Following are some suggestions for developing a program in your community.

- **Have a story to tell.** So says Michael C. Carroll, FACHE, managing director of Tribrook Healthcare Consultants in Tampa. Carroll, who will lead the seminar "Innovative Programs to Address the Problem of the Uninsured" at ACHE's 2004 Congress on Healthcare Management, says this means being able to describe who the uninsured are, where they're located, and what services they need most. Look for specific populations—based on race, ethnicity, age, income level, geographic location, etc.—whose access to care may be disproportionately poor, and identify barriers to access.

- **Look for seed money to fund start-up costs.** All of the programs profiled here received grants to assess community needs, evaluate program feasibility, or support development and implementation. Local businesses, private institutions, and philanthropists may shy away from ongoing commitments but provide valuable onetime funding.
- **Find a champion to lead the charge.** Carroll cautions against having a local hospital or one of its leaders in that role. “It could appear self-serving, as though you’re simply trying to make up for uncompensated care costs. But a community leader or elected official can make it an emotional issue and can focus public attention on the problem.”
- **Establish a program development coalition that is a collaborative, public-private partnership.** “If it’s not,” says Carroll, “it’s not going to happen.” Make sure all constituents are represented—public officials, providers, employers, potential enrollees.
- **Decide what type of program will have the best outcomes and will be most cost-effective, independent of funding structure.** “For example,” says Hillsborough HealthCare Director David Rogoff, “you may have enough providers in the community, and your primary issue will be how to coordinate their participation so that patients have access to various services—primary care, specialty care, hospitals—in the appropriate

geographic locations. Figure out how to set that up; then address the issue of how to fund it separately.”

- **Establish methods of measuring outcomes.** While the program’s primary goals may be to reduce inappropriate ER visits and uncompensated care costs and to improve community health status, it may have ripple effects in other areas: healthcare utilization and capacity, incidence and duration of disabilities, enrollment in other social services and programs. Look for ways to measure and respond to those outcomes.

Perhaps most important, emphasize that providing care to the uninsured benefits the entire community. “If you look at who pays for uncompensated care,” says Rogoff, “the government pays for some of it, through DSH payments and other programs. Providers pay for some of it—voluntarily or involuntarily—through uncompensated care. Insured employees and their employers pick up part of the tab through cost shifting, as do the uninsured who pay for care out of pocket. Healthcare for the low-income uninsured can’t be viewed as just another insurance plan. This is important to the entire community.”

MaryAnn Lando is a Chicago-based freelance writer.