

**The Medicaid DSH Program
And Providing Health Care
Services to the Uninsured:
A Look at Five Programs**

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Executive Summary

Perhaps the most important health policy issue facing the United States is how to care for the uninsured. In 1999, 42 million people had no health coverage, more than one out of every six Americans under age 65. Uninsured individuals often lack access to appropriate care, but they still use health services when they become ill and, in many cases, they do not have the financial resources to fully pay for their care. Hospitals, in particular, serve as providers of last resort for the uninsured. Through various public programs—local, state, and federal—many hospitals receive subsidies to help pay for the costs associated with uncompensated care. One of the largest subsidy programs is the Medicaid disproportionate share hospital (DSH) program. Medicaid DSH represents an important funding source for hospitals in their efforts to care for the uninsured in the communities that they serve.

This study provides some insights on the experiences of five programs that have used Medicaid DSH funds to enhance care for the uninsured. We examined five current programs located in Denver County (Denver), Colorado; Marion County (Indianapolis), Indiana; Ingham County (Lansing), Michigan; Wayne County (Detroit), Michigan; and Bexar County (San Antonio), Texas. These programs were chosen, in part, to reflect a diverse set of design choices with regard to target population, organization, financing, delivery system, and services provided. It was also important that they all appeared to be sustainable over the long term. Finally, an attempt also was made to include programs that represent a variety of economic and other environmental conditions. This study, which was financed by the United States Department of Health and Human Services, was intended to provide background information for the Community Access Program, a major department initiative designed to provide grants to localities to improve health care access for the uninsured.

LESSONS LEARNED

While each program is unique and faces its own set of circumstances, there are several lessons that can be learned from the study programs which can guide other communities as they look to find local solutions to the growing problem of caring for the uninsured.

Understand all of the financing options. Medicaid DSH can be a critical financing component of local health care safety nets. Indeed, without DSH, some of the programs we studied would not be financially viable. However, DSH was never the sole funding source for the programs. Instead, study communities relied on a combination of funding streams. Local leaders will need to assess how to structure program financing that is in keeping with available resources.

Build political support. Political support is critical to both the development and sustainability of the program. Without exception, program administrators stressed the importance of securing local and, sometimes state, support of policymakers in developing an initiative. Having solid political backing is central to gaining and keeping program financial support and ensuring long-term success.

Use existing programs as a starting point. Communities should examine existing indigent care programs as a starting point for creating a new program. All of the study sites

began the development of the new initiative with a pre-existing health care program or programs. In some cases, the local community simply revamped an existing program. By contrast, in other communities a broader policy change brought about a fundamental restructuring of an existing program.

Start with primary care. If a comprehensive system of care is not initially feasible, localities should start with a limited set of services. A good first step is to start with primary care and drugs. Then add specialist care, followed by inpatient care. By starting with primary care, a program can cover more people with the same amount of money which allows the program to build momentum and community presence.

Apply insurance concepts to programs without actually offering insurance. All of the programs examined were modeled like health insurance but in fact, were not insurance. By adopting such a strategy communities were able to avoid state insurance regulations, minimum reserve requirements, reporting requirements and the like. Such an approach is a big plus as its is considerably less expensive than developing a regular insurance product.

Plan carefully. In designing their programs, communities need to account for a range of factors. For example, each community must decide what is the target population of the program. Related to defining the target population, localities will need to development a marketing and outreach plan. They will also need to decide the scope and depth of services offered through the program as well as whether they want to impose co-payments on participants.

Develop strategies to get previously uninsured individuals to access the health care system in a new way. Many individuals enrolled in these programs are accustomed to using the emergency room as their usual source of care. Getting these people to access health care in a new way—for example, by way of a physician office or clinic—is often critical to the success of the program.

CONCLUSIONS

This study has examined five programs that have used Medicaid DSH funds to enhance the provision of care to uninsured populations. While each of the initiatives relied on DSH in varying degrees, DSH was a very important source of funding for all programs. Although the Medicaid DSH program sometimes has been a contentious policy issue, the programs examined here highlight how DSH funds have been used in a positive way: To provide health care services to the uninsured. By emphasizing primary care services, all of these programs, as diverse as they are, aim to reduce hospitals' uncompensated care burdens, one of the principal goals of the DSH program.

Policymakers, both state and federal, should look again at the possible opportunities afforded by the DSH program. In 1998, more than \$15 billion was spent through the DSH program. Further, about \$3 billion of available DSH monies went unspent in that year. With the passage of the Benefits Improvement and Protection Act of 2000 (BIPA), DSH spending will likely rise in the future: scheduled cutbacks in federal DSH spending were eliminated and, now many states are allowed to increase their DSH spending. Given the growing number of uninsured, the need to provide services to this population in a more rationale, efficient way will

become increasingly important in the future. The programs studied here provide models by which states and localities could provide such services using Medicaid DSH funding.

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Chapter 1

PROJECT SUMMARY

Perhaps the most important health policy issue facing the United States is how to care for the uninsured. In 1999, 42 million people had no health coverage, more than one out of every six Americans younger than age 65. Owing to the high cost of health insurance, low-income persons are at the highest risk of being uninsured: Nearly two-thirds of uninsured individuals come from families with incomes less than 200 percent of the federal poverty level.

Being without health care coverage has important consequences. The uninsured are more likely than those with insurance to report that they could not see a physician when needed due to cost, and less likely to have had a recent checkup or undergone screening for cancer or cardiovascular problems (Ayanian et al., 2000). Further, the uninsured as a group are less likely to report being in good or excellent health compared to the general population (Kaiser Commission on Medicaid and the Uninsured, 2000).

The uninsured population also has important consequences for the health care providers. While uninsured individuals often lack access to appropriate care, they do use health services when they become ill and, in many cases, they do not have the financial resources to fully pay for their care. Hospitals, in particular, serve as providers of last resort for the uninsured. In 1995, hospitals across the country provided more than \$17 billion in services to patients for which they received no payment (Mann et al., 1997).¹

Through various public programs—local, state, and federal—many hospitals receive subsidies to help pay for the costs associated with uncompensated care.² One of the largest subsidy programs is the Medicaid disproportionate share program (DSH): In 1998, more than \$15 billion in Medicaid DSH payments were issued to hospitals.³ Established in the early 1980s, the Medicaid DSH program is designed to provide financial support to hospitals that serve a large number or a “disproportionate” number of Medicaid and other low-income patients (Prospective Payment Assessment Commission 1994). The rationale behind the DSH program was that by helping to offset hospitals’ losses resulting from caring for Medicaid patients and the uninsured, hospitals could survive and access for the low-income population could be maintained.

Although the Medicaid DSH program has been the subject of considerable controversy in recent years (Ku and Coughlin, 1995; Coughlin and Liska, 1998; Coughlin et al., forthcoming; U.S. GAO, 1994, 1995, 1998), the program does represent an important funding source for hospitals in their efforts to care for the uninsured (Fagnani and Tolbert, 1999; Norton and Lipson, 1998; Meyer et al., 1999). Much of the work to date on the DSH program has focused

¹ Although not discussed here, besides hospitals many other health care providers (such as federally qualified health centers and public health departments) render care to the uninsured.

² In addition to publicly-funded programs, other organizations, such as charitable and religious groups, also help finance uncompensated care.

³ While \$15 billion in DSH payments were issued, not all funds represented new dollars to hospitals. See discussion below.

on tracking program expenditures (Ku and Coughlin, 1995; Coughlin and Liska, 1997; Coughlin et al., 2001). However, very little is known about how hospitals use DSH monies to render care to uninsured patients.

The aim of this study is to provide some insights on the experiences of five programs that have used Medicaid DSH funds to enhance care for the uninsured. More specifically, we examined five currently active programs located in Denver, Colorado; Indianapolis, Indiana; Lansing Michigan; Wayne County, Michigan; and San Antonio, Texas. Among other things, we sought information about how the programs developed and how they function operationally. With a special focus on the role of DSH payments, we also wanted to find out how the programs were financed. This study, funded by the United States Department of Health and Human Services, was intended to provide background information for the Community Access Program; a major department-sponsored initiative designed to provide grants to localities to improve health care access for the uninsured.

This project summary chapter is organized as follows. As background, we begin with a brief overview of the Medicaid DSH program. Then we describe our approach to conducting the study, including the selection of communities. This is followed by an overview of the characteristics of the study sites and programs. We conclude with a discussion of the lessons learned from the study programs. The remaining chapters of the report describe each of the study programs in detail.

THE MEDICAID DSH PROGRAM AND RELATED FINANCING PROGRAMS

The Medicaid DSH Program. The Medicaid DSH mechanism was intended to supply additional public funding to support hospitals that provide a large amount of safety net services.

As mentioned above, the DSH program in recent years has sparked substantial debate among policymakers and several federally mandated reforms have been made to the program during the past decade.⁴ In large part, the reforms were undertaken in response to the dramatic rise in DSH payments that took place in the early 1990s: Between 1991 and 1992 alone, DSH spending went from \$5.3 billion to \$17.5 billion. The states had discovered that provider donations or taxes as well as other financing methods like intergovernmental transfers (IGTs) from public-owned hospitals could be added to the amount counted as state Medicaid spending for purposes of obtaining federal Medicaid matching dollars. This would, without any net increase in expenditures by the state, generate additional federal funds that then could be used to reimburse those hospitals for their contributions and leave enough additional revenue available to allow higher Medicaid reimbursements to certain providers (frequently state hospitals), to reduce state budget deficits, or to support other state activities. A 1993 survey of 39 state Medicaid agencies found that about 30 percent of federal DSH funds were retained by the states and not going to hospitals (Ku and Coughlin, 1995). (An example of how such DSH financing worked is provided in Appendix A.)

⁴ For a full discussion of the DSH readers are referred elsewhere (Ku and Coughlin, 1995; Coughlin and Liska, 1997).

In response to this situation, Congress on three separate occasions—1991, 1993, and 1997—passed legislation aimed at reforming the DSH program. Among other things, restrictions were imposed on the use of provider taxes, and state-specific limits on DSH spending were established. Congress also imposed “facility-specific” DSH limits whereby an individual hospital could not receive more in DSH payment than the total of the hospital’s Medicaid payment shortfall and its losses on uninsured patients. Finally, in 1997, as part of the Balanced Budget Act, Congress set out reduced state-specific caps on federal DSH payments.⁵

Although the rapid rise in Medicaid DSH payments in the early 1990s caused concerns about their potential misuse, there is evidence that some part of it has, in fact, been used to subsidize safety net hospitals, the facilities for which it was intended (Prospective Payment Assessment Commission, 1994; National Association of Public Hospitals, 2000). Other studies focusing on selected communities have also reported that the Medicaid DSH Program has become a key part of financing care for the uninsured (Norton and Lipson, 1998; Meyer et al., 1999). In addition, a 1997 survey found that the proportion of federal DSH funds retained by the states had fallen to about 15 percent, compared to 30 percent in 1993 (Coughlin et al., 2001). Moreover, this study also reported a higher proportion of Medicaid DSH funds was going to private and county or local government hospitals than in 1993.

Related Financing Programs. With increasing pressure on both aggregate and hospital-level DSH payments, some states developed “supplemental payment programs” (more recently referred to as “upper payment limit” (UPL) programs) that are akin to DSH programs (Coughlin and Liska, 1998; Coughlin et al., 2001). Generally, these programs involve making payments to certain providers (typically public facilities including hospitals, nursing homes or intermediate care facilities for the mentally retarded) above their basic Medicaid reimbursement levels. As of September 2000, 19 states had established Medicaid UPL programs (Ku, 2000).

Like DSH, providers that receive supplemental payments may in many cases contribute revenue to the state Medicaid agency to help cover the state share of the payments. Thus, UPL programs provide a mechanism for states to leverage additional federal dollars while limiting their spending. Further, UPL payments are viewed as regular Medicaid expenditures and thus are not counted against a state’s DSH cap. Since UPL programs allow states to target Medicaid monies to selected providers, the ability to increase DSH spending for other providers is possible. This tradeoff between DSH and UPL spending is an important feature of two of the programs examined in this study.⁶

STUDY APPROACH AND METHODS

This project began with an effort to identify examples of using Medicaid DSH funds to enhance the provision of care to uninsured populations. A list of 23 potential sites was

⁵ Both the Balanced Budget Refinement Act of 1999 and the Benefits Improvement and Protections Act of 2000 restored Medicaid DSH ceiling for several states.

⁶ UPL program have recently generated a lot of concern among federal policymakers (Ku 2000). Indeed, the Health Care Financing Administration issued proposed regulations in the fall of 2000 that would greatly limit the use of UPL programs (HCFA, 2000). Further, UPL language was also included in the Medicaid portions of the Benefits Improvement and Protections Act of 2000 that was passed December 15, 2000.

developed that reflected the variety of initiatives that have been put in place in communities around the country (Guterman et al., 2000). In selecting the five programs for focused study, we considered several factors, including the program target population, program organization, sponsorship and financing, the approach to care delivery (for example, managed care or fee-for-service arrangements), and types of services provided by the program. We also considered whether the program appeared to be sustainable; that is, whether the program appears to have lasting effects, rather than one that may be time-limited either in its effectiveness or its applicability. Finally, an attempt also was made to include programs that represent a variety of economic and other environmental conditions.

To carry out the study, a team of two researchers visited each of the five communities where the programs operate for two days between July and September 2000. On site we interviewed a range of people, which varied depending upon the nature of the program, but included program and hospital administrators, program medical directors, and program enrollees. We also talked to representatives of the state hospital association, state and local provider groups, insurers and individual providers. Among other things, we asked program respondents how the program got started, how the program was designed, how it works, and what role DSH played in program financing. In all sites, we spoke with state Medicaid officials to gather background information about the state's DSH program and to determine what role, if any, the state played in developing the study program. The list of interviewees at the five study sites is in Appendix B.

OVERVIEW OF STUDY SITES

Each of the five programs are located in areas varying in terms of population, economic conditions, the structure of the health care sector, and the nature of their DSH programs.

Population and Demographic Characteristics. The five study sites represent an array of population sizes and compositions (Table 1-1). Wayne County is one of the largest counties in the country, with more than 2.1 million people, while Ingham County, in the same state, has fewer than 300,000. Ingham County and Marion County are predominately (more than 70 percent) white, while the white populations in Wayne County and Denver County are barely majorities and Bexar County has a minority white population. The make-up of the non-white population differs across the study sites, as well, with Wayne County and, to a lesser extent, Marion County, having sizeable black populations, while Bexar County and Denver County have larger Hispanic populations. In terms of age, the sites are fairly comparable.

Economic Conditions. Three of the five study sites have poverty rates above that for the nation which was 13.9 percent in 2000 (Table 1-1). In Wayne County, 21.5 percent of the population is in households with incomes below the FPL--more than 50 percent higher than the nationwide rate. In Detroit, the core city of Wayne County, the poverty rate is higher still (not shown). Bexar County and Denver County also have poverty rates considerably higher than average. By contrast, Ingham County is about equal to the nationwide rate and Marion County is slightly below. The unemployment rates generally reflect the poverty rates across the study sites. That is, Wayne County and Denver County had the highest unemployment rates while Marion County and Ingham County the lowest.

Table 1-1: Selected Population and Economic Characteristics by Study Site

	Denver County (Denver, CO)	Marion County (Indianapolis, IN)	Ingham County (Lansing, MI)	Wayne County (Detroit, MI)	Bexar County (San Antonio, TX)	United States
Population, 1998						
Total	498,402	812,662	285,874	2,116,540	1,354,837	270,248,003
Per Square Mile	3,258	2,052	511	3,447	1,086	76
Percent of Population by Race, 1998						
White (non-Hispanic)	56.1%	73.4%	79.4%	53.2%	35.7%	72.3%
Black (non-Hispanic)	13.2%	23.5%	10.4%	42.1%	6.5%	12.1%
Hispanic	27.2%	1.6%	6.0%	2.9%	56.1%	11.2%
Other	3.5%	1.5%	4.3%	1.7%	1.7%	4.3%
Percent of Population by Age, 1998						
Under Age 18	23.4%	25.2%	24.3%	26.6%	29.5%	25.9%
Age 18 to 64	64.4%	63.3%	65.9%	60.7%	59.9%	61.4%
Age 65 and Up	12.1%	11.5%	9.8%	12.7%	10.6%	12.7%
Individuals Living Below the Poverty Level, 1995						
	17.0%	12.7%	13.6%	21.5%	19.6%	13.9%
Unemployment Rate, 1998						
	4.1%	2.8%	3.3%	4.3%	3.8%	4.5%

Sources: Population Estimates Program, Population Division, U.S. Census Bureau; Area Resource File, February 2000 Release, Office of Research and Planning, Bureau of Health Professions, Health Resources and Services Administration, U.S. Department of Health and Human Services

* Calculated using the 1990 land area as included in the Area Resource File, February 2000 Release, Office of Research and Planning, Bureau of Health Professions, Health Resources and Services Administration, U.S. Department of Health and Human Services

Structure of the Health Care Sector. The five study sites differ in terms of the health care resources that are available, and in the scope and magnitude of those resources (Table 1-2). In keeping with their larger populations, Wayne County and Denver County have more hospitals than the other three counties in this study, while Ingham County has only two hospitals. About 70 percent of the hospitals in the five counties combined (39 of 56) are private voluntary (not-for-profit) hospitals, with this category being particularly dominant in the two Michigan site counties. Those two counties are alike in that neither has any public hospitals. By contrast, Denver County has two public hospitals. Proprietary (for-profit) hospitals have very little presence in the Michigan counties as well, with only one in Wayne County and none in Ingham County. By contrast, for-profit hospitals are much more prevalent in Bexar County—7 of the 14 hospitals in that county are proprietary hospitals.

