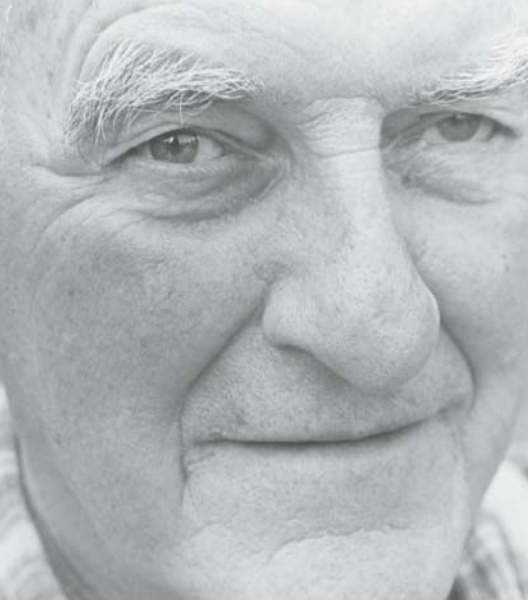
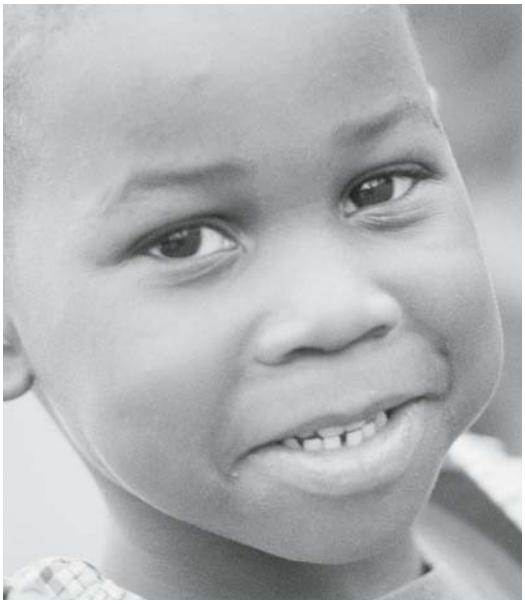


Making Coverage for the Uninsured: The Role of Community Initiatives

prepared for

Andrew Young School of Policy Studies
Georgia Health Policy Center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January 2005

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Working Paper 05-01
January 2005

Making Coverage for the Uninsured:

The Role of Community Initiatives

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Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and should not be attributed to The Commonwealth Fund or its directors, officers, or staff.

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reimbursement rates have created a more difficult environment for local initiatives to recruit and sustain provider volunteerism. Similarly, in states and communities where private insurance plans have negotiated low rates or raised enrollee cost sharing (potentially contributing to provider bad debt), local initiatives may have more difficulty relying on volunteer providers.

Where public and/or private reimbursements are frozen and reduced eligibility or higher premiums increase the number of uninsured, community initiatives may find it especially difficult to succeed. This combination of circumstances appears largely to explain the problems that each local initiative has experienced in serving undocumented immigrants.

However, many local initiatives appear to have succeeded in various and important ways despite significant challenges. They represent a potentially important link in the nation's pluralistic approach to health care financing. Gaps in coverage are most visible at the local level, where approaches to bridging gaps can be most tailored to local circumstances.

Greater resources could be devoted to cultivating community initiatives that demonstrate basic components for success—including strong leadership and capacity to adapt strategically to state and local context. However, to argue for greater resources, more compelling evidence of their success is needed. Without rigorous and systematic evaluation evidence, it is impossible to gauge their real potential for ensuring access to care for the uninsured.

List of Tables and Figures

Executive Summary

As health care costs and the number of uninsured Americans continue to increase, community initiatives across the country are steadfast in their efforts to bridge the growing gap between public and private health insurance coverage. This report summarizes an 18-month research study of five initiatives—in Wichita, Kansas; Paris, Arkansas; Milwaukee, Wisconsin; Olympia, Washington; and Forsyth, Georgia. Selected because of their geographic and operational diversity, each of these initiatives attempts to provide coverage and/or access to care to individuals, who have difficulty finding or navigating conventional insurance arrangements and public programs. The purposes of the study were to:

a. Describe these initiatives' efforts to increase coverage or access and the impact of these efforts on their target populations.
b. Examine the cost effectiveness and efficiency of their operations.
c. Identify the factors that enhance or challenge their sustainability and expansion of the initiatives.
d. Understand the lessons for their replication.
e. Examine how states and communities cooperate to close gaps in funding and access.

Access and Coverage

All five local community initiatives attempt to provide access and coverage to a specific population: nonelderly adults. Most limit the duration of enrollment and offer comprehensive benefits (though often narrower than Medicaid's very broad benefit design). All use "high touch" methods of caring for clients or chaperoning them through the system.

On average, the programs have been operational for about 6 years. Anecdotal evidence suggests that they have succeeded in improving access to care in their communities, adding value to a "safety net" that is burdened by the growing number and complexity of the uninsured population. Forced to be flexible and adaptable in their approach to coverage, the initiatives nevertheless have held to their respective visions and missions. They view themselves as important though stopgap measures; all appreciate that, in their current form, they do not have the capacity to address the health care needs of all uninsured individuals.

Rating of Selected Community Initiatives 🟢🟡🔴

	Wichita, Kansas	Paris, Arkansas	Milwaukee Wisconsin	Olympia, Washington	Forsyth, Georgia
Coverage	🟢	🟡	🟢	🟢	🟢
Cost Effectiveness	🟢	🟢	🟢	🟢	🟢
Better Care	🟢	🟢	🟢	🟢	🟢
Replicable	🟢	🟢	🟡	🟡	🟢

Table 4

Note: Green indicates a positive rating; yellow indicates insufficient evidence.

With respect to coverage, efficiency, and quality of care:

- ❖ These programs generally enhance coverage, although in one case the program was very small.
- ❖ The program leaders have been able to show in various (though typically subjective) ways that the programs reduce the costs of caring for enrollees.
- ❖ It is generally believed that those who are enrolled in these initiatives get better care.

The replicability of a program fundamentally depends on the similarity of local context and the program's ability to adapt to differences in local context. But in addition, successful replication requires the right combination of leadership, shared responsibility, and state support—all at the right time.

