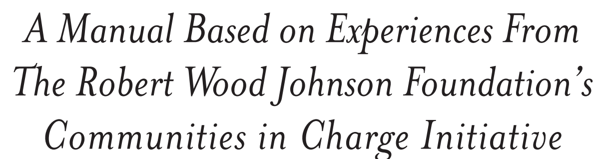
Improving Access to Health Care: Building a Community-Based Program



A Manual Based on Experiences From The Robert Wood Johnson Foundation's Communities in Charge Initiative

January 2005

CommunitiesInCharge

A national initiative supported by The Robet Wood Johnson Foundation
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www.communitiesincharge.org

Dedication

This manual is dedicated to the memory of:

Phebe Conrey King
(1966–2004)
Project Director, CarePartners
Portland, Maine

Phebe's compassion and good work continues
through all that were touched by her
determined commitment to improve
access to health care for the uninsured.

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INTRODUCTION AND AN OVERVIEW OF THE TASKS

What Is *Communities in Charge*?

Communities in Charge is a competitive grants program funded by The Robert Wood Johnson Foundation that provided funding and technical assistance to help 12 communities design and implement new community-based approaches to financing and delivering health care to the uninsured or to significantly expand existing ones. The program began in 1999 and concluded in early 2004. Its goals were to:

- Create systemwide change to improve access to care for low-income, uninsured individuals
- Develop broad-based community consortia to address local coverage issues
- Implement sustainable delivery systems that manage care, promote prevention and early intervention and integrate services for the uninsured.

The communities in the program had a wide range of experiences in achieving program goals. They had in common, however, the development of a body of knowledge of what is required to build an effective consortium, to design and operate delivery systems, and, through these, to create the changes necessary to improve access to care for the uninsured.

Why a Manual?

The purpose of this manual is to present the highlights of the knowledge from *Communities in Charge* in a clear and usable format. Remember that *Communities in Charge* sought systemwide change, broad-based consortia, and sustainable delivery systems. Its projects were large-scale and complex, and the lessons we present are developed for initiatives that are similarly broad in scope.

Think of this manual as a roadmap, but don't rely on it exclusively. A document that contained everything learned during *Communities in Charge* would be unwieldy, to say the least. This manual will point you to references and examples. More information from the participating communities and links to other sites and organizations that work on health access issues can be found on the web at www.communitiesincharge.org.

What Are the Key Steps in the Project?

Each of the *Communities in Charge* participants worked to develop a locally-based coverage/access program. Such programs focus on specific populations of the uninsured and

marshal the resources (funding, donated services) required for these populations to receive free or low-cost health care services. Equally important, the programs design and implement systems to provide services in a comprehensive, coordinated way—instead of the patchwork of care, at best, usually available to the uninsured.

From the experience of *Communities in Charge* participants, we learned that there are three key phases in developing such a local coverage/access program for the uninsured:

1. **Preparation.** Programs for the uninsured are most likely to succeed if they have certain elements in place at the beginning. Is there a key champion who will lead this effort in your community and who is able to bring other community leaders to the table? Do you have a staff that can support them? The right organizations as partners? Will the political and fiscal environment support this effort for both the short and long term? Do leaders agree on what they want to accomplish? Do you really know what it's going to take to get a program up and running, and do you have the money to carry out the planning and program development?

   The output from this phase is a functioning, funded planning coalition able to make an informed decision to proceed with the project.

2. **Analysis and Design.** Decisions on the form the program will take must be based on a clear understanding of need, existing services, the political environment, and cost estimates and options for financing the program.

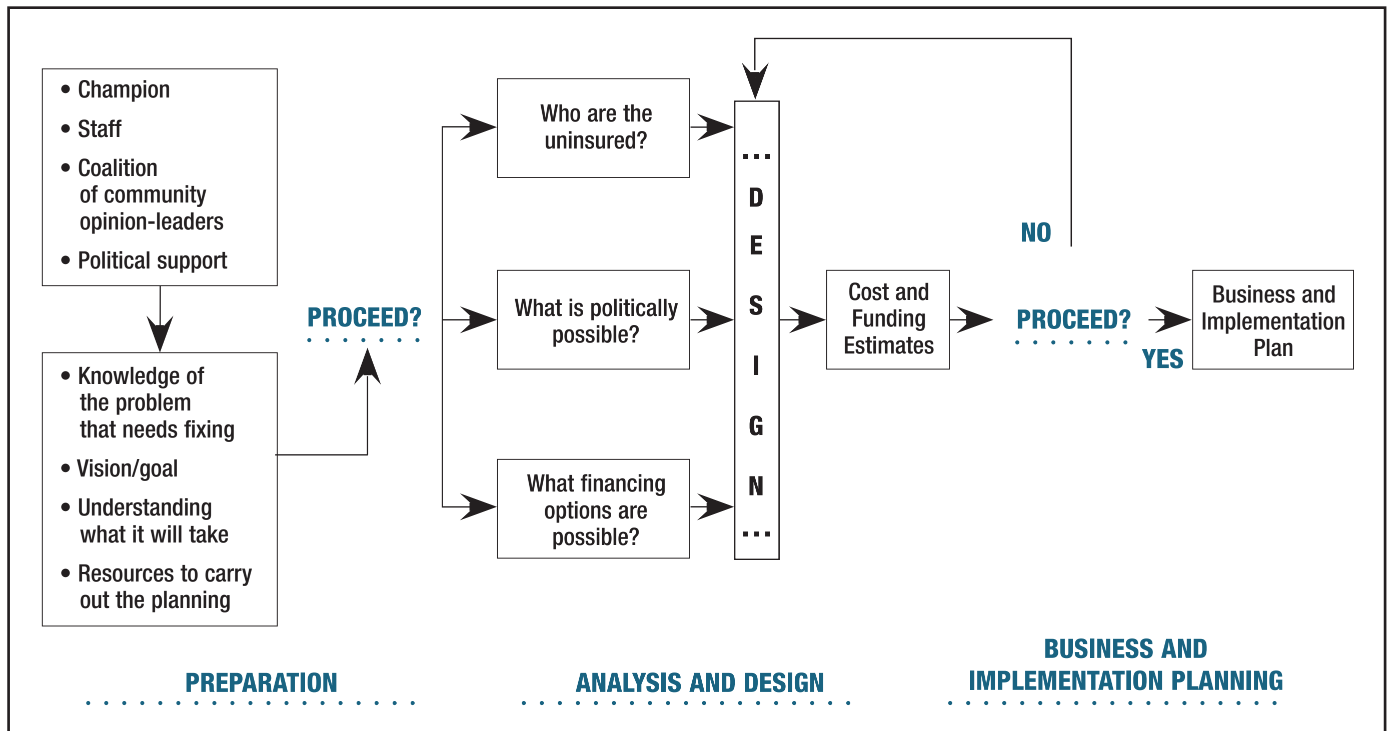
   This phase generates two products: First a design document that describes the program's target population, the financing model, services to be offered, eligibility requirements, and the planned structure for governance and administration; and second, an estimate of how much this program design is likely to cost, compared to the funds you expect to have. Once again, the coalition will face a decision on whether to proceed. Do you think the design, including the financing plan, will succeed? Is there senior leadership investment and community support for the project? If so, the work can move ahead. If not, you'll need to revisit the design and perhaps even your program objectives.

3. **Business and Implementation Planning.** This final phase involves clarifying exactly how the program will work. The program design you create in Phase 2, for example, will describe your target market. Now, in Phase 3, you have to determine the steps needed to reach out to this market and how to enroll and serve members when your marketing efforts succeed. You need to develop a clear estimate of your expected costs and working capital needs as your program gets up and running.

   The output from this phase is a business plan for the program that includes all financial and operational details and an implementation plan for the program.

Sometimes it's easier to follow a diagram. Figure 1-1 displays the flow of these three phases, and describes some of the specific tasks that take place within each phase.

Figure 1-1. Key Phases and Tasks



The sections that follow describe each phase and associated task in greater detail. As you go through them you'll see highlighted important things that we've learned.

KEY POINT: This project will not be easy. But there are communities that have done this work before you and information available about what worked for them. Begin your project with a commitment to mine these resources for all they are worth—you do not have to re-create everything yourself. Get to know and use the contents of www.communitiesincharge.org.

We've also pulled out particularly relevant examples that may be useful:

EXAMPLE:

Among the priorities of the **Austin TX** *Communities in Charge* initiative was to maximize enrollment in public programs such as Medicaid and SCHIP. The project therefore created a method for easy, consistent and systematic communitywide screening for public programs—including the Medical Assistance Program (MAP), a city-sponsored coverage program—using a web-based tool that quickly assesses an applicant's eligibility for Medicaid, SCHIP, SSI and other federal programs as well as local charity care programs. Through use of this tool, with expanded outreach services, some 11 percent of persons screened have been identified as eligible for public coverage programs and the 97 percent of the others screened as eligible for local charity care programs.

This document presents the development of a program for the uninsured as a linear process. In fact, the experience of *Communities in Charge* participants has shown that the work is often more complex. Along the way we will emphasize places where it will be important for your Planning Coalition to stop and evaluate the progress made. Sometimes, this evaluation leads the coalition back a few steps to rework a difficult issue. That's okay. Approaching planning thoughtfully and carefully will lead ultimately to a successful coverage program for the uninsured in your community.

PREPARATION FOR THE PROJECT

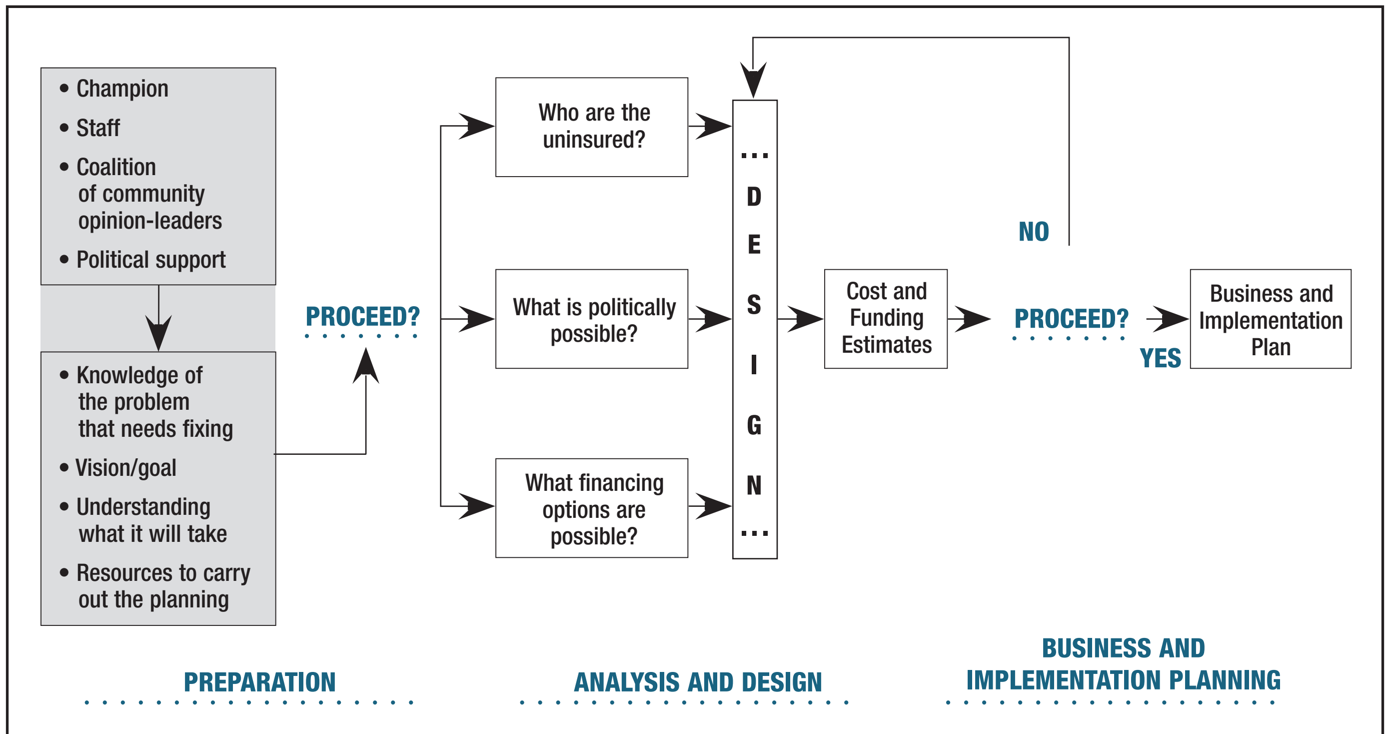
Our experience with the *Communities in Charge* program has shown us that any effort to develop a program for the uninsured needs to have some things in place from the beginning. You can think of these as "critical success factors" (or, more colorfully, "drop-dead elements"). The purpose of the preparation phase is to pull these factors together and then to stop and think about proceeding with the project. Do we have what it takes to move forward? Are there elements missing? Are they essential? If so, can we as a community develop these elements or are they beyond our control? What should we do next?

Here are questions you should be asking in this phase:

- *Who is going to champion this project?* You need a senior-level leader able to build and maintain enthusiasm and energy for the project, particularly among the other community leaders in your planning coalition, especially when the going gets tough. Your champion should be a respected community leader, preferably not associated with any particular group. The champion serves as the voice of the initiative, gets others to participate, and takes responsibility for the group's actions. Champions of various *Communities in Charge* initiatives included a semi-retired business leader and philanthropist, the long-standing CEO of a large safety-net hospital, and the two CEOs of the community's largest mission-driven health systems (which happen to be competitors).

- *Do we have a staff that can make things happen?* The project will require seasoned staff members with a range of skills. Most important, they need to be able to guide, support and facilitate the work of the senior leaders who make up your coalition and to build trust among them.

Figure 2-1. Key Phases and Tasks



In addition, your project will need a racially and culturally diverse staff with strong political, financial, analytic, strategic and project management skills, and very strong oral and written communication skills. It's hard to find all these skills in one or two people; you will likely have to augment some staff skills with assistance from partner organizations or consultants. At a minimum, the staff leadership should be able to engage your champion and other senior leaders, keep the project on track, and translate the champions' enthusiasm into real progress on the tasks that have to be done.

- *Do we have the right partners, and are they committed to the project?* Your goal is to form a functioning coalition of senior leaders who represent key providers and other important constituencies and who have political clout and standing in the community, especially with the segment of the uninsured population your program plans to serve. The leaders must be willing to look beyond their private interests to collaborate on this effort. Coalitions take a long time to develop; it is

unlikely yours will be fully-formed at the start of the project. At this point, however, coalition members should at least be making a public commitment to the project's success, for example, by providing financial support or using political clout to gain public backing.

EXAMPLES:

Portland ME's program is governed by a steering committee made up of key hospital and physician executives, the state Medicaid director, a local public health director, a consumer group representative, and business leaders. The program also has a local advisory committee for each region where it is active. Each local advisory committee consists of front line representatives from all local providers and social service organizations involved in the program as well as consumer representatives.

Jacksonville FL began with a coalition steering committee that included senior executives from each hospital and community health program in the city/county, the director of the public health department, the city council president, a representative of the mayor's office, business leaders, and consumer organization executives. As the project evolved, the steering committee recommended creation of a new 501(c)3 corporation to manage the pilot program and other coalition activities. Board members for the new corporation include the CEOs from each of the hospitals, the mayor, and business and other leaders whose organizations provide financial and other resources for the program.

Louisville KY included in its original project coalition representatives from local hospitals, other major providers, social service organizations, the faith community, and local public health departments involved in the county's Medicaid managed care program. As the project's mission and objectives took shape, the coalition realized that it needed to evolve to a larger, independent entity with a clear communitywide focus. As a result, the project planners formed a 501(c)3 corporation (getCare Health Network, Inc.) that replaced the original coalition. The corporation has an independent board made up of key community and provider leaders who have invested significant resources (money, staff time and services) in the project. Also part of the management structure is an advisory committee with more than 100 members from consumer groups, social service organizations, the faith community, legal aid, local insurers and health plans, and local and state government.

- *Are our state, county and city governments likely to support a change at this time?* It is important to be aware of your state and local political culture, historical trends, and current fiscal environment. Political leadership gives weight to a project and creates access to possible funding streams. Without political and fiscal support, a project may not be capable of broad communitywide change. A community with a track record of creating successful coalition-based programs may be more likely to get the necessary support from politicians and others in government than one without such experience.

EXAMPLES:

Brooklyn NY intended to create a low-cost health insurance coverage program for small businesses. To lower the cost of this insurance, project planners sought state approval for a waiver of the Professional Education Pool Covered Lives Assessment (PEP) surcharge on health insurance premiums, which in the New York City region was more than 8 percent. (The funds support teaching hospitals.) Action on the waiver stalled and was finally halted due to New York State's financial uncertainty after September 11, 2001, and concern among lawmakers that such a waiver would set a precedent and erode funding for teaching hospitals.

Wichita KS Project Access planners knew city and county funding would be required to support the cost of prescription drugs. Before approaching city and county officials with its funding request, the coalition assembled a group of community and local philanthropy leaders, including the chief executives of area hospitals and the medical society, to meet with elected officials and educate them about the proposed program, the commitments already obtained from providers, funders and others, and the funding required from local governments. Combined annual commitments of more than $500,000 were obtained.

- *Do we know what we're trying to fix?* In most communities, there are many facets to the problem of health care for the uninsured. The most successful communities identify a specific part of the problem on which to focus: working with the state to expand health care coverage, for example, or filling gaps in the existing safety net (prescription drug coverage, access to specialty services), or facilitating enrollment in existing public programs. People are much more willing to work toward change when they believe that the status quo is no longer an option and that positive change can be made. You need a good baseline understanding of the local health care system and its shortcomings in order to energize your champions, staff and partners.

- *What vision do we have for our community in the future?* In order to change, people need to know that alternate ways of providing health coverage are working in other places and to see how they could be applied locally. This provides a focus to the work, as well as a feeling of hope and a sense of the size of the task ahead.

- *Do we know what we're really getting into?* The purpose of this document is to clarify what it takes to develop a program for the uninsured. Any guidebook, however, can make the project look simpler and more straightforward than it is. At this point, the community needs to understand that rethinking health care financing and delivery is hard work–if it were easy, it would have been done long ago. Many people, for example, resist any attempt at change. They may be benefiting from the current situation or just be reluctant to do things differently. You will need to respond to myriad social, political and economic shifts in your environment and revise your plans accordingly.

EXAMPLE:
The leaders of the partner organizations of the **Austin TX** planning coalition agreed to meet biweekly during the initial planning period. Each leader committed at least 24 additional hours or whatever was needed to complete the strategic planning process, which ended up taking six months. Leaders made available staff members from their organizations to do background and between-meeting tasks, including pursuing grants.

- *Do we have the resources to get started?* Once again, this project takes hard work. Hard work doesn't happen by itself. Do we have the money, the time, the people to do the analysis and program design tasks that need to happen next?

The Resources section that follows contains references for additional information on these topics.

The output from this first phase of the project is a functioning, funded, planning coalition able to make an informed decision to proceed. This is the where your coalition must make its decision: Given what we have learned from answering the questions listed, and what we can see of the work that lies ahead, *should we move forward*? The success of your effort will depend on whether your coalition answers this question honestly. The work involved in creating a strong foundation will repay itself many times over as you analyze, design, refine and implement your coverage program for the uninsured.

Resources

Sources of additional information on topics discussed in this section include:

Coalitions and Collaboration

- The Robert Wood Johnson Foundation-funded Access Project's **"Developing a Community Based Response to Healthcare Issues: A Framework for Planning and Action."** Available at http://www.accessproject.org/publications.htm
- The "Community Building Tools" section of the **University of Kansas Community Toolbox.** Available at http://ctb.ku.edu/
- **Working Together, Moving Ahead: A Manual to Support Effective Community Health Coalitions** by Shoshanna Sofaer, Dr. P.H. (School of Public Affairs, Baruch College).
- **Building Coalitions: Evaluating the Collaboration** by the University of Florida, Cooperative Extension Service.
- **The Collaboration Primer** by Gretchen Williams Torres, M.P.P., and Frances S. Margolin, M.A., a publication of the Health Research & Educational Trust. Available at http://www.hospitalconnect.com/hret/programs/content/colpri.pdf
- The **Amherst H. Wilder Foundation** website http://www.wilder.org/pubs/Collaboration contains publications on collaboration.

The Nature of the Uninsured in Your Community

- The Agency for Health Research and Quality's web-based **data books and tool kits for communities to Monitor the Health Care Safety Net.** Available at http://www.ahrq.gov/data/safetynet/.
- The State Health Access Data Assistance Center (SHADAC) website http:www.shadac.org.
- Most state Departments of Health have data on health status, insurance and usage patterns.
- Cover the Uninsured Week website http://www.covertheuninsuredweek.org/issue/.
- The Institute of Medicine of the National Academies Consequences of Uninsurance Project website http://www.iom.edu/project.asp?id=4660.
- The **Henry J. Kaiser Family Foundation** website http://www.kff.org/about/kcmu.cfm.
- Interviews with local providers, payers, academics, administrators, business executives and community members can be useful.