Table 1-2: Selected Characteristics of the Health Care System by Study Site

	Denver County (Denver, CO)	Marion County (Indianapolis, IN)	Ingham County (Lansing, MI)	Wayne County (Detroit, MI)	Bexar County (San Antonio, TX)	United States
Number of Hospitals, 1998						
Public	2	1	-	-	1	1,234
Voluntary	5	5	2	21	6	2,918
For-Profit	3	2	-	1	7	714
Percentage of Beds by Hospital Type, 1998						
Public	24.2%	5.6%	-	-	13.5%	16.1%
Voluntary	47.2%	87.0%	100.0%	98.3%	42.7%	69.9%
For-Profit	28.6%	7.4%	-	1.7%	43.8%	14.0%
HMO Penetration Rate, 1998						
	46.3%	26.5%	41.8%	34.2%	20.4%	27.6%

Sources: American Hospital Association Annual Survey Database (hospital data); Area Resource File, February 2000 Release, Office of Research and Planning, Bureau of Health Professions, Health Resources and Services Administration, U.S. Department of Health and Human Services (HMO penetration rates)

Note: Includes only non-federal general medical/surgical hospitals. Does not include specialty hospitals.

The structure of the sites' health care market had some bearing on the health care safety net and its delivery of care to the low-income population. While on site, we asked respondents about the safety net and to identify the major providers of care to the low-income and the uninsured. In Denver County, the county hospitals were cited as being the principal provider of care to both the uninsured and Medicaid populations. Likewise the county hospital in Bexar County, Texas was described as the major provider of care to uninsured. Some of the non-profit hospitals in Bexar, especially those with religious affiliations, also provide substantial care to the uninsured. In Ingham County, Michigan, care for the uninsured was described as being spread among the county health department and the local hospitals. In Wayne County, Michigan, it was described as being concentrated primarily in one hospital system.

DSH Programs. The four states included in the study (two of the sites were located in Michigan) varied considerably as to their Medicaid DSH spending (Table 1-3). Texas had the largest program in terms of DSH spending, which totaled more than \$1.4 billion in 1998. Further, as a share of total Medicaid expenditures, Texas spent the most on DSH—nearly 15 percent of Texas's total Medicaid spending went to DSH payments. By contrast, the other three states fell between 5 and 9 percent. None of the four study states fully spent their DSH allotment. Indiana spent the least (59 percent), followed by Michigan (69 percent) and Colorado (78 percent). Texas, with the highest allotment, spent 92 percent of its DSH cap.

That the states were spending below their allotments had important implications for this study: Since the states were not fully spending all DSH funds available meant that the states had the option to devote additional DSH finding to the kinds of innovative programs that were the subject of this study. By contrast, if a state is at its DSH cap, programs designed to expand access to care for the uninsured would have to find other sources of funding to support their start-up or ongoing activities. Nationally, 82 percent of the DSH allotment was spent in 1998. In other words, about \$3 billion in DSH allotments were not spent in that year given the DSH allotment. Given the DSH modifications included in the Benefits Improvement and Protection Act of 2000 (BIPA), more funds will be available under the Medicaid DSH program in the future.

Table 1-3: Selected Medicaid DSH Program Characteristics in the Four Study States

	Colorado	Indiana	Michigan	Texas	United States
DSH Payments, 1998	\$139,080,856	\$194,660,496	\$319,344,308	\$1,438,878,261	\$14,961,831,256
DSH Allotment, 1998	\$178,949,394	\$327,308,256	\$464,725,644	\$1,571,933,205	\$18,159,399,514
DSH Spending as a Share of Total Medicaid Spending	8.7%	7.5%	5.6%	14.8%	8.8%
Share of DSH Allotment Used, 1998	78%	59%	69%	92%	82%
Had UPL Program(s), 2000	No	Yes	Yes	No	19 States*

Source: Urban Institute estimates based on data from the Health Care Financing Administration (DSH payments); *Federal Register*, Vol. 63, No. 195, October 8, 1998 (DSH allotments); Ku 2000 (UPL programs)
 * This is the number of states that had active UPL programs in 2000.

UPL Programs in Study States. Among our states, in 2000 Indiana and Michigan had UPL programs whereas Colorado and Texas did not have such programs (Ku, 2000). As will be discussed later, UPL programs in Michigan played a significant role in the development of both the Lansing and Wayne County programs examined as part of this study. Michigan was among the first states to develop UPL programs and, as early as 1997 was spending more than \$600 million a year on such programs (Coughlin and Liska, 1998).

SNAPSHOTS OF STUDY PROGRAMS

In this section we summarize characteristics of programs examined in the study. While all the programs used Medicaid DSH funds to provide care to the uninsured, the design of the programs vary substantially. For example, the programs vary as to their sponsorship, financing, eligibility, scope of services, and how services are delivered. Table 1-4 highlights some key characteristics of the study programs. A full discussion of each program is provided in Chapters 2 through 6 of this report.

	Denver Health (Denver, CO)	Wishard Advantage (Marion County, IN)	Ingham Health Plan (Ingham County, MI)	PlusCare (Wayne County, MI)	HealthChoice (Wayne County, MI)	CareLink (Bexar County, TX)
Start Year	1994	1997	1998	1992	1994	1997
Approx. Enrollment (2000)	N/A	20,000	11,000	30,000	20,000	70,000
Main Sponsor	Hospital	Non-profit corporation	Non-profit corporation	Non-profit corporation	Non-profit corporation	Hospital
Funding (ranked approx. from highest to lowest)	<ul style="list-style-type: none"> ▪ Medicaid DSH ▪ Denver City funds 	<ul style="list-style-type: none"> ▪ Local property taxes ▪ Medicaid DSH ▪ Patient Cost Sharing 	<ul style="list-style-type: none"> ▪ Medicaid DSH ▪ State funds ▪ County funds 	<ul style="list-style-type: none"> ▪ Medicaid DSH ▪ County funds ▪ State funds 	<ul style="list-style-type: none"> ▪ Medicaid DSH ▪ County funds ▪ State funds ▪ Employer & employee premiums 	<ul style="list-style-type: none"> ▪ Local property tax ▪ Medicaid DSH ▪ Patient cost sharing
Role of Medicaid DSH Funds	Moderately large	Moderate	Large	Large	Large	Moderate
Eligible Population	Uninsured residents of the city of Denver with incomes <185% FPL	Uninsured city/county residents with incomes <200% FPL	<ul style="list-style-type: none"> ▪ People eligible for state program for low-income, disabled persons ▪ Uninsured residents with incomes <250% FPL 	Uninsured residents with monthly incomes <\$250	Uninsured workers in firms meeting the following: <ul style="list-style-type: none"> ▪ Firm located in Wayne County ▪ 50% of employees earn <\$10/hr ▪ At least 3 people eligible ▪ Did not provide insurance to eligible people in last 12 mos. 	Uninsured county residents with incomes <185% FPL
Managed Care Approach	No	Yes	Yes	Yes	Yes	Yes
Services Covered	Acute and primary	Acute and primary	Primary only	Acute and primary	Acute and primary	Acute and primary
Patient Copayments	No	For some groups	For some groups	No	Yes	Yes

Program sponsorship. The programs had a range of sponsors. Two programs—Denver Health and CareLink—are sponsored by safety net hospitals. By contrast, non-profit corporations sponsored the other programs, but all had close ties with the local health care safety net. Wishard Advantage, for instance, is run by a municipal corporation that consists of the city’s largest safety net hospital and the local health department. Likewise, the Ingham Health Plan (IHP) program is operated by a private corporation but gets administrative support from the Ingham county health department.

Program Financing. The study programs were also diverse in terms of their financing. While all relied on Medicaid DSH funding, the extent of that reliance varied. For instance, Wishard Advantage uses DSH more as backup funding. The bulk of Wishard’s support comes from local property taxes. By contrast, all three Michigan programs relied heavily on Medicaid DSH. Indeed, the Ingham Health Plan and PlusCare programs relied exclusively on the DSH funding: That is, state and county funds listed in the table are used as the state share to earn the federal DSH match.

Beyond public funding, two programs—HealthChoice in Michigan and CareLink in Texas, look to program participants to help pay for their programs. In HealthChoice, a program targeted at the working uninsured, participant support comes in the form of “premium” payments from both employer and employees. In CareLink, program participants are required to pay a share of the services, up to some pre-determined maximum amount based on the patient’s ability to pay. (This cost-share is in addition in to patient copayments.) In 2000, CareLink participants contributed about \$8 million towards program funding.

Program Eligibility. All of the programs are targeted to the uninsured but specific eligibility rules vary. For example, both Denver Health and CareLink are available to uninsured residents with incomes up to 185 percent of the federal poverty line (FPL) while Wishard Advantage covers uninsured county residents up to 200 percent FPL. The Ingham Health Plan covers the uninsured up to 250 percent FPL. In addition, the Ingham plan also enrolls individuals eligible for a Michigan-sponsored health program for the low-income disabled population.

In Detroit, there are two programs that operate side-by-side but with different target populations. PlusCare is akin to the other study programs and targets uninsured residents with monthly incomes less than \$250. By contrast, Health Choice is targeted expressly to low-income uninsured workers who are employed in firms meeting the following criteria:

- located in Wayne County (the county where Detroit is located)
- 50 percent of the firm’s workforce earns less than \$10 per hour
- at least 3 people are eligible for the program
- did not provide insurance to eligible person in past year

Among the programs that we examined, HealthChoice was the only one with an employer component; all the others were aimed directly at the uninsured person.

Service Delivery. With the exception of Denver Health, all the programs applied managed care principles to their programs. Among other things, some assign participants to a primary care physician who provide primary care and act as gatekeepers for specialists. Some programs set out schedule of services specifying both service limits and participant copayments. Others have developed a specified list of providers including private physicians, health clinics, pharmacies, and hospitals that participants can use. All but the Ingham Health Plan covers both acute and primary care.

Some of the programs also apply managed care concepts on participating providers. For example, the Wishard program pays its primary care doctors a capitated per member per month fee to provide both primary care. Likewise, the two Wayne County programs—PlusCare and Health Choice—also capitates most of its outpatient providers, including primary care doctors, specialists, and dentists.

It is important to note that although the study programs look and act like health insurance programs, they are not. Instead, they are programs that offer a service package to uninsured individuals with an established network of providers. None of the programs guarantee participants coverage of services. Further, none of programs are licensed by the state as insurance.

The primary objective of all the study programs was to provide a health care structure to the uninsured population. By providing such a structure, program administrators feel that the costs of caring for the uninsured can be both better managed and controlled. Further, by using managed care concepts its it hoped that costs can be better tracked. Finally, it is hoped that by improving access to primary and preventative care, and providing a medical home to the uninsured, quality of care will improve. Unfortunately, as of this writing, rigorous evaluations estimating program impacts had not been conducted at any of the study sites.

LESSONS LEARNED

Our examination of the study sites revealed that some local communities have come together and fashioned innovative programs that are designed to help better serve the uninsured in their area. While each program is unique and faces its own set of circumstances, there are several lessons that can be learned from the study programs which can guide other communities as they look to find local solutions to the growing problem of caring for the uninsured.

Medicaid DSH can be a critical financing component of local health care safety nets. All of the sites relied on DSH to help fund their initiatives. Indeed, without DSH, some of the programs would not be financially viable. For several of the programs, the use of DSH came about because the state was not fully spending out its DSH allotment. Given that in 1998, about \$3 billion in available DSH was not spent, DSH potentially represents a rich resource for other communities.

However, DSH was never the sole funding source for the programs. Instead, in highly diverse ways, study communities relied on a combination of funding streams such as property taxes, state health care funding, and the like. Local leaders will need to assess how to structure

program financing that is in keeping with available resources. Further, communities should think expansively about available resources, including possible state and federal sources.

Political support is critical to both the development and sustainability of the program. Without exception, program administrators stressed the importance of securing local and, sometimes state, support of policymakers in developing an initiative. Having solid political backing is central to gaining and keeping program financial support. At all site, program funding depends on state and local government support (especially those that rely heavily on DSH), so broad-based community support is key to long-term success.

Communities should examine existing indigent care programs as a starting point for creating a new program. All of the study sites began the development of the new initiative with a pre-existing health care program or programs. In some cases, the local community (e.g. CareLink in Texas) simply revamped an existing program. By contrast, in other communities (e.g. Denver Health and Wayne County Michigan) a broader policy change brought about a fundamental restructuring of an existing program. For example, in Denver a decision to build a highly integrated safety net system helped to lay the foundation for its indigent care program. Likewise, in Michigan, the state's cutback in general assistance funding forced local communities such as Wayne County to come up with new strategies to serve the indigent. Thus, sometimes an outside policy change or a local changes to the health care market (such as a closure of a public hospital) can provide the impetus for establishing a new initiative.

If a comprehensive system of care cannot be developed, start with a limited set of services. A first step is to start with primary care and drugs. Then add specialist care, followed by inpatient care. Beginning in this way a program can cover more people with the same amount of money which allows the program to build momentum and community presence.

Communities can apply insurance concepts to programs without actually offering insurance to participants. All of the programs examined were modeled like health insurance but, in fact, were not insurance. By adopting such a strategy communities were able to avoid state insurance regulations, minimum reserve requirements, reporting requirements and the like. Such an approach is a big plus as its is considerably less expensive than developing a regular insurance product.

In operationalizing programs, communities need to account for a range of factors. Each community, for example, must decide what is the target population of the program. Related to defining the target population, localities will need to development a marketing and outreach plan. They will also need to decide the scope and depth of services offered through the program as well as whether they want to impose co-payments on participants.

Finally, communities need to develop strategies to get previously uninsured individuals to access the health care system in a new way. Many individuals enrolled in these programs are accustomed to using the emergency room as their usual source of care. Getting them to access the system in a new way—for example, by way of a physician office or clinic—is often critical to the success of the program. Among other strategies, communities can provide enrollee education about using the system. Another possibility is to structure incentives to encourage the desired use of the system.

CONCLUSIONS

This study has examined five programs that have used Medicaid DSH funds to enhance the provision of care to uninsured populations. While each of initiatives relied on DSH in varying degrees, DSH was a very important source of funding for all programs. Although the Medicaid DSH program sometimes has been a contentious policy issue, the programs examined here highlight how DSH funds have been used in a positive way: To provide health care services to the uninsured. By emphasizing primary care services, all of these programs, as diverse as they are, aim to reduce hospitals' uncompensated care burdens, one of the principal goals of the DSH program.

Policymakers, both state and federal, should look again at the possible opportunities afforded by the DSH program. In 1998, more than \$15 billion was spent through the DSH program. Further, about \$3 billion of available DSH monies went unspent in that year. With the passage of BIPA 2000, DSH spending will likely rise in the future: scheduled cutbacks in federal DSH spending were eliminated and, now many states are allowed to increase their DSH spending. Given the growing number of uninsured, the need to provide services to this population in a more rationale, efficient way will become increasingly important in the future. The programs studied here provide models by which states and localities could provide such services using Medicaid DSH funding.

Chapter 2

DENVER HEALTH (DENVER, CO) By Amy Lutzky and Teresa A. Coughlin

Description of Denver Health. Established by the Colorado legislature in 1994, the Denver Health hospital authority (DH or the Authority), is an integrated health system that include an acute care hospital (Denver Health Medical Center), an ambulatory health center, 11 federally qualified health centers (FQHCs), the local public health department, and 12 Denver school-based clinics. In addition, DH, in partnership with other Denver providers, operates Colorado's largest Medicaid HMO. At the heart of DH, is the hospital, a 349-bed acute care facility that had more than 20,000 inpatient admissions and 50,000 emergency room visits in 1998.

DH is the main source of care for the uninsured in the Denver metropolitan area. The principal program by which the Authority serves the uninsured is called the Colorado Indigent Care Program (CICP), a statewide program created by the Colorado legislature in 1983. The CICP is not an insurance program but rather a way for providers to partially recover their costs of providing care to Colorado's medically indigent population. Initially funded with state funds, the CICP is now financed through the Medicaid DSH program. DH is by far the largest CICP provider in the state: In 1999, the Authority provided care to about one-third of the 150,000 individuals served through CICP (Colorado Indigent Care Program, FY 1999 Annual Report).

Safety Net Funding Mechanisms. Despite DH's significant provision of care to the uninsured, its financial situation is sound. As of mid-2000, for example, the system had cash reserves totaling \$62 million. The Authority's strong fiscal shape has not always been the case: As recently as 1991 the system had nearly a \$40 million deficit. DH officials credit the financial turnaround to a several factors. Among others is DH's newly created vertically integrated structure linking several health care funding sources and providers: Denver Health consists of a hospital, 11 FQHCs, the local health department, and 12 school-based clinics. DH's integration allows for efficient referrals between primary, preventive, and specialty care providers, more consistent and comprehensive screening of uninsured patients for public program eligibility, and greater flexibility in channeling resources to needed areas.

In addition to the benefits of a vertically integrated system, Denver Health (along with other safety net providers) implemented Colorado Access in 1994—an HMO targeted at the Medicaid population. Since that time, DH has developed several other managed care products (see below). These efforts have not only brought DH additional revenue but they have also helped in maintaining its patient base, especially Medicaid enrollees. With the combination of resources and alignment of key safety net providers, DH has evolved over the past decade into a robust health care safety net system.

Support from both local and state government has also contributed to DH's financial situation. At the local level, DH receives an annual payment from the city of Denver to help cover charity care costs. At the state level, Colorado continues to pay FQHCs 100 percent of

their reasonable costs for Medicaid beneficiaries—both those enrolled in managed care and those still in fee-for-service program. Given the central role of clinics in the DH system, maintenance of FQHC cost-based reimbursement has also added financial stability to the system.

While cost-based reimbursement, a vertically integrated system, local funding, and the like contributed to DH's financial turnaround and its ability to provide care to the uninsured, the rapid infusion of Medicaid DSH dollars in the 1990s has perhaps been the single largest factor: The Authority *netted* over \$200 million in Medicaid DSH between 1991 and 1997.⁷ Further, between 1998 and 2000, DH projects netting an additional \$120 million in DSH.

DEVELOPMENT OF THE DH AUTHORITY

Impetus. Increasing competition in the Denver health care market in the early 1990s was the major factor leading to the development of the DH Authority. As managed care quickly penetrated the Denver marketplace, for-profit and not-for-profit hospital consolidations siphoned off commercial payers, and Denver's number of uninsured rose, Denver Health was left with increasing amounts of uncompensated care. In response Denver Health adapted its structure and developed new markets to not only survive, but thrive in a competitive environment.