Because local initiatives typically build on public programs or private insurance, the state context in which they operate is critical. They rely heavily on strong systems of public programs, private insurance, or both. All operate in part or in total as outreach agencies for public programs, enrolling applicants whenever they are eligible for these programs. In addition, to the extent that they rely on volunteer providers, they also rely on adequate financing for care used by the insured population. States that have frozen or reduced Medicaid and SCHIP

motivations and expectations—and the incentives and conditions that would prompt greater volunteerism—is critical to understanding the potential for community initiatives to serve the uninsured.

Preliminary research investigating these questions would entail approximately thirty interviews with physicians selected from community initiative models that rely on volunteerism and approximately twenty interviews among physicians in three states (to be selected) with high uninsured rates but no community initiatives contemplated or in place. The community initiative models would include Project Access, a three-share model, and free-clinic model. Both rural and urban physicians would be recruited for participation, and states would be selected to achieve geographic diversity. Data would be analyzed and summarized to offer lessons learned.

Conclusions

Local initiatives can enhance coverage and access for "high touch" populations who often are not well-served by conventional systems of public programs and private insurance. Moreover, they may improve the efficiency of serving these populations. However, some factors clearly contribute to their chances of success: visionary and capable leadership; responsiveness to a well-understood need in the community; and a context of provider resources, supportive state leadership and programs, and/or strong private insurance capacity.

Community initiatives typically build on public programs or private insurance by garnering local government investment, enhancing provider participation, and drawing grant monies into communities. But they also draw federal support by assisting enrollment in Medicaid and SCHIP, and by creative use of indigent care trust fund dollars. Those that provide coverage or direct services could possibly benefit were federal refundable tax credits or other federal funding (such as payment vouchers) made available. However, community initiatives are characteristically pragmatic and none have plans based on the expectation of imminent federal relief.

The project team rated each local initiative on their impacts (do they enhance coverage, decrease the cost of serving the uninsured, or offer better care?) and whether they seemed replicable. The scoring of each initiative, reflecting informed judgments by the research team, is summarized in Table 4.

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Cost Effectiveness

In each community, local leaders contend that providing more appropriate health care services is cost effective both for providers and for the community at large. Though each offered evidence that it is cost effective in providing care to the uninsured, variation in how and what program leaders measure made it difficult to compare their experiences. Estimated annual cost per enrollee varies widely (from $178 to $5,556), as does estimated program penetration (from 3.3 percent to 34.7 percent of the eligible population).

The initiatives use various cost control strategies to achieve net savings to the community. All of the programs require cost sharing in the form of modest co-payments, administrative fees, and/or membership dues. Health care providers bear significant risk in the form of voluntary participation, discounted rates, or capitated reimbursement.

While attempts at quantitative evaluation have been limited, it seems likely that some of the initiatives have reduced hospital utilization and uncompensated care. For example, one initiative concluded that its enrollees use 27 percent less hospital care and 15 percent less ER care than a statistical control group. A few communities have measured hospitals' return on investment in the program, most finding fair to moderate success.

Sustainability & Expansion

With diminishing grant funding, program leaders have fought to maintain momentum and remain relevant to community efforts to cover the uninsured. Though most of the programs are believed to be sustainable in the short run, all recognize that ongoing sources of funds are needed to thrive in the long run.

Questioning around the sustainability of the programs and opportunities for expansion produced a number of common themes.

- The mission of the program must be grounded in the needs of the target population.
- Strong leadership at all levels of the organization is essential.
- The programs require sustained financial support to be viable.

- Programs should develop data to evaluate and demonstrate success throughout implementation.
- Any model based on provider volunteerism has limited growth potential.
- Flexible and adaptive programs can be sustained in a changing environment.

Lessons for Replication

The difficulty of replication can be attributed both to the complexity of the innovations attempted and also to differences in context between alpha and beta sites. Innovations are most easily transferred when they are simple and quick, and when their benefits are easily observable. However, initiatives to improve access and health status are necessarily complex, and their results generally are not quickly or clearly observable. As a result, every factor that influences the diffusion innovation of innovation must be pursued more intensively. Essential to replication of these programs are: (1) extensive interpersonal communication in face-to-face exchanges between multiple individuals in alpha and beta program sites; (2) high levels of knowledge among highly interconnected parties to the initiative; (3) a formalized organizational infrastructure; (4) strong local leadership; and (5) a state environment with opinion leaders and change agents who value local initiative innovation.

The beta sites replicated alpha sites with varied success. In only one site was the replication complete: this beta site differed from the others in the study in having a local and state context that is similar to the alpha site, as well as having had extensive communication and collaboration with the alpha site.

State/Community Interface

The context of community programs – the presence of supportive public programs and/or strong private insurance capacity – is an essential factor in successful replication. Public policy that supports provider participation and state-level leaders who believe in local innovation are important to programs that entail provider volunteerism or acceptance of reduced compensation. Local programs can support or complement state public and private insurance programs, but they are unlikely to thrive independent of them. All of the study sites are involved in enhancing enrollment in state programs, especially for hard-to-reach populations.

- Which state policies or regulations promote community-led solutions to care for the uninsured, and in which states are those policies and regulations found?
- Which models require a culture of provider volunteerism, and how does/can state policy or regulation support and encourage that culture?
- Which models work best in states with a robust private insurance market, and why?
- Which models are best suited for rural communities, and why?

A simple, initial approach to these questions would involve constructing a scale to measure state context. The research would review the states' characteristics and place each state within a continuum on selected factors in order to identify models of community initiatives that each state might best support. Factors would be identified based on additional case studies, building on the research reported here, and might include: (1) the nature and penetration of public coverage; (2) private insurance markets—including the rate and terms of employer offer, and regulation to improve health insurance access or reduce cost; (3) state-level vision and supportive programs and policies; (4) provider and community culture; (5) investment partnerships; and (6) technical support. Each factor and combinations of factors would be considered in light of the apparent relationship to communities' ability to develop different types of local solutions.

Evidence regarding the contextual "fit" of alternative models would facilitate communities' ability to sort through their options for adopting any of the approaches in the study, with the goal of improving the rate and degree of their success. Armed with a descriptive framework for creating a more conducive state-level environment for local initiatives, state leaders would be better positioned to develop strategic state-level relationships, investments, policies, and technical support to improve the sustainability and effectiveness of local efforts. State leaders interested in catalyzing community-level innovation would have a better understanding of levers that might be used to create a supportive policy environment for local efforts.