Defining your vision

- The W.K. Kellogg Foundation's **Logic Model Development Guide** presents a method for defining a vision and understanding the activities necessary to achieve that vision. Available at http://www.wkkf.org/Pubs/Tools/Evaluation/Pub3669.pdf

Promoting Community Vision and Action

- The Forums Institute has developed a model for communitywide policy discussion and policy-setting. See http://www.forumsinstitute.org/NJHPF.html for Policy Forum guiding principles.
- Jacksonville FL successfully used this model, and the resulting policy briefs from The Jacksonville Community Forums on Health Care and the Uninsured are available on the JaxCare web site (http://www.jaxcare.org/policy_briefs_rev_1050.aspx)

ANALYZING YOUR MARKET, ENVIRONMENT AND FINANCING OPTIONS

Your community has prepared to do the work of creating a program for the uninsured and has made the conscious commitment to proceed with Phase 2: Analysis and Design. In this phase, your community will undertake three analyses:

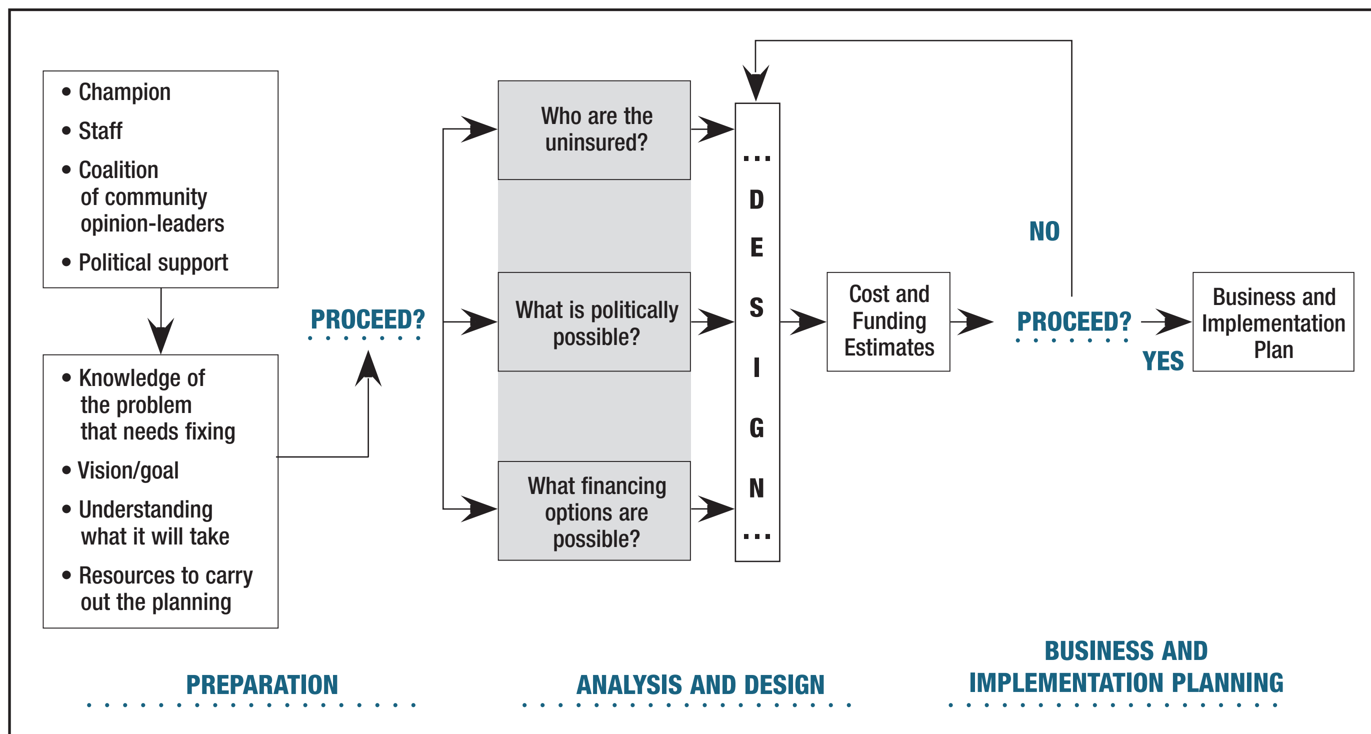
- A quantitative market assessment of the demographic characteristics of the uninsured in your community, the current capabilities of your health care delivery system, and local trends in care delivery, financing and utilization;
- A qualitative assessment of the existing political environment, how these relationships and pressures may affect your program, and how you can use this information to develop an appropriate strategy for expanding health coverage; and
- An evaluation of possible financing mechanisms for health coverage programs to help you build a case for securing local/state funds, political support and community involvement.

First Analysis: Quantitative Market Assessment

In conducting the market assessment, your community will gather and analyze four types of information:

- **Demographic data about the uninsured in your community.** This includes an estimate of the number of uninsured individuals within the region and a categorical breakdown of the segments of this population.
- **An inventory of the provider community.** This involves a survey of all care delivery sites (physicians, hospitals, inpatient/outpatient clinics, etc.) within a region, the services and capacity each offers and the availability of free or reduced-price services for persons without third-party health care coverage.
- **Utilization and cost data,** which reveal patterns of medical use and the cost of seeking medical care within a community.

Figure 3-1. Key Phases and Tasks

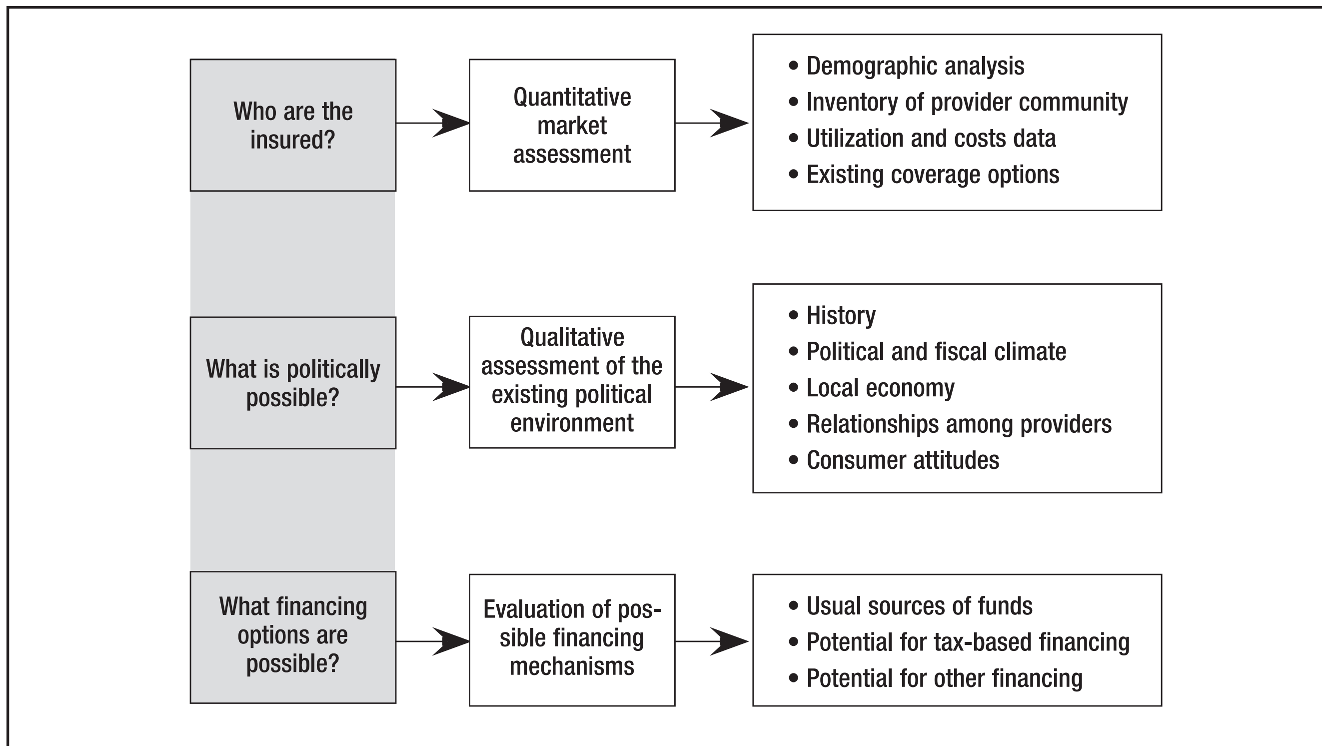


- **Existing coverage options,** including federal, state and/or local programs for individuals without health coverage who meet certain income, disease state and/or other eligibility criteria.

> **KEY POINT: Do not gather information at a finer level of detail than you really need. Knowing, for example, that there are 51,817 uninsured persons in a community is much less critical than understanding why 50,000 to 55,000 persons are without health coverage. Focus on the information that will help you design a good program and convince others of its worth.**

Experience has shown that it will take your coalition two-to-three months to complete an initial market assessment. You'll also need to conduct reassessments from time to time, especially if the economy worsens or there are other changes in health financing (for example, cuts in the Medicaid budget that lead to the elimination of coverage for certain groups, such as medically needy adults).

Figure 3-2. Components of the Three Analyses



Demographic Analysis

The purpose of the demographic analysis is to help you more precisely define the size, characteristics and likely needs of the segment of the uninsured you will choose as your target market. The uninsured in your community may fall into several categories, for example:

- Individuals eligible for publicly-financed health care coverage (i.e., Medicaid, State Children's Health Insurance Program [SCHIP] or Supplemental Security Income [SSI], the federal program for the disabled) but not enrolled in these programs;
- Low-income, chronically uninsured and unemployed persons; or
- Part-time and full-time employed persons and dependents of employed persons who are not eligible for employer-sponsored coverage, cannot afford to pay employee-required contributions toward health coverage premiums, or work for companies that do not offer health coverage.

You will want to assess the nature of each of these categories, remembering that you may further define your intended population as a subset of one of these categories. You may focus, for example, on the

number of uninsured individuals in each group with incomes under and over a certain percentage of the federal poverty level (FPL), or those individuals with chronic illnesses. For the employed, you may want to break down the number of uninsured individuals by size of firm or by employment status (hourly, part time, full time).

The demographic analysis may also reveal local, racial and ethnic health coverage disparities, the prevalence of special needs populations that may experience significant barriers to care, or regional concentrations of the uninsured. All this information will help focus efforts on a particular geographic or categorical segment of this population.

When combined with the utilization analysis described below, the demographic analysis will allow you to make statements such as, "In our community, individuals who are chronically ill, chronically uninsured and unemployed make up 20 percent of the community's uninsured population but use 80 percent of existing resources." Such quantitative statements make your case clear and will help to engage others in your project. It also moves you forward to developing the strategies to reach this clearly defined market.

> **KEY POINT: In order to understand the financing required to serve your intended population and to create an effective, sustainable coverage program, you will need to provide specific data on every segment of the uninsured population to be targeted. General data will not be useful.**

Data to Collect

Your demographic analysis should include four types of data:

- The number of uninsured residents within an area;
- Descriptive information about these residents (age, gender, race, prevalence of chronic disease, existing health coverage);
- Geographic location – where they live; and
- Economic status: household income and employment status.

Tools and Resources

Three good sources on how to conduct a local demographic assessment are:

- **Using Data: A Guide for Community Health Activists.** Boston: The Access Project, 2001. Available at http://www.accessproject.org/downloads/products/data.pdf.
- Socholitzky, Elinor and Nancy Turnbull. **How Many Uninsured? A Resource Guide for Community-Level Estimates.** Boston: The Access Project, 1999. Available at http://www.accessproject.org/downloads/uninsured.pdf.
- Agency for Healthcare Research and Quality, **Safety Net Monitoring Initiative (Lynn A. Blewett, Ph.D. and Timothy Beebe, Ph.D.). Estimating the Size of the Uninsured and Other Vulnerable Populations in a Local Area.** Available at http://www.ahrq.gov/data/safetynet/blewett.htm.

The Current Population Study (CPS) and Survey of Income and Program Participation (SIPP) are frequently used to assess the health coverage status of individuals nationwide.

The Resources section at the end of Part III contains a list of recommended references for demographic data.

Finally, remember that you may not be the only organization interested in learning more about the nature of your community's uninsured population. Another organization may be planning a community-based study or survey, and you can build on its work.

EXAMPLES:

Alameda County, California, worked with the UCLA Center for Health Policy Research to conduct the County of Alameda Uninsured Survey (CAUS). CAUS was the first county-specific, multilanguage survey of the adult uninsured.

Portland ME, on learning that the state Medicaid program had contracted with the University of Southern Maine to conduct a comprehensive survey of the state's uninsured, joined the project and gained the more detailed regional information it sought through a simple grant-funded expansion of the survey's scope.

Inventory of the Provider Community

The purpose of assessing the provider community is to quantify the capacity, availability and accessibility of the local health care safety net. Creating this inventory also affords an opportunity to work with these providers and engage them in program design and planning.

Data To Collect

The provider inventory should contain information on the services currently offered to low-income, uninsured individuals and the extent to which these services are used. Developing the ideal inventory of a provider community involves several steps:

- *Gather a comprehensive list of the providers of inpatient and outpatient care within a defined region.* Providers include hospitals (public and private), primary and specialty care physicians including independent physician associations (IPAs) and medical groups, and public health care facilities (community health centers, Federally Qualified Health Centers, local/state health department clinics, medical center clinics, mental health facilities and other health agencies). The geographic distribution of providers can be mapped using readily available mapping software.
- *Determine the general breakout of medical professionals by region or provider site.* Medical professionals include physicians, nurse practitioners, case managers and social workers. (**The Council of Graduate Medical Education** [http://www.cogme.gov/rpt8.htm] provides a requirement of 60 to 80 generalist physicians per 100,000 population and 85 to 105 specialist physicians per 100,000 population.)
- *Determine the type of care that each provider delivers.* You should assess the general type of care delivered (primary, specialty, tertiary); the type of specialty care provided (orthopedics, cardiology, etc.); and any wraparound services (disease management, case management, outreach) made available. The uninsured and underinsured can face real problems gaining access to specialty physician services, mental health services and dental services. Be sure that your provider inventory clarifies that these services are indeed available to the uninsured and underinsured.
- *Define each provider's service area and service capacity.* The **service area** refers to the geographic region (town, county, city, etc.) that a provider typically serves. **Service capacity** refers to a provider's typical and/or maximum available resources (number of beds, patient schedule, etc.). Important information to gather includes:
    - Whether or not a provider participates in Medicaid, SCHIP or Medicare and whether it has established a charity care policy (this can be an indication of a provider's willingness to serve the uninsured).

- The level of emergency room overcrowding and the prevalence of ambulance diversion at each hospital. Overuse of the emergency room may be a sign of unmet need for primary care.
- Each provider's ability to supply affordable prescription drugs. Some providers may participate in the federal Health Resources and Services Administration's 340B programs and/or may have an established network for distributing low-cost prescription drugs. A community can capitalize on these assets in designing a new program for the uninsured.
- The extent to which community clinics have unused capacity to treat the uninsured. Data on number of days to the next available appointment and summaries of clinic hours may give an indication of how fully used these important resources are.

KEY POINT: Remember that no community clinic can survive without a base of paying patients. These providers cannot be expected to take on the full burden of caring for the uninsured.

- *Categorize each provider's patient population.* This step involves applying the data collected in the demographic analysis to the provider inventory to show the kinds of patients currently being served by each provider. While this data "crosswalk" may be difficult, the result provides useful information on existing patterns of care.
- *Determine the amount of free care that each provider delivers as a rough percentage of total free care delivered within the community.* Are governmental (e.g., Medicaid, Disproportionate Share, city or county general revenue) funds evenly distributed, or are there providers who do not receive them and therefore absorb the cost of delivering care to persons without insurance? It is important for a community to understand which area providers deliver free care and to what extent. This information enables the community to evaluate the breadth and depth of the local health care safety net. If one hospital has traditionally received public funding to provide health care services to the uninsured population, it may be difficult for a community to develop a coverage program in which other area providers share this burden.

The Resources section at the end of Part III provides additional references for collecting the information.

Utilization and Cost Data

Utilization data will help your planning coalition understand how much free or subsidized care is currently provided in your community, and the nature of the demand that exists for that care. It is important also to understand the costs incurred by the local health system in providing these free medical services. Note that this part of the analysis deals only with currently provided services. There may be additional demand for health care services to meet unmet needs.

Data To Collect

While it is important for a community to collect utilization data for its intended target uninsured population, this task is difficult. There is no exact count or listing of locally uninsured persons and providers do not typically keep track of the diagnoses and procedures specific to this population. Uninsured individuals also may receive services from multiple providers, making it hard to track the frequency of patient visits and the services received. Public Medicaid and Medicare programs and employer-sponsored health insurance programs are, however, able to provide utilization statistics for their members from medical claims data. In some cases, this information can provide a proxy for expected health services utilization by the uninsured, at least for planning purposes.

This same lack of "counts" of the uninsured also makes it hard to calculate the actual cost (not what is charged) of providing free care. Calculating the cost of any episode of care is already difficult enough, owing to the need to separate fixed from variable costs and to allocate overhead correctly. At this point in the project, a proxy cost estimate for major visit types (primary care office visit, inpatient day, emergency room visit, etc.) based on a provider's general experience is sufficient.

Tools and Resources

A reference for utilization and cost analysis is:

- Miller, Michael. **The Free Care Safety Net Fact Sheet.** Boston: The Access Project, Revised February 1999. Available at www.accessproject.org.

Other references are given in the Resources section at the end of Part III.

KEY POINT: **While accurate cost and utilization data are important, they are much less crucial than the information gathered in the previous steps. A community should concentrate on obtaining basic cost and utilization data and moving the assessment process forward, as opposed to spending a significant amount of time refining data.**

Existing Coverage Options

KEY POINT: **The first priority of any community health coverage initiative is to enroll individuals who are eligible for public coverage into existing local, state and federal programs (Medicaid, SCHIP, Medicare, or other local programs).**

The first priority of any community health coverage initiative is to enroll individuals who are eligible for public coverage in local, state and federal programs (Medicaid, SCHIP, Medicare, or other local programs). Conducting the market assessment provides an opportunity to gather and disseminate information on existing public and private coverage options, and helps you develop plans for taking full advantage of such programs.

EXAMPLE:

Among the priorities of the **Austin TX** *Communities in Charge* initiative was to maximize enrollment in public programs such as Medicaid and SCHIP. The project therefore created a method for easy, consistent and systematic screening for public programs—including the Medical Assistance Program (MAP), a city-sponsored coverage program—using a web-based tool that quickly assesses an applicant's eligibility for Medicaid, SCHIP, SSI and other federal programs as well as local charity care programs. Through use of this tool, with expanded outreach services, some 11 percent of persons screened have been identified as eligible for public coverage programs and the 97 percent of the rest as eligible for local charity care programs.

Data To Collect

Your coalition should begin by collecting eligibility information—that is, information about income requirements, age requirements and residency requirements—for the following programs:

- *State Medicaid programs.* Medicaid eligibility requirements differ among states, and it is important to identify what these are in your community. You should also assess whether your state is operating under an 1115 (or other) waiver, which may expand Medicaid eligibility to new populations (1115 and other types of waivers are granted by the federal government for new Medicaid initiatives).
- *SCHIP.* Some states have received State Children's Health Insurance Program waivers to cover parents of children enrolled in SCHIP or pregnant women with incomes up to and above 185 percent of the FPL. Understanding who *is* eligible for Medicaid and SCHIP coverage can also reveal who *is not* covered under these programs and help a community design an appropriate benefits package.
- *State insurance programs to expand coverage.* Do these exist in your state, and, if so, what are their eligibility requirements? (Examples of such programs include New York State's Healthy New York and Washington's Basic Health Plan).

KEY POINT: A community wishing to design a new coverage program for the uninsured may be able to work with the state to develop a joint state and locally-sponsored coverage program that builds on the statewide model. Another option might be to adapt the state's model to use at the local level.

Depending on the nature of your intended population, you may also consider investigating:

- *Existing health coverage programs.* If your community already has a coverage initiative, include its leaders in your coalition and learn all that you can from its experience. What can your coalition do to make sure the existing program operates at full capacity? Can it serve as a model for your program? Is there an infrastructure in place that you can use? Can this program provide you with current market data? Can it offer access to key stakeholders, providers and resources that may be critical to the short- and long-term sustainability of a new program for the uninsured? What other ways can you collaborate with this program rather than duplicate efforts or vie for limited resources?

> **EXAMPLE:**
> In **Alameda County, California,** the *Communities in Charge* project has worked with the Alameda Alliance for Health, the local not-for-profit managed care plan, to develop, implement, and evaluate Alliance Family Care, a new "gap" coverage program for families, including recent immigrants. This has allowed *Communities in Charge*–Alameda County to use an existing infrastructure and provider network with medical and dental staffs that are able to meet this population's diverse health needs.

- *Commercial insurance.* If you are exploring employer-sponsored coverage for small and large businesses, you should conduct an analysis of commercial insurance products within the defined service area. Product information, e.g., employee benefits, scope of physician network and limitations on pre-existing conditions, can help a community design a competitive benefits package that does not encourage insured individuals and small groups to drop existing health coverage and enroll in a product designed for the uninsured population. Your analysis may also help the community identify insurance companies that may be willing to share actuarial information, federal and state governmental affairs expertise, contacts and legal knowledge to facilitate program design and implementation.

Tools and Resources

Information on State Coverage Initiatives is available online at http://www.statecoverage.net/.

The Resources section at the end of Part III includes additional data references.

Second Analysis: Qualitative Assessment of the Existing Environment

Even the most carefully gathered quantitative market data only tell part of the story. An understanding of the informal, unspoken processes and dynamics that shape a community is fundamental to program planning and development. A community that wants to expand access to affordable health coverage must come to understand the predominant environmental barriers to obtaining this coverage. In conducting the analysis, you should evaluate:

- The history of new initiatives in your community:
  - Whether your political climate promotes communitywide coalitions and change efforts
  - Elements in your local economy that may support or hinder your program.