Process. Denver Health's initial step toward improving their viability was a change in governance. For years, Denver Health was a department within the Denver government and thus subjected to many purchasing, civil service, and legal constraints. In 1993, the mayor of Denver appointed a panel of community and business leaders to make recommendations on how the city's public hospital system could be transformed into a more competitive structure. The panel considered four possible structures: a not-for-profit corporation, a public benefit corporation, a hospital district, and a hospital authority. A not-for-profit corporation was rejected because it might not continue its responsibility to care for the uninsured and would not have the benefits of governmental immunity. A public benefit corporation was unappealing because the state lacked experience with these structures. The option of a hospital district was rejected because it would require changing the local property tax and there would be little political or public support. Thus, the panel recommended a shift to a hospital authority structure, which would enable Denver Health to remain a public entity.

In 1994, the Colorado legislature enacted enabling legislation that transformed Denver Health into a hospital authority. It was believed that this new structure would allow the public health care system to continue its mission of serving indigent residents of Denver County, but have more flexibility over its day-to-day operations. The legislation created a nine-member governing board, which is appointed by the mayor and confirmed by the city/county council. In order to insulate the board from political pressures, members can only be removed by a vote of the council. The governing board appoints the chief executive officer of the authority. In addition, the legislation also specified that every new employee would be an authority employee rather than a civil service employee. Finally, the authority could issue debt.

⁷ Like many other states, the bulk of the state share for Colorado's DSH program is funded with intergovernmental transfers (IGTs) from public entities like DH. Net DSH dollars represents how much a facility receives after accounting for the IGT payments.

As a hospital authority, Denver Health reorganized into a vertically integrated delivery system that includes a hospital, 11 FQHCs, the local health department, and 12 school-based clinics. This integration allows DH to deliver health care in the most appropriate and least costly setting. A relatively seamless referral system benefits patients as their needs shift between public health, ambulatory, specialty, and inpatient services, and benefits Denver Health as they are better able to minimize costly and inappropriate emergent care.

In addition to its new structure, the Authority made several internal changes to their information system (IS) and staffing arrangements that contribute to its efficient operation. Highly developed and continually improving IS allow Denver Health to communicate and implement policy on a system-wide basis. With its current single information system, Denver Health has been better able to reengineer clinical and accounting practices. As a result of improved IS, patient collections are up 40 percent in two years. In order to insulate physicians from financial incentives that may encourage unnecessary or marginally beneficial procedures, DH's physicians are salaried employees. Medical staff are organized into teams within and across disciplines, and also between hospital and ambulatory care which furthers integration of care.

As part of its new competitive strategy, DH developed several new products. Mentioned above, DH partnered with other Denver safety net providers to create Colorado Access—currently the largest Medicaid managed care plan in Colorado. With a network consisting exclusively of safety net providers, Colorado Access helped DH maintain its Medicaid population. Then in 1997, DH developed a non-profit commercial health plan, The Denver Health Medical Plan (DHMP), for Denver public employees. In 1998, the plan was expanded to include the Small Employer Initiative HMO that provides insurance to qualified small employer groups. DHMP also became a participating HMO with Child Health Plan Plus (Colorado's CHIP program). In addition to developing managed care products, the Authority began providing inpatient and outpatient services to prisoners in both state and local correctional facilities, as well as outstate hospitals. Together, these initiatives have greatly helped DH to not only preserve its own revenue streams but to grow new ones.

DH PROGRAM OPERATIONS

Overall Organizational Structure. Mentioned earlier, DH's system consists of an acute care hospital, FQHCs, school-based clinics, and the local health department. It also includes the 911 emergency response, a locked forensic unit, a women's care clinic, a 100 bed non-medical detoxification unit with a nonambulance transport service, and the regional poison control center. With its integrated structure, DH officials maintain that the authority is able to provide better and more efficient care to Denver's indigent population than had been provided under the old system.

As part of the new structure, DH emphasizes primary and preventive care through its Community Health Department—which is viewed as the “backbone” of the system, managing over 300,000 outpatient visits and serving 20 percent of Denver's population annually. Community Health includes not only the FQHCs and school-based clinics—where the bulk of primary care is provided but also the Denver Health Specialty Clinics, where hospital-based care physicians offer subspecialty services. In short, DH has placed a high premium on integrating

primary and specialty care. To stress this importance, management of the Community Health Department was given a prominent position in DH organizational structure.

DH's structure also allows for public health functions to be more integrated into patients' ambulatory and inpatient care. The Denver Public Health Department serves as the center for communicable disease reporting, surveillance, investigation, and control. Infectious disease physicians from Denver Public Health attend hospital patients, and clinical staff carry out disease prevention and treatment in both DH's hospital and health centers.

There are also several Denver Health services that provide patients with alternatives to costly and inappropriate emergency room use. Patients can receive information on minor poisoning emergencies by calling the 24-hour Rocky Mountain poison control. Similarly, patients can call the 24-hour NurseLine for information on health problems. Denver Health also operates the Denver CARES Community Detoxification unit, which provides a non-medical facility for safety detoxifying public inebriates.

CARING FOR THE UNINSURED

DH's mission is to provide health care to indigent residents within the city and county of Denver. In order to screen uninsured residents for public health insurance programs, Denver Health created a Facilitated Enrollment Department. A team of up to 31 Enrollment Specialists are stationed in 14 DH facilities around the city and screen patients for eligibility in Medicaid, Child Health Plan Plus (CO's SCHIP program), and the Colorado Indigent Care Program (CICP). CICP is the principal program by which DH provides care to the uninsured.

To be eligible for CICP, a person must meet both residency and income and asset requirements. A resident is anyone who is 1) a Colorado resident and a U.S. citizen or legal alien or 2) a migrant farm worker and a U.S. citizen or legal alien. To qualify, a person must have income and assets combined at or below 185 percent FPL, and cannot be eligible for Medicaid. CICP eligibility has no age limits and clients may have third party insurance as long as these funds don't cover needed services or are exhausted.

Once Denver Health or other CICP providers screen patients for CICP eligibility, they assign the patient a "rate" based on their total income and assets. For example, a patient with combined income and assets less than or equal to 40 percent FPL, receives a rate of "N" and is required to make inpatient facility copayments of \$15, inpatient physician copayments of \$0, outpatient copayments of \$5, and prescription copayments of \$3. Those receiving an "N" rating have annual copayments capped at \$120. All other patient ratings have annual copayments capped at 10 percent of the family's total income and assets. Patient ratings usually occur on the initial day of service and are retroactive for services received up to 90 days prior to application.

CICP covers all services that a provider "customarily furnishes to patients." These services include medical services furnished by participating physicians as long as they are

deemed medically necessary. CICIP reimburses providers for outpatient mental health benefits if these services are provided on-site and are normally offered by the provider.⁸

CICIP contracts with any provider that is licensed as a general hospital, community clinic, or maternity hospital by the Department of Public Health and Environment, provides a minimum of 3 percent charity care, and hospitals must have at least one on-site physician with staff privileges to perform non-emergency obstetric procedures. Providers are reimbursed up to 30 percent of cost. In FY 1999, a total of 67 providers participated in CICIP, which included 49 hospitals and 51 satellite facilities. CICIP categorizes providers in the following manner:

Outstate CICIP Providers

- Outstate clinics—clinics outside of the City/County of Denver
- Outstate Hospitals—hospitals located outside the City/County of Denver

Medicaid/DSH Providers

- Specialty Indigent Care Program—Children’s Hospital and National Jewish Hospital
- Denver Health
- University Hospital
- Other DSH Hospitals—Platte Valley Medical Center, San Luis Valley Regional Medical Center and Valley View

As indicated in Table 2-1, Denver Health provides a large portion of CICIP inpatient and outpatient visits. As CICIP utilization relates to Medicaid DSH distribution, as will be discussed in the next section, it is not surprising that Denver Health receives the lion's share of the state’s Medicaid DSH funds.

Table 2-1: State CICIP Inpatient and Outpatient Visits, FY 1999⁹

CICIP Program	Inpatient	Outpatient
Outstate Clinics	NA	33.6
Outstate Hospitals	37.5	10.0
Specialty Hospitals	2.0	2.0
Denver Health	38.8	42.1
University Hospital	18.6	11.9
Other DSH	3.1	0.4

FUNDING FOR THE UNINSURED

DH relies on several funding sources to support the costs of caring for the uninsured, which totaled about \$75 million in 1999. In this section we describe those sources.

⁸ Department of Health Care Policy and Financing. Colorado Indigent Care Program, FY 1999 Annual Report.

⁹ Ibid.

Role of Medicaid DSH Payments. Medicaid DSH provides the single largest revenue source for covering DH's costs of providing care to the medically indigent. Through Colorado's so-called Component 1A DSH program—the largest of Colorado's DSH programs—selected hospitals across the state are partially reimbursed for expenses incurred taking care of persons eligible for CICP. To qualify for the Component 1A DSH program, a hospital's percentage of Medicaid inpatient days must be one standard deviation above the mean for all CICP hospitals in the state. The threshold percentage varies from year to year but it generally hovers around 25 percent. While a hospital's share of Medicaid inpatient days qualifies a hospital for DSH, the *allocation* of DSH dollars among qualifying hospitals is based on what share of statewide CICP expenses an individual hospital provides. In other words, the Component 1A DSH payments are tied directly to the level of indigent care costs a hospital provides.

Beyond the Component 1A program, Colorado, on several occasions in the 1990s, made special DSH “bump” payments aimed at helping hospitals cover bad debt payments.¹⁰ When issuing the bump DSH payments, the state stipulated that the funds be spent only for capital expenditures or debt service, not for expansion of direct patient services. According to Colorado officials, this directive was made because they feared that federal DSH funds may be eliminated or greatly reduced, and hospitals would not be able to support expanded patient programs.

Between the Component 1A and the bump DSH payments, DH netted nearly \$320 million over the 1991-2000 time period (2000 funding is projected.) The 2000 projection estimates Denver Health will net \$39,034,238. These funds have helped pay for both ambulatory and inpatient care provided to uninsured patients. In addition, DH, retired a \$40 million deficit, put \$37 million into capital purchasers, and established a capital reserve account that now has a balance of \$62 million.

Other Public Sources. Beyond Medicaid DSH payments, DH receives funds from the Denver City/County government to help pay for the costs of caring for the uninsured. When DH was established in 1993, it entered into an operating contract with the city, which, among other things, set out a mechanism by which the city helps pay for indigent care. Each year Denver Health and the City negotiate the amount of city funds targeted to indigent health care. In recent years, the City has paid for half of DH's charity care (exclusive of bad debt) *after* accounting for DH's Medicaid DSH payments, collections from indigent patients, and any other federal indigent funds (such as 330 monies).¹¹ In 1999, after netting out these revenue sources, DH had \$57 million dollars in uncompensated care expenses and Denver paid DH \$26 million to help cover these residual expenses.

The continued support of the city was cited by DH staff as being highly important in securing financial stability. Unlike other local governments, Denver did not cutback its indigent care funding when DH started to receive large increases in Medicaid DSH payments in the early 1990s. Instead, the Denver government has actually increased the level of local funding throughout the 1990s—between 1990-1999, local funding increased by 9.8 percent while state

¹⁰ More recent bump payments have been made because Colorado did not fully spend its federal DSH allotment set out in the BBA.

¹¹ A \$3 million payment for assets is also netted out before the city's indigent care payment is made.

funding increased by 201 percent. Thus DSH payments really represented additional funding for DH rather than simply offsetting cuts in local funding.

Since FQHCs are part of system, DH also receives federal 330 funds to help cover indigent care expenses.

In addition to directed funds to support indigent care, DH staff maintain that its other initiatives have added significantly to the system's revenue stream, and, in turn, helped support care for the indigent. These efforts include its integrated organizational structure, developing a Medicaid HMO, and pursuing new markets such as CHIP enrollees and prisoner care.

SUMMARY AND FUTURE PROSPECTS

In sum, Denver Health's reorganization into a vertically integrated system allows for innovations in safety net care and greater financial viability. Patients are better served by a system that can be more fluid in referring them to appropriate health care settings and providers, and by the consistent emphasis DH places on screening uninsured patients for public programs. Efficiencies in the referral and screening processes enable DH to deter costly and inappropriate emergency room use and decrease their amounts of uncompensated care. Denver Health's integrated system also allows for greater flexibility in how resources are spread across its various components. For example, ambulatory care facilities benefit from resources they wouldn't be eligible for as stand-alone clinics, such as Medicaid DSH funding. While Denver Health's vertically integrated system provides a structure to better manage patients' care and maintain their strong financial footing, it is important to note that operations may be affected by the BBA reductions in Medicaid DSH—a critical revenue source for Denver Health.

Colorado's Medicaid DSH levels were substantially reduced by the BBA DSH provisions. Between 1998 and 2002, the state's federal DSH allotment will drop about 20 percent, going from \$93 million to \$74 million. Colorado officials stated that at present there are no plans to backfill the DSH losses with new state funds. (Indeed, Colorado, by a citizen-initiated referendum (akin to California's Prop. 13), is limited in the percentage increase in state public revenues and spending.) Instead, the state plans to continue funding the Component 1A (CICP) DSH program at its current level of about \$100 million (federal and state).¹² The state also plans to maintain the current spending level of Colorado's other smaller DSH programs.¹³ What will likely be discontinued are the bump DSH payments for bad debt, which the state required hospitals to spend on capital.

State officials hope that some of the DSH cutbacks can be offset by CHIP, which will help to decrease the number of uninsured children, thereby decreasing providers' indigent care expenses. Tobacco settlement funds may also be used to help safety net providers in the future. At the same time, officials acknowledge that the DSH cuts will probably cause some providers to

¹² Given that the state share of the Component 1A program is funded with certified public expenditures, the net revenue to hospitals is the federal share which is about \$50 million.

¹³ In addition to the Component 1A DSH program, Colorado operates four other DSH programs: the HMO DSH payment program, a rural DSH hospital program, the Outstate Medically Indigent Program, and the MMIS DSH program which enhances Medicaid inpatient rates.

decrease the amount of indigent care they render, either reducing services or cutting back on costs.

For DH, the DSH cutbacks will likely have a substantial impact on its finances and, in turn, its operations. While its DSH funding for CICP will remain the same (assuming that the state's current plans are implemented), DH will likely sustain other DSH cuts. Most prominent, is the loss of bump DSH payments. Among other things, these lump-sum payments have helped DH retire its debt and build a healthy reserve account. With its reserve balance and many program initiatives, DH's financial picture seems to be comparatively solid in the short-term. However, for the long-term, the loss of bump payments coupled with limited growth (or possibly no growth) in Component 1A DSH potentially could have a significant effect on DH's ability to sustain its current level of indigent care. The situation could be further exacerbated if Denver continues to experience an increase in its uninsured population.

Chapter 3

WISHARD ADVANTAGE (INDIANAPOLIS, IN)

By Brian Bruen and Stuart Guterman

Description of Wishard Advantage. The Wishard Advantage program provides access to care for uninsured residents of Marion County, Indiana, the borders of which are also the city limits of Indianapolis. The Health and Hospital Corporation (HHC) of Marion County created the program in 1997. Wishard Advantage provides primary and specialty care, inpatient services, and pharmaceuticals for people with incomes up to 200 percent of the federal poverty level (FPL) who are not eligible for other public programs. Beneficiaries select a primary care physician who provides primary and preventive services and acts as a gatekeeper for specialty and inpatient care. Most enrollees pay little or nothing for their care. Program funding comes from a combination of local property taxes and Medicaid disproportionate share hospital (DSH) funds.

Key factors leading to the program's development included a growing number of uninsured residents in Marion County, and a tendency among these patients to seek episodic treatment in inappropriate settings, particularly emergency rooms. By using a managed care model, Wishard Advantage strives to improve access to, and use of, primary and preventive care for indigent patients while reducing emergency room visits and inpatient stays. Through this strategy, HHC hopes to use its resources more efficiently to cover more people and also improve health status among the low-income, uninsured population.

The Safety Net in Marion County. The Health and Hospital Corporation (HHC) of Marion County is a municipal corporation that operates the Marion County Health Department and Wishard Health Services. The health department deals with both traditional public health issues and environmental health regulations. Wishard Health Services includes Wishard Memorial Hospital and its network of health centers, mental health services, and long term care facilities. HHC is governed by a seven-member board, with members appointed to four-year terms by the Mayor of Indianapolis (3), the City-County Council (2), and the County Commissioners (2). The corporation is funded through local property tax dollars, and has statutory responsibility to provide health services to all who fall ill or injured within Marion County.

As the county hospital, Wishard Memorial Hospital has historically been the main safety net hospital in Marion County. Wishard Health Services expanded this role when it took over management of several clinics from the Marion County Health Department around 1990. Despite the relatively high concentration of uncompensated care within Wishard Health Services, this care was much less coordinated prior to the creation of the Wishard Advantage program in 1997. Many uninsured patients did not receive primary and preventive care, partly because Wishard's clinics were small and ill equipped to support major initiatives. Wishard Memorial Hospital served many uninsured patients, but high rates of emergency room use and hospitalization among this population made this care expensive to provide.

It should be noted that other hospitals, health clinics, and providers in Marion County serve uninsured patients. There has always been some interaction among these safety net providers, but they have never been closely linked. Providers recognize that people likely receive care in multiple locations, but there has never been a significant effort to coordinate this care. As discussed later, HHC recently expanded the Advantage program to include more of these local providers and further consolidate and coordinate efforts to care for the uninsured.

DEVELOPMENT OF THE WISHARD ADVANTAGE PROGRAM

Underlying Conditions. Several underlying conditions contributed to the development and design of the Wishard Advantage program. One was that uninsured residents tended to seek care only when they were sick, and they often waited until their illnesses were farther along before seeking care. These patients also tended to rely on emergency rooms as their usual source of care. This combination—episodic care, late in the disease stage, provided in inappropriate settings—led to relatively high costs of care and inefficient use of health care resources for this population. The lack of use of preventive and primary services among this population helped to perpetuate this pattern of care. A desire to change the utilization patterns of uninsured patients became a motivating factor behind the Wishard Advantage program.

A second factor behind the development of Wishard Advantage was an increase in demand for services. During the 1990s, Wishard Health Services recognized that it was serving a growing number of uninsured, indigent, and self-pay patients. The passage of state and federal welfare reform legislation heightened concerns that these populations would continue to grow. Officials at both Wishard Health Services and HHC felt that they had to come up with a more efficient way of providing indigent care services to be able to meet the growing need.