Investigation of Provider Capacity Options

Provider capacity limits program expansion, particularly in local initiatives that rely heavily upon physician volunteerism. Therefore, understanding provider

partners engaged, inform mid-course program corrections, and encourage investors (public and private) to contribute over time. However, valid research documenting the outcomes of most of these programs is very limited. The prevalent impression among key informants that each initiative improves health care access and efficiency for enrollees is largely grounded in anecdote and theory.

The complexity of the health care systems being built or modified, the interaction of multiple community-based interventions, and state and local context of the interventions present important challenges for formal evaluation. But limited evaluation experience, capacity and resources in the community are also important barriers. Because rigorous evaluations of effects are rare, aggregating evidence to inform state and national policy discussions and decision-making is impossible.

To better understand the contribution made by local initiatives and to advance the policy conversation regarding their role in the larger system of health coverage, a utilization-focused, participatory evaluation is proposed that could be applied across sites. The goals of such a study would be to:

- Identify a set of common indicators and methods for measurement across study sites;
- Provide technical assistance to strengthen skills and build evaluation capacity at the local level, building appreciation for the connection between strong documentation of outcomes and program sustainability; and
- Aggregate data across local initiatives to answer state and national policy questions about the potential of local initiatives to offer long-term solutions to issues of the uninsured.

Understanding State Context

The replicability and effectiveness of different local models depend critically on state context. A state's public and private insurance markets, culture and larger policy environment all drive what is possible and needed to build community-based programs to assist the uninsured. Both communities and states would benefit from a better understanding of the contextual factors that constitute a conducive environment for the implementation of various models.

Research to build that understanding would address the following questions:

There are many opportunities for national and state policies and resources to combine to support local initiatives; just a few of these possible support strategies were implemented in each site. Examples include:

- The Arkansas General Assembly passed legislation which established a statutory framework for community-based health care access programs (Act 549 and Act 660).
- In Washington State, the Medicaid program contracts with CHOICE to provide outreach and enrollment services to the Medicaid population in their service area.
- In Wisconsin, the state Medicaid agency collaborates with the county and program to draw down Disproportionate Share Hospital (DSH) dollars through Intergovernmental Transfer (IGTs).

Implications for Future Research

This study suggests that local initiatives can contribute to building a bridge between private insurance and public programs for individuals who have difficulty remaining or thriving in either. Three types of research could guide states and communities that are considering local initiatives to improve access to care and decrease the cost of care for the uninsured:

- A multi-site evaluation of the impact of local initiatives;
- An analysis of the state-level contextual factors that make a conducive environment for introducing local initiatives of different types; and
- An investigation of options for overcoming provider capacity issues in local models that rely heavily on physician volunteerism.

These research projects would provide an evidence base for national, state, and local decision making regarding how to design, sustain or replicate relevant local programs.

I. Context and Background

For a growing number of Americans, the problem of finding and keeping health insurance is acute. Low-wage workers may hold several part-time jobs, rely on seasonal work, and be unemployed or underemployed during the year. They are less likely to work in establishments that offer a health plan and less likely to be eligible for coverage when it is offered.[1] Individual health insurance coverage is prohibitively expensive for them, even if it would cover the health conditions they may have developed over years without consistent access to health care.

Many low-income working families have relatively little history with means-tested public programs, and for various reasons do not enroll in Medicaid or do not remain enrolled even when eligible. Many are adults who do not qualify for public coverage, though their children typically do. A significant number are older adults without children and, therefore, may not qualify for public coverage.

The consequences of being uninsured are well documented.[2] Health care needs are addressed late, and opportunities to avoid serious and chronic illnesses are missed. Poor management of chronic conditions, often related to lack of access to prescription drugs, creates acute episodes and avoidable hospitalizations. Health outcomes are compromised, productivity is reduced, and lives are shortened. The quality of life and the economic security of families are eroded. The cost of care, when families are unable to pay, falls on just a few providers – in most communities, a small safety net for a very large problem.

Encouraged by private foundations and government efforts to strengthen local health care safety nets, some communities have developed programs to integrate piece together access and financing for individuals and families who live between the worlds of private insurance and public coverage. These efforts attempt to

[1] Even when insured, low-wage workers are more likely to pay a significant share of income toward coverage, and less likely to have any coverage for prescription drugs or dental or vision care. Sara R. Collins, Ph.D., Cathy Schoen, Ph.D., Diane Colasanto et al., *On the Edge: Low-Wage Workers and Their Health Insurance Coverage.* New York: The Commonwealth Fund, April 2003 (http://www.cmwf.org/usr_doc/collins_ontheedge_ib_626.pdf).

[2] See, for example, National Academy of Sciences, Institute of Medicine, *Coverage Matters: Insurance and Health Care.* Washington, DC: National Academy Press, 2001.

VII. Implications for Future Research

Insights from this study imply that local initiatives can contribute to closing the gap between private insurance and public programs. Three types of research might help to guide communities and states in building local initiatives to enhance coverage and access, and to improve the efficiency of care for the uninsured. These include:

1. A multi-site evaluation of the impact of local initiatives;

2. A description of the state context conducive to different models; and

3. An investigation of options for overcoming provider capacity issues in local models that rely primarily on physician volunteerism.

Taken together, these research projects would help to build an evidence base for national, state, and local decision-making regarding how to design, sustain, or replicate successful local programs. Findings would:

- Help national leaders, state elected and agency leaders, academic institutions, and foundations to understand the potential of communities to work together in new ways to provide increased access to care for the uninsured at a reduced cost in a time of shrinking resources and growing need.

- Help national and state policymakers will better understand how state-level policy and infrastructure can support communities' ability to attract and retain health care provider volunteers to staff local community initiatives and support the local health care safety net.

- Help local leaders who are faced with enormous challenges in caring for the uninsured to make informed decisions about alternative options based on their compatibility with the context and the range of local provider and population needs.

Multi-site Evaluation of Effects

Credible, objective evidence of impact is critical to understanding of the value of local access initiatives and, in turn, to the long-term success of local initiatives that serve the uninsured. Demonstration of value and effectiveness can help keep

Community Enhancement of State Initiatives

Each of the study sites attempts to place clients in state programs—usually Medicaid or SCHIP—when they are eligible. In the CHOICE network, applicants who received assistance with enrollment were twice as likely to be enrolled in public programs (98 percent) as those who did not receive such assistance (40 percent). With CHOICE assistance, 96 percent of enrollees remain enrolled after three years, compared to only 40 percent of unassisted enrollees. Key informants described the local programs as *"slowing the frazzling of the safety net"* and *"catching some of those falling through the safety net."*

State and National Enhancement of Local Initiatives

While there are many opportunities for national and state policies and resources to come together to support local initiatives, the programs survived with the state having implemented just a few of the support strategies possible. Much of the potential for state and national leaders to create contexts that enhances the abilities of local initiatives remains untapped. Such strategies would include:

- Allowing tax write offs for volunteer services to build provider participation.
- Modify medical liability coverage laws to protect and/or insure participating providers.
- Allowing communities to partner with Medicaid to supplement employer/employee contributions to insurance, and allowing access to government rates on prescription drugs.
- Encouraging local innovation, recognizing the potential of communities to contribute to solutions, and thinking of local initiatives as potential vendors or partners.