- The relationship of your local elected officials to those in state government: Does your program have the potential to become a "political football" or will both entities join to support it?
- Historical care-seeking patterns among various racial and ethnic groups and the extent to which providers are sensitive and responsive to how such differences can influence care-seeking and follow-through on treatment regimens.
- The relationships among providers in your community, and the likelihood of their ability to collaborate on this work.
- Consumer attitudes in the community, especially about health care coverage and the use of health services.

A well-developed understanding of these environmental factors will help you create a program design that makes sense for your community and will enable you to go about implementing this design in an informed and intelligent way.

Historical factors. Ideally, a community needs to be open to change and able to demonstrate a pattern of successful, communitywide collaboration to undertake this project. A community with a winning track record of coalition-building and public decision-making is more likely to succeed in communitywide health coverage reform than a community that is more resistant to change. Past collaborative planning efforts will influence the success of this project, and your planning coalition should assess this history.

EXAMPLE:

Portland OR, the site of the Tri-County *Communities in Charge* project, successfully initiated a public process to design and, later extend, the Metropolitan Area Express (MAX) regional light rail system. Through this project, Portland showed it was open to community-driven large-scale change in the public sector.

Political and fiscal factors. The political and fiscal environment will affect program design and implementation. Both the short- and long-term success of a program are largely due to its political and fiscal support. In this task, your coalition needs to learn about:

- **Local/state fiscal status.** Communities and states in economic peril are not likely to allocate new funds to support local, indigent health care, nor are they likely to increase or initiate a local or state tax for this purpose.

EXAMPLE:

The **Jacksonville FL** *Communities in Charge* project had originally planned to use local and state funds to draw down federal matching dollars to support an enrollment-based, health care program for the uninsured. After assessing the realities of the state's fiscal status and policy climate, the community decided to pursue a shorter term funding strategy that relies on local, public-private dollars.

- **Timing of local/state budget review process.** You should also clarify your state and local government's budget review process: Is it an annual process? Biennial? At what time of year will government officials be open to requests for budget allocations for your program?
- **Elected officials.** Elected officials can be an important and effective source of support for your program. Learn about local and state politicians so you can approach these officials ready to explain to them how supporting your program helps their community.[1]
- **Local government restructuring.** Some communities are merging city and county government agencies. The mergers themselves can absorb all the energy of government staff members, including those whose participation you need in your coalition. If this type of restructuring is occurring in your community, take time to learn about the political climate of the merged government, identify key leaders and other influential staff members, and become aware of the priorities of the newly merged administration.
- **State government officials.** Your community should also develop a good working relationship with state government officials, especially the state Medicaid director and those in the state health department. These officials can provide access to essential data and, possibly, play a role in crafting a regional, as opposed to a city or county-specific, health coverage approach. A community may be able to take advantage of Medicaid initiatives within the state. It also may be valuable to network with state senators and representatives in your area, particularly if they are in leadership positions or on health or appropriations committees.

EXAMPLE:

In **Jackson MS** the Hinds County Health Alliance (HCHA), a *Communities in Charge* project, is working with the University of Mississippi Medical Center and McKesson Health Solutions to negotiate a contract with the state Medicaid program. The goal of the partnership is to establish a call-center and disease management program for the state's Medicaid population. HCHA ultimately hopes to use the program infrastructure to serve non-Medicaid, uninsured individuals within the state.

[1] The Internal Revenue Service places limitations on the use of private foundation funds for lobbying and political campaign activity. Check with grantmakers to understand specific boundaries.

State officials may also help your community understand the intricacies of state or federal coverage options, modify guidelines to benefit your community, or support a federal waiver. From your standpoint, you need to understand your community's relationship with the state, as well as key issues facing the state government. Your goal is to obtain financial and political support from the state government. Your coalition will be best able to devise an appropriate strategy to do so by understanding its political environment among the different levels and the branches of government.

KEY POINT: Pay attention to both "Politics" and "politics." "Politics" refers to the official government and elected officials. At the local level, "politics" refers to how power and control are shared and distributed in a community. Engaging the right community leaders can catapult your process and significantly raise the profile of your project. In the same way, not being mindful of "Political" relationships could sink your efforts.

Economic factors. Changes in the economy can affect your project. An economic downturn may lead to budget cuts that will certainly hamper your efforts to develop coverage expansion programs. A slowing of the economy will raise unemployment levels and cause individuals to lose health coverage. While economic forecasting is an inexact science, your coalition should develop a grasp of how robust your local economy is. And, in some cases, having a poor economy may strengthen the case for your health coverage program.

EXAMPLE:

Health*for*All of WNY, Inc., a *Communities in Charge* project in **Buffalo NY** has developed a small business premium subsidy program to expand local coverage. The depressed local economy is a communitywide concern, and Health*for*All has used this fact to solicit financial contributions to the program from state and local government.

Provider community. Area health care providers compete for market share. Because the success of a community-based effort is largely dependent upon provider collaboration, competition can affect program design and viability. There may be tension among local providers around Certificate of Need (state oversight of major capital expansion projects), distribution of public dollars or other fiscal issues.

KEY POINT: A community should assess the dynamics of the provider community and determine whether providers will be able to overcome local competition and work toward a common goal.

Your community may also wish to assess the level of managed care penetration. Physicians who provide significant portions of their services through discounted managed care contracts may face fiscal pressures that will limit the amount of charity care they are willing to provide. This may be especially true for physicians in large group practices.

Consumer attitudes. The final elements your coalition should seek to understand are consumers' attitudes toward health coverage and reasons some consumers do not purchase health insurance. Uninsured individuals may not know how to access health coverage; they may be reluctant to complete an arduous enrollment process or join a government-sponsored program; there may be cultural, racial or language barriers that are difficult to maneuver; or they may not be offered insurance through their employment.

Some information about accessibility of health coverage will come from your demographic analysis. You may use qualitative methods (surveys, focus groups and in-depth interviews) to identify the financial, sociocultural and organizational barriers that deter people from purchasing health coverage.[2] (Communities may wish to hire a professional research partner to carry out this process.) A community must recognize the limitations of qualitative research. Outcomes will vary depending on the type of questions asked, the people involved, and the process used to gather information.

Third Analysis: Evaluation of Possible Financing Mechanisms

A successful program makes the best use of the funds it has and makes sure it has gathered funds from every available source. Most local coverage programs are funded through multiple funding sources. Your community must carefully assess the opportunities that are available to raise long-term, sustainable funds for the program, and work to understand how these financial resources can be used—especially whether it may be possible to leverage available funding (for example to use local dollars and matching state dollars to draw down federal funds, thus tripling its financial resources). At this point, you are seeking a general understanding of the sources and levels of financing that may be available, so your initial program design can reflect financial reality.

[2] McDonough, Dr. P.H. Healthcare Policy: The Basics. Boston: The Access Project, 1999.

The Usual Sources of Funds

Providers of uncompensated care most often use a small number of sources to pay the cost of this care:

- Philanthropy—funds donated for this purpose
- Cost-shifting—charging other payers higher prices to recoup the cost of charity care
- Federal subsidies—such as payments to community health centers and Federally Qualified Health Centers or Disproportionate Share Hospital (DSH) dollars; and
- Other local/state/federal dollars.

Your task is to identify which sources currently are being used in your community and whether these funds might also be available for your program for the uninsured. You should evaluate these sources of funds to identify any that you might access, if your community is not doing so already. Finally, your coalition should discuss how your potential access to these sources might lead to funds from other sources: either because you can leverage these funds, or because your access to them might make other funders (private or community foundations, local business partnerships) more willing to give you money.

KEY POINT: Typically, local foundation grantmaking takes the form of discrete, nonrenewable grants; it therefore is not a sustainable source of funds for your ongoing project operations. Local foundations can be important resources for your efforts, however, even if they cannot contribute large dollar amounts. Foundations can play a unique role as conveners for community dialogue and planning and may fund a specific project such as a market assessment, communications campaign, or a program evaluation.

What About Tax-Based Financing?

Some states grant communities the legal authority to levy a local tax or pass a referendum reserving a certain portion of local/state general funds for medical care of indigent people. Your coalition should first determine whether your state has granted your community this legal authority. If so, you need to determine whether it is wise to use it. Levying additional taxes can be highly unpopular unless there is deep community support for the effort to provide health coverage. Even with such support, your local government will face a challenge in distributing the tax-levy dollars among providers in the community. If your community does not have legal authority to levy a tax, you must then decide whether and how to seek such authority—the legislative process requires patience, finely-honed political skills, and the expenditure of significant political capital.

When you have completed these three analyses, your coalition will have developed a common understanding of the nature of the population you wish to serve and the main elements in your environment that you must consider in designing the program. Remember that you need to keep the data you gather up to date and may need to revisit your analyses to reflect new facts you discover or changes in the nature of your community. Above all, use the knowledge these analyses give you as your coalition moves ahead to the task of program design.

EXAMPLE:
The Appendix section of this manual explains the many different financing mechanisms used by participants in *Communities in Charge*. Please refer to it for more information.

Resources

Demographic Data References

- **US Census Bureau** [http://www.census.gov/population/www/index.html]
  - **State & County Quick Facts** [http://quickfacts.census.gov/qfd/]
  - **American Community Survey** [http://www.census.gov/acs/www/]
- **The Henry J. Kaiser Family Foundation** [http://www.kff.org/]
  - **State Health Facts** [http://www.statehealthfacts.kff.org/]
- **Assessing the New Federalism** (The Urban Institute) [http://www.urban.org/Content/Research/NewFederalism/AboutANF/AboutANF.htm]
  - **State Database** [http://www.urban.org/Content/Research/NewFederalism/Data/StateDatabase/StateDatabase.htm]
- **Claritas** [http://www.clusterbigip1.claritas.com/claritas/Default.jsp] (Database of current year estimates and five-year projections of local market demographics.)
- **2004 Federal Poverty Guidelines** [http://www.aegis.com/factshts/network/access/poverty.html]
- **MUA/MUP** (Medically Underserved Areas/Populations) [http://www.bphc.hrsa.gov/databases/newmua/]
- State/Local Health Department
- Local University (School of Public Health, Government and/or Policy)
- Existing surveys

Provider Inventory References

- American Hospital Association Hospital Guide (available through **AHA Online Store**) [http://www.ahaonlinestore.com/ProductDisplay.asp?ProductID=7&cartID=1972506]
  - Annually publishes a guide to U.S. hospitals and health systems
- Community Benefits

  "Community Benefits: The Need for Action, An Opportunity for Healthcare Change. A Workbook for Grassroots Leaders and Community Organizations"
  The Access Project (2000) Available at http://www.accessproject.org/publications.htm

  More information available at http://www.communityhlth.org/communityhlth/resources/communitybenefit.html
- **HospitalBenchmarks.com** [http://www.hospitalbenchmarks.com/]
- **Solucient** (A provider of health care information) [http://www.solucient.com/aboutus/mission.shtml]
  - **Products & publications** [http://www.solucient.com/publications/books/default.shtml]
  - Annually publishes Profiles of U.S. Hospitals
    a. Indicates whether a hospital is a disproportionate share hospital
- **Dorland Healthcare Information** [http://www.dorlandhealth.com/]
- **HRSA Bureau of Primary Health State Workforce Profiles** [http://www.ask.hrsa.gov/OrgAndPubSearchResults.cfm?type=keyword&keywordselect=552]
- **American Medical Association** (AMA) [http://www.ama-assn.org/]
- **Directory of Physicians Groups and Networks** [http://www.dpgn.com/]
- **The Little Blue Book Companies** [http://www.thelittlebluebook.com/]
- State/Local Licensing Societies (e.g., Medical Societies)
  - Provide a list of physicians and zip codes for defining provider distribution
- State health departments and their web sites
- Local Managed Care Organizations
- Local/National business and/or health care journals
  - May provide information on provider access and Medicaid participation rates
- City/county web sites

Cost and Utilization Data References

- HospitalBenchmarks.com [http://www.hospitalbenchmarks.com/]
- **Solucient** (A provider of health care information) [http://www.solucient.com/aboutus/mission.shtml]
- **Health Care Cost & Utilization Project** [http://www.hcup-us.ahrq.gov/overview.jsp]
- **State Inpatient Database** [http://www.hcup-us.ahrq.gov/sidoverview.jsp]
- **Medical Expenditure Panel Survey** (MEPS) [http://www.meps.ahrq.gov/whatis.htm]
- **Agency for Healthcare Research and Quality** (AHRQ) [http://www.ahrq.gov/] (Medical care financing and utilization probability studies)
- **Medical Group Management Association** (MGMA) (Financial information on private practices and the provision of free care) [http://www.mgma.com/]
- Completed actuarial work
- Existing studies on high utilization patterns and/or the chronically ill
- Medicaid and/or HMO proxies
- State/local hospital associations
- State health department website
- Provider websites
- Local research institutions and/or universities
- Local partner insurance companies/managed care organizations

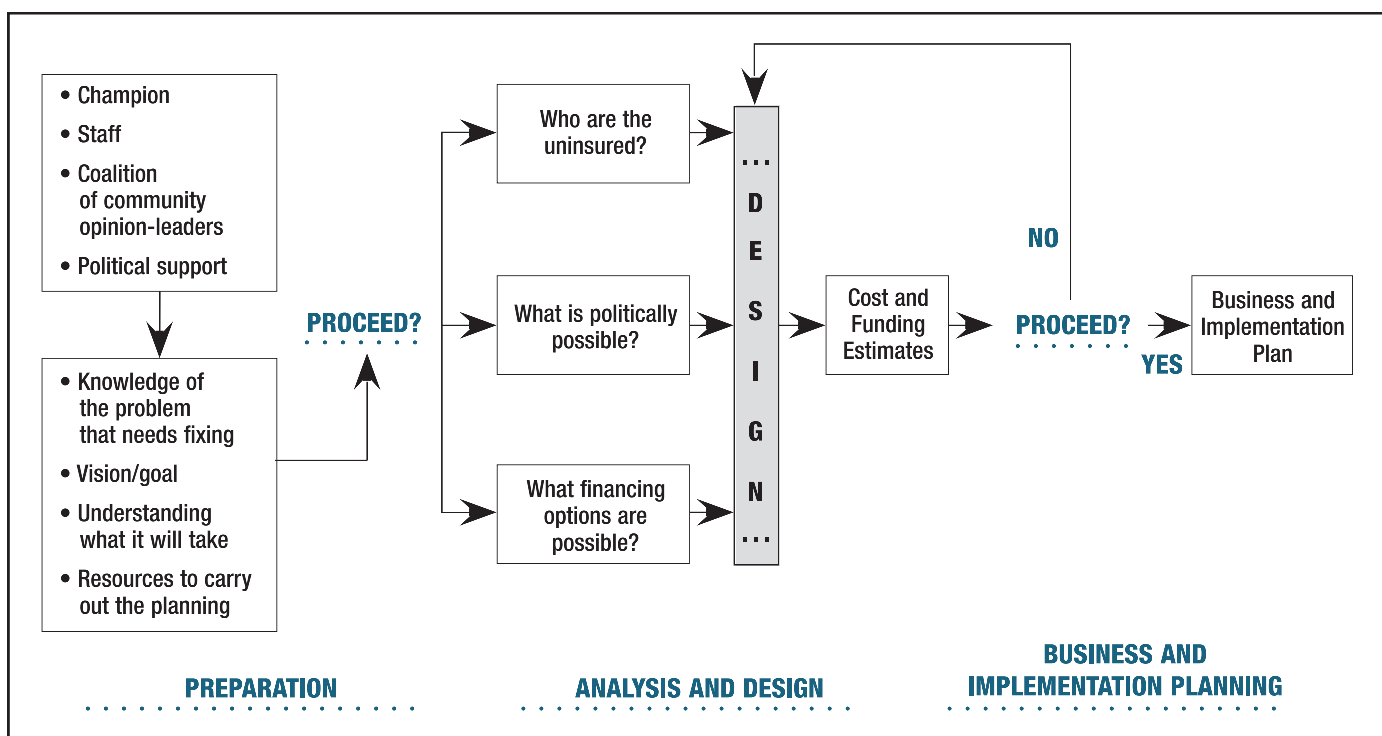
Coverage Option Data References

- **Center for Medicare and Medicaid Services** [http://www.cms.hhs.gov/]
- Local/state (community) health department website
- Local/state medical society
- State/county legislation
  - State Senate and/or House website
  - City/county website
- State Department of Insurance
- **State Coverage Initiatives** [http://www.statecoverage.net/]
- Chamber of Commerce
- **Atlantic Information Services** [http://www.aishealth.com/]
- State Departments of Insurance and Labor
- HMO Quarterly Statements
  - State Department of Insurance
- **America's Health Insurance Plans** [http://www.ahip.org/]
- **InterStudy Competitive Edge Reports** [https://www.managedcarestore.com/yinterst.htm]
- **Dorland Healthcare Information** [http://www.dorlandhealth.com/]

PROGRAM DESIGN

Having completed your analysis of the uninsured population in your community, political and other environmental factors, and possible financing mechanisms, your coalition now begins to design the framework of your program for the uninsured. This section assumes that you are designing a program to expand health coverage that has a single focus and targets a single segment of the uninsured population. Several *Communities in Charge* sites, however, developed programs that took a more comprehensive approach. The design steps are the same; a comprehensive effort just has a broader size and scope.

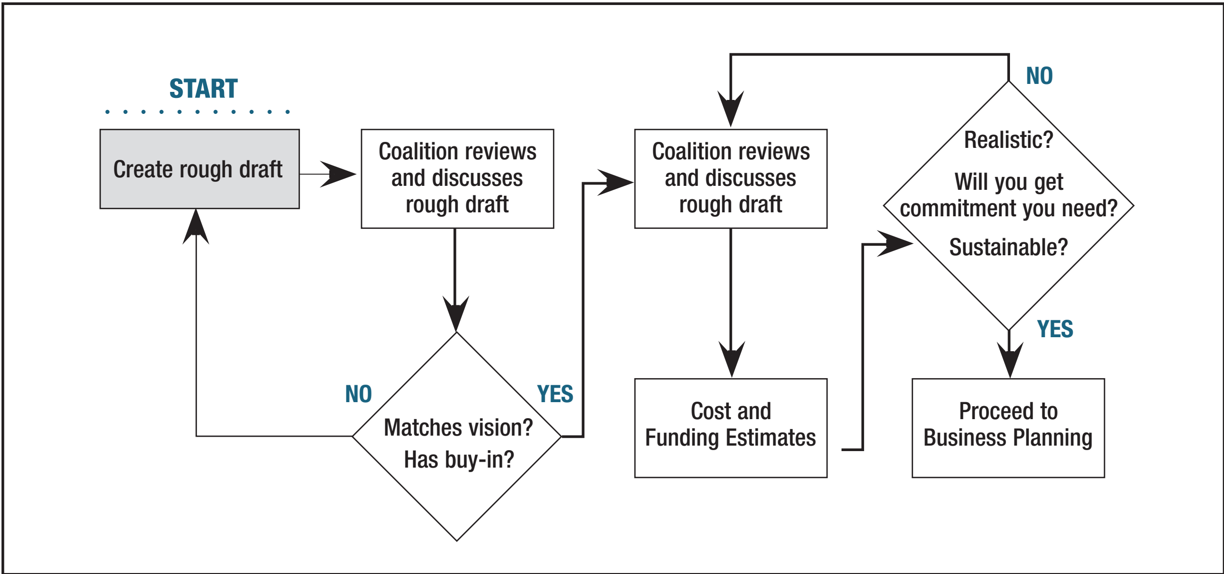
Figure 4-1. Key Phases and Tasks



KEY POINT: **The design process is not linear. Each component invariably affects the others. As you refine each element of your program design, you will see the overall program gradually take shape.**

Program Design roughly follows the process described in Figure 4-2.

Figure 4-2. The Program Design Process



Collaborative planning is critical to the design process. Your coalition should establish design committees, composed of knowledgeable decision-makers from the organizations most likely to contribute to the program's success, to hash out program details.

KEY POINT: **Explore how other communities have created their program designs and use what they have learned. Visit www.comunitiesincharge.org for more information.**

Program Details: The Rough Draft

Your first task in program design is to get a quick sense of where you are heading. This is the rough draft of your program and, at a high level, answers the **"who, what, how, where, when"** questions about the program.

Who?

The "who" is the intended target of your program, the segment of uninsured/underinsured people you intend to serve. The "who" is not easy to determine; it may require your coalition to make difficult choices—based on politics, finances or logistics—to include some segments and not others.

It is not enough to know the nature of the uninsurance problem in your community; you must also know why you want to focus your efforts on a specific segment. For example, your coalition may select uninsured people with chronic diseases who are frequent users of hospital emergency rooms. Improved access to a medical home, specialty physician care, and free or low-cost prescription drugs will not only benefit the people served but will better control the costs for coalition partners. Or your program may decide to select uninsured workers and their families in response to a strong community desire to seek business investment in solutions to the "problem of the uninsured."

EXAMPLE:

In **Alameda County,** Alliance Family Care was designed for uninsured family members with children enrolled in Medi-Cal, Healthy Families or Alliance Family Care. This strategy was part of an umbrella countywide strategy to invest in families, not just children A second program, Alliance Group Care, was designed for in-home supportive services workers, a group of the uninsured who are typically older, single and without dependent children. This strategy fit within the larger county strategy to leverage local investment to gain more funds. In this case, the federal and state government provided matching funds for coverage of these workers.

You began to answer this question in your market assessment (Part II). The job of the coalition now is to use the information you've gathered to select your intended population, which will guide the rest of your program design.

What?