At the same time, Wishard Memorial Hospital faced economic pressures from increased competition among the hospitals in Marion County. At one point, there was talk of privatizing or closing the hospital. This dialogue sparked concern about the stability of the safety net because of Wishard's traditional role as the primary provider for low-income, uninsured residents. Wishard Memorial Hospital also considered a merger with Indiana University Medical Center. The two hospitals had long-standing ties to each other due to the close affiliation between Wishard and the University's medical school, as well as their geographic proximity (the two hospitals are about a quarter-mile apart). University Hospital eventually merged with Methodist Hospital of Indiana to create Clarian Health Partners. The merger raised additional concerns about the future of the relationship between Wishard and the medical school, and also about the continued viability of Wishard as the major provider of indigent care in Marion County.

Responding to these concerns, the task force overseeing the merger recommended that HHC and the medical school establish stronger ties, particularly for the provision of indigent care. This recommendation led to the formation of the Indiana University Medical Group (IUMG), a physician group sponsored by the medical school and HHC. The primary care arm of IUMG (called IUMG-PC) operates commercial and Medicaid managed care programs, and also staffs Wishard Memorial Hospital and the Wishard clinics. Many of these physicians staffed Wishard facilities before IUMG was created, but under the old arrangement HHC paid the medical school a lump sum to provide this staffing rather than directly compensating the

physicians. Because of IUMG physicians' experience serving indigent patients and ties to Wishard Health Services, IUMG played a key role in the development and initial success of Wishard Advantage.

Key Players. The Wishard Advantage program is a result of the strong leadership of HHC, Wishard Memorial Hospital, and IUMG in recent years. In the mid-1990s, all of these organizations recognized that there was a need for more effective use of safety net funds given the greater demands being placed on the system. In 1997, they hammered out a plan for the Wishard Advantage program, built provider and community support for it, and began enrolling patients—all in a span of just a few months. HHC contracted with IUMG to provide primary and specialty care for uninsured patients, and also to manage Wishard Health Services' community health centers. Other area hospitals and health centers were not involved in the creation of Wishard Advantage. The state's role was also limited, consisting mostly of helping to break down existing governmental barriers.

The ability to enlist the services of an existing physician group was a major reason that Wishard Advantage was able to get off the ground quickly. Physicians from IUMG worked closely with HHC during the design phase and were also critical to getting all of the IUMG physicians to participate in the new program. Both HHC and IUMG benefited under Wishard Advantage. Many IUMG physicians already served uninsured, indigent, and self-pay patients, and the new program guaranteed that they would receive some form of payment for these patients. HHC benefited because IUMG provided a broad range of primary care physicians and specialists with experience serving the target population. The fact that IUMG operated successful private insurance and Medicaid managed care plans may also have helped to reduce the stigma often associated with public programs. Many IUMG physicians also served an identifiable group of indigent patients, which helped to boost enrollment in the program during its early stages.

Initial Challenges. The implementation of Wishard Advantage was not without its challenges. The speed at which HHC rolled out the new program created some of these challenges. Some people expressed concern that employees were not adequately trained before the program went into effect. Others noted that some IUMG physicians were not adequately informed about the program—most of the design and implementation discussions only involved department heads and program administrators, not the physicians who actually provide the bulk of the care. Some physicians were also skeptical about participating in the new program, viewing it more as an attempt for the hospital and HHC to save money rather than a real effort to improve care for the uninsured. There was also some tension with other local hospitals and other indigent care providers because HHC does not pay for care provided to Wishard Advantage patients who seek care in other facilities. These concerns seem to have dissipated with the initial success of the program.

Some of the initial design choices turned out to be barriers to participation. When the program first began, people enrolling in Wishard Advantage were only eligible for three months. There was a significant amount of paperwork required at initial sign up and also to maintain eligibility at the end of the enrollment period. The combination of factors caused considerable churning of the rolls, as people dropped off and then re-applied when they became sick again.

This led program administrators to extend eligibility to six months shortly after the start of the program, and eventually they further extended eligibility to a full year. They also simplified the enrollment and re-enrollment processes by reducing the amount of paperwork and establishing automatic eligibility for people already receiving other public assistance with similar eligibility criteria.

It took time for patients to catch on to the new system. When Wishard Advantage started, the program sent letters to established indigent patients asking them to enroll and choose a physician. Many of these people either did not sign up at all or did not choose a physician. Those patients who did enroll and choose a physician did not always go to their selected providers and would still seek care in the emergency room. In part, the response of these patients reflects the difficulty in changing ingrained patterns of care among the uninsured who are more likely not to have a usual source of care. It may also reflect a lack of community outreach at the beginning of the program.

As discussed below, some of the funding for the Wishard Advantage program comes from Medicaid disproportionate share hospital (DSH) payments. Recently, HHC approached the state with recommendations to increase Indiana's DSH revenues by using all means available to maximize the amount of federal matching funds drawn down by the state. By increasing the amount of DSH funding, HHC increased the amount of DSH funding received by Wishard Memorial Hospital and, consequently, Wishard Advantage. At first, the Indiana Hospital Association opposed HHC's efforts to maximize DSH because other hospitals thought they might lose funding. This opposition died down when it became apparent that no DSH hospital would lose under the new arrangements.

DESIGN OF THE WISHARD ADVANTAGE PROGRAM

Organizational Structure. The Wishard Advantage program changed both the financing and delivery of health care for the uninsured in Marion County. Historically, HHC provided health care for the indigent population by operating Wishard Health Services. Under the old system, many uninsured patients only saw a doctor when they were sick and went to one of Wishard's clinics or the emergency room. Their care tended to be episodic, late in the disease state, and not in appropriate settings; as a result, it was expensive and inefficient. Under Wishard Advantage, HHC contracts with IUMG primary care physicians who provide primary care and act as gatekeepers for specialists and inpatient care in exchange for a capitated per member per month fee. IUMG physicians staff and manage Wishard's community health centers, and many also treat Advantage patients in their IUMG offices. HHC contracts separately with IUMG specialists for specialty care, and pays IUMG-SC through the Dean of the Medical School.¹⁴ Inpatient care is only provided at Wishard Memorial Hospital, and HHC's own pharmacies located in the hospital and health centers provide pharmaceuticals. This managed care approach stresses primary and preventive care, and encourages more efficient use of resources to care for the uninsured.

¹⁴ IUMG is actually two separate organizations, IUMG-PC (primary care) and IUMG-SC (specialty care). HHC provides funding for specialty care provided to Advantage patients, but these funds are distributed by the Dean of the Medical School on the basis of "relative value units," or RVU's.

While HHC ultimately runs Wishard Advantage, there is a considerable level of interaction between HHC and the providers and community centers participating in the program. Wishard Health Services and IUMG were involved in the initial design and planning stage, and remain active in program planning and decision-making processes. The Advantage Advisory Group—a collection of people from Wishard Health Services, IUMG, and the community—meets regularly to discuss the program’s present and future activities. Clinic advisory boards consisting of patients and community leaders from the neighborhoods around each of the community health centers provide feedback to the clinics, get the word out around the community about the program, and interact with HHC to keep up-to-date on the program.

Target Population. Wishard Advantage covers all uninsured Marion County residents with incomes at or below 200% of the Federal Poverty Level (FPL). The program particularly targets the working poor, people who earn too much to qualify for other public assistance but who work at jobs that either do not offer health insurance or offer coverage at a price that is not affordable. Enrollees must also not be eligible for any other public health insurance programs such as Medicaid or the State Children’s Health Insurance Program (SCHIP).¹⁵ Estimates of the number of people in Marion County that met these criteria ranged from 40,000 to 60,000 people.

Wishard Advantage particularly fills a void in public coverage for low-income parents and other adults. Indiana’s Medicaid program covers pregnant women and children under age 19 with incomes up to 150% of the FPL. Hoosier Healthwise for Children, the state’s SCHIP program, extends coverage for children under age 19 up to 200% of the FPL. Public coverage for parents and other adults is more limited. Medicaid eligibility is limited to parents in families with incomes up to approximately 25% of the FPL; other adults are not eligible for Medicaid unless they qualify under special provisions for the disabled or elderly.

Outreach and Enrollment. At first, HHC concentrated its outreach on indigent patients already registered with Wishard Advantage providers. They sent letters to these patients informing them about Wishard Advantage and asking them to enroll. Beyond these patients there was little outreach, and most new enrollees came from provider or patient referrals. Staffs at the clinics and hospital are told to ask patients who come in without insurance to apply for Medicaid or Advantage. HHC facilitated enrollment in these programs by getting the state to outstation eligibility staff at Wishard Memorial Hospital. Eventually, HHC was able to place financial counselors in all seven community clinics to determine eligibility for Advantage, Medicaid, and other programs.

Documentation required to enroll in Wishard Advantage is limited to one pay stub, or an unemployment check if the individual is not working, and proof of county residency. Patients who receive other public assistance with similar eligibility criteria, such as Food Stamps or SSI, are automatically deemed eligible for Advantage with proof of receipt. The financial counselor screens the patient for Medicaid, SCHIP, and other health programs, and enrolls them in those programs whenever possible. The individual then chooses a primary care physician. Many

¹⁵ Despite the limitation on other coverage, about 2,000 Medicare beneficiaries are currently enrolled in Wishard Advantage. These enrollees primarily enroll for prescription drugs, which are not covered by Medicare, but Advantage also helps with Medicare’s out-of-pocket charges.

uninsured patients do not to have a usual source of care, so it is not unusual for the counselor to refer them to a physician based on availability. Patients who have a physician or choose a physician based on a referral (e.g., from a friend) are assigned to that physician as long as the physician is accepting new patients. Once enrolled, patients are eligible for Advantage for one year, and HHC sends a reminder to patients prior to expiration of their eligibility.

Benefits and Cost-Sharing. Covered benefits are modeled after Indiana's Medicaid managed care offerings, since many Advantage patients have children that qualify for Medicaid and many people move between these two programs. Patients receive primary and preventive care, free pharmaceuticals, and access to specialists and inpatient care with referrals. Coverage of vision and dental services is limited, but includes dental check-ups, vision screening, and discounted eyeglasses. The program is free to enrollees with incomes less than 150% of the FPL. Enrollees with incomes between 150% and 200% of the FPL have a five dollar co-pay for office visits and pay 20-60% of the cost of their care, based on their incomes. Physicians are supposed to bill patients at rates similar to Medicaid fees, but program officials noted that billing outside the hospital has not been closely monitored to this point. There is no cap on out-of-pocket expenses by enrollees.

Wishard Advantage mirrors IUMG's commercial offerings. Advantage patients receive a membership card, member handbook, and access to a 24-hour nurse hotline just like people in the commercial plan. Patients entering the program choose their primary care physician from the list of participating physicians at the location where they receive most of their care. This doctor is responsible for providing all primary and preventive care, writing prescriptions, and making referrals to specialists or admitting to the hospital when necessary. Patients may access care in any IUMG location, but they must have a referral from their primary care physician before seeing another doctor.

Service Delivery & Payment. Patients generally must make an appointment to receive care from a Wishard Advantage provider. The most common place for people to seek care is at one of the seven neighborhood health centers. These centers, which were all built or renovated recently, replaced the undersized and outdated clinics previously run by the Marion County Health Department. They are capable of serving much larger numbers of patients, and they also house the Advantage program's pharmacies and other community and social service functions, such as WIC offices. The typical community health center is open from 8 a.m. to 4:30 p.m., but the clinic next to the hospital provides after-hours care. For patients needing consultation concerning symptoms or medications, there are triage nurses on call 24-hours. The triage nurse also helps to direct patients to the most appropriate source of care.

As noted above, primary care physicians receive a capitated per member per month fee for each Advantage enrollee to provide primary care and make referrals for specialty and inpatient care when necessary. HHC channels its payments for specialty care through the Dean of the School of Medicine, who distributes these funds to the specialists HHC is based on "relative value units," or RVU's. HHC originally planned to use capitated payments for specialty care, but the lack of reliable data on the target population prevented them from using capitated system at the beginning. Representatives of both HHC and IUMG doubt that a capitated payment system will be put into place for specialists in the near future because of

opposition from the providers. HHC pays for inpatient care on a fee-for-service basis, and provides prescription drugs free of charge to patients through its own pharmacies.

The program's single case manager and her assistant track utilization, evaluate requests for services requiring prior approval based on established medical criteria, and resolve conflicts when problems arise concerning coverage or denial of services. If a patient needs a medically necessary service that is not covered by Wishard Advantage but is provided at Wishard Memorial Hospital, the hospital generally provides the service but does not receive payment from Wishard Advantage. If a patient needs a medically necessary service that is not covered and unavailable at Wishard, the patient is referred to an appropriate provider. That provider is notified of the referral and asked to see if the patient would qualify for an indigent care program that might cover the service, but no payment is associated with the referral.

PROGRAM FUNDING

Funding for Wishard Advantage comes primarily from a share of local property taxes designated as funding for HHC. The corporation is rather unique in that it has direct taxing authority and can set its own tax rate, subject only to state legislative approval. This property tax generates about \$70 million a year in revenue for HHC; about \$56 million goes to Wishard Advantage and the remainder goes the Marion County Health Department and HHC staff. The tax rate used to fund HHC (79.1 cents per \$100 assessed valuation) has not changed since 1992, and it seems to be a stable and secure source of funding.

Medicaid disproportionate share hospital (DSH) payments are also an important source of funding for the program. DSH payments compensate hospitals that care for a disproportionate number of low-income, Medicaid, and uninsured patients. As a major part of the Marion County safety net, Wishard Memorial Hospital receives a significant amount of DSH payments.¹⁶ These payments contribute to the pool of funds used to run the Wishard Advantage program. HHC's recent effort to garner additional DSH funding for Wishard Memorial Hospital by maximizing the level of federal matching funds obtained by the state is a primary reason that the Advantage program recently expanded both within Marion County and beyond the county borders, as discussed below.

OBSERVED RESULTS

On average, there were over 22,000 people enrolled in Wishard Advantage over the 12-month period from June 1999 through May 2000, about one-third to one-half of the number of people originally estimated to be eligible for the program.¹⁷ In part this is explained by geographic barriers. That is, the Wishard Advantage program does not have facilities in all areas of the county, and people can and do seek care at other facilities. Most Wishard Advantage members are adults between the ages of 19 and 64 (84% in May 2000). Most members have incomes under 150% of the FPL (88% in May 2000), and therefore pay nothing for their care.

¹⁶ According to data from the Health Care Financing Administration (HCFA), Wishard Memorial Hospital received nearly \$52 million in total DSH payments (federal and state) in state fiscal year 1997.

¹⁷ Wishard Advantage has also helped to boost enrollment in other public programs, as thousands of other people have been enrolled in Medicaid or SCHIP by the program's financial counselors.

Forty-five percent are black, 43% are white, 8% are Hispanic, and the remaining 5% are other or unknown (May 2000).

The designers of the Wishard Advantage program wanted to develop a system of indigent care where patients would recognize the importance of receiving ongoing primary and preventive care rather than seeking episodic care only when they are sick or a chronic medical condition becomes worse. They also hoped to curb the tendency of this population to seek care in inappropriate (and expensive) settings for their level of illness, particularly emergency rooms. Because IUMG assumes the risk for the primary care of Wishard Advantage patients, these physicians have incentives to build relationships with these patients, encourage appropriate use of the delivery system, and improve the provision of primary and preventive care. Wishard Advantage staff constantly are looking to improve the coordination and quality of care for low-income patients by collecting and analyzing utilization data, creating HEDIS-like reports, and conducting patient satisfaction surveys. In general, the approach seems to be working. Consumer advocates noted that patients are happy with the program, in particular the feeling that they have access to a choice of providers.

Nevertheless, there still are some areas of concern to HHC and others involved in Wishard Advantage. The cost of pharmaceuticals is a concern; HHC officials noted that they are the largest single share of program expenses and also the fastest growing. Another area of concern shared by both HHC and Wishard Health Services is that patients who get insurance tend to leave the Wishard network. They noted that people seem to think that the quality of care is better elsewhere, perhaps reflecting a stigma associated with use of a county hospital. In addition, the provider network is broad but does not reach all areas of Marion County, so there are geographic reasons for patients in some areas to go elsewhere.

Nearly everyone connected with the program noted that at any given time the program serves much fewer people than were originally thought to be eligible. Among those thought to fall through the cracks are undocumented aliens and patients who wait until they are sick to seek care (or who drop off the program when they are not sick). Lack of community knowledge about the program is still a problem, particularly in those areas not served by the community clinics. Some self-pay patients may also choose to continue to pay out-of-pocket as long as they can afford the care, particularly if they are toward the upper end of the income scale and face higher cost-sharing requirements, rather than go through the process of signing up, choosing a doctor, and meeting the program requirements for referrals and pre-authorization.

VISION FOR THE FUTURE

Buoyed by the success of the program so far, HHC recently expanded the Advantage network to include other safety net providers in Marion County outside the Wishard system. This effort expanded the provider network within the county, increasing capacity and extending the program into areas of the county not served by Wishard Health Services. Raphael Christian Health Center was the first provider to join the expanded network. HHC wants to negotiate contracts with other provider networks, physician residency programs, and non-Wishard clinics to serve Advantage patients. Ultimately, the current HHC leadership would like to see Wishard Advantage used as a model for indigent care programs statewide. To this end, HHC will help to

fund a similar program in St. Joseph County, IN, as a demonstration project to prove that the model can work in other areas.

Concurrent with this expansion of the network, HHC would like to increase participation in the program. There are plans to step up outreach and enrollment efforts with a door-to-door campaign using Neighborhood Associations to sign up people for Wishard Advantage and Medicaid. HHC would also like to add an employer-sponsored program for small businesses, although they acknowledged that it would be difficult to come up with a plan that would work given that many people in the target population would qualify for free care under the regular Wishard Advantage program.

Funding for Wishard Advantage seems to be secure and stable, at least in the short term. The Indiana General Assembly granted HHC the ability to enact legislation and set its own tax rate, subject to legislative approval. The corporation has not changed its tax rate since 1992, but continues to collect increasing revenues due to rising property values. HHC has also been able to secure additional DSH funding to build capacity and infrastructure for the expansion by helping the state to maximize spending under its DSH cap. However, the Balanced Budget Act (BBA) of 1997 placed limits on the total amount of federal DSH funds that each state, and also individual hospitals in the state, could receive. Indiana's recent increases in DSH spending brought the state up to its maximum DSH allotment, so the ability to significantly increase funding for the program will be more difficult in the future. The state's DSH allotment also decreases over time, so there may be less DSH funding available to help run the Wishard Advantage program in the future. Even so, the general sentiment of people involved in Wishard Advantage is that they are committed to the program and will find other funding sources if necessary.