Rural areas require additional support from state and national government as they have fewer resources upon which to build community programs. *"[Building on] employer based health care is not easy in rural communities"* where employers are more likely to be small and less likely to offer insurance. In addition, there are fewer providers to support a volunteer program. As a result, a higher percentage of rural residents are without insurance, the private insurance infrastructure is weaker, and there is less potential for local initiatives to build on provider volunteerism.

weave the threads of provider discounts, free care, and public financing into a more coherent system of coverage and care.

II. Intent and Description of Initiatives

Each of the initiatives is a locally crafted response to problems of health care access among uninsured and indigent residents in its community. By uniting community leaders, providers and other key stakeholders, they build and capitalize on good-faith relationships to reduce uncompensated care and support the local safety net.

Each program is concerned about reducing local health care costs, but their missions also emphasize real efforts to enable "user friendly" access to care. They employ common strategies of building coverage, coordinating access, integrating care, and conducting outreach in their varied economic and political environments. The community initiatives have made significant efforts to coordinate with the local network of private providers, FQHC, health departments, and hospitals to ensure service to their clients and provide a medical home for their clients. None of the programs studied is simply a health insurance plan.

In all of the initiatives, program staff enroll applicants in their own programs and also screen them for eligibility and enrollment in state-sponsored health insurance programs. Program employees stationed in clinics, health centers or hospitals all provide eligibility assistance. Significant resources and energy have been expended to enroll initial populations, and the programs use multi-media approaches to connect with eligible populations. Nevertheless, much of the programs' outreach continues to be "word of mouth."

By providing a medical home for clients, the programs attempt to achieve earlier preventive and preemptive medical intervention to improve health outcomes and reduce costly hospitalizations. Even in instances where secondary or hospital services are often the reason for first contact with the initiative, post intervention attempts are made to link individuals who retain eligibility to local primary care physicians.

The initiatives typically use case management and health education to control use of services. They provide a "high touch" approach to care that helps to chaperon individuals through a complex care system to improve the appropriate use of local health care services. Key features of each initiative are summarized in Table 1

Table 1

	Project Access Wichita Kansas	**Community Health Link** Paris Arkansas	**GAMP** Milwaukee Wisconsin	**CHOICE** Olympia Washington	**Community Health Works** Forsyth Georgia
Administration	501c(3) organization under Medical Society leadership	501c(3) with independent Board	County government	501c(3) organization	501c(3) organization under joint hospital leadership
Enrolled	625 active; 4,472 over program life	130 active	22,000	17,000* * duplication	2,200
Presumed Eligible	10,000	4,000	75,000	93,000	6,500
Period of Enrollment	3 months primary care/ 6 months secondary care	Indefinite period once eligible	6 months with mandatory reapplication	N/A	Indefinite period once eligible
Income Eligibility	< 150% of FPL	< 300% of FPL < 200% of FPL subsidized	< $902 per month for single individual	< 250% of FPL	< 200% of FPL
Other Eligibility	❖ County residents ❖ US citizen ❖ Not eligible for other insurance	❖ Resident of county ❖ Working uninsured	❖ Resident of county for > 60 days ❖ US citizen ❖ No other insurance ❖ Seeking service	❖ Resident of participating county	❖ Resident of participating county US citizen ❖ No other insurance ❖ Diagnosis of DM,HPT, CHD and depression
Intent	Short-term enrollment of individuals who require services for specific conditions, with a link to a medical home for ongoing care. Screening for public program eligibility and enrollment	Provide working low income uninsured or underinsured adults with affordable access to care. Link eligible individuals to primary care providers and reimburse providers for care	Provide services in community care settings rather than hospitals. Decrease inappropriate use of hospital ERs. Client self-determination and sensitivity to cultural norms and expectations.	Stabilize the safety net Identify and enroll low income residents in a medical home Improve efficiency of care to reduce costs and expand coverage	Cover care in four chronic disease states. Improve use of primary care services to reduce inappropriate ER use Create systematic change in local safety net and improve community health status

Project Access - Wichita, Kansas

Administered by the Sedgwick County Medical Society, this program is a modified replication of Project Access in Buncombe County, North Carolina. Program staff coordinates donated primary and secondary care services for uninsured clients with income below 200 percent of the Federal Poverty Level (FPL). The program attempts to enroll eligible people who require services for specific conditions and link them to a medical home for ongoing primary care.

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The state/national context can affect the ability of local initiatives to add value to their community by:

- ❖ Developing policies that support provider participation;
- ❖ Supporting robust public programs that recognize the benefits of local initiatives and provide financial support for them;
- ❖ Developing state policies and resources that strengthen the private insurance for low-wage workers and low-income families; and
- ❖ Encouraging opinion leaders and change agents who believe in local innovation.

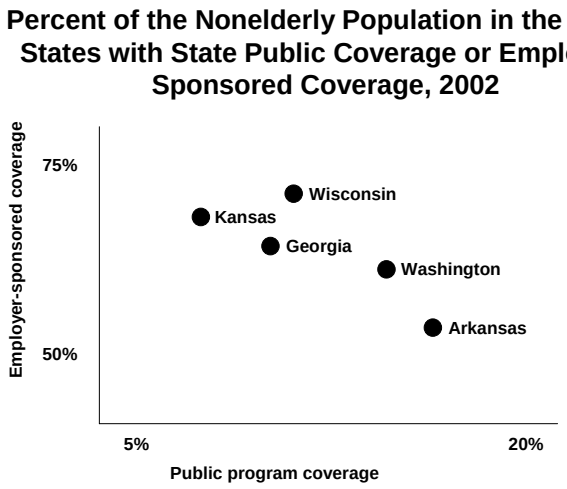
States have supported the studied local initiatives by enacting legislation to exempt them from state insurance regulation (Arkansas), extending malpractice insurance to providers in clinics (Kansas), changing good Samaritan laws (Washington), placing state eligibility specialists in safety net clinics (Kansas), giving grants for local network development (Georgia), providing block grants (Wisconsin), and participating with local and federal government to use Disproportionate Share Hospital dollars to support the local initiative (Wisconsin). These state policies and resources foster innovation in the community and provide critical support for community initiatives do develop funding streams and volunteer support.