The "what" is the program or range of services made available to meet the needs of the uninsured segment of the population you have defined for your program. This may include a comprehensive array of services similar to those offered through a public coverage program such as Medicaid or a commercial health plan. Services offered may be more limited, incorporating only outpatient services such as primary care and specialty physician office visits, prescription drugs, and outpatient diagnostic testing.

KEY POINT: Your program needs to include services to which your intended population does not already have access, especially if you wish to change the utilization patterns of uninsured persons who frequently use costly service sites such as hospital emergency rooms.

EXAMPLE:
Community Health Works, a *Communities in Charge* project in **Macon GA**, serves medically complex, uninsured low-income people in central Georgia who have no access to primary care. Its program combines intensive medical and psychosocial case management, prescription drug coverage, coordinated primary care and specialty physician, diagnostic, ancillary and hospital services.

How?

The "how" is the rough idea of how you intend to pay for and deliver the program. To address the question you need a sense of the scale of your program's funding needs. A community intending to develop a comprehensive benefit program will need significantly more funding than one that seeks to fill discrete service gaps.

EXAMPLES:

Understanding that program costs would be high (multiple tens of millions of dollars), the planners of Hillsborough HealthCare in **Hillsborough County, Florida**, set out to secure a local half-cent sales tax to finance their program.

The designers of **Community Health Works** (who included the CEOs of the two affected hospitals) determined that a portion of hospital Disproportionate Share funds could be used to support the projected cost of prescription drugs. No new funding was available to pay for physician and hospital services, and the initial design of the program therefore included the assumption that providers would donate these services.

Where?

The "where" is the geographic area you intend to serve. Typically, this is a single political jurisdiction (county or city) but it does not have to be. Community Health Works, for example serves seven counties in central Georgia that make up the primary area served by a major referral center. CarePartners in Portland ME serves cities and towns in certain zip codes and people living in two counties, one rural and one suburban.

When?

The "when" is the timeline for developing and implementing your program. You may decide to test your model with a pilot phase or jump in with a full-scale program. JaxCare, in Jacksonville FL, began with a pilot program; Hillsborough HealthCare began by offering its complete program.

Once you have completed your rough draft, review it with the members of your planning coalition and a sample of intended beneficiaries. Is it in line with the vision you established at the beginning? Are there new constituencies that need to be brought into your process to strengthen your coalition? Have all members of the coalition accepted and committed to this framework? If so, you are ready to move forward and can use this draft to guide more detailed discussions of the program's design components. If not, work to improve the rough draft until you have consensus on its necessary elements.

EXAMPLE:

ICC collaborators in **Austin TX** realized that they did not have the more than $300 million in new dollars that would be needed to implement a broad-scale local coverage program like Hillsborough HealthCare. Project principals therefore undertook a structured strategic planning process to design a program that would work in their community. The result was a 15-year plan with more than 40 objectives, including a five-year plan to create a new Health Financing District (successfully accomplished in May 2004) and shorter term goals such as maximizing enrollment in existing public programs and improving the efficiency and effectiveness of existing health resources.

Refining the Program: Honing Design Components

At this point, you have reached agreement on the framework of your program. The next task is to clarify the details of seven design components:

1. Intended population
2. Product
3. Financing model
4. Eligibility criteria
5. Payment arrangements
6. Program governance
7. Program administration.

KEY POINT: Every decision you make regarding one design component will affect all the rest. The design process will require you to move from one design component to the next and back again, making thoughtful adjustments as you move forward.

1. Intended Population: Who will be served?

The key elements in refining the definition of your intended population are: age, family income—usually described as a percentage of the federal poverty level (FPL)—employment, and health status.

Again, it is important that your program not duplicate other coverage programs in the community. As you define your intended population, pay attention to requirements for existing programs, and set your parameters to serve a new group.

Age. Local coverage programs are typically structured to include only those individuals who are not eligible for federal or state supported programs. Because Medicaid and SCHIP cover most low-income children and Medicare covers the majority of adults age 65 years and older, most local coverage programs are directed to adults ages 19 to 64.[1]

KEY POINT: Remember, the first priority of any community health coverage initiative is to enroll individuals who are eligible for public coverage into existing local, state and federal programs (Medicaid, SCHIP, Medicare, or local programs).

Family income. Local coverage initiatives may target persons who earn too much money to qualify for state Medicaid coverage and who fall within certain income thresholds relative to the federal poverty level, e.g., up to 100 percent, 200 percent or 300 percent of the FPL. Often, the income threshold is linked to the state SCHIP program threshold to simplify program communication, outreach and administrative processes.[2]

EXAMPLE:

The **Louisville KY** getCare program (which coordinates primary care and specialty physician and hospital services) targets individuals with family income under 100 percent of the federal poverty level (FPL), because the major teaching hospital in the community has contracts with local government to provide free hospital and specialty physician care to all individuals under 100 percent of the FPL. All of the area's community health centers and university system primary care clinics also have the same fixed fee payment required for an office visit for persons with incomes under 100 percent of the FPL. By linking getCare to an existing, simple payment structure, the planning coalition could focus its energies on developing new systems to increase access to primary and specialty physician care and on improving care coordination and continuity.

[1] Some communities have focused on children ineligible for state and federal coverage programs, including Alliance Family Care in Alameda County, California, and a Medicaid-like program for immigrant children in the District of Columbia.

[2] For example, income verification processes can be streamlined for families with SCHIP-enrolled children. Rather than complete a detailed review of family income, a program might simply ask parents to produce proof of a child's enrollment in SCHIP.

Employment. Since many of the uninsured are employed or are dependents of employed individuals, a few communities have decided to direct their programs to people employed full or part time without access to employer-sponsored coverage. JaxCare in Jacksonville FL focuses on this population. Some programs exclude workers who are eligible for employer-sponsored coverage even though, for many low-wage workers, the affordability of employer-sponsored coverage is an issue. The CarePartners' program in Portland ME considers this issue in its eligibility determination process and will allow enrollment of persons with access to employer-sponsored coverage if the costs of coverage exceed a threshold of family income.

Health status. A community may choose to direct efforts to people with certain medical conditions or psychosocial risk factors. For example, the Hinds County Health Alliance (Jackson MS) targets individuals who have diabetes and hypertension. The Alliance forged an arrangement with the University of Mississippi School of Medicine's Metabolic Clinic to provide these patients specialized education that emphasizes self-management. The Alliance facilitates access to prescription drugs and transportation to follow-up appointments at the clinic.

2. Product: What services will we offer?

No single program can meet the needs of all uninsured persons in a community. Your planning up to this point has included defining a specific segment of the uninsured population. Your product should respond to the specific needs of this group. The second challenge in defining the program is balancing the needs of intended beneficiaries with financial reality. Your planning coalition should include members who take seriously the job of creating a program that your community can afford.

The services that can be offered cover a wide range. The ones most often included in coverage programs (and the reasons **why** the need is greatest) are:

Primary and preventive care services. Community health centers in many communities provide these services to uninsured individuals. Federal and other financial sources help subsidize a portion of the costs of care in these settings, but these payments cannot cover all the costs of care, especially if the site does not have a counterbalancing paying population. Individuals with income under 100 percent of the FPL usually receive care for a fixed nominal payment at the time of service. Services to those with income between 100-and-200 percent of the FPL are available on a sliding scale discount from charges. Unfortunately, these discounted fees may be more than individuals can afford. Capacity is often limited. Some private physicians will agree to see uninsured people, but availability is limited.

Specialty care services. Some community health centers and most medical school and residency programs provide some specialty care services to the uninsured. To fill their patients' needs community health centers develop and carefully protect lists of specialist physicians in private practice who agree to take a few uninsured patients. Unfortunately, most communities find timely—and sometimes any—access to needed services extremely limited for anyone without insurance.

Diagnostic testing services. Many community health centers and private physician offices have only limited diagnostic testing capacity. Hospitals and private laboratories perform these testing procedures in most communities. Hospitals usually have charity care policies that support delivery of these services for persons with incomes under certain levels. These policies can vary from hospital to hospital, however, and information on how to access charity care or free services is not always easy to obtain. Few communities are able to obtain free diagnostic services from private facilities.

Prescription drugs. Prescription drugs are expensive, especially for people with chronic diseases or multiple expensive medications. Some pharmaceutical companies sponsor prescription assistance programs for people with income below certain thresholds (usually 100 percent of the FPL); other programs allow organizations such as community health centers to purchase prescription drugs at the federal discount rate and to pass this rate along to their patients. This discounted rate, however, may be too expensive for many low-income patients.

Care management services. While most communities have many organizations available to provide assistance, individuals most in need may not know what is available or how to access the services. For certain groups, information on how to use the health care system, care management, and coordination of medical and psychosocial services can significantly improve compliance with medical regimens and help people move toward self-sufficiency.

Psychosocial support services. A major role for care management services is linking clients to a community's psychosocial support services. These include payment assistance for utility bills, temporary housing, transportation, access to food pantries, education and job training, and other life skill development programs.

When funds are available, communities may include these services in their program:

Hospital inpatient care. As with diagnostic services, most hospitals have policies that provide for free or reduced-cost inpatient care for low-income patients (partially supported, in many cases, by Disproportionate Share funds), but these policies vary and information on how to access free or low-cost services is not always easy to obtain.

Behavioral health (acute and chronic mental health and substance abuse care). Some segments of the uninsured population may have significant behavioral health needs; others may need temporary assistance to deal with a personal crisis. Many communities have some level of publicly funded services, although these seldom fully meet the demand for such services.

EXAMPLES:

Planners of the **San Francisco CA** General Hospital Emergency Room Case Management Program saw the need among its target population for social service and nurse practitioner support as a vehicle for better managing scarce resources. The initial pilot program used new county and private foundation dollars to pay the salaries of case managers and nurse practitioners, based in the emergency room, who managed and coordinated the care of each program enrollee, facilitated referrals to other providers (including community agencies and social services), and accompanied clients to medical and other appointments.

Ingham County, Michigan, faced both a large pool of uninsured residents and limited funds to meet their needs. Ingham Health Plan, therefore, was designed to improve access specifically to primary care, specialty physician and diagnostic services, and prescription drugs.

Jacksonville FL leaders also needed to balance the product design of JaxCare with funding realities. Because of funding constraints, the initial program design offered only outpatient benefits to uninsured, low-wage, working individuals ineligible for the county-funded indigent care program. Further discussion with hospital leaders led to all of the area hospitals, including the for-profit hospital, agreeing to donate services in order to offer a program with a more comprehensive set of services.

Take care not to design a program that is too rich for its own blood. It might be wonderful to be able to offer a certain service, but if paying for that service means the program as a whole cannot sustain itself, then no one gets helped. Make sure there are people in your planning coalition who will make the necessary hard decisions.

Coalitions should consider existing resources and programs when deciding what services to include. For example, Hillsborough County planners focused on low-income uninsured people under 100 percent of the federal poverty level and had sufficient financial resources to provide a full continuum of services. Hillsborough's program, however, was designed to be a "payer of last resort" and would not cover services funded through other government programs. Because Florida's Medicaid program already paid for maternity services for pregnant women at this income level, Hillsborough planners therefore chose not to include maternity benefits in their program.

Coalitions should use their initial visions to help guide the development of the product. Many coalitions seek to design programs that provide some level of coverage while an individual is between jobs or temporarily in need, for example. Their products therefore may be designed to be less generous than Medicaid or employer-sponsored offerings. Communities seeking to provide care to a broad swath of residents may exclude coverage for highly technical and very expensive services such as transplants in order to lower per-person medical costs. Exclusion of high-cost items may make local providers more willing to participate in the coverage program (Jacksonville FL and Sedgwick County,

Kansas, had just this experience). Hospitals, which may contribute free or deeply discounted care, worry that inclusion of such services will attract greater numbers of needy persons than they can afford to accommodate.

3. Financing Model: How are we going to fund this?

A financing model identifies the means for funding the services included in the program and the mechanism to be used to manage risk under the coverage program. Funds need to be obtained to support both medical and program administrative services.

KEY POINT: The financing model is the most critical component of program design. Without an adequate, realistic and sustainable source of program support, a community-based coverage program will not succeed.

Possible sources of funding to support community-based coverage programs include general revenue funds from city/county government, a mixture of general revenue or other local and state dollars and private funding (Jacksonville's JaxCare added employer contributions and donated services to its general revenue funding, for example, and Alliance Group Care in Alameda County, California, also used combined public-private funds), or a mix of local, state and federal funding. Most communities obtain funding from more than one source. The Appendix section contains examples of different communities' approaches to financing their programs.

EXAMPLE:

In central Georgia, new state and local funds to pay providers were not available. Local hospitals, however, agreed to allocate more than $1 million annually in Medicaid Disproportionate Share or general operations funding to support payment of prescription drug costs for **Community Health Works** enrollees. Hospitals and local physicians donate/volunteer services for program enrollees. Grant funds and cash contributions from other community hospitals and organizations totaling almost $2 million annually pay for care managers and other program infrastructure, allowing the program to serve almost 1,700 people.

Most communities also require enrollees in their programs to make some sort of payment for participation and for care. These may include program application fees, copayment and coinsurance amounts collected at the time of service and, more rarely, premium payments—note that tracking, billing for, and collecting premium payments are labor-intensive and therefore expensive. For example, in Alameda County, adult enrollees in Alliance Family Care make average monthly premium payments of $25 and modest copayments at the time of visits to providers.

Care Financing Versus Health Insurance

With a few exceptions, most community-based coverage programs involve obtaining "care financing" rather than outright purchasing of health care insurance for local program enrollees. With care financing, community assets (cash and donated services) are used to provide or pay for medical and program administrative services directly. Services are typically limited to the care provided by participating providers, with certain services, e.g., transplants, not covered. The community entity providing care financing does not assume the risk of providing a package of health care services, the way an insurance company or managed care plan does. Care financing models are not considered insurance and, for this reason, are not regulated by a state's insurance department. Many communities find it useful, however, to involve state insurance regulators in their planning. This typically is accomplished through periodic meetings to discuss program design and clarify any provisions necessary to protect consumers through clear communication of product descriptions and provider contract provisions.

Examples of care financing models include Hillsborough HealthCare. HealthCare staff negotiates contracts (later approved by the County's Board of Commissioners) with provider systems and makes payments directly to the contracted provider systems in each of its four network service areas. In return for these payments, the provider networks agree to provide all medically necessary primary and specialty physician and hospital care services for program enrollees assigned to their network. Providers understand that no further payments will be forthcoming should service utilization and costs exceed the contract payment. Likewise, the General Assistance Medical Program (GAMP) in Milwaukee County, Wisconsin, makes fee-for-service payments directly to physician and hospital providers from an annually appropriated fund. If provider payments exceed available funding, program administrators may implement a revised payment mechanism that protects payments to primary care physicians and scales back or eliminates payments to area hospital providers, depending on the amount of available funding.

Communities should carefully estimate the dollar cost of the payments that program enrollees will be expected to make. Out-of-pocket payments should total no more than 3-to-5 percent of family income for the program to remain affordable to your intended population

Once you have identified funding sources, you may want to revisit the definition of your intended population. How you will pay the costs of the program may very well influence whom you can aim to serve.

4. Eligibility: How do we identify our intended program beneficiaries?

Program eligibility criteria typically include age, income and local residency requirements. The first function of program eligibility criteria is to ensure that a program does not enroll people eligible for Medicaid, SCHIP, Medicare or other coverage programs, who should be enrolled in these programs. These programs, especially the government-sponsored ones, operate with an entirely different level of resources than your community-based initiative will have. Your program should serve the population you designed it to serve.

Your coalition can determine whether any other eligibility criteria should be used for your program. With a few exceptions,[3] most community-based programs do not place limits on enrollee assets, following the lead of SCHIP and many state Medicaid programs. Many programs require enrollees to have been without health insurance coverage for a specific length of time—typically three to twelve months—in order to avoid employers' dropping or reducing health benefits coverage due to the availability of public coverage ("crowd-out").

The vision you have for your program may determine eligibility criteria. In Alameda County, the Alliance Family Care program seeks to provide coverage for all members in a low-income family whose age or citizen status preclude enrollment in Medi-Cal or Healthy Families. For this reason, the program structured its eligibility rules to include undocumented family members with a child enrolled in one of these other programs or Alliance Family Care.

Eligibility criteria may also be influenced by program financing. Alliance Group Care, another Alameda County coverage program, limits its eligibility to in-home supportive services workers, as the program is financed through a state initiative specifically for this population.

5. Payment Arrangements: Who will be paid what amounts for providing services?

Providers agreeing to serve enrollees in your coverage program will need to understand how they will be paid or how the value of their donated services will be tracked. In some cases, providers receive discounted fees; typically the payment level for local coverage programs is described in relation to Medicaid or Medicare payments (e.g., 80 percent of Medicare payment). Providers may be permitted to collect set copayments from enrollees. Where providers donate their services, your coalition will need a mechanism for tracking and reporting the value of these services. Some communities value donated services at the provider's charge schedule; others agree to a fee schedule by type of service; and others use an established fee schedule (such as Medicare's).

[3] Exceptions include programs such as Contra Costa County's Basic Health Care and others linked with public hospitals that require an asset test to qualify for free or low-cost care. In order to simplify program eligibility for a continuum of benefits including hospital services, these programs have elected to adopt the hospital's asset test requirement.

6. Governance: Who should "own" the program?

Governance refers to the entity responsible for program oversight and administration. Program financing and local politics largely dictate the governance structure of a community-based coverage program. In most cases, local groups and organizations that contribute significant resources (cash or donated services) to finance a community-based coverage program expect a role in program governance.

Programs financed through significant public funds, such as Hillsborough HealthCare, are almost always governed by public entities—a health care authority with a local government-appointed or elected board—to ensure accountability to taxpayers for the use of public funds. Hillsborough HealthCare is governed by the county's elected board of commissioners, and a health care advisory board is appointed to advise the commission. If your community plans to use this financing mechanism, seek to ensure that the authorizing legislation requires that board members have substantial understanding of health care and its complexities, government and the factors contributing to the lack of health care coverage.

Programs with a mix of public and private financing are usually governed by a separately incorporated, not-for-profit organization that is responsible and accountable to the community for the operations of the coverage program. In some communities, this organization also is responsible for overseeing and initiating policy discussions at the local and state level as well as managing other community-based coverage programs.

EXAMPLES:

The Ingham Health Plan Corporation, a 501(c)3 corporation in **Ingham County, Michigan,** manages its coverage program and participates in community efforts to improve oral health and access to mental health services. It is governed by a nine-member board of community representatives.

In **Austin TX** the Indigent Care Collaboration (ICC) is responsible for many programs including local public and provider coverage expansion efforts; an eligibility screening program; a dental sealant program; and the implementation of a master patient index and clinical data repository (MPI/CDR) system in a three-county region. The ICC is a tax-exempt, nonprofit organization governed by a 10-member board of community representatives.

The board is the governing body of a not-for-profit organization. The board of your coverage program should include representatives, with the power to make decisions, from:

- key provider groups (hospitals, community health centers, private physicians and mental health services);
- local government (city/county public health directors, county commissioners or other elected officials, and government agency staff). If your coalition has collaborated with the state Medicaid program, try to include a representative from the program or its lead agency in an advisory capacity to your board;
- insurers and managed care organizations;
- local business leaders; and
- leaders of community organizations who are especially knowledgeable about the health needs of, and resources available to serve, the intended population.

In addition to having the final legal responsibility for the coverage program, board members play an important role in raising awareness of the costs of "the uninsured" among local business leaders, providers, government officials, key individuals and the overall community, and in gaining ongoing support for the coverage program from all these groups.

7. Program Administration: What business functions will be necessary to support our product, and how will we carry them out?

The final step in program design is to clarify the business functions that will be necessary to run your program and identify how these functions will be carried out. These business functions include:

Program management, the day-to-day oversight of program operations.

Marketing and communications, the design of strategies, materials and campaigns to attract your intended population for enrollment, engage the participation of identified providers and enlist the political and/or financial support of the key stakeholders—elected officials, key business and other community leaders, the media and the general public—whom you need to support your program.

Outreach, actually meeting and explaining your program to the intended population.

Eligibility determination and program enrollment, the ability to use public program intake and enrollment resources already stationed in community health centers and hospital settings.

EXAMPLE:

Led by the county Social Services Agency, **Alameda County** developed the "No Wrong Door" enrollment program, a new approach to conducting health coverage outreach and enrollment. In addition to health care services sites, clients who visit County Social Services sites are screened for and, as appropriate, assisted with enrollment in available coverage programs, including Medi-Cal, Healthy Families, the local coverage programs Alliance Family Care and Alliance Group Care, and other programs operated by the county and other agencies. Before this program, Alameda County clients seeking coverage had to go to the specific office charged with determining program eligibility—and for Medi-Cal only. If the clients and their family members were not eligible for Medi-Cal, they were not offered other options. This new streamlined and comprehensive process, modeled after successful programs at health care sites, has greatly increased the number of approved applications and reduced processing time.

Communities not able to leverage existing outreach and enrollment workers—or where the existing structure cannot meet the expected demand—will need to hire staff to screen for eligibility and enrollment in other public programs, assist in the application process for these programs (as appropriate) and enroll eligible persons in the local coverage program. Some communities (CarePartners in Portland ME for example) have built customized web-based software that incorporates and supports program eligibility determination, enrollment and reenrollment processes, and that captures health-screening information.

Premium billing and collection, needed for programs that require enrollee and/or employer premium contributions. Programs that do not have these requirements do not need to support these functions.

Member services, assists enrollees with questions regarding eligibility and enrollment, coverage and provider network, bills and payments. Member services also manage complaints and grievances.