Chapter 4

LANSING, MI, INGHAM HEALTH PLAN

By Brian Bruen and Stuart Guterman

Description of the Ingham Health Plan. The Ingham Health Plan (IHP) is a community-sponsored program that was created in 1998 to provide health care for uninsured people who live in Ingham County, Michigan (which includes the city of Lansing). Two groups of people are eligible for the IHP: “Group A” includes people deemed eligible for the State Medical Plan (SMP), who are primarily people with medical conditions and very low incomes who do not qualify for Medicaid or other medical benefits;¹⁸ “Group B” includes people with incomes under 250 percent of the Federal Poverty Level (FPL) who are uninsured and do not qualify for Medicaid or other medical benefits. Every IHP participant is eligible for primary care, specialty care, pharmaceuticals, and outpatient laboratory and radiology services; Group A participants also receive outpatient hospital services, emergency ambulance services, and durable medical supplies. There are no co-pay requirements for Group A, but there are co-pays for Group B. Participants may only receive services at assigned IHP primary care locations unless authorized to receive care elsewhere. The IHP can also restrict eligibility or services for Group B—but not Group A—if funding is limited. The state does not consider the IHP to be insurance, so it is not subject to insurance regulations.

The IHP is operated by the Ingham Health Plan Corporation (IHP Corporation), a not-for-profit corporation set up to act as a vehicle to provide access to organized systems of health care and to improve the health status of uninsured people in the county. The Ingham County Health Department provides administrative support. Funding comes from three sources: local government funding for indigent health care, state government funding for the former SMP program, and federal funding in the form of Medicaid disproportionate share hospital (DSH) payments. Prior to formation of the IHP, Ingham County spent about \$2 million to support local health centers. Under the IHP, the county passes this funding through the state as matching funds for DSH to get a larger amount of federal matching dollars, more than doubling the amount of money available to the program. To make the arrangement worthwhile from the state perspective, the state adds funding for the former SMP participants—IHP Group A—to the local funding, also generating federal match. All of the federal DSH payments flow through a local hospital that contracts with IHP Corporation to carry out the program including provision of services, enrollment, and administration.

DEVELOPMENT OF THE INGHAM HEALTH PLAN

Underlying Conditions. The safety net in Ingham County has several components. The Ingham County Health Department operates a system of nine primary care centers. Historically, these clinics provide services to primarily low-income, vulnerable populations—mostly people enrolled in Medicaid, uninsured, or underinsured. There are two hospitals in the county, Ingham

¹⁸ The SMP provides basic outpatient health care services to low-income adults who do not qualify for Medicaid or other medical benefits. Typically, SMP enrollees have a medical problem, a physical or mental impairment, and very low income (for example, less than \$264 per month for an individual living independently).

Regional Medical Center (IRMC) and Sparrow Health System, both of which offer financial assistance to the uninsured and people with limited financial resources. This assistance may consist of discounted rates and/or monthly payment plans depending on factors such as family income and balance due to the hospital.

Health Department officials estimate that there are 25,000 to 30,000 uninsured people in Ingham County, roughly 10 percent of the county population. Most of these people (20,000 to 22,000) live in households with at least one employed person. Some (3,000 to 5,000) are students or dependents of students at Michigan State University, and others (3,000 to 5,000) are unemployed non-students. These uninsured people formed the core group that seeks care from the Health Department.

Prior to the IHP, two separate programs served some of the population that is now eligible for the IHP: the state-sponsored SMP and a local health care program for low-income people called the Medical Access Program (MAP). The MAP used different eligibility criteria and consisted of a provider network of volunteer physicians and other vendors who agreed to charge/accept Medicaid rates from patients. The IHP replaced the SMP, but the MAP is still around and serves about 1,000 people.

Factors Leading to Development of the Ingham Health Plan. IHP officials noted that there had long been a desire within the Ingham County Health Department to provide care for the uninsured in a program similar to Medicaid or private insurance. In the early 1990's, Health Department officials hoped President Clinton's health reform plan might offer a solution to the problem of the uninsured. The demise of the Clinton plan shifted the impetus for action back to states and localities. At the same time, analysts projected difficult times ahead for the Ingham County Health Department. The number of uninsured was growing, and there were pressures to reduce or even forego services for the uninsured if money became tight. The growth of Medicaid managed care added to the anxiety of Health Department officials, who believed that they would lose money if they were left out of managed care contracts or lost patients to other providers.

In response to these pressures, Health Department officials committed themselves to finding a community-level solution to care for the uninsured. They applied for and received a grant from the Robert Wood Johnson Foundation to support community development of programs to provide care for the uninsured. At the same time, they began piecing together the framework of a program that would ultimately become the IHP. During this process, they became aware of a way to use Medicaid disproportionate share hospital (DSH) funding to generate federal match for the local dollars that they were already spending. By bringing in the federal DSH dollars (and some state funding as well) they were able to dramatically increase funding for the new program, making it possible to implement the IHP without a significant increase in local funding.

Key Players. Key players in the development of the IHP include the Ingham County Health Department, a health care consulting group, state and local government officials, local hospitals, and the local health care coalition. The Health Department came up with the basic plan for the new program, provided the sites through which the program would be run, and set about convincing local government officials that it would work. Health Management Associates

(HMA), a Lansing-based health care consulting firm, assisted with program design—particularly the DSH funding mechanism—and worked with the state to secure the DSH funding. State and local government officials played a role in the success of the program by working with the Ingham County Health Department to provide the state match necessary to get the federal DSH funds. A local hospital, Ingham Regional Medical Center (IRMC), became the channel for the DSH dollars that go to IHP Corporation to support the program. The Capital Area Health Alliance (CAHA), a local health care coalition which focuses on public health goals such as wellness and universal access to health care, helped to build community support for the program.

Initial Challenges. The biggest initial challenges to the IHP were securing funding, getting local hospitals to participate, and building community knowledge of and support for the new program. The entire process was quite involved and difficult. Securing funding required the cooperation of both the county and the state. The funding mechanism called for the county to redirect about \$2 million that was already dedicated to support primary care provided in clinics run by the Health Department and use it to fund the IHP. Before they agreed, the county needed to understand what the IHP was, how it would work, and that the Health Department would earn enough money through its relationship with the IHP Corporation (as a provider and also in an administrative support role) to replace the funds that they had received from the county in the past. County officials also had to understand all of the complex relationships involved (for example, between the IHP and the hospitals, and the hospitals and the state), and enter into agreements with the IHP Corporation that spelled out everyone's responsibility.

The IHP also needed the cooperation of the state. The proposed funding mechanism called for the county to transfer funds to the state in the form of an intergovernmental transfer, or IGT, which the state would certify as a DSH payment to the local hospital(s) in order to generate the federal match. The state agreed to the plan, but required that the IHP also cover people eligible for the State Medical Plan (SMP), a state-sponsored program for low-income disabled people. The state added funding equivalent to the amount of money that was historically spent to pay claims in Ingham County for SMP participants. This change transferred most of the responsibility for serving the SMP population to the IHP (the state would continue to determine eligibility), but it also increased the funding for the IHP because the state funds are also used as match for federal DSH dollars.

The cooperation of the state and local governments provided the funding needed to generate federal DSH, but under federal law DSH payments must be paid to a hospital, not a public health institution like the Health Department. Medicaid DSH payments are only payable to hospitals that serve a disproportionate share of Medicaid and uninsured patients, and the amount payable to a particular hospital is limited. The two hospitals in Ingham County qualify for a combined total of about \$10.6 million in regular DSH funding. However, the IHP requires about \$6.6 million in DSH for full implementation, which is more than either hospital can receive individually. Therefore, while the IHP required cooperation of only one local hospital to get started, it will need the cooperation of both hospitals to reach full implementation.

To secure funding through the hospitals, the IHP designers designed an Indigent Care Agreement between the hospitals and the IHP Corporation to create and administer an organized system of care for uninsured people. If a hospital signed an agreement, it had to turn over all

DSH revenues specifically generated to fund the IHP to the IHP Corporation. It is important to note that these payments neither increase nor reduce the existing DSH payments provided to a hospital, so no hospital would lose its DSH by participating in the IHP.

IHP designers marketed the plan to the hospitals as a community service, not something that would save money in the short term. Neither hospital was happy with the design of the IHP because it did not cover inpatient services and provided only limited coverage of outpatient services, and both hospitals were concerned that the program might stimulate use of these services. Sparrow Health System refused to participate because they wanted a program that served fewer people with a more comprehensive benefit package including inpatient care. However, Ingham Regional Medical Center (IRMC) signed a contract because they felt that the opportunity for the community outweighed the risk. They also felt that a more organized system of care like the IHP, with better access to primary care, might eventually be more cost effective than the existing system of indigent care. Nevertheless, Sparrow's refusal to participate limited the amount of funding available to the IHP; an individual hospital can only receive a set amount of federal DSH funds and with the IHP, IRMC is very close to their cap.

The designers also faced the challenge of building community knowledge of, and support for, the IHP. One of the key players in this endeavor was—and still is—CAHA, the local health care coalition that consists of 108 members representing employers, providers, health plans, unions, the Ingham County Health Department, and other health care stakeholders. Program officials attribute much of the growth in enrollment to word-of-mouth from providers and patients, but CAHA is clearly important to the current and future support for the program within the larger community that is not directly involved in or affected by the IHP.

DESIGN OF THE INGHAM HEALTH PLAN

Organizational Structure. The Ingham Health Plan Corporation (IHP Corporation) operates the IHP. The IHP Corporation is a not-for-profit corporation that was incorporated on May 26, 1998. The corporation's mission is to act as a vehicle to provide access to organized systems of health care and to improve the health status of the uninsured in Ingham County area. Its initial responsibility was to oversee the IHP, but now it also oversees the Capital Area Prescription Program (CAPP), a discount prescription drug program for seniors that started in October 2000. The IHP Corporation has a nine member Board of Directors including representatives from the City of Lansing (1), the two local hospital systems (1 each), and the physician community (2), as well as two former state government officials and two current IHP participants.

The IHP Corporation contracts with other organizations and providers to deliver services to members and administer the IHP. It contracts with primary care providers who provide services to IHP members and manage their care in exchange for a per member per month fee. As of August 2000, there were 14 sites in the primary care provider network: 10 Health Department sites, one private office, and three sites run by Michigan State University. The IHP Corporation hopes to add 12 IRMC-owned locations to bring the total to 26 sites by December 2000. It contracts with the Health Department to provide enrollment services, arrange and pay for specialty care services, and give administrative support to the Board of Directors. The IHP Corporation also contracts with specific providers for outpatient laboratory and radiology

services, and a Michigan-based pharmacy benefits manager that maintains a statewide network of participating pharmacies.

Target Population. The population eligible for the IHP includes two populations. Group A includes people determined to be eligible for the former State Medical Plan (SMP). Group B includes people with gross household incomes at or below 250 percent of the federal poverty level (FPL). Group B enrollees must be Ingham County residents, meet the income requirement noted above, and be ineligible for Medicaid, Medicare, MICHild, or any other health insurance or medical benefit. Group A includes State Disability Assistance recipients and other low-income people that do not qualify for Medicaid or other health programs. Group A enrollees typically have a medical problem, a physical or mental impairment, and very low income (e.g., a max of \$264 per month for individuals living independently). The state's Family Independence Agency determines eligibility for Group A; the IHP determines eligibility for Group B.

The IHP particularly fills a void in public coverage for low-income parents and other adults. Michigan's Medicaid program covers pregnant women and infants with incomes up to 185 percent of the FPL, and children under age 19 with incomes up to 150 percent of the FPL. MICHild, the state's SCHIP program, extends coverage for children under age 19 up to 200 percent of the FPL. Public coverage for parents and other adults is more limited. Adults with dependent children qualify for Medicaid only if they meet the income standard for their family size, all of which are well below 100 percent of the FPL; other adults are not eligible for Medicaid unless they qualify under provisions for the disabled or elderly.

It is important to note that the IHP is not insurance—it is basically a service program with an established network of providers. It also does not guarantee coverage. The IHP Corporation's Board of Directors can limit eligibility, for example if funding runs short. In such instances, people with the lowest incomes receive priority and people with higher incomes can actually be disenrolled from the program.

Outreach and Enrollment. As noted above, the IHP determines eligibility for all applicants except those determined eligible for Group A by the state. Required documentation for IHP purposes includes proof of current address (e.g., a driver's license, Michigan ID, recent utility bill, or pay stub with an address on it) and proof of gross monthly household income (e.g., recent pay stubs, previous year's tax form, or unemployment statement). The household income used to determine eligibility excludes income from children under age 20.

Enrollment and outreach efforts for the IHP primarily rely on word-of-mouth communication through providers, IHP enrollees, and other agencies. Providers may help enroll people who appear to be eligible for the IHP by asking them to fill out an enrollment form. Providers and patients can obtain applications from the IHP, and patients can return the form by mail along with any required documentation. People can also apply in person through IHP Member Services, located in the Ingham County Health Department headquarters. Member Services offers enrollment interviews both by appointment and on a walk-in basis.

People participating in the IHP receive an ID card that identifies them as eligible for the program and lists required co-pay amounts. It can take 7-10 days for people deemed eligible for

the IHP to receive their ID card; they are not eligible for services during this period. In addition to the ID cards received by patients, the IHP maintains computerized eligibility records that providers can use to verify eligibility. Providers at sites operated by the Health Department can access the records electronically; other providers receive a hard copy participant list each month. Providers can verify the eligibility of Group A participants through the State of Michigan. Participants also receive a member guidebook that describes eligibility, enrollment and disenrollment procedures, covered and non-covered services, and the other rights and responsibilities for IHP participants.

Benefits and Cost-Sharing. The benefit package offered to all IHP participants includes visits to an assigned primary care provider, visits to specialists, outpatient laboratory and radiology services, and prescription drugs. Group A participants are eligible for additional services, including emergency services in outpatient hospitals, ambulance services for life-threatening emergencies and accidental injury, and durable medical supplies. Inpatient hospital services are not covered for either group. IHP participants may be eligible for financial assistance from the local hospitals, but they must apply for such assistance from the hospital, independent from the IHP. Most services require co-pays from Group B participants; Group A participants do not have any co-pay requirements. The participant's assigned physician must deem all covered services medically necessary.

Primary care covered services include routine physicals and health examinations, immunizations (for vaccines supplied by the Health Department), shots (medicine not included), treatment of minor burns, destruction of lesions, pulmonary assessment, EKG, blood pressure screening, simple hearing tests, simple laboratory tests, and routine care for minor medical problems such as colds, flu, and back pain. There is a co-pay of \$5.00 per visit for Group B participants, which can be waived by the provider. The IHP does not cover family planning or breast and cervical cancer screening services, but the Health Department provides these services at reduced or no cost. The IHP covers office visits and outpatient hospital procedures done by a specialist when medically necessary. These procedures must be ordered and authorized by the enrollee's assigned primary care provider. Group B participants have a co-pay of \$10.00 per visit for specialist services.

The IHP covers outpatient laboratory services if they are required in the diagnosis of an illness or injury. To be covered, all laboratory tests must be provided at one of the Sparrow Regional Laboratory Patient Centers, the sole contractor with the IHP Corporation for these services. There is no co-pay for laboratory services. The IHP covers radiology services at authorized outpatient radiology facilities when approved by an assigned primary care provider or specialist. Radiology services include diagnostic imaging services used for diagnosis, assessment, treatment, or prevention of a medical condition. There is a co-pay of \$5.00 per procedure for Group B participants. The IHP does not cover radiology services provided to Group B participants during an emergency room visit. Mammograms for women over age 40 are also not a covered service, but are available through the Health Department.

The IHP covers prescriptions and refills filled by participating pharmacies. The plan maintains a strict formulary for Group B participants; Group A participants can get some drugs that are not on the list of covered drugs if approved by their physician. Group B participants

have a co-pay of \$5.00 per prescription/refill for generic drugs, and \$10.00 per prescription/refill for brand name drugs.

The IHP does not cover outpatient hospital care or emergency room services for Group B participants, but Group A participants are covered for these services. The IHP does not cover inpatient hospital services for any enrollees. As noted above, both local hospital systems offer financial assistance for inpatient services through charity care programs, but it is the responsibility of individuals to apply for assistance at the time of service. Other non-covered services include dental or vision care, hearing aids, occupational therapy, mental health, substance abuse, home health, and hospice care.

Service Delivery and Payment. At the time of enrollment, the IHP assigns members to a primary care site. The IHP coordinates all placements; the plan makes “all reasonable attempts” to assign each member to his/her choice of participating primary care sites, but the requested placement may not always be possible due to capacity and contractual issues. At the request of the participating provider site’s request, and with good cause, the IHP may place a Group A participant with a non-participating primary care provider. The IHP must approve and coordinate any such placement. Once per year, a member may request a transfer or reassignment to another participating primary care site; the IHP or primary care provider may also initiate transfers in certain circumstances.

Primary care providers are responsible for providing either directly or through approved subcontractors all medically necessary, covered services. Their responsibilities include: coordinating covered services; making referrals and authorizations for specialty, lab, and radiology services; ensuring continuity of care; and assuring that the quality and intensity of care is appropriate for the member’s condition. Participating providers must offer members 24-hour access by telephone to either the provider himself/herself or a qualified representative. Providers must have a quality assurance program designed to objectively and systematically monitor and evaluate quality and appropriateness of care. The IHP Corporation or a representative of it (e.g., the Health Department) may also monitor quality. Each provider must also establish a dispute resolution procedure as part of their contract with IHP Corporation that describes the method for receiving and responding to member complaints. Members may appeal to IHP Corporation if they exhaust the standard dispute procedure without a satisfactory resolution.