VI. State/Community Interface

Each of the initiatives attempts to bridge public and private coverage: each serves individuals who have difficulty finding or staying public or private coverage, or navigating between the two systems. Because the programs operate close to the world of public coverage, they are especially sensitive to political, financial and administrative changes in public programs.

Because Washington has strong public programs—including the state-subsidized Washington Basic Health Plan, the CHOICE network was able to cover many uninsured simply by extending outreach to enroll eligible residents. The three-share program in Paris, Arkansas has struggled in an environment of systematically low employer support for private group coverage; in contrast, the Michigan program on which it is modeled was built on a relatively strong base of employer group coverage. The general context of public programs and private coverage for each of the five initiatives is summarized in Figure 2.

Figure 2 – Public and Private Coverage in Study States



Source: Fronstein, Paul. (2003). *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2003 Current Population Survey*. Employee Benefit Research Institute (EBRI) Issue Brief No. 264.

The Dental Society provides emergency dental services, and the city of Wichita and Sedgwick County offer funding to provide prescription drugs.

Like its "alpha site," Wichita's Project Access relies heavily on physician leadership and volunteerism. The initiative links more than 600 physicians with local hospitals six outpatient clinics, 36 dentists, and 69 participating pharmacies. Enrollment in the program is limited to three months.

Community HealthLink - Paris, Arkansas

Operated by the Arkansas River Valley Rural Health Cooperative as a non profit 501(c) 3 organization, Community HealthLink is a subsidized, capitated health insurance plan that operates much like a preferred provider organization, or PPO. It provides fairly comprehensive health care coverage for working uninsured residents with income below 300 percent FPL.

The program is broadly patterned on the "three-share" program in Muskegon, Michigan. Employers and employees (clients) together support two-thirds of the cost of care, with the final third covered by a subsidy fund set up by the Cooperative. Participating providers agree to accept Medicare rates and also to continue seeing patients whose care may exceed the plan's reimbursable limit. The provider network currently includes two tertiary care hospitals, four critical care access hospitals, six primary care clinics, four mental health counseling centers, and 200 medical specialists. It also is seeking to branch into the use of telemedicine. The program recently completed its initial 2-year pilot phase.

General Assistance Medical Program (GAMP)- Milwaukee, Wisconsin

GAMP functions as a county-operated managed care organization that purchases services for enrollees. Administered by Milwaukee County, GAMP provides access to primary and secondary health care services for uninsured county residents with income less than $902 per month. Reflecting the program's primary care emphasis, 17 clinics (including FQHCs) at 23 sites act as gatekeepers for care. Eligible residents are enrolled when they seek medical services. The program reimburses providers at Medicaid rates with funding from leveraged state contributions, local taxes and intergovernmental transfers. Enrolled individuals must requalify for coverage every six months.

CHOICE Regional Health Network - Olympia, Washington

CHOICE attempts to improve access to care for uninsured individuals residing in a five county service area with income at or below 250 percent FPL. Governed by a non-profit Board of Directors, CHOICE enrolls eligible individuals in state sponsored programs or links them to donated or discounted local provider services. It does not provide either coverage or medical services directly. CHOICE also collaborates with other regional stakeholders—including three hospitals, 11 outpatient clinics, local FQHCs and hundreds of physicians—to increase coverage options where possible. There currently is a waiting list for admission to the Washington Basic Health Plan (BHP). Aside from Medicaid, BHP is the major state program for which CHOICE is, in effect, an outreach agent. CHOICE plans to design an insurance product for state government and local businesses, but it currently only brokers available public coverage and services for low-income residents.

Community Health Works - Forsyth, Georgia

Community Health Works is a significantly modified version of the Buncombe model that operates across a seven-county region in central Georgia to serve uninsured residents with income at or below 250 percent FPL, with one or more of four specific chronic diseases—hypertension, diabetes, heart disease, or depression. Administered as a 501(c)3 organization, the program relies heavily on provider volunteerism and hospital leadership, emphasizing appropriate utilization of services and a rigorous case management element across the continuum of care. The program relies on a medication bank to provide access to affordable prescription drugs. The local care network consists of 3 hospitals, 2 clinics, nearly a hundred physicians, and 21 pharmacies; it has developed software to track client service use and assist in care planning. Currently, there is a waiting list for admission to the program.

The initiatives' general strategies to serve the uninsured are summarized in Figure 1. Located between public programs and private insurance, they seek to avail themselves of either—enrolling applicants in public programs when they are eligible and capitalizing on provider volunteerism which in part relies on adequate reimbursements for care of patients enrolled in public programs and private insurance plans.

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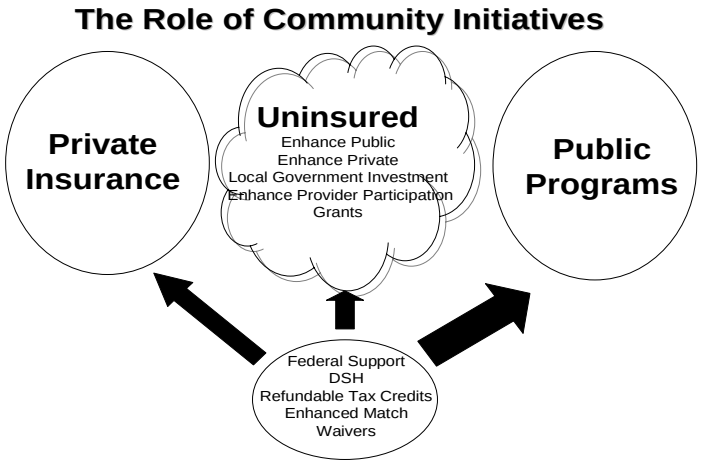
the other study sites in that the contexts in the alpha and beta site were similar and there was extensive communication/collaboration with the alpha site. The site with the least success had a context that was very different from the alpha site and there was no communication with the alpha site. The difficulty with replication can first be attributed to the complexity of the innovation and second to the differences that exist between alpha and beta site contexts.