Provider network development and management. Most community-based coverage programs use a network of physicians, hospitals and other providers and agencies to serve their intended populations. These networks may already exist as contracted providers to a managed care plan, members of a physician hospital organization or other type of provider contracting organization. Special payment (or nonpayment) arrangements may require separate provider recruitment and contracting processes. These provider networks need ongoing support; provider needs must be addressed, enrollees must be equitably assigned to providers, and providers must be recognized for their contributions to the coverage program.

Medical and case management, reviewing and monitoring inpatient and outpatient service utilization, providing disease management services and overseeing the quality of care. Medical management may include case management where licensed social workers, nurses and specially trained lay workers coordinate medical and psychosocial services for assigned enrollees.

Claims payment. Tracking enrollee service utilization or making payments to providers requires programs to have highly automated claims systems that will accept bills from providers electronically, adjudicate through a set of programmed rules, make payments (or not) and deliver statements as directed by electronic protocol.

Data warehouse and reporting. Access to data is critical to sound financial and program management, effective oversight of the quality of care and program evaluation. Output from a program's claims payment system is an important foundation for the data warehouse and reporting functions.

Financial management. All coverage programs need to monitor and track program revenues and expenses—including such factors as enrollee demographics, service use rates and payments—against planning projections.

Other business functions. The product design of some community-based programs may require the support of other business functions. For example, Health*for*All's three-share program in Western New York State uses a licensed health plan product offered by all area health plans. State regulators require that Health*for*All transfer the appropriate share of subsidy dollars to the health plans before enrolled employers are billed by the health plans for premium. Health*for*All therefore had to create infrastructure to manage, transfer and track these subsidy dollars.

Some programs will require most of these business functions; others may only need one or two. Product design and program financing will largely influence the required business operations for your program.

> **KEY POINT: Think aggressively and creatively about how your program can use any existing administrative services. These services can be extremely expensive to build from scratch. If you can share in the services already being provided by other organizations, do so.**

EXAMPLE:

Health*for*All in **Buffalo NY** runs the following business functions: program management, marketing and communications, some limited outreach, and the subsidy management and payment process described above. Health*for*All's contracted health plans perform all eligibility and enrollment activities, premium billing and collection, provider network, member services, medical and case management, claims payment, and data reporting services.

Resources at the end of this section provide links to the web sites of the all programs described.

The Program Design Document

Take the time to commit the program design to paper, but don't use indelible ink. Changes probably lie ahead. But a hard-copy document will serve many purposes. You can circulate it to inform your community of your plans—all part of the process of building excitement about, and support for, the program.

When your coalition reaches the point of having a design document, you will feel the program is ready to fly. You have worked through a multitude of details, answered hundreds of questions, and changed an abstract idea into a tangible set of elements that you expect will achieve your goal. It may be exhilarating, but there's still work to be done. The immediate next step is to create a careful costing-out of the program design, for which you will need an actuary's help. It is essential that your coalition be able to hand your actuarial firm a clear statement of all the components of your planned program, as Part V describes. When you have the design and the financial estimate in hand, it's time to meet again with all the key stakeholders, to ensure their continuing support for the final work of bringing the program to life.

Resources

More detailed information about the design of community-based coverage and access programs can be found at program websites:

The Communities in Charge *Initiative*
www.communitiesincharge.org

Communities in Charge-*Funded Programs*

- Indigent Care Collaboration (ICC), Austin TX: http://www.icc-centex.org/index.htm
- Alliance Family Care Program, Alameda County, California: http://www.cfctac.org/countyinitiatives/alameda.html

- JaxCare, Jacksonville FL: http://www.jaxcare.org/
- Project Access, Sedgwick County, Kansas: http://www.projectaccess.net/
- Community Health Works, Macon GA: http://www.chwg.org/
- getCare, Louisville KY: http://www.getcarenetwork.org/
- Health*for*All of Western NY, Buffalo NY: http://www.healthforall.org

Other Community Models

- Hillsborough HealthCare, Hillsborough County FL: http://www.hillsboroughcounty.org/health_ss/hchcp.html
- San Francisco General Hospital Emergency Room Case Management, San Francisco: http://www.calendow.org/news/press_releases/2002/special/press101102/FREQUENTUSERSBESTPRACTICES.pdf
- General Assistance Medical Program, Milwaukee County, Wisconsin: http://www.seniorlaw.org/bengamp.htm or "Lessons Learned from Community-Based Models of Care for the Indigent/Uninsured" on the CIC website at www.communitiesincharge.org.
- Buncombe County Medical Society (BCMS) Project Access, Buncombe County, North Carolina: http://www.projectaccessonline.org/bcms_project_access.html

Other Summaries of Community-Based Coverage Models

- Silow-Carroll, Sharon, et al., "Community-Based Health Plans for the Uninsured: Models and Lessons," Community Voices, February 2004. Available at http://www.communityvoices.org/Uploads/CommunityBasedCoverageFINAL_00108_00044.pdf
- Andrulis, Dennis; Gusmano, Michael, "Community Initiatives for the Uninsured: How Far Can Innovative Partnerships Take Us?" The New York Academy of Medicine, August 2000. Available at http://www.rwjf.org/publications/publicationsPdfs/community-init.pdf

Links on Specific Design Issues

- Programs using a mix of funding sources: The PlusCare and HealthChoice programs in Wayne County, Michigan, are funded through local, state and federal Disproportionate Hospital Share dollars. Please refer to http://www.urban.org/UploadedPDF/Hp_mich.pdf for a more detailed description of these programs.
- Governance: An example of the board makeup of a nonprofit charged with designing and building coverage programs in Louisville/Jefferson County, Kentucky, can be found on the CIC website at http://www.communitiesincharge.org/Documents/Gifts/Gift.Louisville.The%20Articles.doc.

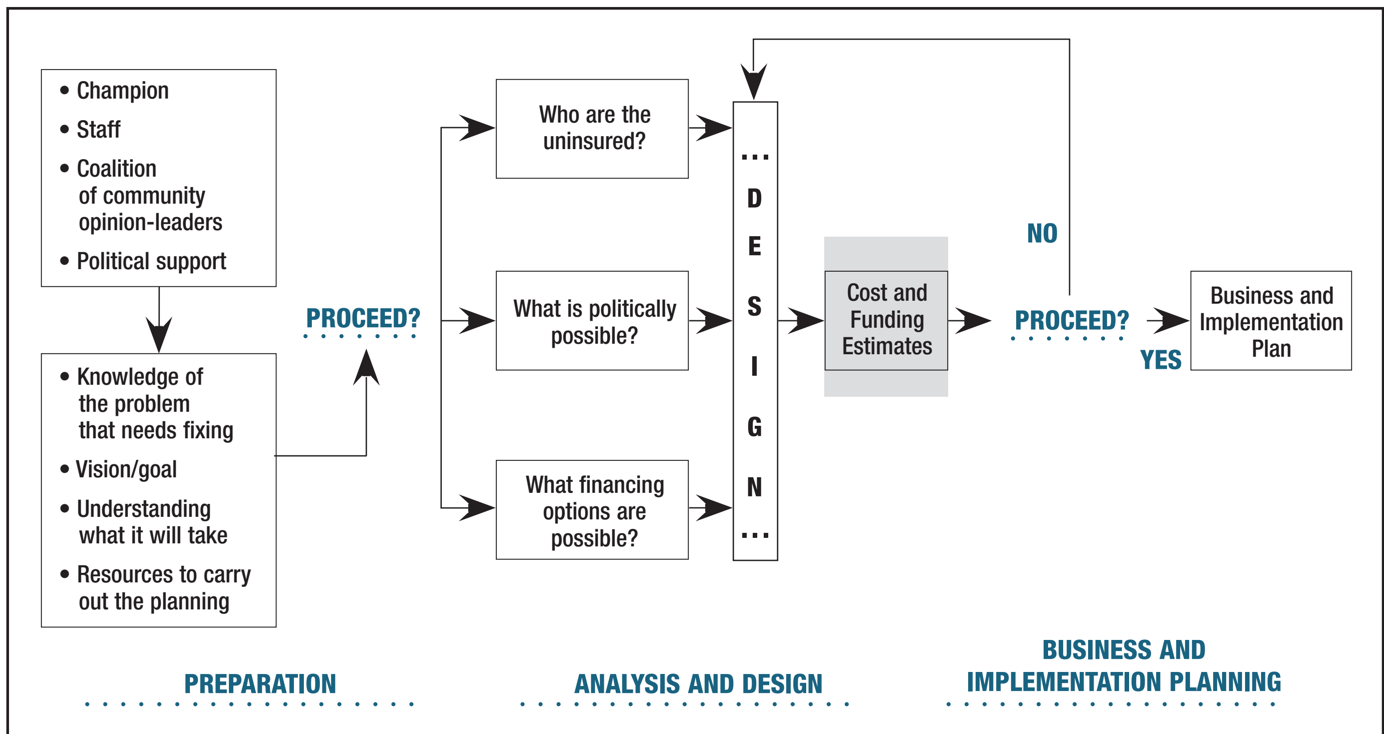
- Outcome Measurement: United Way of America's Outcome Measurement Resource Network provides various outcome measurement resources tools, these are available at: http://national.unitedway.org/outcomes/resources.
- Accessing Pharmaceutical Company Prescription Assistance Programs and Volunteer Services. Volunteers in Healthcare, a resource center for organizations that use volunteer services to address the issues of the uninsured. http://www.volunteersinhealthcare.org/home.htm.

COST AND FUNDING ESTIMATES

Once your coalition has designed the components of the program, the next step is to estimate what this program will cost and to identify resources you can use to meet these costs. When you have both this estimate and a sense of funding possibilities, your coalition can make an informed decision about whether to proceed with the program as designed.

Are the proposed program's scale, costs and financing realistic given your community's political and fiscal climate? Do you have commitment from community leaders to provide the resources necessary to obtain program financing? Can your community continue to work together to complete a comprehensive business plan and carry out the implementation?

Figure 5-1. Key Phases and Tasks



Creating the cost estimate involves three steps:

1. Using an actuary to develop a high-level medical cost estimate based on the expected utilization of your program and resulting costs of care (if your program will be paying for medical services or prescription drugs);
2. Determining administrative costs;
3. Creating estimates of a several years' worth of program expenses, using different assumptions about program operations.

Compare these estimates of program expenses to the funding that you expect to have available. Your coalition must then recognize and work through the budget gaps that will exist between the costs of the desired program design and available resources, and, if necessary, return to revise the program design.

> **KEY POINT: You need to estimate costs and funding for several years of program operations. One year is not enough. Programs take time to get up and running and you will need to assess the financial viability of operations throughout the startup period. After the program is operating at full speed, you will need to determine whether its financial health can be sustained over several years.**

Estimating Program Costs

1. The Actuarial Assessment

Your coalition will need an actuary to develop a high-level assessment of medical costs, based on the number of potential users of your program and the intensity of the services they are likely to require. (When the coalition decides to proceed with implementation planning, you will need additional help from an actuary to prepare a detailed actuarial analysis.) Use an actuary who has experience estimating the utilization and care-seeking patterns of your intended population(s). An insurer or HMO coalition partner may volunteer the services of an experienced company-employed actuary or access to its consulting actuaries. Your coalition also may elect to engage the services of an actuarial consulting firm.

Actuarial services are expensive. Firms bill by the hour, so don't spend their time—and your money—in watching the coalition debate design approaches. As a result of the preceding task, Program Design, you should have a good, concise document describing your design. Send this to the actuary before your first meeting. Use the time with your actuarial consultant to become better educated on the cost implications of your design and payment considerations. The actuary can play a useful role as a neutral party, able to show the dollar implications of many program design decisions.

The actuary has skill and experience building a cost estimate that takes into consideration:

The existing medical status and severity of illness of the beneficiaries you have targeted, and the level of medical services they can be expected to use. In order to do this, the actuary will examine your proposed eligibility criteria and the types of individuals you seek to cover (e.g., employed adults and their dependents, or people with chronic illness).

Whether your proposed enrollment strategies, product structure or other factors will lead to adverse selection. For example, individuals enrolled upon discharge from an inpatient hospital stay will likely have significantly greater expected medical costs than low-income people enrolled in a subsidized employer-sponsored health coverage program. The actuary will assess whether your design will lead only the sickest individuals to enroll in a program, thus driving up average medical costs.

The extent of pent-up demand (if any), for the services your program intends to offer. Members of your intended population may have put off receiving certain services that are now covered. This can lead to higher utilization of services in the first few months of a new program (a well-documented phenomenon). In making this determination, the actuary will look at your proposed program benefits, plans to phase-in the program's enrollment, expected final program size, and your program implementation strategy and time line.

Whether your proposed program may be subject to "crowding out." New programs for low-income employees may not only attract uninsured individuals, but could result in some business transferring from commercial insurance to a new publicly subsidized program. Your actuary will assess your market and help you determine whether you are at risk for this; if so, how much it could add to program costs, and how you could restructure the program to reduce the likelihood of this occurring.

The impact of your proposed provider payment arrangements. In developing your program design, the coalition will have struggled with the difficult issue of balancing costs against the levels of payment providers will require to participate. As it may be hard to achieve this balance, be sure that you come to agreement before involving your actuary. The actuary's job then is to evaluate your proposed benefits, the characteristics of your target population, and the proposed provider payment arrangements to assess the ultimate cost of your planned program.

What type of support programs you will need. The actuary will estimate your need for staff and efforts to promote compliance with preventive care and treatment standards by very low-income individuals, who typically require intensive case management services, transportation and health education initiatives. Again, the intended population and proposed benefit package, as well as information about proposed staffing, will be crucial to the actuary's estimate.

Based on this design document and conversations with the planning coalition, the actuary will develop an estimate for the cost of care, i.e., the cost of delivering and paying for services for the target population, expressed as a dollar amount "per member per month."

EXAMPLES:

JaxCare, a *Communities in Charge* program in Jacksonville FL, targets uninsured workers with family income between 150 and 200 percent of the FPL. See Attachment I for JaxCare's included medical services and www.jaxcare.org for more information on the program. In late 2003, JaxCare's consulting actuary estimated the program's per member per month cost of care to be between $161 and $322, depending on the demographics of the employees enrolled.

Health*for*All of Western New York, a second Communities in Charge program based in Buffalo, developed a demonstration program that leveraged a state-sponsored program for small businesses with low-income employees. Health*for*All provides low-income workers a subsidy equal to about one-third of premium. The employer and employee split the remaining premium costs, with the employer required to pay for at least 50 percent of the individual premium rates. (For more information on Health*for*All's premium subsidy program see www.healthforall.org.) The program's benefit package is described in Attachment 2. In June 2004, the lowest price single premium for a small business in Buffalo was about $107 per month.

Note that these estimates are specific to each program's service area and other unique components (for example, the state-subsidized stop-loss provisions in the Health*for*All program, which substantially lower premium costs). The dollar estimates cannot be transferred to any other setting.

After meeting with the actuarial consultant, you will likely refine the features of your program. Most communities are surprised at program per member per month costs resulting from their initial program design and end up scaling back benefits or the level of provider payments.

2. Administrative Costs

Your administrative cost estimates should include both (a) the costs you will incur before the program begins operation and (b) the ongoing expenses of administering a functioning program.

Preoperational costs include fees for:

- *Legal services,* to cover expenses related to the creation of a new 501(c)3 organization (if required), preparation of provider agreements, and discussions with state agencies such as the department of insurance. Some communities may be able to have these services donated; most communities, however, find that it is better (and faster) to pay for these services. The *Communities in Charge* experience shows that fees for legal services can range from $10,000 to $40,000.
- *Actuarial services,* specifically for fine-tuning actual product costs for your business plan. Consulting actuary fees can range from $10,000 to more than $50,000, depending on whether rates need to be certified for state regulators.
- *Marketing and communication services,* including naming and branding your program, creating the marketing and communications plan, and designing and producing materials for outreach and enrollment, provider recruitment, etc.
- *Business planning,* the assistance your coalition will need to complete your detailed business and implementation plan.
- *Start-up setup,* including configuring any systems needed to manage program enrollment (e.g., member services, claims processing), and working with health plan or provider partners to educate front line staff about the program.

If the program will have paid staff in this preoperational phase, an estimate of salary and benefits costs should be included.

Preoperational expenses can range from $100,000 to well over $250,000, depending on the program's design and scale, the extent to which you use existing community administrative resources, and the amount and value of donated services.

Ongoing administrative costs are usually described as a specific dollar amount or percentage of medical costs. These estimates vary based on the design of the product and the nature of the program (an enrollment-based model that operates like a managed care organization will cost more to run than a program that simply subsidizes premiums for low-income workers). In fully mature health care delivery programs with a significant enrollment base, administrative costs can range from 6-to-8 percent of medical costs for public Medicaid programs and 15-to-20 percent of medical costs for managed care organizations.

> **KEY POINT: These examples are for programs with large numbers of enrollees (at least 30,000 to 50,000). New programs always will have proportionally higher administrative costs for beginning operations until full membership levels are reached and the program can spread administrative costs over a larger base.**

Administrative costs for indigent care programs can easily exceed these levels, perhaps by a great deal. Programs with small numbers of members (under 10,000), or ones that focus on high-cost populations such as the chronically ill, will continue to have administrative costs significantly higher than these examples.

3. Estimated Annual Program Costs

With your per member per month estimate of the cost of medical services and estimates of both preoperational and ongoing administrative costs, your planning coalition is ready to develop estimates of the annual proposed cost of the program. You should develop estimates for different scenarios. You cannot predict exactly how your program will function; valuable information can come from altering certain elements of the program and seeing the impact these alterations have on the bottom line. For example, you can cost out a program with several different assumptions about the participation rate, that is, the percentage of your intended population who actually join your program. Other assumptions to test include the nature of your intended population (low-income employed? chronically ill and unemployed?), provider payment arrangements, and how your administrative services are provided (managed by your program or subcontracted from another source). Choose scenarios based on factors you think actually have a chance to vary. This is your coalition's opportunity to learn what is viable about your program and what needs to change.

To create an estimate of annual program costs:

- Take the estimated number of uninsured individuals in your target population.
- Make an assumption of the portion of this intended population that will join the program (the participation rate) or that you think you can afford to cover.
- Apply your actuarially-determined per member per month estimate for the cost of delivering services under various scenarios of benefit packages and/or provider payment arrangements.
- Determine your preoperational expenses and choose your ongoing administrative cost factor.
- Identify the total resources required for the program or programs.

Determining Program Funding

To understand the potential viability of your program design, the coalition will also need to estimate the amount of funding it expects to be available to the program. Sources of funding for a program include:

- Public dollars, which may take the form of either monthly per capita payments for each enrollee, or fixed amounts. Funding may come from local or state governments, general county tax subsidies, state and federal matching funds through a Medicaid demonstration program in your community, distribution of tobacco settlement funds, or other sources.
- Premium payments by employers or employees/enrollees.
- Copayments made to participating providers by enrollees.
- Other contributions (for example, significant cash grants from foundations, usually for pre-operational expenses or some element of program administration).
- Services donated by providers (either pro bono services or acceptance of reduced payment rates).
- Donated administrative services (for example, Anthem Blue Cross and Blue Shield donates claims processing services to CarePartners in Portland ME).

In the same way that you estimated the costs of different program scenarios, a full financial model requires that you also estimate the funds available under differing conditions. If your major source of funds is, for example, a per capita payment or a premium payment, changing assumptions about numbers of enrollees will affect both cost and revenue estimates. Fixed appropriations will vary less with the size of your program. Your job at this point is to provide the most accurate estimate you can of the money (cash payments or the equivalent in donated services) that your program will have, and to compare it to your estimated program costs.

By creating and discussing these cost estimates, your coalition will move the program for the uninsured from a conceptual idea to tangible plan. Hard numbers, and perhaps red ink, display better than any discussion the implications of your program design. The examples that follow show how two communities took information from their initial cost and funding estimates, realized their initial design was not sustainable, and—because they had good cost estimates and clearly stated assumptions about program operations—reconfigured their programs to be more realistic. No doubt the discussions in Jacksonville and Buffalo when the first cost estimates appeared were difficult, but they were also intensely valuable.

Examples of Cost and Funding Estimates

The two *Communities in Charge* programs described earlier, JaxCare in Jacksonville FL and Health*for*All in Buffalo NY, show how these two communities used the results of their cost and funding estimates.

Example 1: JaxCare

As the key community leaders in Jacksonville were initially designing the scope of the JaxCare program, they estimated the costs of a program that would reach roughly one-third of Jacksonville's 14,500 uninsured with incomes between 100-and-150 percent of the FPL. Several scenarios were explored. This example shows the cost estimate for a scenario that assumed:

- JaxCare benefits as described in Attachment I
- Hospitals agreeing to donate care; thereby reducing per member per month medical costs by a little more than half
- Half of projected program enrollment coming from direct enrollment of individuals (estimated actuarial costs of $158 per member per month)
- Balance of program enrollment recruited through arrangements with large employers for their low-income employees working at least 20 hours per week and not eligible for employer-sponsored health benefits coverage (estimated actuarial costs $80 per member per month); employers would contribute $50 per employee per month for these enrollees
- Preoperational expenses of about $300,000, covered through existing grant funding **(Table 5-1)**
- Contracting out program administrative expenses, including case management, at $20 per member per month
- Average monthly enrollment in the first year of the two-year pilot would be 2,500; average monthly enrollment in the second year, 5,000

Table 5-1: JaxCare Estimated Preoperational Expenses

Preoperational Expenses	
Staffing and Benefits Costs	$152,400
Consulting Costs:	
Legal Services	$25,000
Actuarial Services	$30,000
Marketing and Communications	$75,000
Implementation Assistance	$30,000
Total Consulting Costs	$160,000
Estimated Total Preoperational Expenses	**$312,400**

Table 5-2 displays the estimated program costs and revenue for this scenario. Under these assumptions, JaxCare would need to obtain almost $10.6 million in new cash funding for its program. Participating partner hospitals would agree to supply a little more than $11.3 million in uncompensated care (estimated at Medicare payment levels).