In exchange for their efforts, primary care providers receive per member per month (PMPM) payments. The budgeted PMPM payments to primary care providers for 1999-2000 were \$12.00 for Group B members and \$41.00 for Group A members, reflecting the greater health needs of the former SMP population. Specialists received \$9.00 PMPM, and the laboratory and radiology providers each received \$0.50 PMPM. Pharmacy payments are not capitated; the average monthly amount budgeted in 1999-2000 was \$2.00 for Group B enrollees and \$33.00 for Group A, again reflecting the greater needs of the latter. The remaining budgeted funding, about \$6.00 PMPM, covered administrative, legal, and other costs. The average monthly payment per member worked out to \$30.34 for Group B and \$90.34 for Group A, for an average PMPM cost of \$39 for both groups combined.

PROGRAM FUNDING

The State of Michigan encourages communities to set up organized systems of indigent care, and has been quite aggressive in its efforts to receive federal matching funds through Medicaid to support these initiatives. The state makes extensive use of IGTs to help finance the Medicaid program, and as a result has a complicated system of DSH and DSH-related payments. Some of these payments count toward federal caps on DSH payments but others do not. By shifting expenditures into the programs that do not count toward federal caps, Michigan has room under its DSH cap to fund programs such as the Ingham Health Plan.

Medicaid DSH funding is a critical component of the IHP budget. In 1999-2000, the total budgeted cost for the IHP was \$5.5 million and total budgeted revenues were \$5.9 million. Of the \$5.9 million in revenues, \$1.1 million (19%) came from Ingham County, \$1.6 million (27%) came from the State of Michigan, and \$3.2 million (54%) came from the federal government in the form of Medicaid disproportionate share hospital (DSH) payments. To draw down the federal funding, Ingham County sends its share of the IHP funding to the state through an intergovernmental transfer (IGT). The State of Michigan Department of Community Health added its funding for the SMP population, and claimed the full \$2.7 million as match for \$3.2 million in federal Medicaid DSH payments on behalf of Ingham Regional Medical Center (IRMC). IRMC transferred the Medicaid DSH payments generated by this transaction to the IHP Corporation to run the IHP, as required under contract.

The plan for full implementation of the IHP requires the participation of Sparrow Health System. IRMC can only draw down a fixed amount of federal DSH payments, and it is currently close to that limit. As long as Sparrow withholds participation in the IHP, funding for the plan will remain at roughly its current level, thus limiting the size and scope of the program.

OBSERVED RESULTS

The IHP started enrolling members in October 1998, beginning with 1,463 SMP enrollees. Enrollment grew steadily as non-SMP enrollees began to participate, climbing from 6,016 members in January 1999 to 8,426 in October. By July 2000, the IHP had 10,781 members. The vast majority of IHP members are non-SMP enrollees; 8,829 (82%) of the members in July 2000 were SMP enrollees and 1,951 (18%) were non-SMP enrollees. According to program officials, 90 percent of the people enrolled in the IHP have incomes below 140 percent of the Federal Poverty Level.

Most IHP members are women (68% in July 2000), but the gender breakdown varies dramatically between the two eligible populations. In July 2000, nearly three-quarters (73%) of non-SMP enrollees were female but less than half (41%) of SMP enrollees were female. Most IHP members are under age 40, but the age distribution also varies considerably between the two eligible populations. There are similar numbers of SMP enrollees in the 21-30, 31-40, and 41-50 age brackets, while almost half of the non-SMP enrollees are 21-30 years of age, with enrollment dropping off significantly among older groups. The distribution of enrollees by race is quite similar across both eligible groups; over half of all members are white, about one-quarter are black, another 10 percent are Hispanic, and the remainder are of other descent.

In addition to the enrollment data presented above, the IHP collects a variety of other measures used to monitor and improve the program. For example, the plan tracks expenses and utilization of pharmacy and radiology services, monitors payments to each of its vendors, and keeps track of referrals to specialists. These data show that numbers of prescriptions, radiology procedures, and referrals to specialists are increasing, but that these increases are consistent with the growing enrollment in the program. Budget and spending figures also show that the average PMPM expenditures for IHP services are generally at or below the budgeted amounts. All of these data allow the IHP to better monitor utilization and spending to help make care more efficient and cost-effective.

Although the IHP does not pay for inpatient hospital services or (in most cases) outpatient hospital services, the plan also monitors gross charges for IHP patients that go to IRMC for these services (Sparrow does not generate reports for the IHP). The reports from IRMC include the number of visits/admissions for IHP members, average number of procedures, and top diagnosis categories and charges per diagnosis. Despite pressure to do so, program officials did not promise the hospitals that the IHP would reduce emergency room use or hospitalization. Nevertheless, reports from IRMC suggest that the rate of hospitalization for IHP members is low.

In general, patients and participating providers seem happy with the program. One provider noted that IHP members get access to high quality care that is just as good as what they would receive if they had private insurance. An IRMC official said that the IHP exceeded their expectations, significantly increasing access to and use of primary care without significantly increasing demand for the hospital's charity care. One of the IHP clients who also serves on the IHP Corporation's Board of Directors liked the fact that she now had a "medical home" where she feels she gets very good care. Prior to the IHP, she moved from clinic to clinic. She also noted that the co-pay requirements helped her to feel better about the program because she contributed something toward her care, although she also said that there was still a stigma associated with accepting assistance from a public program.

State and local officials tout several benefits of the Ingham Health Plan. The IHP gives uninsured people a medical home and a health care program with features similar to private insurance. People with chronic conditions that can be managed on an outpatient basis get a regular source of care and a source of medicines. Case management strategies can be designed to assist in helping patients get more efficient and cost-effective care. The formal system allows the collection of data on uninsured people and their utilization patterns that were previously unavailable. Local control allows solutions tailored to the differing needs of people in the county. Lastly, benefits are limited and not guaranteed, so incentives still exist for people to get insurance coverage if and when they can.

VISION FOR THE FUTURE

The short-term goals of the IHP are to expand provider capacity and increase enrollment. Program officials hope to have contracts with as many as 26 primary care provider sites by the end of December 2000. The expanded provider network should include 10 Health Department sites, three sites run by Michigan State University, one private practice, and 12 IRMC-owned locations. All but the 12 IRMC-owned sites are now operational, and the IHP is currently

working to schedule training sessions for the remaining sites. Adding more providers will expand capacity and extend the network into more areas of Ingham County, which officials hope will increase participation.

The expansion of the IHP is part of a larger, long-term plan to expand health care access for Ingham County residents, led by the Capital Area Health Alliance (CAHA). Future IHP plans include a subsidized health insurance program for small employers that have not provided benefits in the past, an IHP/MSU student health insurance initiative, and a prescription drug program for seniors. Grants from major health care foundations are in place to assist the development of the IHP and other community initiatives.

Funding for the IHP seems relatively secure. In August 2000, program officials were hopeful that Sparrow Health System would sign a contract with the IHPC before the end of the year. Adding Sparrow would allow full implementation of the IHP because it would add a second channel for DSH funding; Sparrow is also bigger than IRMC and serves more Medicaid and uninsured patients, so its DSH cap is higher. More recently, Ingham County officials authorized an additional \$1 million in funding for the IHP in November 2000, which is new money intended to increase the number of people using the program. Additional funding may also become available from the City of Lansing and Michigan State University to support new initiatives through the IHP.

There is some concern among state officials about pending federal changes to Medicaid's "upper payment limit." Michigan relieved some of the financial pressure imposed by federal DSH caps through use of supplemental payments. Alarmed by the growing number of states taking advantage of this loophole, the federal government appears ready to take steps to close it. State officials in Michigan expressed concern that if federal legislation curbs their ability to use supplemental payments and/or Medicaid DSH payments, the state might have no choice but to eliminate programs using DSH funding to serve non-Medicaid populations. IHP officials did not seem as concerned about the payment limitations at the time of our visit.

Chapter 5

CARELINK PROGRAM (SAN ANTONIO, TX)

By Amy Lutzky and Teresa A. Coughlin

Overview of CareLink. The *CareLink* Program is a health care payment plan, which provides financial assistance with health care expenses to uninsured residents of Bexar County (San Antonio) Texas. The program is sponsored by the University Health System, the Bexar County public hospital. Implemented in 1997, *CareLink* currently serves nearly 70,000 individuals, the bulk of whom have incomes below 150 percent of the federal poverty line. While not an insurance plan, several features of the *CareLink* program are modeled on managed care concepts. For example, participants are assigned to a primary care provider and make monthly payments, primary and preventative care are emphasized, and *CareLink* set outs a defined schedule of benefits.

Under a state mandate to provide care to uninsured residents of Bexar County—estimated at 30 percent of the county’s population or about 350,000 persons—the University Health System (UHS) is the San Antonio primary safety net provider. The system includes a 642 licensed bed hospital, 5 clinic locations providing primary and specialty care, a managed care plan. In addition, UHS holds a contract with the University of Texas Health Science Center to provide physicians to staff its facilities. Annually, UHS provides 18,541 inpatient days and manages roughly 160,000 outpatient lives per year, with 60 percent of its patient mix being uninsured.

Safety Net Funding Mechanisms. The Texas County Indigent Health Care program or CIHP is a state program requiring counties with an excess of 190,000 residents create county-wide hospital districts that assume responsibility for providing medical and hospital care to needy residents. There are currently 120 hospital districts in Texas, with Bexar County being one of them. Through state law, hospital districts are granted local property taxing authority, which serves as the primary funding source for the *CareLink* program. Each hospital district's County Commissioner Court, an elected body of local officials, determines the actual level of funding obtained through the property tax.

Hospital Districts have significant latitude in defining eligibility standards and scope of services, but they cannot establish income and resource eligibility standards that are more restrictive than set out by the Texas Department of Health-- which is currently 17 percent federal poverty line (FPL).¹⁹ Bexar County is relatively generous in their commitment to providing health care to uninsured residents, as UHS’s mission is to provide services to both “indigent” and “needy” residents, defined as those residents falling at or below 75 percent FPL and those falling between 76-185 percent FPL, respectively. *CareLink* does allow families over 185 percent of FPL to participate; however, they must make substantially higher payments.

¹⁹ The County Indigent Health Care Program was mandated by state legislation in 1985 and provides state assistance to counties not served by a public hospital or hospital district and spend more than 8 percent of their general revenue tax levy on Department of Health-established services. CIHCP’s income eligibility limit is 17 percent FPL.

Beyond property tax funding, UHS relies on Medicaid DSH monies and patient collections to support its safety net programs (see below).

DEVELOPMENT OF THE CARELINK PROGRAM

Impetus. While county property tax dollars provide UHS funding to help pay for care to the uninsured, patients are also expected to contribute. Before *CareLink* was implemented, UHS operated a sliding scale payment methodology program that calculated an indigent patient's contribution as a straight percentage of their total incurred expenses, regardless of their ability to pay. However, only a small share (estimated at less than 5 percent) of indigent patients ever paid anything. UHS officials wanted to improve the patient contribution rate and in early 1990s began exploring ways to determine an individual's ability to pay what they could afford rather than imposing a flat percent of the bill. In addition, as a further effort to help patients pay part of the bill, it was decided to spread payments over time rather than requiring one lump sum payment. Eventually UHS officials developed a formula to assign patients a maximum family liability (MFL):

$$\text{MFL} = (11\%) (\text{annual family income}) (\text{FPL index})$$

The MFL would then be broken down into monthly installments over a 48-month period. If a patient's expenses exceeded their maximum liability fee, the remainder of the costs would be absorbed by the UHS's budget for indigent care (financed largely by property tax revenue). This new program was called CostShare and was implemented in 1993.

This payment model soon developed into the *CareLink* program, which was influenced by the Clinton health care reform efforts and the national and state shift to managed care. In effect, UHS wanted to prepare themselves for both managed care and the prospect of health care coverage for the uninsured. *CareLink* was implemented April 2, 1997, which was shortly after their implementation of a Medicaid managed care plan, Community First Health Plan. *CareLink* uses CostShare's payment formula but added some of the basic concepts of managed care. While *CareLink* is built around managed care tenets, it is not an insurance program, but rather a post payment plan. As of 2000, the share of uninsured UHS patients contributing to their care is estimated at nearly 60 percent, a substantial increase from the 5 percent contribution rate under the Sliding Scale Program that charged a flat percentage.

It should be noted that uninsured persons are not required to participate in *CareLink* to receive services. However, for those uninsured persons who do not participate, only emergency care services and emergency inpatient care are provided unless they pay for the services in advance.

While the major impetus behind *CareLink* was to improve patient satisfaction and patient collections UHS officials also viewed the program as having several other benefits. For the *CareLink* participant, a health care structure is offered to them for the first time. For example, designated staff is available to help them obtain care. They are assigned a primary care physician, can make appointments, and are encouraged to use preventive care.

Another benefit is that *CareLink* will help manage and control costs of caring for the uninsured: By imposing some structure and utilization review it is hoped that costs can be better tracked. Likewise, by improving access to primary and preventative care, and providing a medical home to the uninsured, it is hoped that costs will be contained.

Another motivating factor was that the *CareLink* population is a group whose insurance status changes with some frequency: sometimes they have insurance and sometimes they don't. Officials felt that *CareLink* affords UHS the opportunity to establish a medical relationship with program participants so that when they get insurance they will continue to come to UHS rather than go elsewhere.

Finally, UHS officials also feel that politically *CareLink* has been important. That is, once *CareLink* and its predecessor *CostShare* were implemented, local politicians understood that the uninsured were contributing what they could afford and that property taxes were needed to pick up the balance. As a consequence, unlike some other areas in Texas, UHS property tax funding has remained fairly stable in the 1990s. (According to UHS officials, other hospital districts' property tax funding was cutback beginning in the early 1990s with the infusion of federal DSH funds. UHS believes they were able to afford such cutbacks in part because of *CareLink*.)

Key Players and Relationships. *CareLink* grew out of a vision of creating a better payment plan for uninsured residents of Bexar County, and further developed into a program that seeks to improve the uninsured's access to health care. In addition to the efforts and vision of UHS staff, the program's development was enabled by the support of UHS's board members and the commitment of Bexar County's Commissioners Court to maintain property tax rates as the *CareLink*'s primary funding source.

Another important ingredient to the development of *CareLink* was securing the participation of physicians from the University of Texas Health Sciences Center (UTHSC). While UHS had a longstanding agreement with UTHSC doctors to staff their facilities, *CareLink* changed the dynamic somewhat. For example, when *CareLink* was implemented UTHSC physician reimbursement for indigent care changed. Previously, UHS made a pre-determined lump sum payment UTHSC to provide care to indigent patients. UTHSC then allocated the funds among different academic departments with the department chairs deciding how the funds would be used within each department. Thus the funds were not tied to an individual patient nor to the volume of care that an individual doctor provided. Now under *CareLink*, the doctors are reimbursed on a FFS basis making reimbursement directly linked to the volume of care. This shift in payment caused some tension between UHS and UTHSC and among some UTHSC departments.

Initial Challenges. An initial challenge to developing *CareLink* was trying to ascertain the psyche of uninsured residents in Bexar County. At the outset, program developers contemplated the following issues:

- Can one manage the health care of the uninsured, low-income population;
- Does this population want a medical home; and

- Does this population want to take greater control over their health and well-being by seeking preventive and primary care, rather than just relying on emergent care.

CareLink developers also had the challenge of creating a schedule of benefits. While they wanted the package to be comprehensive, they decided that it could not be richer than other programs such as Medicaid. Determining what service limits and copays to impose was another issue.

In addition, encouraging physician participation and developing a physician network that operated efficiently proved challenging. When CareLink was established there was little managed care in San Antonio and some doctors were reluctant to follow the managed care concepts embedded in the program. Also the change in physician reimbursement was controversial.

CareLink participants were also unfamiliar with managed care and were often resistant to the program restriction and rules. The population had been accustomed to accessing health care on an episodic basis often through the hospital outpatient department or the emergency room. Consequently, CareLink administrators put in place a substantial patient education program that, among other things, includes receiving an explanation of patient rights, responsibilities and benefits from an enrollment worker. CareLink participants also receive a member handbook. Finally, UHS administrators had established NurseLink, which is a 24-hour hotline manned by nurses that assist patients with their questions and triaging their illnesses. NurseLink is a great resource for CareLink members needing to access services and assist in managing costs by direct patients to the most appropriate setting for care.

PROGRAM FUNDING

Role of Medicaid DSH Payments. Medicaid DSH plays a significant role in covering CareLink's expenditures. While funds from the property tax are used first to cover the program costs, once those are exhausted UHS administrators rely on DSH funds to "fill the holes." Although, Bexar County has not cut its property tax for indigent care in recent years, it has not increased it. However, the number of uninsured in the county has increased. As a result, the share of uninsured expenses covered by the property tax funding has declined in recent years. According to UHS staff, property tax revenues use to cover about 50 percent of uninsured care expenses but now cover only about 25 percent. Consequently, UHS has looked to the DSH program to make up shortfalls in the CareLink program. In 1997, for example, CareLink's shortfalls totaled about \$7 million and in 1999, about \$15 million.

Other Sources. In addition to property tax revenue and Medicaid DSH funds, CareLink also receives funding from patient collections—both regular monthly payments and co-payments. Prior to CareLink's implementation there were very few uninsured patients that contributed toward the cost of their care. One of the successes of CareLink is that it has substantially improved collections from uninsured patients: In 2000 it is estimated that patients collections from the uninsured will total about \$8 million up from \$2.4 million in 1996, the year before CareLink was implemented.

DESIGN OF THE CARELINK PROGRAM

Organizational Structure. *CareLink* is within University Health System’s Tax Division program, as the majority of its funding is derived from county property taxes. *CareLink*’s main office is located at the University Health Center Downtown. Members can receive primary and preventive services at the University Health Center Downtown as well as four other UHS clinics. Inpatient and specialty services are offered at University Hospital.

Eligibility. To be eligible for *CareLink*, individuals must be residents of Bexar County. Residency is defined as having an abode in the county and intent to stay. There are no income eligibility requirements, as those with higher incomes are just required to pay larger portions of their medical bills. As shown in Table 5-1, most of the 68,369 current members are low income residents, with only a small percentage (7 percent) earning more than 185 percent FPL.

CareLink administrators acknowledged that the program does have some problems with adverse selection. Program participants, by definition, are services users. Indeed, patient information reveals that many *CareLink* participants are chronically ill, with the biggest diagnosis categories being mental illness and diabetes. In addition, higher income members tend to have serious medical conditions that prevent them from getting private health insurance.