Site	Project Access Wichita, Kansas	Community Health Link Paris, Arkansas	GAMP Milwaukee, Wisconsin	Choice Olympia, Washington	Community Health Works Forsyth, Georgia
Replication Alpha Site	Project Access Buncombe, NC	Three Share Program Muskegon, MI		Jesse Tree Galveston, TX Project Access Muskegon	Project Access Buncombe, NC
Communication with Alpha Site	Extensive	None	Visited Michigan and Florida	Yes	Limited
Similarity of Context	Yes	No	No	No	No
Simple Program with Easily Observable Benefits	No	No	No	No	No
Wide Variety of Easily Observable Partners	Yes	Yes	Yes	Yes	Yes
Leadership	Yes	Yes	Yes	Yes	Yes
State Level Opinion Leaders and Change Agents	No	Mixed	Yes	Mixed	Mixed
Success of Replication	Complete	Very limited	NA	Too Soon to Tell	Limited

The success of beta site replication of alpha sites varied among the initiatives (Table 3). In only one site was the replication complete. That site differed from

However, local initiatives also draw new funds to care for the uninsured. These new funds include private grant funding as well as federal funding in the form of federal matching and use of disproportionate-share hospital (DSH) payments.

Figure 1



III. Effectiveness of Models

Effects on Coverage

The community initiatives primarily cover the subset of the uninsured population who are young to middle-aged adults. In contrast, low-income children and seniors are much more likely to be eligible for federal/state public insurance programs. Eligibility by income ranges from approximately 120 percent of the federal poverty level (FPL) in Milwaukee to 300 percent of FPL in Paris. Most enrollees have incomes near poverty—substantially lower than the programs' income limits.

In most of the sites, coverage for undocumented immigrants is a contentious issue. This was most tangible in Wichita, where some provider dissatisfaction with treating this population led the program to make undocumented immigrants ineligible for coverage. The programs in other communities either cover few undocumented immigrants or program staff have adopted a "don't ask, don't tell" policy about enrollees' immigration status.

All of the programs identify eligible individuals only after they present for medical care; two cover only uninsured individuals with particular conditions. As a result, the covered populations typically are ill, and many have chronic diseases. Yet the programs typically limit the enrollment period. Some offer coverage for just three or six-months, with the ability to reenroll if health needs require ongoing care. In Milwaukee, an estimated one-third of clients are enrolled for one six-month period; another third are enrolled for two six-month periods; and the last third are enrolled continuously.

The programs typically require enrollees to pay an application fee or premium to enroll, as well as copayments when they obtain services. For a low-income population, these costs affect enrollment. For instance, in Milwaukee a recently established $35 application fee was reported to have "*... kept more people out of the program than any [other] single thing."* In Paris, with low employer participation and loss of the program subsidy, now 70 percent of enrollees must themselves pay the full cost of the premium— from $60 to $200 per month, depending on age and gender. It is not yet clear how this cost will affect enrollment and retention in the program.

Reflecting differences in community structure, demographics and available funding, enrollment in the programs varies widely—from fewer than 200 enrollees in Paris to approximately 26,000 in Milwaukee. However, none of the

- **Communication.** More complex innovations require greater interpersonal communication.[5] In each site, key informants reported "significant interface" with the alpha site prior to starting the program, involving numerous consultations and conversation with leaders from the alpha community and, change agents traveling to and from the alpha site to visit, observe, and discuss. Expanded opportunities for interpersonal communication among initiatives are likely to increase diffusion and replication of local initiatives.

- **Leveraging context.** The context of community programs—the presence of supportive public programs and/or strong private insurance capacity—can contribute importantly to a successful replication.[6] Programs that capitalize strategically on their context are most likely to succeed. For example, in the presence of strong state programs, Milwaukee's GAMP has succeeded in enrolling a relatively large share (35 percent) of its target population. In contrast, the Paris, Arkansas initiative—which attempts to transplant a model developed in heavily industrialized Michigan—has had considerable difficulty gaining enrollment. Because the program attempts to attract employer participation in an environment where employers are unlikely to offer coverage at all (and to low-wage workers, in particular), enrollment has remained very low: just 130 people currently are enrolled. a state environment with opinion leaders and change agents who value local initiative innovation.

Table 3 – Replication Comparison

[5] Diffusion theorists suggest that interpersonal channels of communication are more effective in the program diffusion process than mass media (Rogers, 2003). Personal intercommunications among multiple initiatives will foster the transfer of innovation.

[6] The literature documents the strong influence of the social system (community attributes/attitude, system norms, opinion leaders and change agents) on the diffusion of innovation (Rogers, 2003). The social system in which these five community initiatives operate is the state. The state level attitude toward community innovations, the state level norms and the influence of state level opinion leaders and change agents will influence the diffusion of innovation at the local level. As with the other factors that affect innovation, the complexity of these innovations requires a stronger state "social system" of support.

Innovations are most easily transferred when they are simple and quick, and when their benefits are easily observable.[4] However, the intricacies of health care financing necessarily make initiatives that focus on access and health status complex, and their results generally are not quickly or clearly observable.

The complexity of the programs and their organizational structures creates the need for more intensity in every factor that influences diffusion of innovation. The comments offered by key informants in each site suggest a number of important lessons for replication of local initiatives in other sites—including thoughtful adaptation of models to local circumstances, strong leadership, communication, and leveraging context. Each is discussed below.

- **Adaptation**. Community programs develop in response to a specific local culture; it is unlikely that another community will have exactly the same culture among either providers or uninsured residents, and therefore the same needs. Each local initiative must be realistic about what will succeed in its community. A member of the network in Olympia articulated the uniqueness of its community and the process of adaptation: *"One type of model will not result in 100-percent access. Our network has engaged in a continuous blending of programs to shape a complex portfolio of efforts to connect the community to care."*

- **Leadership and structure.** Local initiatives focused on health care also require a special kind of leadership and a strong sense of organizational structure, sentiments expressed in nearly every interview. Moreover, more complex initiatives require still stronger leadership and greater formalization of the initiative's organizational infrastructure. Components of successful leadership include the ability to develop a wide variety of highly interconnected network partners with high levels of knowledge, and to manage and facilitate the collaboration and communication among partners. *"You need passion, intelligence, flexibility, political savvy, and dedicated workers."*

[4] Rogers (2003) defines innovation as "an idea, practice, or object that is perceived as new by an individual or other unit of adoption (p12)" and diffusion is "the process in which an innovation is communicated through certain channels over time among the members of a social system (p5)". When local health access initiatives seek to replicate programs from other communities, they are entering into the process of diffusion of innovation. Rogers, Everett M. (2003). *Diffusion of Innovations*. 5th ed. The Free Press, New York: NY.

initiatives has the capacity to cover most of people eligible for the program, even though eligibility is defined to include just some in the community who are uninsured. Even Milwaukee's relatively large program has reached approximately 35 percent of people believed to be eligible, and just 23 percent of the estimated 115,000 uninsured in the county.