When the planning coalition modeled the cost of a program that served only persons enrolled through employers, the need for total program funding dropped to about $4.7 million **(see Table 5-3)**. This program design assumed that each enrollee would generate an employer contribution of $50 per month and that the lower per member per month cost for employed persons would apply for all enrollees, resulting in a financially more realistic and potentially sustainable program.

In the end, the community leaders designing JaxCare decided that a scaled-down version of Scenario #2 **(Table 5-3)** made sense as their pilot program. The city committed $2.5 million in new funding. These funds were joined by more than $1.5 million in cash commitments from other private sources, and the program began operating in March 2004.

Table 5-2: JaxCare Scenario #1 Individual and Employer Group Enrollment

Program Costs	PMPM Costs[1]	Avg. Monthly Enrollment Year 1	Avg. Monthly Enrollment Year 2	Year 1 Costs	Year 2 Costs[2]	Total Year 1 and Year 2 Costs
Preoperational Expenses						[$312,400]
Medical Costs						
Individual Enrollment	$158	1250	2500	$2,370,000	$4,929,600	$7,299,600
Group Enrollment	$80	1250	2500	$1,200,000	$2,496,000	$3,696,000
Administrative Costs						
Individual Enrollment	$20	1250	2500	$300,000	$618,000	$918,000
Group Enrollment	$20	1250	2500	$300,000	$618,000	$918,000
Total Program Costs				$4,170,000	$8,661,600	$12,831,600
Donated Hospital Costs						
Individual Enrollment	$164	1250	2500	$2,460,000	$5,116,800	$7,576,800
Group Enrollment	$81	1250	2500	$1,215,000	$2,527,200	$3,742,200
Total Donated Costs				$3,675,000	$7,644,000	$11,319,000
Program Revenues	**Monthly Contribution**			**Year 1 Revenue**	**Year 2 Revenue**	**Total Year 1 and Year 2 Revenue**
Grants for Preoperational Expenses						[$312,400]
Employer Contributions	$50	1250	2500	$750,000	$1,500,000	$2,250,000
Other Public/Private Funding Needed				$3,420,000	$7,161,600	$10,581,600
Value of Hospital Donation						
Individual Enrollment	$164	1250	2500	$2,460,000	$5,116,800	$7,576,800
Group Enrollment	$81	1250	2500	$1,215,000	$2,527,200	$3,742,200
Total Value of Hospital Donation				$3,675,000	$7,644,000	$11,319,000

[1] PMPM medical costs and the value of hospital donation are inflated 4 percent in Year 2. Year 2 administrative costs are inflated 3 percent.
[2] Year 2 medical costs and the value of hospital donation reflect a 4 percent increase. Year 2 administrative costs reflect a 3 percent increase.

Table 5-3: JaxCare Scenario #2 Employer Group Enrollment Only

Program Costs	PMPM Costs[3]	Avg. Monthly Enrollment Year 1	Avg. Monthly Enrollment Year 2	Year 1 Costs	Year 2 Costs[4]	Total Year 1 and Year 2 Costs
Preoperational Expenses						[$312,400]
Medical Costs						
Group Enrollment	$80	2500	5000	$2,400,000	$4,992,000	$7,392,000
Administrative Costs						
Group Enrollment	$20	2500	5000	$600,000	$1,236,000	$1,836,000
Total Program Costs				$3,000,000	$6,228,000	$9,228,400
Donated Hospital Costs						
Group Enrollment	$81	2500	5000	$2,430,000	$5,054,400	$7,484,400
Total Donated Costs				$2,430,000	$5,054,400	$7,484,400
Program Revenues	**Monthly Contribution**			**Year 1 Revenue**	**Year 2 Revenue**	**Total Year 1 and Year 2 Revenue**
Grants for Preoperational Expenses						[$312,400]
Employer Contributions	$50	2500	5000	$1,500,000	$3,000,000	$4,500,000
Other Public/Private Funding Needed				$1,500,000	$3,228,000	$4,728,000
Value of Hospital Donation						
Group Enrollment	$81	2500	5000	$2,430,000	$5,054,400	$7,484,400
Total Value of Hospital Donation				$2,430,000	$5,054,400	$7,484,400

[3] PMPM medical costs and the value of hospital donation are inflated 4 percent in Year 2. Year 2 administrative costs are inflated 3 percent.
[4] Year 2 medical costs and the value of hospital donation reflect a 4 percent increase. Year 2 administrative costs reflect a 3 percent increase.

Example 2: Health*for*All

Health*for*All's steering committee modeled many cost scenarios as it developed its program. One scenario sought to provide coverage to about a quarter of the region's 46,000 low-income uninsured persons employed by small firms. The scenario assumed:

- A three-year, three-share demonstration under New York State's Healthy New York initiative where Health*for*All provided a fixed subsidy, and the employer and employee split the balance of premium costs
- The premium subsidy for each enrollee would be equal to one-third of the current lowest priced premium for Healthy New York in Buffalo's Erie County (about $36)
- Premium costs would increase eight percent per year for years two and three, and the subsidy amount would also rise
- Health care benefits as described in **Attachment 2**
- The average enrollment in year one would be 2,500; this would grow to 7,500 in year two and 11,000 in year three
- Because Health*for*All would be using the Healthy New York product and its contracted health plans, ongoing administrative expenses would be minimal at about $50 per new program enrollee for marketing and outreach
- Preoperational expenses would be limited to (1) legal expenses related to developing contracts with the Healthy New York contracted health plans and working with the state Departments of Insurance and Health on refining the program and (2) staff time to work with health plan staff on protocols for information and subsidy fund transfer. The estimated $100,000 in preoperational expenses would be covered by an existing foundation grant.

Table 5-4 shows that, with these assumptions, Health*for*All would be required to obtain more than $11 million in new funding. After consideration of the new funding required to implement this scenario successfully and the realities of the general economic climate in Western New York, Health*for*All's Board chose instead to begin a pilot demonstration program using $276,000 in federal grant and state delegation funds. These funds have permitted 12 months or more of subsidized enrollment for more than 600 persons.

Table 5-4: Health*for*All Scenario #1

Healthy New York Three-Share Subsidy Demonstration					
Costs	**Ave. Monthly Enrollment**	**Estimated Level of PMPM Subsidy**	**New Enrollees per Year**	**Marketing Costs per New Enrollee**	**Costs**
Preoperational Costs					[$100,000]
Year 1 Subsidy Costs	2,500	$36			$1,080,000
Year 2 Subsidy Costs	7,500	$39			$3,499,200
Year 3 Subsidy Costs	11,000	$45			$5,953,306
Year 1 Per Enrollee Marketing Costs			2,500	$50	$125,000
Year 2 Per Enrollee Marketing Costs			5,000	$50	$250,000
Year 3 Per Enrollee Marketing Costs			3,500	$50	$175,000
Estimated Total Costs					$11,182,506
Revenues					
Foundation Preoperational Funds					[$100,000]
Other Public/Private Funding Needed					$11,082,506

Using Cost-Benefit Analysis Estimates

Your coalition may need to convince your partners of the value of buying-in to a strategy or program you propose. An effective way to make your argument is to lay out the relative costs and expected benefits of this strategy or program, simply and in a straightforward manner. In many cases, the financial bottom line may be the best argument in favor of your plans.

For example, the ICC in Austin TX sought support for the implementation of Medicaider in its community. Medicaider is a common, communitywide, online health care eligibility screening program that assists clinic and other agency staff in determining eligibility for Medicaid, SSI, SCHIP, and other federal and state programs for low-income individuals. The coalition had run a grant-funded demonstration project in the use of Medicaider and therefore had data on these aspects of its operation:

- The number of screenings completed per hour, as calculated from the Medicaider system tracking logs, which recorded the time required for each screening
- Staff costs per screening based on a salary of $15 per hour
- Software licensing costs of $12.50 for each individual identified as eligible for Medicaid or SCHIP (no other licensing fees are charged)
- Medicaid payment rates for primary care and emergency room visits of $17.50 and $265, respectively (the lowest amount paid by Medicaid to this provider for these two types of visits)
- Each eligible person screened at a provider site generated payment for the primary care visit on the date they were screened and, based upon the health system's experience, one in ten eligible persons would also have a "spill over" non-urgent emergency room visit
- While eligible, total encounters per person would be 2.8.

Using these data, the coalition developed an estimate of the costs of using Medicaider and the benefit that could be expected from its use. These estimates are displayed in tabular form in **Table 5-5**. Cost/benefit analysis showed that use of Medicaider could result in a net benefit of almost $80,000 for the health systems, with a benefit–to–cost ratio of 4.7.

Table 5-5: Medicaider Cost Benefit Analysis

April 1, 2002	
Costs	
Total number of screenings completed	5,255
Total number persons eligible for SCHIP/Medicaid	817
Number of screenings per hour	6.9
Staff cost per screening, at $15 per hour	$2.17
Total staff costs for screening	$11,382.91
Software costs ($12.50 x 817)	$10,212.50
Total Costs	$21,595.41
Benefits	
Total primary care payments	$14,297.50
ER visit payments	$21,650.50
Total Immediate payments	$35,948.00
Average number of encounters while Medicaid eligible	2.8
Total Benefits	$100,654.40
Benefit/Cost Ratio	4.7
Net Benefit	$79,058.99

The design of a program for the uninsured must take into consideration the realities of program costs and potential revenues. Creating a program that is not financially viable ultimately becomes a useless exercise.

The modeling of costs and revenues as described is critically important to bringing a community coalition's plans to fruition. These cost and revenue estimates derive from, and build on, all the previous work of the project: from the analytic tasks of defining options, assessing the market and understanding the political environment, to the coalition-building work of gaining the participation of an inclusive group of community partners. In this task it all comes together, and the cost and revenue estimates provide the community with a clear, focused picture of what it will take—what all community members will have to commit—in order to create a program that will be successful.

At this point, the community must decide whether to proceed with this program; the well-crafted cost and revenue estimate provides an essential tool for making a wise decision. This is the second key decision point for the project **(see Figure 5-1)**.

KEY POINT: Many successful programs for the uninsured have gone through several design iterations, and it's important not to be discouraged if your design requires refinement at this point. It's a sign you're doing the job right.

Once your coalition agrees on a design that appears to be financially sustainable and able to meet the need you originally identified, and commits sufficient cash and other resources—including political capital—to the project, then it is time to move on to the detailed work of developing the Business and Implementation Plan.

Attachment 1

JaxCare Included Services[5] (As of 6/04)

JaxCare Included Services (subject to change from time to time)	
Hospital Services: - Inpatient Services - Outpatient Surgery or Observation - Emergency Room (ER)	 100% after a $100 copayment per admission 100% after a $100 copayment per visit 100% after $100 copayment per visit. The ER copayment is waived if the ER visit results in an inpatient admission.
Outpatient Diagnostic Lab and X-Ray (not performed in conjunction with an office visit)	100% after $5 copayment per visit
MRI, PET, CT scans	100% after a $25 copayment per scan
* Ambulance Services	100% after a $100 copayment per transport
* Home Health Care and Outpatient Therapies (Physical, Occupational, Speech) Combined	100% after a $10 copay per visit; a maximum of 60 visits per calendar year
* Durable Medical Equipment	100% after a $50 copayment per rental or purchase (rental covered up to purchase price) with a maximum of $1,000 per calendar year
Physician Services (including Routine Care): * Primary Care[(1)] * Specialist[(2)] Hospital-based services	 100% after $10 copayment per visit 100% after $10 copayment per visit 100% with no copayment

[5] http://www.jaxcare.org/included_services_rev_1012.aspx, June 2004.
[(1)] A Primary Care Physician (PCP) will be assigned to JaxCare Members.
[(2)] Primary Physician Care (PCP) must provide a referral for all services provided by a Specialist Physician.
* Services provided as part of the JaxCare Health Flex Pilot Plan

JaxCare Included Services (subject to change from time to time)	
* Urgent Care Center Services	100% after a $25 copayment per visit
* Skilled Nursing Facility Services	100% with no copayment; a maximum of 30 days per calendar year; covered only if initiated after an inpatient hospital discharge
* Prescriptions –Generic Only formulary drugs atparticipating pharmacies only: (Duval County Health Department Pharmacy)	100% after $5 copayment per prescription
Mental Health and Substance Abuse Services Combined	
* Outpatient	100% per visit after a $10 copayment per visit, with a maximum of 20 visits per calendar year
Inpatient	100% per visit after $100 copayment per admission for a maximum of 10 days per calendar year
* RN Case Management and Disease Management Programs	Limited services to members identified through enrollment risk screening process

* Services provided as part of the JaxCare Health Flex Pilot Plan

Attachment 2

Healthy New York Benefit Package[6] (As of 6/04)

Benefit Package

The Healthy New York benefit packages consist of streamlined packages of health benefits that cover essential health needs including inpatient and outpatient hospital services, physician services, maternity care, preventive health services, diagnostic and x-ray services, and emergency services. Applicants may choose a benefit package with or without a limited prescription benefit. Keep in mind that even though Healthy New York benefit packages are the same, the health plans may charge different premium rates.

Once you have chosen which type of benefit package you want—with the prescription drug benefit or without— you will not be able to change the type of package you have chosen for 12 months.

Covered services are subject to a copayment. All benefits are provided "in-network" only, except for emergency services or where care is not available through a health care plan's providers. Otherwise, you must use a health care plan's network of providers. Covered services include the following:

- Inpatient hospital services consisting of daily room and board, general nursing care, special diets and miscellaneous hospital services and supplies
- Outpatient hospital services consisting of diagnostic and treatment services
- Physician services consisting of diagnostic and treatment services, consultant and referral services, surgical services (including breast reconstruction surgery after a mastectomy), anesthesia services, second surgical opinion, and a second opinion for cancer treatment
- Outpatient surgical facility charges related to a covered surgical procedure
- Preadmission testing
- Maternity care
- Adult preventive services consisting of mammography screening, cervical cytology screening, periodic physical examinations no more than once every three years, and adult immunizations
- Preventive and primary health care services for dependent children including routine well-child visits and necessary immunizations
- Equipment, supplies and self-management education for the treatment of diabetes
- Diagnostic x-ray and laboratory services

[6] http://www.ins.state.ny.us/hnybenif.htm, June 2004

- Emergency services
- Therapeutic services consisting of radiological services, chemotherapy and hemodialysis
- Blood and blood products furnished in connection with surgery or inpatient hospital services

If the prescription drug benefit is selected:

- Prescription drugs obtained at a participating pharmacy ($3,000 maximum per person, per year)

Please note that coverage pursuant to the Healthy New York program is provided subject to a preexisting condition waiting period. You should check with your health plan to determine how this waiting period would impact the initial coverage of any existing health conditions you may have.

Copayments and Deductibles

Covered services are subject to a copayment. The copayment is an amount that you must pay at the time you receive services. Additionally, for prescription drugs there is an annual deductible. The amounts of the copayments and deductible are the same for each health plan. The applicable copayments are*:

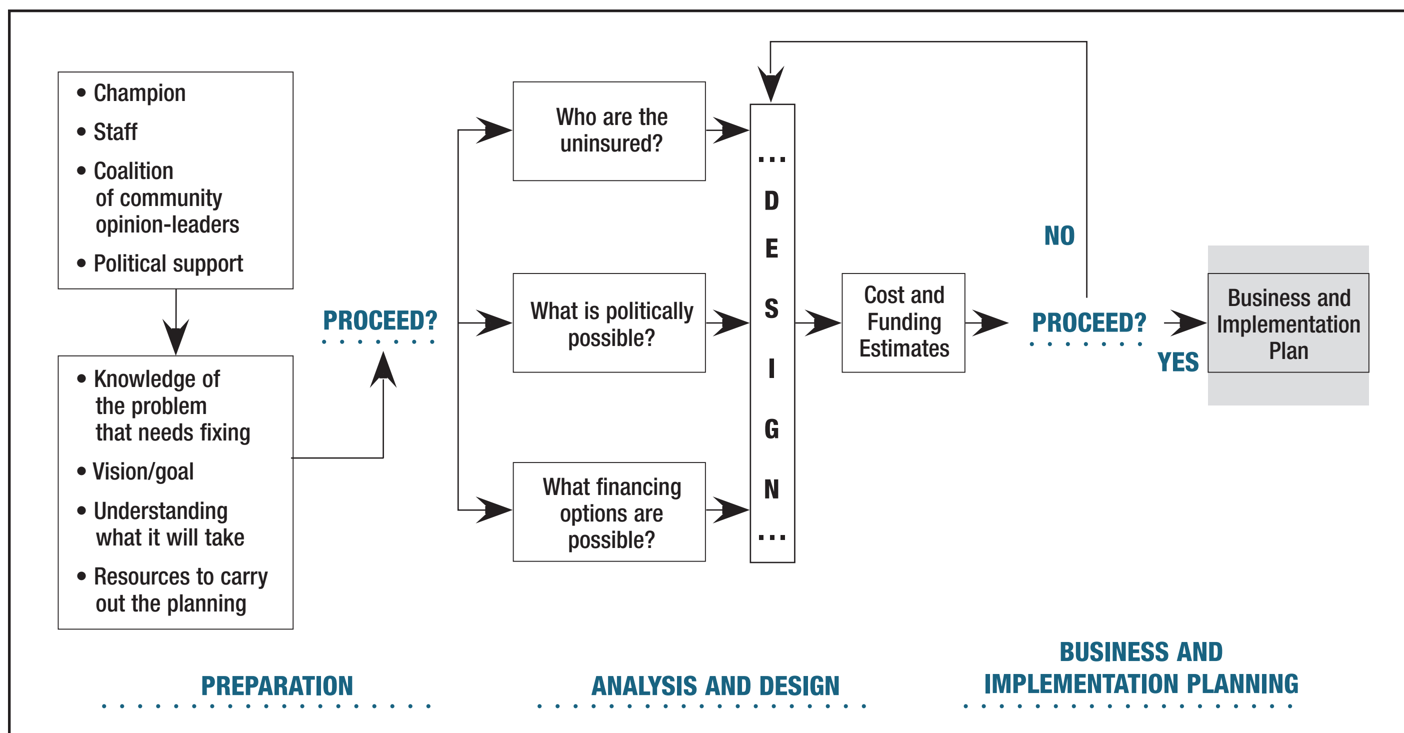
- Inpatient hospital services – $500 copay
- Surgical services – 20 percent or $200 copay
- Outpatient surgical facility – $75 copay
- Emergency services – $50 copay, waived if admitted to the hospital
- Prescription drugs – Maximum benefit of $3,000 per individual per year; $100 deductible per calendar year; generic drugs have a $10 copay; brand name drugs have a $20 copay plus the difference in cost between the brand name drug and generic equivalent
- Prenatal services – $10 copay
- All other services – $20 copay

* Beginning June 1, 2003, there will be no copayments applied to preventive and primary health care services for routine well-child visits and necessary immunizations.

BUSINESS AND IMPLEMENTATION PLANNING

Your coalition has estimated the costs and projected the revenues for your proposed design for a coverage program for the uninsured. Perhaps you have revisited the design, once or several times, to be sure that the program you are planning can be sustained over time and make a lasting contribution to your community. Your steering committee has committed the resources you will need to move forward. Now you need to develop a detailed business plan and a plan for implementing the program.

Figure 6-1. Key Phases and Tasks



The Business Plan

A comprehensive business plan is the document that details the program design, the purpose of the initiative, its financing plan— including multiyear pro forma financial statements that will specify monthly income and expenses—and the infrastructure necessary to operate it successfully. Anyone starting a new business needs to create a business plan, and as a result there are many books, courses, web sites and templates for standard business plans. We will not repeat those here. **Attachment 1** to this chapter also outlines components of a business plan.

This section instead will focus on two parts of developing a business plan that are critical—perhaps unique—to community-based coverage and access initiatives:

1. The business planning process in a community coalition; and
2. The calculation of enrollment ramp-up and other critical elements that will affect the financial plan.

1. The Business Planning Process

Throughout your project to develop a coverage and access initiative, your coalition worked to gain consensus on each element of the program and to test the product offering with a sample of the intended population. Writing the business plan is, at its core, the same task—just at a finer level of detail. Preparing the business plan gives your coalition one more chance to work through inconsistencies or problems. Areas of focus in this process should be:

- **Understanding program cash flow requirements.** The most important new analysis to conduct involves the development of multiyear pro forma financial statements, including income statements, balance sheets and statements of cash flow. These provide, for the first time, important information on cash requirements and timing for payments of program expenses and show whether expected revenues will be sufficient to meet these expenses each month. You may have designed a program that will break even over three years, but its financial picture may be very different in month three or month thirteen. Creating pro forma financial statements will allow you to see when the program will require infusions of cash and highlight the need to develop strategies for meeting these cash needs.

EXAMPLE:

As a result of the detailed financial modeling component of its business planning process **getCare** in Louisville KY identified a significant funding gap. getCare's board quickly mobilized to work with the state to secure $1.4 million in annual state and federal funding to support its operations.