Table 5-1: CareLink Demographics, August 2000

Ethnicity:	Percent	Percent of Poverty:	Percent
Hispanic	79%	Less than 75 % FPL	23%
White	13%	76-150% FPL	59%
Black	6%	151-185% FPL	11%
Other	2%	Greater than 186 % FPL	7%
Age:	Percent	Gender:	Percent
0-12	12%	Male	44%
13-18	8%	Female	56%
19-34	24%		
35-64	49%		
65+	7%		

Outreach and Enrollment. In order to qualify for *CareLink*, individuals must bring proof of identification for every household member, proof of residency, and total household income for past 30 days. There is no screening for immigration status. Residents interested in applying for *CareLink* can apply at the *CareLink* main office, which is the largest enrollment center with 15 eligibility workers, or at one of 7 other sites including 3 federal qualified health centers (FQHCs). While residents can complete a mail-in application, most apply in person when in need of services.

The *CareLink* application process includes screening for other health programs individuals may be eligible for. If someone in the household is eligible for Medicaid or Children

Health Insurance Program (CHIP) a 60-day enrollment into *CareLink* is granted during which they are supposed to apply for Medicaid and/or CHP. If a child is found eligible and the parents fail to apply within the 60-day window, the family is disqualified from *CareLink*. UHS administrators and the Board of Managers feel that children should not be denied medical care if the parents fail to enroll him/her in the proper program. Therefore, children in these families will continue to have access to services but the parents will be billed full charges and normal collection policies are followed.

Membership in *CareLink* is one year, except for those with fixed incomes who are granted two-year membership. Members receive notification in the mail 90, 60, and 30 days prior to their redetermination date. *CareLink* administrators noted that most of the mail-in applications they receive are for redetermination.

Benefits. As mentioned earlier, *CareLink* benefits were designed to include a comprehensive array of primary, preventive, specialty, and inpatient services. Among other things, *CareLink* participants can purchase at a discounted rate preventive care services, family planning, primary and specialty care, drugs, and mental health services (see Table 5-2). The level of payment is determined by the MFL formula set out above.

CareLink administrators began a benefit authorization process in 1998 to monitor compliance with the schedule of benefits and assess medical necessity. In 1999, benefit authorization became mandatory for all outpatient services costing more than \$250 and for other procedures defined in a protocol made available to all participating physicians. The benefit authorization process has enabled *CareLink* to better manage its costs.

In addition to implementing a benefit authorization process, *CareLink*'s efforts to enroll patients in Medication Assistance Programs—whereby pharmaceutical companies provide selected drugs for free—has reaped significant savings. Many of *CareLink*'s members are diabetics or have mental health problems—as mentioned above—which require frequent or ongoing medication utilization. Other members require medication that is particularly costly, such as drugs for Hepatitis C. *CareLink* receives about \$300,000 per month in medical assistance.

Mentioned earlier, NurseLink, a 24-hour nurse-staffed hotline, is another means to foster efficient use of medical services. NurseLink operators answer members' questions and can make doctor appointments, thereby deterring inappropriate emergency room use. NurseLink is so popular, receiving 2-4,000 phone calls per day, that they are currently working on a guide for members which discusses the 25 most common reasons people call NurseLink and appropriate protocols to follow.

Table 5-2: *CareLink* Benefits²⁰

²⁰ *CareLink* Member Handbook, 1999

Benefit	Description
Preventive Care	Well child care, physical exams, mammography
Physician Services	Primary and specialty care
Family Planning	Sterilization and birth control
Medical Services and Supplies	Radiation therapy, chemotherapy, allergy testing and serum, x-rays and lab testing, dialysis
Hospital Inpatient	All inpatient covered services and supplies, intensive care unit stays, physician charges, oxygen, lab services, x-rays
Outpatient Services	Clinic visits and outpatient surgery
Health Education	Nutritional/dietetic counseling
Mental Health Services	Inpatient facility and service charges, day treatment facility, outpatient visits for intervention and evaluation
Emergency Room	Physician services and supplies
Pharmacy	Approved list of medications with some restrictions

Service Delivery. Physicians are paid generously under *CareLink*: 100 percent of the Medicare fee schedule, plus an additional 15 percent performance bonus if they meet certain quality standards—for example, appointment wait time, provision of preventative care and the like. *CareLink* administrators purposefully paid physicians high rates to encourage them to see their patients. Historically, uninsured persons have experienced very long waits before a doctor saw them. Typically, according to *CareLink* staff, they would arrive in the morning and plan to spend the day. Now wait time has improved (i.e., there used to be a 4-hour wait for the eye clinic, but it is now a 1.5-hour wait).

Cost Sharing. An applicant’s maximum family liability over four years (including monthly payments and co-payments for pharmacy and emergency room) are assessed at the time of enrollment and reviewed annually. As previously mentioned, maximum family liability over 4 years is determined by the formula:

$$\text{MFL} = (11\%) (\text{annual family income}) (\text{FPL index})$$

Because *CareLink* is a financial assistance plan and *not* an insurance plan, members do not receive monthly statements or have any financial obligation until they actual use services and incur a charge. Once a member incurs a charge, their account balance will be their maximum family liability or actual charges, whichever is less. For example, an individual member at 75 percent FPL would have a 4-year maximum liability of \$495, with monthly payments of \$10.31, no pharmacy copayment, and a \$0.25 emergency room copayment. Table 5-3 provides an example of how the program would work for an individual at 75 percent FPL.

Table 5-3: Example of Financial Assistance Provided to a CareLink Individual Member, Income of 75% FPL²¹

Scenario	Member Cost-Sharing Responsibility
January clinic visit charge	\$25.00
February payment due	\$10.31
March payment due	\$10.31
April payment due	\$4.38
April hospital stay	\$10000.00
Paid coverage by tax dollars	\$9505.00
Member's CareLink account balance	\$495.00
Monthly payments for 4 years	\$10.31
Medicine cost	\$30.00
Copayment at time medicine is received	\$0
Added to CareLink account	\$30.00
Emergency room charge	\$100.00
Copayment at time of ER visit	\$0.25
Added to CareLink account	\$99.75

THE FUTURE

UHS administrators see several potential changes to *CareLink* in the near future, largely owing to declines in funding for the uninsured. Most prominent is the decrease in DSH funding. Between 1996 and 2000, UHS Medicaid DSH payments have dropped by 40 percent. The decline has occurred for two reasons—the BBA DSH cutbacks and loss of Medicaid patients because of the shift to Medicaid managed care. (Texas distributes its DSH dollars to hospitals based on a formula that takes into account both indigent and Medicaid inpatient days. As Medicaid recipients move into commercial health plans are treated in private hospitals, an increasing share of DSH funds are going to private hospitals and away from public hospitals such as UHS.) Given *CareLink*'s reliance on DSH for funding, the continued loss of DSH dollars has important implications for the program. Further, UHS staff do not see that Bexar County officials will increase the property tax to offset the DSH cutbacks. Like many other places, the political will to increase taxes is lacking.

With cutbacks in DSH and no increase in property tax in sight, *CareLink* administrators have considered several programmatic changes, such as:

- applying income eligibility limits to say 200 percent of FPL;
- making the schedule of benefits more restrictive;
- imposing more co-payments;
- reducing physician reimbursement; and
- capping program enrollment.

²¹ CareLink Member Handbook, 1999

Another strategy UHS staff has contemplated is cutting back on services for non-CareLink uninsured persons. Such a cutback would help preserve the integrity of CareLink. At the same time, it may encourage more of the uninsured to participate in CareLink.

As of the time of our visit, it was not clear what course UHS would follow. While staff did not feel that they would dismantle the CareLink program and return to emergency care only for the uninsured, they did feel that UHS financial picture was bleak enough—last year UHS had losses of \$14 million—that some fundamental changes would be required in the near future.

Chapter 6

PLUSCARE AND HEALTHCHOICE (WAYNE COUNTY, MI)

By Brian Bruen and Stuart Guterman

Overview. Wayne County has two innovative service-based health care programs to increase access to health care for low-income residents: PlusCare and HealthChoice. The programs are the latest installments in a long history of efforts by Wayne County to provide health care for indigent residents. Both programs target specific groups of low-income residents who do not qualify for health coverage under other public programs such as Medicaid or Medicare. PlusCare targets the non-elderly, adult indigent population—people ages 19 through 64, with net incomes of \$250 or less per month.²² HealthChoice targets low-income workers in companies that 1) do not offer health care benefits, 2) pay 50 percent or more of their employees less than \$10 per hour, and 3) have at least three employees eligible for HealthChoice.

PlusCare and HealthChoice use managed care approaches to deliver services to program participants. Participants in both programs receive a wide array of services, including inpatient and outpatient hospital care, physician services, lab and x-ray services, home health care, and pharmaceuticals. In addition to these services, both PlusCare and HealthChoice offer additional services tailored to the needs of their respective populations and the goals of each program. PlusCare is free to all participants. By contrast, HealthChoice charges premiums (\$126 per month for an individual as of September 2000) which are spread equally among employers, participating employees, and HealthChoice. PlusCare serves roughly 30,000-35,000 people annually, and HealthChoice had over 20,000 members as of September 2000.

The Safety Net in Wayne County. Wayne County is a large metropolitan county in southeast Michigan that includes the City of Detroit. Its population in 1998 was 2,116,540, which made it the most populous county in Michigan and one of the most populous in the country. Detroit accounts for about one-half of the county's population, but there are sharp differences between the populations in Detroit and in the rest of Wayne County. For example, Detroit's population is about 80 percent black, while the population in the county as a whole is less than 50 percent black (implying that the rest of the county is only about 15 percent black).

The City of Detroit has no public hospital, and local funding for the safety net in Detroit is scant. The safety net consists mostly of large hospital systems; there are relatively few clinics and federally qualified health centers. The city government provides substantial funding to the local health department, but it provides no funding to local safety net hospitals. There also is relatively little coordination between the city and county governments, particularly for indigent health services.

By far, the largest volume of safety net services in Wayne County are performed by the Detroit Medical Center (DMC) system, which includes what used to be the city hospital and

²² PlusCare eligibility is determined on an individual basis. Household income is equally divided among the recipients of that income. A \$90 standard work expense is deducted from monthly income. Child support payments are not counted as earned income, and Social Security payments issued to any household member other than the applicant are not counted as earned income.

several other hospitals in the area. The DMC system accounts for 19 percent of total inpatient days in the Detroit area, but it accounts for almost one-third of all Medicaid inpatient days. The DMC system, however, has lost a large amount of money over the past few years.²³ Other hospital systems in the county provide inpatient and outpatient indigent care services, but roughly in proportion to their size. There is virtually no coordination of indigent care among the hospital systems. There is also no cohesive system of community clinics. Indeed, several of the large hospitals in the area have recently closed or sold the clinics they had opened or purchased in previous years.

The Detroit area has not benefited from the general economic boom that has been enjoyed throughout the country: the proportion of the population in families with incomes less than 200 percent of poverty was about the same in 1999 as it was in 1997, and the proportion of the area's low-income population that had no health insurance coverage increased between 1997 and 1999.²⁴ These discrepancies between the general improvement in economic conditions and the situation in the Detroit area are thought to be even sharper when the City of Detroit is considered apart from the rest of the metropolitan area. This combination of circumstances—the persistence of economic problems in the City of Detroit and the lack of a well-developed and strongly supported safety net in the city—means that programs like PlusCare and HealthChoice are extremely important for access to care in their communities.

DEVELOPMENT OF PLUSCARE AND HEALTHCHOICE

The origins of Wayne County's current indigent care programs date back to the Welfare Public Act 280 of 1939, which required that county governments in Michigan provide funds to cover services for indigent residents. For many years, Wayne County's commitment to indigent care consisted of the Resident County Hospitalization (RCH) program, which paid for inpatient hospital care provided to indigent county residents. The costs for the RCH program escalated in the late 1970s and early 1980s, reaching \$30 million in 1982—an amount equal to 30 percent of total property tax collections. In response, the state authorized Wayne County to create the Patient Care Management System (PCMS), a division of the county's Office of Health and Community Services that was given the task of holding down the costs of the RCH program. Costs, however, continued to rise.

Meanwhile, the state was spending \$42.5 million per year for medical care provided to Wayne County residents through the state's then-operating General Assistance (GA) income-support program. In 1987, Wayne County received permission to combine the RCH and GA medical programs under the administration of the PCMS. This new program, called County Care, was implemented in October 1988. Most of its participants came from the GA medical program. County Care used a managed care approach to coordinate care to its members and to control indigent care utilization and costs. A total of \$58 million was allocated to this program, including \$42.5 million from the state (the same as its contribution under the GA program) and

²³ See N. Brennan, S. Guterman, and S. Zuckerman. *How Are Safety Net Hospitals Responding to Health Care Financing Changes?* Washington, DC: The Urban Institute, forthcoming.

²⁴ Urban Institute analysis of the National Survey of American Families, 1997 and 1999.

\$15.5 million in county funds. The decrease in county funding (relative to the \$30+ million that it had been paying for the RCH program) represented anticipated savings from managed care.

In 1991, the state faced a budget deficit of more than \$1 billion. In response, the state eliminated the GA program and its associated medical programs, including the state's funding for the County Care program. The PCMS encouraged providers to continue serving the GA population, and worked with county officials to lobby the state to restore funding. By April 1992, the state's budget had stabilized and the county's lobbying efforts paid off as the state agreed to fund a new indigent care program in Wayne County called PlusCare. PlusCare was essentially the same as County Care, except it received Medicaid funding through a newly designed upper payment limit (UPL) arrangement. As discussed below, this arrangement substantially lowered the state's financial commitment to indigent care in Wayne County, with federal Medicaid funding making up for most of the drop in state funding.

In 1993, Wayne County sought to further expand access to care by developing a program for the uninsured, working poor. In collaboration with the medical and hospital communities, the county established a new employer-based program, HealthChoice. This program, also administered by the PCMS, began enrolling members in May 1994 under Michigan's Municipal Health Facilities Corporation Act, which authorizes certain local governmental units to establish, modify, operate, and manage health services. It was the first such program in the state.²⁵

FUNDING FOR PLUSCARE AND HEALTHCHOICE

As mentioned above, when PlusCare was implemented in 1992, it received Medicaid funding through a UPL arrangement. (By contrast, PlusCare's predecessor program, County Care, did not receive Medicaid funding. It relied solely on state and local financing.) Seeking to limit the state's financial commitment to PlusCare, Michigan officials looked to Medicaid as a financing source. In 1992, Michigan did not have room under its federal DSH cap because it was still making substantial DSH payments to the University of Michigan hospital system. However, the state was able use a UPL financing mechanism, which at the time was a new type of arrangement. Working with consultants, the state developed a special "Outpatient Hospital Adjustor" payment within Medicaid that would be made to certain hospitals in addition to the state's usual reimbursement without counting against existing DSH caps. The state defined eligibility for these special UPL payments such that only seven Wayne County hospitals could qualify to receive them.

The financing for PlusCare worked as follows. In 1992, the state allocated \$7.5 million for PlusCare (down from \$42.5 million per year for its predecessors), conditional upon receipt of \$15.5 million in county funds provided to the state through an intergovernmental transfer (IGT). However, the state used the combined state and county funds (\$23 million) to make the Medicaid UPL payments, generating \$28 million in federal Medicaid funds and making a total of \$51 million available to fund PlusCare.

²⁵ Muskegon County also has a program operating under the authority given by this law.

By using the UPL mechanism, the state was able to restore most of Wayne County's indigent care funding while cutting the state's share of the cost by \$35 million (\$42.5 million - \$7.5 million). This deal was beneficial to Wayne County, even without a reduction in its outlays, because the \$35.5 million in outside funds (\$7.5 million from the state and \$28 million in federal matching funds) allowed county officials to enact PlusCare at a time when they were facing a discontinuation of their ability to provide indigent care.

The hospitals receiving the UPL payments agreed to pool these monies together and allow a fiduciary to manage the funds, which would be used to finance PlusCare. There were incentives for the hospitals to participate. The managed care approach used by PlusCare offered the potential to reduce the amount of costly emergency room care and improve the health status of the low-income population, and at the very least it would pay for hospital services provided to many indigent patients, which would reduce uncompensated care costs for the hospitals. In addition, it was agreed that some of the pooled funds would be used to make additional "indigent volume adjustor" payments to the participating hospitals (who argued that they would still provide care to uninsured people who did not participate in PlusCare).

For example, Detroit Medical Center initially received additional payments of about \$5 million as part of its agreement with UHCP (this amount has since been reduced). A non-profit organization called Urban Hospital Care Plus (UHCP) was created to act as the fiduciary for PlusCare. When HealthChoice—PlusCare's sister program that provides services to the uninsured working poor—was implemented in 1994, it was funded by the same funding pool, with UHCP playing a similar fiduciary role.

For state fiscal year (SFY) 1996, total funding for Wayne County's programs was cut from \$51 million to \$44 million for political and financial reasons. Under the reduced budget, the state contributed \$4 million, the county added \$15 million, and federal Medicaid funding accounted for the remaining \$25 million. The compromise also lowered income eligibility for PlusCare, which was originally \$600 per month, to the current limit of \$250 per month, which reduced the number of participants in the program.

From 1996 through 2000, total funding for PlusCare and HealthChoice remained at \$44 million. Then, in 1999, keeping funding levels constant, the state shifted the funding for Wayne County's programs from UPL payments into its Medicaid DSH program. The state's extensive use of UPL financing for other purposes had opened up room under the state's DSH cap for this funding. Furthermore, by shifting funding for PlusCare and HealthChoice to the DSH program the state could make an additional \$50 million in UPL payments to Hurley Hospital in Flint.²⁶ In 2000, about \$36 million of Wayne County's indigent care funding was used for PlusCare and the remaining \$8 million for HealthChoice. The total funding consisted of \$15.0 million in county funds, \$4.7 million in state funds, and \$24.3 million in federal funds.²⁷ In 2001, the state added

²⁶ The Wayne County payments originally were made as Outpatient Adjustor Payments, which are a type of UPL arrangement. While the amount that can be paid to individual hospitals is limited for inpatient care, there is no hospital-specific limit on the outpatient side. So the entire difference between the outpatient UPL and outpatient payments for all hospitals (other than state hospitals) was paid to Hurley Hospital in Flint.