Because people often stay in the programs for short periods, the number of people served over time is significantly higher than current enrollment. For instance, Wichita's program has approximately 625 active enrollees, but since 1999 it has served more than 4,000 people—40 percent of the 10,000 people believed to be eligible.

All five of the programs offer generally comprehensive medical coverage. The programs typically provide primary, specialty and hospital services, as well as prescription drugs. For example, the program in Forsyth, which enrolls people with specific chronic illness, offers comprehensive coverage all of the enrollee's health needs. All programs offer more holistic care and support services than what is considered traditional medical care. However, in an attempt to reduce their clients' reliance emergency departments, some restrict the use of emergency services or do not cover them at all. Some programs provide 24-hour nurse call lines to direct enrollees to appropriate services, address their concerns, and offer care management for chronic illnesses. Services such as dental, vision and behavioral health typically are limited.

Effects on Access

Across the five communities, the initiatives are perceived as having improved access to care for the uninsured by expanding the network of providers willing to treat them. For instance, the uninsured in Milwaukee now can seek care at any community hospital; formerly they could obtain care at just one public hospital. More people have a medical home or ready access to a primary care facility, as well as access to specialty referrals, prescription drugs, and hospital care—all conducive to obtaining more timely and appropriate care with less reliance on emergency departments.

However, the extent to which local initiatives can measure their impacts on access varies. Much of the information they are able to provide is anecdotal. Their relatively short enrollment periods also make it difficult to gauge impacts on utilization by a consistent group of clients. While most of the programs attempt to track utilization for their enrollees, they typically do not yet have data to share.

In most cases, local key informants perceive that program enrollees use more outpatient care—particularly primary care—than they had before they enrolled. For example, Olympia's access coordinators not only help people enroll in public insurance, but key informants report that these staff have also helped the uninsured—clients and others alike—find medical homes and obtain specialty consultations and prescription drugs. In Paris, a local health agency representative reported receiving fewer calls from people who cannot find a doctor to treat them since the program was implemented. In the Wichita program tracks the "charges" that providers submit for services they have donated; these data indicate that the average number of outpatient encounters per patient increased from 1.5 to 1.8 in the program's first three years.

The programs' effect on access to outpatient specialty care is mixed. The donated care models that focus heavily on clients' specialty care needs were reported to offer good access to specialists, though none were able to measure program impact. For example, though the Forsyth program has provided $13.6 million in donated care since 2001, it is unclear how much care was donated before, but in a less structured way (and therefore not measured). In programs that do not focus on specialty care specifically, access to specialty care continues to be difficult.

Because the programs focus on increasing outpatient care (addressing medical conditions early to avoid hospitalization), local leaders expect inpatient utilization to decline among enrollees. Tracking utilization of its enrollees against a statistical control group,[3] the Forsyth initiative concluded that its enrollees use 27 percent less hospital care—even though the average enrollee has three medical conditions compared to an average of just one medical condition in the control group. In addition, clients' use of hospital care declines further as they are in the program longer. In Milwaukee's program, disease management is believed to have contributed to "significant declines" in the rate of claims for inpatient care among enrollees with for asthma, hypertension, or diabetes. In contrast, in Wichita's program, the average number of inpatient admissions and length of hospital stay per enrollee have increased over three years, possibly due to a greater number of chronically ill enrollees.

In each program, emergency department utilization is believed to have declined as a result of the program. Again, however, few data exist to confirm whether this is

[3] This control group was a national sample constructed from the Medical Expenditure Panel Survey (MEPS), conducted by the federal Agency for Healthcare Research and Quality.

funding streams are essential to support operation in the long term. The programs were seeking this funding by developing programs or products to be marketed to other community initiatives, local hospitals, or state or local governments. They also were seeking financial commitments from local and state government including Disproportionate Share Hospital (DSH) funding or dedicated tax levies.

- **The collection of data to evaluate program success should be planned and started early in program implementation.** Formal evaluation is essential to demonstrate the effects of the program and return on investment. In several sites, community partners looked for "short-term wins" as an incentive to continue their financial and organizational commitment to the initiative.

- **Provider participation is important to the success of local initiatives.** Three of the programs relied heavily—or hoped to rely—on health care provider volunteerism; the other programs relied on health care providers assuming risk for providing care to enrollees, even when program funds were exhausted. However, it is difficult or impossible to harness volunteerism over the long term, and in each community the numbers of uninsured have grown beyond the service capacity of available programs. As the states have frozen or reduced Medicaid and SCHIP reimbursement rates, "doctors are struggling to sustain their own practices." Low public-program payment levels have hampered recruitment of volunteer providers, stalling program growth. To continue to recruit volunteer providers, the programs need strong incentives for participation—including payment for services. In addition, physician "champions" are essential to the ability of community initiatives to sustain physician volunteerism, recruiting additional physicians and motivating those already involved to continue.

- **Flexibility to adapt to a changing environment, programs is essential to sustaining the program.** Changes in the health care market disproportionately affect programs that serve the uninsured: they feel the cumulative impacts of changes in the economy, state regulation, political administration, and available funding on all other insurers and programs. The initiatives most likely to be sustained, therefore, are those able to adapt their goals and approaches to achieving their goals, while staying true to their mission of serving the uninsured.

V. Lessons for Replicating Local Initiatives

IV. Lessons for Sustaining & Expanding Local Initiatives

In questioning key informants in each site, several lessons emerged from their collective experience in attempting to sustain and expand their efforts, despite substantial differences in the programs' visions and strategies.

- **The mission of the program must be grounded in a comprehensive understanding of the needs of the uninsured**. Each of the programs had to balance the factors compelling change—the burden of uncompensated care and compassion for the uninsured—with the needs of the local uninsured population. Each program gauged the needs of the community in a different way. In Paris, a community health needs assessment provided data on the number of uninsured in the community. In Forsyth, analysis of self-pay hospital discharge data revealed the highest-cost diagnoses amenable to disease management services to reduce the cost of care for the uninsured. In other sites, a review of public programs—Medicaid and the State Children's Health Insurance Program (SCHIP)—identified gaps that a new initiative could fill.