- **Creating a blueprint for implementation.** Moving a local coverage program from concept to reality requires simultaneous action on multiple fronts: development, testing, refining and execution of communications and outreach strategies to the intended population, for example, or creation of an infrastructure to assess eligibility, manage and track the enrollment process, process claims, and track and monitor financial performance. Sections of the business plan can be given to managers to identify and guide next steps for each functional area and to help those working in one area understand how their piece fits within the overall project.

Funders will be assessing the quality of your business plan, looking for a well-developed document that presents a sound business case for your program. A good business plan justifies the requested funding and reflects the competence and reliability of the project's leadership.

EXAMPLE:

JaxCare's business plan for its pilot program (Jacksonville FL) played a pivotal role in obtaining its $2.5 million in new local government funding. The financials were reviewed by both the mayor's and city council's auditors before the formal city council vote to approve funding.

Frequently Asked Questions About the Business Planning Process

Who should be involved?

Your business plan should be developed by a small team supported by, and reporting to, the project's steering committee. This team usually includes the executive director of the initiative, the finance director (or someone with strong financial skills and experience appointed by or from the steering committee) and consultants who will write the plan (if the executive director or finance director hasn't assumed this responsibility) and develop the financial projections (if the finance director hasn't assumed this responsibility).

The consultant or consulting firm hired to help develop the business plan ideally should have experience with new coverage programs to ensure that appropriate program functions are addressed realistically and to provide suggestions and support for certain financial assumptions (e.g., expense items such as marketing and communications, insurance, etc.).

EXAMPLES:

Health*for*All's business planning work group (Buffalo NY) consisted of the program's CEO (who had an accounting background), a local consultant hired to write and assemble the plan and a team of consultants from a national business consulting firm responsible for creating the financial projections and financial section of the business plan. The local consultant was the former head of a successful multi-site community health center who had a strong business planning background. Technical assistance available through HFA's RWJF grant supported the use of the financial consultants.

In Jacksonville FL, **JaxCare's** business planning team included its CEO, operations Director, a volunteer finance director and a team of consultants from a national business consulting firm. The CEO and operations director were charged with writing the formal plan. The consultants were responsible for creating the financial projections and financial section of the business plan. JaxCare also involved managers from partner organizations who advised on staffing projections and implementation planning decisions.

Where should we start?

The business planning process has two parts: developing the financial projections and writing the formal document. We recommend that communities start with the development of the financial projections. As you create these projections you will be clarifying your assumptions about how the program will operate. It is therefore best to wait until after completing the projections to begin writing the formal business plan.

What tone should we use?

Before you begin writing the business plan you should understand to whom you are aiming the document. Are you appealing to funders—hospitals, local government(s), foundations, the voting public—or is the first draft for internal purposes to guide program implementation or will versions of the business plan serve both audiences? For example, the original audiences for JaxCare's business plan were the mayor's and city council's auditors. Once the document targeted to them was complete, the executive summary was retooled to attract support from elected officials and other funders.

Another By-Product of Your Business Plan: The One Page Business Rationale

The Indigent Care Collaboration (ICC) in Austin TX used its business plan as a base for a series of one-page business rationale documents. These documents became a tool to communicate to key stakeholders how the ICC was going to make its case for financial support and also provided the stakeholders with a framework for gaining support of ICC's efforts by key decision-makers and constituencies within their own institutions.

We are including here (see next page) an example of the one-page business rationale developed by Paul Gionfriddo, the executive director of the ICC, for the Medicaider system described in Part 5.

Business Rationale for ICC Initiatives

October 1, 2002

Initiative #1: Medicaider Online eligibility

Summary: Medicaider is an online eligibility tool for use with uninsured patients. Its purpose is to assist eligibility workers in determining eligibility for Medicaid, SSI, SCHIP, and other federal and state programs for low-income individuals. The ICC has contracted with Network Sciences LLC to customize the tool with the addition of criteria for eligibility for Title V, Title XX, and MAP funding, as well as COA Sliding Scale, Seton Care Plus, and Project Access eligibility. In addition to assisting in the determination of public funding eligibility, these customizations will make it possible for ICC members to direct patients to whichever charity care program or programs they desire at any given time.

Rationale for Choosing this Initiative: The ICC HRSA CAP grant included eligibility determination in a project objective. Eventually, the ICC would like to integrate information received through use of this tool into the I-Care system (a communitywide shared clinical record).

Development Costs: The ICC has committed to paying the full cost of developing the tool as described above from its HRSA grant revenues. Development costs are $22,000, plus a $12.50 transactional fee per Program Eligible Applicant during a three month pilot (estimated to be approximately $3,750 for 300 PEAs) for a total of $25,750. In addition, the ICC paid Seton eligibility workers $6,000 to complete 1,000 eligibility screens during the three-month pilot, so that potential ongoing costs and benefits could be determined. These prices do not include the cost of Case Tracker, a module that could enhance the ability of members to assure that eligible individuals file assistance applications.

Ongoing Costs: $12.50 transactional fee per PEA, plus staff time for eligibility reviews, plus costs associated with assuring that eligible individuals complete applications.

Return on Investment: The pilot has yielded a benefit-to-cost ratio of 6.1- to-1, based on the following findings (n=1,013): Eligibility workers completed 10.7 Medicaider determinations per hour (85 percent of determinations were completed in 3 minutes or less), 20.3 percent of those interviewed (n=206) were determined eligible for a federal or state funding source; a potential reimbursement of $17.50 per clinic visit (based on the lowest actual average reimbursement at a Seton clinic) could be collected for each eligible individual; each eligible individual will have 2.8 encounters in a year (based on national data and ICC Primary Care Use and Capacity Study); and that one in ten visits would be in an emergency department (based on ICC ED use study).

In the pilot, a $3,996 "ongoing" cost yielded a potential $24,514 in captured reimbursement. The pilot group represents an opportunity sample of approximately 1 percent of uninsured people presenting for care at ICC member sites. If this were a representative sample and Medicaider eligibility determination were adopted throughout the ICC system, the return on investment could be between $2 million and $5 million annually (representing captured third party reimbursement), assuming that members assured that eligible individuals completed the application process.

How long will it take?

Depending on the time commitment, resources available, experience and expertise of your business planning team, and the complexity of your model and financial modeling, the business planning process can take as little as four to six weeks or as long as several months.

What should we expect?

Business planning is iterative, much like the program design and cost estimating tasks. You will probably need to revise your original operating assumptions once you see the first draft of financial projections. Make sure you spend sufficient time to think through, research, and review all of your decisions. You may want to develop different scenarios based on best case and worst case projections, and then reality-test them with members of the planning coalition. Be practical in walking through the steps of each process. Some examples of the items to consider are provided below. Don't be afraid to talk with other communities and to learn from their experience.

KEY POINT: Be realistic. Find experts to challenge your financial assumptions. Be appropriately conservative in estimating both revenues and expenses. You need to describe—and be prepared to cope with—what you *think* will happen, not what you *hope* will happen.

2. Enrollment Projections and the Financial Plan

As is mentioned above, the financial plan is a major component of the business plan. The financial plan includes pro forma financial statements, meaning they are projections of the future financial status of the coverage initiative over a certain period of time.

Most communities develop these financial statements for at least two to three years of program operations, plus a preoperational period (probably lasting from five to twelve months). There is no need to go beyond five years, as costs and the health care market are difficult to predict that far in the future.

Before you begin you should also decide whether you want or need to structure financial projections by "product line" as well as for the overall initiative. This will be determined by your design and whether you, in fact, have several product lines. For example, Health*for*All's operations include not only the subsidy program but a referral service and database on the uninsured in western New York. Health*for*All's business plan includes a section on revenue and expense details for each of these product lines. This permits funders of one product line to understand relevant revenues and expenses.

Enrollment

Program enrollment is a key driver of program expenses, especially staff expenses. For this reason you need to develop monthly enrollment assumptions for the operational period covered in your financial statements.

Many factors will determine how quickly program enrollment will grow. Three of the most critical are design of your program, the nature of your marketing and outreach strategies, and how well you have tested the attractiveness and efficacy of both with your intended population. There are, for example, well-documented challenges in persuading small business owners to purchase health insurance coverage for their employees; a program that targets small businesses will therefore experience a slower enrollment ramp-up than one that targets a different population. In the same vein, well-designed marketing and outreach strategies, developed with user input, will result in faster program enrollment.

Disenrollment is a feature of every program. The *Communities in Charge* program in Portland ME has monthly disenrollment rates between 5 and 8 percent and uses 7 percent for its planning purposes. Research the experience of other communities. If you fail to factor disenrollment in your program you may overstate enrollment and end up hiring staff prematurely.

Examples of Enrollment Ramp-Up

Projections of enrollment ramp-up must take into account the segment of the uninsured you are targeting, how difficult this group will be to reach, interest, and enroll, and what kind of capacity you expect to have to bring on new members. Different situations and different assumptions will lead to different results, and strategies for dealing with these results will vary, too. We show here as examples projections of enrollment ramp-up for two communities from *Communities in Charge* that had different structures and experiences: Health*for*All (Buffalo NY), targeting uninsured workers in small businesses, and getCare (Louisville KY), which sought to serve the chronically ill. Both examples illustrate how even carefully thought-through assumptions and projections need to be monitored and adjusted according to a program's actual experience.

Example 1: Health*for*All's 2003 Healthy New York Three-Share Demonstration

Health*for*All began in 2003 as a pilot program with subsidy for about 600 enrollees. Enrollment projections were especially important in creating Health*for*All's overall financial plan, because the New York State Department of Insurance required that Health*for*All place in an escrow account, at the time of enrollment, an amount equal to each employer group's premium subsidy for the 12-month contract, plus an additional reserve amount. The program needed good projections to understand how much money would be required to meet this escrow requirement.

In creating its enrollment ramp-up projections, the developers of Health*for*All's business plan had to estimate:

- monthly new sales to small firms, given 1) the well-documented, significant challenges in selling to small business owners; 2) HMO sales staff capacity to educate, market, and sell to small firms (process the paperwork and collect the check); 3) scheduled communication campaigns; and 4) seasonal distractions (e.g., the challenges of getting a small business owner's attention between Thanksgiving and New Year).
- the average number of employees in each new group
- the typical mix of contract types within groups (e.g., single, two-parent, family)
- disenrollment within groups (from employees leaving, being fired, etc. balanced with new hiring)
- nonrenewal of groups (e.g., due to cost increases, firms going out of business, etc.)

The first iteration of enrollment projections appears in **Table 6-1.** As you can see, these projections estimated that, by the end of calendar year 2003, 166 employer groups would account for 498 enrollees. In fact, in December, 2003, the program had 104 employer groups and 436 enrollees. While actual enrollment did not vary greatly from the targets, Health*for*All's management and board were sobered by the inherent challenges in marketing to and subsidizing health coverage products for small business owners.

Table 6-1: 2003 Health*for*All Enrollment Projections

Enrollment and Subsidy Model–Health*for*All													
Groups Enrolling 2003 FYE 12/31/03													
Employer Groups		**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Enrolling													
Jan		-	-	-	-	-	-	-	-	-	-	-	-
Feb			-	-	-	-	-	-	-	-	-	-	-
Mar				3	3	3	3	3	3	3	3	3	3
Apr					7	7	7	7	7	7	7	7	7
May						12	12	12	12	12	12	12	12
Jun							20	20	20	20	20	20	20
Jul								30	30	30	30	30	30
Aug									42	42	42	42	42
Sep										42	42	42	42
Oct											5	5	5
Nov												3	3
Dec													2
Sub-total		-	-	**3**	**10**	**22**	**42**	**72**	**114**	**156**	**161**	**164**	**166**
Disenrollment	0.00%	-	-	-	-	-	-	-	-	-	-	-	-
Non-renewal Rate	0.00%												
Net Employer Groups		**0**	**0**	**3**	**10**	**22**	**42**	**72**	**114**	**156**	**161**	**164**	**166**
Employees													
Individual	80%	-	-	7	24	53	101	173	274	374	386	394	398
Two-parent	10%	-	-	2	3	7	13	22	34	47	48	49	50
Parent/child(ren)	5%	-	-	0	2	3	6	11	17	24	25	25	25
Family	5%	-	-	0	1	3	6	10	17	23	24	24	25
	100%	-	-	**9**	**30**	**66**	**126**	**216**	**342**	**468**	**483**	**492**	**498**
Employees/Group	3												

Example 2: getCare

The getCare pilot program involved three phases, with each phase having its own implementation timeline. The program was planned to begin with patients eligible for Phase I (where individuals were recruited by the hospital discharge planning staff from among low-income, uninsured inpatients with no medical home) and Phase II (low-income, uninsured people with a chronic disease who are current patients of primary care safety net providers); recruitment of Phase III patients (like Phase II patients, but referred from volunteering physicians) would begin about six months into the program.

Projecting the enrollment ramp-up for this program was complex because of the need to differentiate the three categories of enrollees. In addition, the business planning workgroup needed to make assumptions about:

- the average time required to screen for program enrollment
- the number of persons eligible as a portion of persons screened
- the time required to complete the enrollment process, including the health screening assessment
- the number of persons each enrollment clerk could screen and enroll in an average day (considering each clerk will serve more than one location and will need to travel among locations)
- the number of uninsured persons with chronic disease discharged from each of the partner hospitals
- expected disenrollment rates given proposed reenrollment procedures and the scope of benefits provided

Tables 6-2 and 6-3 show getCare's projected enrollment for fiscal years ending Dec. 31, 2003, and Dec. 31, 2004. As noted above, the careful construction of the enrollment projections and financial model revealed a $1.4 million revenue gap that was ultimately met by additional state and federal funding.

Table 6-2: getCare FY 2003 Enrollment Projections

Enrollment getCare Health Network FYE 12/31/03													
		Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
Phase 1													
Beginning		14	25	48	70	90	109	126	142	157	171	184	194
New		11	25	25	25	25	25	25	25	25	25	23	25
Disenrolled	7%		2	3	5	6	8	9	10	11	12	13	14
Ending		25	48	70	90	109	126	142	157	171	184	194	**205**
Phase 2													
Beginning		0	45	87	141	231	340	466	593	711	825	931	1030
New Enrollees		45	45	60	100	125	150	160	160	164	164	164	164
Disenrolled	7%		3	6	10	16	24	33	42	50	58	65	72
Ending		45	87	141	231	340	466	593	711	825	931	1030	**1122**
Phase 3													
Beginning		0	0	0	0	0	0	0	15	29	42	54	65
New Enrollees		0	0	0	0	0	0	15	15	15	15	15	15
Disenrolled	7%		0	0	0	0	0	0	1	2	3	4	5
Ending		0	0	0	0	0	0	15	29	42	54	65	**75**
Total New Enrollment		56	70	85	125	150	175	200	200	204	204	202	**204**
Total Enrollment		**70**	**135**	**211**	**321**	**449**	**592**	**750**	**897**	**1038**	**1169**	**1289**	**1402**

Table 6-3: getCare FY 2004 Enrollment Projections

Enrollment getCare Health Network FYE 12/31/04													
		Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
Phase 1													
Beginning		205	216	212	208	204	201	198	214	229	243	256	268
New		11	11	11	11	11	11	30	30	30	30	30	25
Disenrolled	7%		15	15	15	14	14	14	15	16	17	18	19
Ending		216	212	208	204	201	198	214	229	243	256	268	**274**
Phase 2													
Beginning		1122	1247	1285	1320	1353	1383	1411	1437	1461	1484	1505	1525
New Enrollees		125	125	125	125	125	125	125	125	125	125	125	125
Disenrolled	7%		87	90	92	95	97	99	101	102	104	105	107
Ending		1247	1285	1320	1353	1383	1411	1437	1461	1484	1505	1525	**1543**
Phase 3													
Beginning		378	478	545	607	665	718	768	729	693	659	628	599
New Enrollees		100	100	100	100	100	100	15	15	15	15	15	15
Disenrolled	7%		33	38	42	47	50	54	51	49	46	44	42
Ending		478	545	607	665	718	768	729	693	659	628	599	**572**
Total New Enrollment		236	236	236	236	236	236	170	170	170	170	170	**165**
Total Enrollment		**1941**	**2042**	**2135**	**2222**	**2302**	**2377**	**2380**	**2383**	**2386**	**2389**	**2392**	**2389**

Other Components of the Financial Plan

Your pro forma financial statements will be based on your enrollment projections, but also on a set of assumptions about the revenues you are expecting and the costs you will incur in providing services to the program's members. We discuss the highlights below; Attachment I contains additional information about expense items.

Revenue

One of the primary objectives of the financial projections development process is to identify the program's specific funding and funding timing needs. For the first cut of the financial projections, you may not have all of your revenue or funding sources identified or understand when you will receive funding. Use this first iteration of your financial statements to identify the timing of your funding needs from a cash flow perspective. For example, JaxCare used the early iterations of its financial projections to provide recommendations to the city council on the necessary timing for its receipt of city funding.

If you have funding for your first year committed from specific sources but have yet to secure support for later years, create a revenue item titled "funding need." Depending on the amount of funding need, your steering committee or board may use this information to identify and pursue a specific funding source or to scale back project scope. The text of your business plan should provide an explanation of how you intend to fill this funding need.

Medical Expenses

If your program will be paying for medical services you will need an actuary to provide accurate estimates of medical costs, with inflation and use adjustments, for each year included in your financial projections. Your consulting actuary will also help you refine eligibility criteria, provide an opinion on the likely timing of payments for incurred but not reported medical claims[I] and establish controls to monitor and reserve funds to support the program's medical expense risk exposure. More information on the components of an actuarial analysis is found in the Estimating Program Costs section of Part V.

[I] Incurred but not reported claims are medical expenses or bills for medical services provided but not yet billed or received for payment by the entity responsible for paying medical expense under your program. Failure to accurately account for this liability will have significant financial consequences.

Staffing

Use your program design summary to identify all the functions that your program will need to support with staff. For certain enrollment-driven services such as case management and enrollment and outreach, you will need to determine the number of enrollees that can be served by each staff category. For example, a program that targets very low-income individuals with significant chronic disease may need nurse case management ratios of one case manager for each 25 to 50 persons. Research similar programs and use their experience. Develop an organizational chart for the preoperational and operational periods of your program.

You will then need to consider the hiring timing for your staff as well as costs of benefits (usually expressed as a percentage of salary) and inflation assumptions. Factor any hiring costs into both your preoperational and ongoing expenses.

Preoperational expenses

Accurate accounting for preoperational expenses is critical. Be sure to review each expense item to determine both preoperational and ongoing operations costs. Some activities are concentrated in the preoperational period like provider network development and credentialing. Don't forget to include any system configuration costs if you are outsourcing claims processing/tracking and other similar functions. Think about your overall plant and equipment needs and costs. Depending on your program funding source, you may be able to load capital equipment purchases into the preoperational period.

KEY POINT: **Don't skimp on marketing and outreach. Many program planners have been surprised by the effort and investment required for these functions. Don't make the mistake of thinking "if you build it, they will come."**

KEY POINT: **Now would be a good time to touch base again with senior staff members from your state department of insurance and bring them up to date on the program plans, especially as marketing and outreach strategies are more clearly articulated and financing structures detailed through the business planning process. Make sure also that you keep up with staffing changes at the department and make a point of educating any new staff members about your program; this can prevent problems and delays.**

Results

Once you have settled on the assumptions and scenario(s) to be included in your business plan, you will need to summarize the results over the projected period, calling attention to surpluses, deficits and cost structure; capitalization, liquidity and solvency and, most important, cash flow. Calculate and, as appropriate, include your expense ratio or some other computation like the per member per month expense. Your board, steering committee and/or funders will ask for this number. If your program is small (5,000 to 15,000 enrollees or fewer), your expense ratio is likely to be very high because your membership base is too small to reasonably spread your fixed costs. Think about creating a separate memo or appendix that itemizes these fixed costs and explains that these would likely not change with increased enrollment. In some cases it may be helpful to describe the enrollment growth that could be managed without adding to these fixed costs.

The Implementation Plan

Your business plan will outline all the elements your program will have in place. Your implementation plan is the document that describes the steps you must take to get these program elements up-and-running. **Attachment 2** is a sample of an implementation plan for a coverage program for the uninsured that has been shared with several *Communities in Charge* communities. You may wish to use this document as a template, subtracting the tasks that are not relevant to your program and adding tasks your specific approach may require. The list of tasks provided in Attachment 2 shows the amount of work that is necessary to get a program up and running. You should review it carefully.

As is the case with our example, an implementation plan often is a matrix, with the list of tasks down the side and various headings (e.g., name of responsible staff person) across the top. Many programs create a matrix that can also serve as a Gantt Chart, including each week of the implementation period as a column in the matrix. The weeks during which a particular task will be done are then marked on the matrix in the column that matches the week of the work. This can be especially helpful to identify tasks that must be completed in a specific sequence (for example, the office site must be selected and leased before the communications equipment can be installed). Information on the use of Gantt Charts as a project management tool is widely available from books and web sites.

Conclusion

A well-crafted business plan serves two purposes: it gives you critically needed information about the expected financial health of your program, and it gives you a document to use to market your program to funders, politicians and others. Having a business plan shows that your coalition is a professional operation; that your program can be trusted with public (or significant private) funds. It also makes your abstract intent real and tangible: when you get to the point of talking about hiring schedules, enrollment figures, salaries and benefits, office space—all of which help make up your business plan—your project takes shape before your eyes.

As has been true throughout the program development process, other communities have done this before you and have experience to draw on and examples that you can use. The assumptions you make must be specific to your program, but business plan formats and structures can easily be shared.

Reaching the point where you have a finished, polished business plan is a tremendous accomplishment for all who are part of your coalition. While the hard work of implementing your program still lies ahead, take the time to congratulate yourselves for what you have accomplished. In time, the people who now will have health coverage because of the program you have brought to life will congratulate you for it, as well.