²⁷ These figures do not include the additional funds available from the employers' and employees' shares of HealthChoice premiums, which account for two-thirds of the total premium, and copayments by PlusCare and HealthChoice participants.

approximately \$3 million in tobacco settlement funds to the state's appropriation for the Wayne County programs to help cover the growing cost of HealthChoice (as discussed below). This increased the total budget for the programs by \$6 million with the additional federal match.

DESIGN OF PLUSCARE

PlusCare was designed to provide access to medical care for the medically indigent residents of Wayne County. PlusCare is not considered insurance—it is essentially a service program with an established network of providers. The primary objectives of the program are to reduce non-urgent emergency room visits and to promote preventive care for its participants.

Organizational Structure. PlusCare is administered and marketed by the PCMS under contract from UHCP. The PCMS monitors eligibility standards and covered services, ensures that participating residents have access to providers, and provides certain gate-keeping functions, including eligibility and enrollment determination. The PCMS Director and Deputy Director oversee the preparation, negotiation, and implementation of provider contracts and other program operations. Three health care organizations contracted with UHCP to provide medical services to PlusCare participants. These organizations offer services to PlusCare participants at more than 250 primary health care sites. A fourth organization provides dental services at six locations throughout Wayne County. All of the providers use a managed care approach to deliver services, and receive a capitated monthly payment.

Target Population. To be eligible for PlusCare, an applicant must be a Wayne County resident, age 19-64, with a net monthly income of \$250 or less. PlusCare eligibility is determined on an individual basis. Household income is equally divided among the recipients of that income, and a \$90 standard work expense is also deducted from monthly income. Child support payments are not counted as earned income, and Social Security payments issued to any household member other than the applicant also are not counted as earned income. Participants must not be eligible for coverage through Medicaid, Medicare, or any other program. Original actuarial estimates were that as many as 150,000 people might qualify for PlusCare.

After Michigan eliminated its medical program for GA recipients in 1991, the state established a small residual State Medical Program (SMP) for some of the people who lost coverage. The SMP covers limited services for certain poor, disabled individuals and families with children ineligible for SSI or AFDC. These people typically have a medical problem, a physical or mental impairment, and very low income (e.g., a max of \$264 per month for individuals living independently). As it did with County Care and its predecessors, the state enrolls SMP-eligible people in PlusCare.

Outreach and Enrollment. The PCMS performs the functions of recruitment, enrollment, and data collection for PlusCare. The PlusCare Eligibility and Enrollment Division is the component of the PCMS that recruits and enrolls program participants. It serves as the primary liaison to the Wayne County community, representing the program to various local health and social services agencies, churches, community groups, and health care organizations. Its functions include locating potential members; distributing promotional literature, enrollment forms, and other written or printed materials relevant to the program; and making presentations to interested groups. The Eligibility and Enrollment Division also receives monthly enrollment

data from Michigan's Family Independence Agency (FIA), the state agency that determines eligibility for the SMP participants that are enrolled in PlusCare. About two-thirds of PlusCare enrollees sign up through the FIA; the remainder are enrolled by the PCMS through its outreach efforts.

In addition to in-office enrollment, the PCMS maintains several sites around Wayne County where people can sign up for PlusCare, including the emergency rooms at several major safety net hospitals in the area, as well as the Detroit Health Department. About 10,100 people were registered at these sites during 1998-99, of which about 6,200 were new enrollees and another 2,600 were people that were recertified as eligible and subsequently enrolled (about 1,300 turned out not to be eligible for the program).

Benefits and Cost-Sharing. PlusCare provides a range of medical, dental, and preventive care to members through contracts with three provider networks for medical care and one for dental care. Participants are eligible to receive physician services, outpatient services, hospitalization, home health care, prescriptions, vision and hearing services, and dental care. Participants needing mental health or substance abuse services are referred to Detroit-Wayne County area substance abuse treatment programs, where care is coordinated between the PlusCare contractors and the Detroit-Wayne County Community Mental Health Agency. There are no premium or co-payment requirements for PlusCare participants for any of the covered services.

Service Delivery and Payment. PlusCare uses a managed care approach to deliver and pay for services. Participants are assigned to a health provider by the zip code of their residence. All members are covered under the same dental program. The provider organizations are paid a monthly capitated amount based on the number of members they are assigned. The providers are encouraged to emphasize primary and preventive care because they assume the financial risk for these patients.

Providers encourage appropriate service use through health care classes and wellness counseling. PlusCare providers also use prior authorization for services, an assessment of medical necessity, and various cost containment measures. A quality assurance program also is in place, involving efforts by both the PCMS staff and the contracting provider networks to monitor care at both the individual patient and the facility level. This approach encourages appropriate utilization of services while enabling both providers and the organizations that run PlusCare to remain within their respective annual budgets.

DESIGN OF HEALTHCHOICE

HealthChoice is an employer-based program that was established to provide affordable medical services for low-income working residents of Wayne County. The program is designed to prevent low-income workers from becoming too sick to work, forcing them into Medicaid, PlusCare, or no coverage at all. It also is designed to reduce the number of low-income, working uninsured people that seek care in inappropriate settings—particularly hospital emergency rooms—and are unable to pay the resulting fees.

Organizational Structure. HealthChoice was the first program in Michigan established under the state's Municipal Health Facilities Corporation Act of 1987. This law authorizes certain local government units to establish, modify, operate, and manage health services with major medical providers and county government. Like PlusCare, HealthChoice is not insurance—it is a service-based program funded through UHCP. Services are offered to participants through five provider networks that contract with UHCP. Local insurance companies that also offer commercial products run these networks, but all five networks are legally separate organizations established by these companies solely to serve HealthChoice participants. UHCP contracts with a third party administrator (TPA) to manage all daily activities in the program, including billing, premium collection, customer services, and maintaining enrollment records. The PCMS provides outreach and marketing services for the program.

Target Population. HealthChoice is designed to provide affordable medical services for low-income workers. To qualify for HealthChoice, a company must:

- be located in Wayne County (although enrollees do not have to live in the county);
- have a work force of which at least 50 percent earn \$10 per hour or less;
- employ at least three people who are eligible for coverage; and,
- not have provided health insurance for the past 12 months.

Individual employees of the company qualify for HealthChoice if they are uninsured and ineligible for other health programs, work an average of 20 hours per week or more, and plan to work for more than five months. These provisions allow segments of a company's work force to be eligible for the program even if all employees are not. For example, a restaurant that offers health insurance to its managers but not its wait or kitchen staff can enroll those workers in HealthChoice if those particular employees meet the eligibility requirements. The managers, however, would not be eligible because they are already offered other coverage.

Enrollment and Outreach. Most of the outreach for HealthChoice consists of advertising and other marketing from the PCMS and the participating providers. The TPA that administers the program screens each interested business to determine whether the company is eligible for HealthChoice. Enrollees sign up for HealthChoice through their employers, who forward the enrollment information to the TPA. The TPA maintains enrollment lists for providers and monitors eligibility.

Benefits and Cost-Sharing. HealthChoice members are eligible to receive a variety of basic medical services, including physician services, hospital outpatient services, hospital inpatient services (up to 20 days per patient per year), emergency health services, ambulance services, prescription drugs, diagnostic lab and x-ray services, and home health care. HealthChoice also pays for out-of-area emergency health care, subject to certain limitations. Depending on the employer and the provider network, employees may receive other services (at additional cost) such as unlimited hospitalization, vision exams and eyeglasses, outpatient physical therapy, dental care, durable medical equipment, and inpatient drug and alcohol rehabilitation services. During the period between May 1994 and July 1996, almost 80 percent of participating businesses offered at least one (and in most cases several) of the optional riders:

60 percent offered unlimited hospitalization, 56 percent vision exams and eyeglasses, 39 percent outpatient physical therapy, 37 percent dental care, 31 percent offered durable medical equipment, and 10 percent inpatient drug and alcohol rehabilitation services in addition to the basic package of services.

The basic package of services costs \$126 per month for an individual employee. Employees can enroll a spouse or additional dependents in the program for a higher premium, with full family participation (employee, spouse, and one or more dependents) costing \$360 per month. The optional riders are nominally more expensive. For example, family eligibility for vision exams and eyeglasses costs \$6.06 per month (1.7 percent more than basic coverage), and family eligibility for unlimited inpatient hospital days costs \$17.74 (4.9 percent more than basic coverage). HealthChoice, the employer, and the employee each contribute one-third of the cost of the premium, regardless of the number of optional services that the participant is eligible to receive (see below). The employer and employee premiums are guaranteed not to rise faster than the Consumer Price Index.

Under the basic plan, physician services and home health care require copays of \$5 per visit, but hospital inpatient services (up to the coverage limit) and hospital outpatient services do not require copays. Diagnostic lab, radiology, and ambulance services also do not require copays. Non-urgent use of emergency health services is discouraged by copays of \$25 (for a participating provider) or \$75 (for a non-participating provider) if the patient is not admitted to the hospital. Prescription drugs require copays of \$5 per prescription for generic drugs and \$10 for brand name drugs.

Service Delivery and Payment. HealthChoice uses a managed care model to deliver medical services to program participants. As in PlusCare, members are linked with a primary care physician, who refers patients to specialty care or other services when needed. There are hundreds of physicians in the five participating health care networks, with locations throughout the Detroit-Wayne County area. The provider organizations receive a capitated monthly payment based on the number of HealthChoice participants assigned to that network. The TPA collects the employer and employee shares of the premium from each participating business, receives the county's share from UHCP, and forwards the entire premium to the provider with the monthly list of program participants. Because the provider organizations assume the financial risk for HealthChoice participants, emphasis is placed on primary and preventive care and disease management, including screening and follow-up care for members with chronic conditions or episodic illness.

PARTICIPATION IN PLUSCARE AND HEALTHCHOICE

Enrollment in PlusCare was 42,000 when it began in 1992. The initial income eligibility level for the program was \$600 per month, but that level was reduced to \$250 in 1996 when the state reduced its funding. The new eligibility criteria reduced monthly participation to about 38,000 people. Over the next few years, participation in PlusCare continued to tail off. By October 1999, there were 31,344 enrollees in PlusCare. Most (55 percent) of these participants were male. A majority (55 percent) of participants was age 41-64, and nearly two-thirds of all enrollees were SMP-eligible people enrolled in PlusCare by the state.

As of March 2000, almost 1,800 companies were participating in HealthChoice, with just over 17,000 individuals (employees, spouses, and dependents) enrolled. By September 2000, participation had increased to about 2,100 companies and just over 20,000 individuals, including 11,000 employees and 9,000 spouses and dependents. Of the 11,000 employees enrolled, about 55 percent were male and 45 percent female; about 65 percent had employee only coverage, 7 percent employee and spouse, and the rest at least one dependent. The average hourly wage of participating employees was \$7.33 in March 2000.

In 1996, the PCMS conducted a study of companies participating in HealthChoice. The results of 150 interviews with participating companies indicated that affordability of the program was the single most important factor attracting customers to HealthChoice. Companies also felt that the availability of HealthChoice aided them in recruiting and hiring workers, and increased employee retention. These interviews also reflected high customer satisfaction due to the low cost of premiums, the level of coverage and benefits provided, modest co-payment requirements, relatively small amounts of paperwork, availability of supplemental benefits, and quality of care from participating providers.

VISION FOR THE FUTURE

The local programs being run by Wayne County are thriving. PlusCare is expected to maintain its current level of enrollment in the future at a cost of about \$36 million per year. Enrollment is growing in HealthChoice at a rate of 600 covered lives per month, and the annual cost is roughly \$8 million. By 2001, HealthChoice plans to have more than 30,000 participants at a cost of over \$12 million. To support such an enrollment increase, the county had to find additional funding. The state came through, allocating \$3 million in state funds from the tobacco settlement to increase total program funding to \$50 million and fulfilling Wayne County's short-term need for more funding.

Over the long term, it may be hard for Wayne County's programs to increase—or even maintain—their current level of funding. In recent years, Michigan challenged communities to set up organized systems of care for low-income populations that provided defined benefits. PlusCare and HealthChoice are now among several operational programs in the state. The others are Muskegon County and Ingham County (which is described in another chapter in this report). These counties have implemented different programs to expand access to care for their indigent populations, and all three have worked with the state to acquire federal funding through either Medicaid UPL and DSH programs to support their attempts to do so. Other counties have potential programs in the planning stages. Although the state has budgeted \$10 million in grants to communities to design these programs, the addition of these programs will place additional demands on a limited amount of state funding.

Recent federal regulations affecting Medicaid UPL and DSH programs adds further uncertainty concerning the long-term viability of PlusCare and HealthChoice funding. Federal regulations published in January 2001 allowed the caps on Medicaid DSH payments to grow (earlier legislation imposed cutbacks amounts through 2002), but this growth will be limited. In addition, the regulations imposed new restrictions on UPL payments. One estimate by the state

made prior to the release of the final rules stated that Michigan stood to lose as much as \$700 million in federal, state, and local revenue used to fund Medicaid services.²⁸ In previous years, Michigan has been successful in developing alternative strategies to maintain or even increase federal funding when federal restrictions have affected special financing arrangements (the state was one of the first states to turn to UPL payments when DSH use was curtailed). It is not clear that the state can find ways to make up for the projected losses in the future.

In summary, PlusCare and HealthChoice seem to be sufficiently funded for the next couple of years but their long-term future is more difficult to predict. There is a growing constituency for programs such as PlusCare and HealthChoice due to their increasing size and implementation of similar programs around the state. Nevertheless, during recent visits with the state, Medicaid and budget officials suggest that, if faced with significant shortfalls, one of the recommendations would be to eliminate DSH programs for non-Medicaid populations.

²⁸ See Fairgrieve, Bill. "Medicaid Special Financing Payments and Intergovernmental Transfers." *Fiscal Forum* Volume 6, Number 1 (Lansing, MI: House Fiscal Agency, November 2000).

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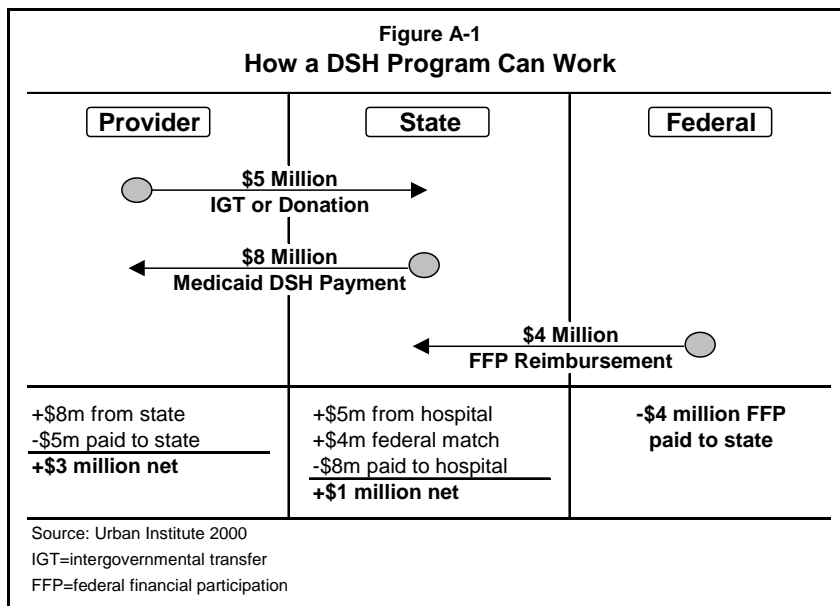
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Appendix A

HOW A DSH PROGRAM CAN WORK

APPENDIX A: AN EXAMPLE OF HOW A DSH PROGRAM CAN WORK

Figure A-1 shows a hypothetical plan for a DSH program. The hospital in this example is located in a state with a 50 percent Federal Medical Assistance Percentage (FMAP), which means that the federal government will reimburse the state for half of the state's Medicaid expenditures. Now assume that the hospital makes a "donation" of \$5 million to the state's Medicaid fund, and in return receives \$8 million in Medicaid DSH payments from the state. At this point, the state is "out" \$3 million. However, the state receives \$4 million in federal financial participation (FFP) for the \$8 million in DSH payments made by the state to the hospital (the \$8 million paid to the hospital, multiplied by the state's FMAP of 50 percent). The result of these transactions is that the hospital nets \$3 million (\$8 million from the state, less the \$5 million "donation") and the state nets \$1 million (\$9 million from the hospital and federal government, less \$8 million paid to the hospital). In effect, the federal government contributes \$3 million to the hospital and \$1 million to the state treasury and the state does not expend any of its own funds to get this federal money.



Appendix B

PEOPLE INTERVIEWED FOR THIS STUDY

APPENDIX B: PEOPLE INTERVIEWED IN STUDY SITES

Denver Health

Frank Barrett, Denver Health
Peg Burnette, Denver Health
Ray Coffey, Colorado Department of Health Care Policy and Financing
Peter Freytag, Colorado Hospital Association
Jim Rizzuto, Colorado Department of Health Care Policy and Financing
Alexis Senger, Joint Budget Committee

Wishard Advantage Program

Melanie Bella, Netgov.com, Inc.
Loretta Day, Westside Health Center
Betty Dinius, Wishard Health Services
Doug Elwell, Health and Hospital Corporation of Marion County
John Fitzgerald, Indiana University Medical Group
Katie Humphreys, Indiana Family and Social Services Administration
Shirlen Johnson, Westside Health Center
Vicki Lamar, Indiana University Medical Group
Charlotte McBeth, Central Indiana Managed Care Organization
Susan Jo Thomas, Health and Hospital Corporation of Marion County
Yvonne Walker, Westside Health Center
Katherine Wentworth, Central Indiana Managed Care Organization
Seema Verma, Health and Hospital Corporation of Marion County

Ingham Health Plan

Joanne Adrian, Ingham County Health Department
Doak Bloss, Ingham County Health Department
Jennifer Dalton, Ingham County Health Department
Eileen Ellis, Health Management Associates
Lee Hladki, Ingham Regional Medical Center
Denise Holmes, State of Michigan Department of Community Health
Carol Isaacs, State of Michigan Department of Community Health
Bruce Miller, Ingham County Health Department
Laura Peterson, Ingham County Health Department
Katherine Quick, Ingham Health Plan Corporation Board of Directors (IHP client)
Paul Reinhart, State of Michigan Office of the State Budget
Jay Rosen, Health Management Associates
Robert Smedes, State of Michigan Department of Community Health

PlusCare, HealthChoice

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