- **Strong leadership is needed at all levels of the organization, and especially at the Program Director level.** All phases of program development—initiation, implementation, and ongoing operation and change—require strong leadership. In each of the study sites, the program director was pivotal to the program's success. In every community, key informants believed it was difficult to find a program director who possessed the qualities and skills essential to success. "Finding competent operational leadership is a challenge. The skill set that is required... is not something you can go to school to learn." Successful program directors were described as having "a strong business perspective," "creativity," and "dedication." They also were connected to local and state government, and strongly committed to the mission and vision of the program. In addition, strong leadership is required within all parties to the initiative—such as government agencies and the healthcare provider community. In each community, strong medical leadership drove program development, recruitment of volunteers, and outreach to potential enrollees.

- **Developing sustainable financial support is key to the ability of a community initiative to stay operational.** Each of the programs currently receives funding from local and state government, federal grant programs, and philanthropies. Key informants in each site observed that time-limited grant funding is inconsistent with financial sustainability and that new

true. Compared to a statistical control group, enrollees in Forsyth's program do use less emergency room care (13 percent fewer visits) and client use of the emergency room declines the longer they are enrolled. However, evaluators of Milwaukee's program found no significant reduction in emergency department use among enrollees with asthma, diabetes, heart conditions, or hypertension.

Finally, some of the communities have attempted to measure impact on clients' health status, but none have conclusive evidence. Case managers in Forsyth administer the Behavioral Risk Factor Surveillance System (BRFSS) survey to their clients every six months and a health risk assessment every three months; the evaluators observed just slight improvements in health status. Nevertheless, key informants in Forsyth believe that the program has improved its clients' health status.

Effects on Cost and Efficiency

While the focus of the initiatives is to increase access to health care services for the uninsured, community leaders contend that providing more appropriate health care services is cost effective for providers and for the community at large. Indeed, the communities recognize the need to develop a business case in order to obtain grant funding and provider support. All of the programs depend on the participation of community hospitals and physicians, and they must demonstrate to stakeholders that the initiatives make financial sense. There is evidence that the community initiatives are cost effective in providing care to the uninsured, although variation in how and what program leaders measure makes it difficult to compare communities' experiences. Efforts to quantify the cost effectiveness of each program is reflected in Table 2.

Table 2 – Estimates of Program Cost and Penetration

Community	Annual Budget/Cost	Estimated Annual Enrollment	Estimated Annual Cost per Enrollee	Current Enrollment	Estimated Potentially Eligible	Estimated Program Penetration
Wichita	$2,000,000*	1,125	$178	600	10,000	6.0%
Paris	$500,000**	90	$5,556	130	4,000	3.3%
Milwaukee	$49,400,000	26,000	$1,900	26,000	75,000	34.7%
Olympia	$1,800,000	20,000	$90	20,000	93,000	21..5%
Forsyth	$1,660,000	1,300	$1,277	800	6,500	12..3%

*Estimate excludes reported $5 million generated in donated services.

**Researcher estimate based on grant funding and dues income for 2003; key informants did not provide total budget figure.

The cost per client served within the Olympia program is relatively low, reflecting the program's limited role as a coverage broker. The Wichita program is also inexpensive, if the estimated value of donated services is not included in overall cost per client. However, inclusive of those services, the average cost exceeded $6,200 per enrollee in 2003. In Wichita (and also in Milwaukee, a program that offers comprehensive coverage), program leaders have found some reductions in inpatient and/or outpatient costs per member per month.

All else being equal, the average cost of programs that provide comprehensive coverage and do not limit duration of eligibility is expected to be higher than programs that only broker coverage and limit the period of eligibility. However, average cost in the Forsyth program appears very low ($1,277 per enrollee in 2003), when it is considered that the program enrolls only individuals with any of four specific chronic diagnoses. The program most like a conventional insurance program—in Paris, Arkansas—incurs the highest estimated average cost per enrollee ($5,556), although the plan's ratio of medical expenditures to total premiums is low relative to the individual coverage that is commercially available.

The programs enroll a relatively low percentage of their estimated target populations. Milwaukee enrolls about a third of its target population of 75,000. The Paris, Arkansas initiative enrolls just three percent of its target population. Forsyth and Olympia—both programs encumbered by waiting lists—enroll 12 percent and 22 percent of their target populations, respectively.

Because the initiatives need to demonstrate their cost-effectiveness to the participating providers, some focus on measuring the impact on uncompensated care at area hospitals. For example, the Forsyth program estimates an annual reduction of over $500 in uncompensated care per enrollee—totaling more than $650,000 in 2003.

Across communities, however, total uncompensated care costs have increased over the past few years due to the economic slowdown and increased numbers of uninsured residents. For instance, hospital uncompensated care in Milwaukee reportedly increased approximately 20 percent between 2002 and 2003. While the community initiatives may have stemmed those increases, it is difficult to know by how much.

Community initiatives have attempted to measure the return on investment (ROI) for providers participating in the community initiative. Leaders of the Olympia program report that their hospitals' ROI increased steadily from 2:1 to 20:1 over

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the course of three years, and hospital leaders interviewed from other programs found these initiatives to be good investments as well.

Moreover, program leaders are trying to demonstrate positive return on investment for the community at large in order to attract more public or private funds – especially to attract more state and local funding and to recruit providers and employers to support the cost of the program. Some are turning to a measure of return on community investment (ROCI) developed by Communities Joined in Action. Communities calculate measures such as direct and indirect health care costs, the amount of federal and state funding drawn down by local investments, and how health status improvements benefit local businesses and the economy by increasing worker productivity. For example, Milwaukee estimates that every county dollar invested leverages one dollar in state and federal funding.

While a number of local leaders are working toward calculating their initiative's ROCI, many components of the equation appear yet to be theoretical. For example, the ROCI model assumes that providing medical homes and coordinating care will reduce the costs of care by one third; Olympia estimates $3.5 million in annual savings based on that assumption.

Overall, while program leaders point to apparently more rational spending for care of the uninsured (more use of outpatient care and prescription drugs, and less hospital and emergency department use), it is difficult to know whether the initiatives offer savings to the community beyond the costs of running the program. Given the complexity of local health care systems and care delivery, it is difficult for program leaders to isolate the effects of their initiatives to determine how they have affected net cost to the community.