Attachment 1

Typical Components of a Comprehensive Business Plan

1. Executive Summary

This section is the short summary that will be the key to selling your program—clearly and succinctly outlining what your program is, who it will serve and how it will operate. The executive summary should describe very briefly the vision, objectives, operating plan, implementation plan, and financial implications of the planned coverage and access program. This section should be able to stand alone as a description of the project as well as serve to introduce the longer business plan.

2. Mission and Business Definition

Here you describe the overall objectives of your program—the vision and mission—and then lay out the specific definition of the business you have designed to meet your mission. This definition should include lines of business (e.g., subsidized local coverage program, case management program), target markets (e.g., uninsured, low-income adults with family income under 100 percent of the federal poverty level). Finally, you identify the operating principles that guide your decision-making.

3. Environmental Assessment

The purpose of this section is to set the context in which decisions have been made. This includes the barriers to access faced by your intended population, characteristics of your community's health care market, and the political environment in which your program will operate. The market and environmental analysis your coalition conducted in Phase 2 of this project will form the foundation for this section.

4. Program Design (Overview)

a. Structure and Governance

In this section, you should provide a description of the formal components of your program and show how these support your vision and mission. You should describe:

- Regulatory and licensure issues (approvals by entities such as the state department of insurance or decision made by a department of insurance that no special licensure is required)
- Ownership and business structures
- Board and committee structures

- Relationships with community entities such as hospitals and other health care organizations
- Relationships with financing sources
- Earnings distribution/contribution sources

b. Leadership and Management

Here you provide a description of the leadership and administrative organization you have designed to manage this business and support your vision and mission. Describe:

- Your organizational structure
- The responsibilities of each person on the management team
- Accountability and reporting relationships

c. Care Delivery Network

Here you describe how you established a comprehensive delivery system to ensure the provision of all covered services and created an administrative management program to involve participating providers in formalized standards for the delivery of care to members. This section should include:

- The number, type and geographic location of providers who will be part of the program (hospitals, primary care physicians, community clinics, specialists, ancillary providers)
- Your provider relations policies and procedures
  - Contracting standards
  - Compensation
  - Communication plan
  - Policies for ongoing contact and communication with providers and their office staff
  - Determine staffing needs for provider relations area
- Plans for clinic management (if appropriate)
  - Practice management services
  - Staffing
  - Policies and procedures
- Your provider contracting and payment arrangements
  - Primary care providers
  - Specialists

- Hospitals
- Community clinics
- Ancillary services (e.g., laboratory, radiology, pharmacy, dental, behavioral health, etc.)

• Plans for medical and case management
  - Medical management initiatives
  - Protocols for referral process (if appropriate)
  - Primary care office testing (if payments are being made for these services)
  - Structure of quality management program and established protocols for direct patient care and medical services
  - Quality assessment protocols
  - Physician education and training program
  - Case management and continuity of care protocols
  - Member health education programs
  - Policies to assure availability and accessibility of services
    - Primary care provider appointment policies (accessibility for routine, urgent and emergency services)
    - Hours of service
    - After-hours coverage and services
    - Emergency care and services

• A statement of desired health status outcomes for members: aggregate achievement of medical outcomes and periodicity of certain procedures, and process for establishing enrollee specific outcomes through the case management process

d. Marketing and Outreach Strategy

Here you will present your:

- Communication strategy for involved parties (intended populations, providers, funders, etc.)
- Communication strategy for the general public
- Market positioning, strategy and plan
- Image/identity
- Media
- Integration with current programs

e. Administration and Operations

This section describes your plans for structuring and developing the administrative infrastructure needed for the program (for example, whether the program will develop these services internally or contract with others for these components). You will need to provide a brief description of:

- Activities and roles
- How function relates to current activities (are these new activities; activities currently performed by organizations in the community; modification of activities currently performed by community organizations?)
- How function and plan relates to your program's mission and vision
- Plan of organization
- Resource and staffing implications (i.e., new staff required, outsourced, etc.)
- Implementation steps for each of the following administrative functions:
  - MIS—administrative and data management: requirements, solutions, and interface including:
    - Eligibility determination and enrollment
    - Membership and member services
    - Provider network and provider relations
    - Case management
    - Claims processing
    - Program evaluation
  - Personnel/human resources
  - Financial management

f. Implementation Plan

- Work plan
- Timeframe and phase-in schedule
- Staffing and responsibilities
- Communications strategies and achieving buy-in

5. Financial Plan.

As this section describes, the financial plan provides a detailed picture of the costs and revenues of the program throughout the program's start-up and on into the period of full operation. The financial plan section of the business plan should state:

- The methodology used in developing these financial projections
- Assumptions made about
  - Enrollment
  - Revenues – amount and timing by source
  - Medical expenses
  - Staffing – positions, salary, staffing ratios, timing of hiring and benefits
  - Administrative expenses
    - Typical staffing-driven expenses
      - Office supplies
      - Minor office equipment
      - Communications such as internet access
      - Telephone
      - Mobile telephone and pager expenses
      - Payroll processing services
      - Travel
      - Capital expenditures such as computers and workstations
    - Typical member-driven expenses
      - Printing
      - Postage
      - Third party administrator costs

Other expenses

Rent

Utilities

Housekeeping and maintenance

Advertising and promotions

Legal

Outsourced staff

Subscriptions, seminars, training

Business insurance

Professional services such as audit, actuary or consulting services

Bank service charges

Costs for MIS modifications and telephone system

Other office equipment

Other preoperational expenses

- Other assumptions

  Financing costs, interest and/or investment income

  Inflation

  Licenses and required reserves

- The results of the financial modeling
  - Overall results over the projected period

    Surpluses, deficits and cost structure

    Capitalization, liquidity and solvency

    Cash flow

  - Results by business line or scenario
  - Conclusions about the financial viability of this business.

6. Evaluation.

Your business plan should include a discussion of how you plan to evaluate, on an ongoing basis, the impact of your program and its success at meeting its goals. You should describe your planned evaluation process, procedures and milestones; how you will use the results of these evaluations to improve your program; and your strategy for showing a return on investment to help justify the contributed funds.

7. Critical Success Factors

This final section is the most narrative. How will you know that your program will be successful? What factors do you think are essential to your program's success and how have you structured your program to ensure that these factors are present and supported throughout program operations? What obstacles do you think you may face and what are your plans for overcoming these obstacles? In this section, you can highlight the careful thinking you have done throughout the program development process. You know what is necessary to make your program work and you know how—to the best of your ability—you are going to put these elements in place.

Attachment 2

Sample Implementation Plan

Tasks:	Date Completed	Staff Resource	Other Resource

I. Organizational Development

A. Develop appropriate administrative options for program

- prepare job descriptions/responsibilities
- major departments/functions such as administrative, claims, finance, marketing, medical management, IT
- Develop the table of organization
- finalize operational budgets
  - salaries
  - benefits
  - administrative

B. Establish policies and procedures

- employee hiring and salary administration
- personnel
- hiring contract review and approval
- employee handbooks

C. Recruit for and/or staff key management positions (see examples below)

- Executive Director
- Director of Finance & Controller
- Operations Director
- Director of Marketing, Outreach and Enrollment

Tasks:

Date Completed	Staff Resource	Other Resource

- Medical Director
- Director of Medical/Case Management
- Provider Relations Director
- Claims Manager
- Member Services Manager
- IT Director

D. Site location for program operations

- select office site
- purchase office equipment and furniture
- develop system requirements
- install communication systems

E. Determine initial department staffing levels based on anticipated weekly/productivity

- conduct space and equipment needs analysis
  - average square footage per staff member
  - multiuse space needs
  - build out options
  - proximity to other operating units
  - satellite locations for decentralized model
  - typical customer service workstation configurations
  - telephone handset and headsets
  - computer terminals
  - general office equipment, including PCs

Tasks:	Date Completed	Staff Resource	Other Resource
F. Develop human resource plan			
• establish key qualifications and experience requirements			
• develop advertising and recruiting plan			
• design training program			
– set training objectives, including managed care concepts, specific products, customer service skills, IT			
– refine curriculum to include above			
– determine evaluation methods			
G. Establish program funding plan			
• identify all funding sources (committed and potential)			
• understand funder reporting requirements			
• establish procedures for securing, managing and reporting on funds			
• develop strategy for ensuring continued program funding			
• execute and modify strategy as appropriate			
2. Financial Management			
A. Design program administration business office functions			
• banking relationships			
– checking			
– lockbox, if necessary			
• payroll			
• accounts payable			

Tasks:

Date Completed	Staff Resource	Other Resource

- cash management
- general accounting
- general ledger software, if necessary
- develop internal workflows and controls

B. Review/finalize pro forma

C. Obtain business insurance/reinsurance /insolvency coverage

- select carriers
- execute agreements

D. Establish policies and procedures

- purchasing
- check requests
- petty cash

E. Develop medical cost assumptions

F. Develop revenue assumptions

3. Billing and Claims Management

A. Billing

- determine appropriate staffing needs
- design policies and procedures (including office manuals)
- develop internal workflow process

Tasks:	Date Completed	Staff Resource	Other Resource
B. Claims management			
• determine appropriate staffing needs			
• check control procedures			
• design policies and procedures (including provider office manuals)			
• develop internal workflow process			
C. Set department quality and productivity standards and design program for periodic evaluation			
## 4. Provider Network			
A. Network development			
• identify physicians, hospitals and ancillary providers which will have direct contracts with program; identify preferred primary, secondary, and tertiary care providers/ facilities, including ancillary services			
– gather necessary information for provider capacity			
– analyze and determine provider capacity			
– investigate other contracting			
nurse practitioners			
durable medical equipment			
home health care/home infusion			
urgent care			
outpatient surgery			
speech therapy			

Tasks:	Date Completed	Staff Resource	Other Resource
laboratory			
hospice			
PT/OT			
MH/SA			
prescription drug			
vision			
dental			
• assess payment/service "value" tracking options			
– review market data on payment methodologies			
– assess payment/"value" options			
hospital (per diem, DRG, global) physician (capitation, FFS, discount) ancillary			
– determine feasibility of payment schedules based upon actuarial estimates			
discuss impact of selected payment methodology			
finalize provider reimbursement methodology			
• finalize and distribute contracts to providers			
• coordinate signing of contracts			
B. Provider credentialing/recredentialing			
• develop provider credentialing/recredentialing policies and procedures			
– PCPs			
– specialists			
– hospitals			
– ancillary			

Tasks:	Date Completed	Staff Resource	Other Resource
• create Credentialing Committee			
• establish provider evaluation and sanction policies			
C. Review provider agreements with state insurance department			
D. Conduct provider education sessions			
5. Provider Relations			
A. Define department structure			
• establish staffing requirements			
• define internal policy and procedure workflow manual			
B. Conduct provider orientation			
• develop provider office manuals (physician, hospital)			
• training session for physicians and office staff			
C. Design and implement on-going physician communication program			
• physician newsletter			
• physician appreciation programs			
D. Determine on-going physician recruitment strategies			

Tasks:	Date Completed	Staff Resource	Other Resource

6. Quality Assurance/Utilization Management

A. Define department structure

- identify medical leadership and medical director
- define program philosophy and activities
  - conduct physician interviews to assess attitudes regarding medical management
- define department structure
- develop internal policy and procedure workflow manual
- develop protocols for referral process
- develop primary care office testing policies
- review peer review statutes

B. Define quality assurance program

- appoint QA committee members
- review and discuss QA models and programs
- create policies/procedures for QA activities, including retrospective review, patient satisfaction, risk management and outcome measurement
- develop quality assessment protocols
- develop required care standards
- discuss physician education & training program
- identify data sources
- evaluate medical criteria
- design reporting formats
- develop plan for program evaluation

Tasks:	Date Completed	Staff Resource	Other Resource
C. Define utilization management program			
• appoint UM committee members			
• discuss UM program (i.e., case management, protocols/critical pathways, criteria for LOS assignment, pre-certification/ prior authorization)			
• develop UM standards and evaluation program			
• develop policies/procedures/workflows for utilization review process			
• develop recordkeeping process			
• determine management reporting requirements			
D. Develop medical and case management procedures, systems and forms			
• develop referral process, system infrastructure, any tracking documents			
• develop case management program			
• develop communication/letters to providers and enrollees			
• set up and configure IT			
• develop procedures			
• develop medical records review process			
7. Member Services			
A. Define role and responsibilities of Member Services			
• develop unit function/goals statements			
• draft key staff job descriptions			

Tasks:

Date Completed	Staff Resource	Other Resource

B. Develop enrollment management policies, procedures and materials

- define data to be collected during enrollment,disenrollment
- define interaction with marketing, outreach and enrollment department
- develop detailed enrollment, reenrollment, disenrollment, change procedures
  - PCP selection procedures and policy (frequency, etc.)
  - member counseling guidelines
  - eligibility verification
  - timeframes for processing
  - data entry procedures
- design, draft and print materials and forms
  - enrollment and application forms
  - enrollment notification (new member packs)
  - member I.D. cards
  - Member handbook, provider directory, etc.
  - information/education materials
  - reenrollment, disenrollment forms

C. Design new member orientation strategy and curriculum

- finalize orientation strategy
  - before, during, after enrollment
  - telephone, person-to-person, direct mail
  - individual versus group orientation

Tasks:	Date Completed	Staff Resource	Other Resource
- promoting individual visits with PCP			
- PCP and member services role			
• develop detailed content for orientation curriculum			
- PCP referral role, emergency care, covered services, I.D. card			
- mix of orientation media (written, oral, audio/visual)			
• identify locations/opportunities for orientation			
• identify staff to conduct orientation			
• develop triage guidelines for intensive orientation			
• develop orientation attendance incentive plan			
• develop evaluation tools measure effectiveness			
D. Design health education and promotion program			
• finalize education and promotion strategy			
- PCP takes primary role			
- case management/member services in support role			
- triage membership for intensive education intervention			
- use existing community resources to support education			
• develop criteria to identify high-risk cases for education			
• design health education curriculum by risk groups			

Tasks:	Date Completed	Staff Resource	Other Resource
• create education materials (written, audio, visual)			
• meet with and negotiate agreements with community agencies			
• develop education incentive program			
E. Develop member appeals and grievance policy and procedures			
• complete analysis of any state requirements			
• outline key steps in handling member problems, complaints, grievances			
– recognizing the nature of the problem			
– evaluating the severity			
– investigating the complaints			
– timeframes for resolving			
– responsible parties, including management			
– typical forms and correspondence			
• establish grievance committee, other governing structure			
F. Develop member retention program			
• establish member advisory committee			
• design member satisfaction survey tool and program			
G. Determine administrative resource needs			
• complete workload/productivity analysis			
– enrollments per month			
– forms to be processed			

Tasks:

Date Completed	Staff Resource	Other Resource

- calls to be received
- outbound education/orientation calls to be made
- other education/orientation initiatives to be completed
- average monthly disenrollments
- anticipated number of grievances/appeals
- define specific work tasks for primary functions
- develop completion estimates by task

H. Establish performance measurement plan

- set unit performance goals and standards
  - handling incoming calls promptly, accurately and courteously
  - processing transactions promptly
  - completing orientations effectively
- determine measurement tools
  - system generated performance reports
  - supervisory observation
  - member satisfaction measurement (surveys, focus groups, disenrollments)

Tasks:	Date Completed	Staff Resource	Other Resource

8. Evaluation

A. Finalize evaluation process and procedures

- develop and link together: grievance procedure and enrollee complaint process, enrollee consumer satisfaction surveys, enrollee survey of access to care and health status, health status/service utilization/medical outcome results, effectiveness analysis of ancillary provider services, internal quality and effectiveness audit results

B. Establish mechanisms for feedback of evaluation results into ongoing operations

9. Benefit Design

A. Finalize program benefits

- work with advisory committee and actuary for design involvement

10. Marketing Outreach

A. Confirm enrollment projections

B. Approve promotion/marketing plans and materials

C. Finalize marketing and public relations strategy For each target market (potential enrollees, providers, funders, general public) establish:

- strategic marketing plan
- media plan
- public relations plan

Date Completed	Staff Resource	Other Resource

Tasks:

- budget for marketing, media & public relations plans
- roll-out and production plan

D. Produce marketing and communication materials

E. Determine compensation structure for outreach and marketing staff

F. Establish marketing/outreach staffing requirements

G. Recruit marketing/outreach staff

H. Conduct marketing campaign

- conduct initial meetings with employers/ collaborative agencies
- develop and implement market education program
- advertising/public relations
- direct mail
- personal calling

I. Develop internal policies/procedures and workflows

J. Initiate enrollment

APPENDIX
HEALTH CARE FINANCING MECHANISMS

I. Introduction

The following appendix provides an overview of the types of financing mechanisms that a community may wish to consider for its locally-based coverage/access program for the uninsured. As mentioned in Part V, *Cost and Funding Estimates,* potential sources of funding for a program include:

- Public dollars, in the form of either monthly per capita payments for each enrollee or fixed amounts, which may come from local or state governments through general county tax subsidies, state and federal matching funds through a Medicaid demonstration program in your community, the distribution of tobacco settlement funds, or other sources
- Premium payments by employers and/or employees/enrollees
- Copayments made to participating providers by enrollees
- Other contributions (for example, significant cash grants from foundations, usually for preoperational expenses or some element of program administration)
- Services donated by providers (either pure pro bono services, or acceptance of reduced payment rates); and
- Donated administrative services.

This appendix presents select examples of many financing mechanisms used by participants in The Robert Wood Johnson Foundation's *Communities in Charge* initiative and other communities around the country.

Note that our focus is on recurring, sustainable funding mechanisms, not one-time grants or donations. Such one-time payments may be useful to cover one-time costs (for example, discrete startup expenses). For the long term, a coverage/access program needs to be able to pay its own way through self-sustaining funding streams that result from careful program planning and development. Reliance on a single source of funding can be risky and many communities adopt multisource strategies.

II. Government-Financed Models

Taxes may be levied at the local, state or federal level to support health coverage initiatives for the uninsured, although local authority to levy taxes is regulated by the state. The major types of tax funding are:

- *discretionary* funds from local general revenues
- funding from a *dedicated* revenue source such as a county or state ad valorem property tax, sales tax, or special tax
- a *specific, nondiscretionary, dedicated tax* to finance the cost of providing indigent health care.

Local Financing Mechanisms

Discretionary funds from general revenues

- **Jacksonville FL.** In 2001, the local consolidated government of the City of Jacksonville and Duval County appropriated $31.2 million in general revenue funds to support health care services for its residents. Of this amount, $800,000 supported HIV initiatives through the Ryan White program, $3.2 million funded mental health and substance abuse programs, and $27.8 million was allocated for medical and dental services. Of the latter amount, the city allocated $23.5 million to Shands-Jacksonville Hospital to support First Care, an enrollment-based, managed care program for the indigent uninsured. In 2004, additional general revenues were allocated to support JaxCare's operations.
- **Wayne County, Michigan.** A special indigent care pool supports two local programs for the uninsured—PlusCare, a program created by the County Board of Commissioners to provide indigent care to county residents and, HealthChoice, a subsidized employment-based managed care program. The indigent care pool comprises county general revenue dollars, state funds, and supplemental federal Medicaid dollars. In 2002, the county contributed $15.5 million to the pool; the state, $4.5 million; and the federal government, $24.5 million.[1]

Dedicated sources of revenue

- **Alameda County (Oakland/Berkeley), California.** In 2000, the Alameda Alliance for Health (AAH), a local, nonprofit, managed care plan in Alameda County allocated reserve funds from its health plan to expand access to health care coverage within the county. AAH is one of the two health plans in the county that provides managed health care coverage for Medi-Cal enrollees. Margins from the contracts are added to a reserve fund and some $20 million of these funds were used to subsidize coverage through Alliance Family Care. AAH leveraged these funds and

[1] Refer to http://www.urban.org/UploadedPDF/Hp_mich.pdf and http://www.waynecounty.com/commServ/healthchoice.htm for a more detailed description of HealthChoice.

$400,000 from The California Endowment to acquire an additional $1.8 million per year in county tobacco Master Settlement Agreement funding, $1 million from the California HealthCare Foundation, and another $2.6 million from other private foundations.

- **Denver CO.** DenverHealth, a public health delivery system consisting of one public hospital, the public health department, and an extensive network of outpatient clinics in Denver, operates as a quasi-public hospital authority. While not an enrollment-based program, the health system coordinates care delivery to low-income uninsured city and county residents who seek a full continuum of services at sites within the network. DenverHealth operates independently of local government and is able to pool funds from various sources, although the city and county finance a significant portion of its uncompensated care.
- **Harris County (Houston), Texas.** Harris County Hospital District (HCHD) operates three public hospitals and a network of clinics that provide inpatient and outpatient services to the county's indigent population. HCHD supports nearly three-quarters of the county's charity care and derives funding from a dedicated ad valorem property tax, tobacco settlement revenues and significant DSH funding.
- **Marion County (Indianapolis), Indiana.** Health and Hospital Corporation of Marion County (HHC) created Wishard Advantage, an enrollment-based, managed care program for uninsured, county residents with incomes at or below 200% of FPL. During 2003, the program was financed with $152 million in funds from Disproportionate Share Hospital (DSH), Upper Payment Limit (UPL), and local property tax dollars.

Specific, nondiscretionary, dedicated taxes

- **Hillsborough County, Florida.** In 1991, Florida passed legislation enabling counties with a minimum population of 800,000 to levy a limited local option sales tax up to one-half cent to fund health care services for the medically indigent. Hillsborough County supports county indigent care entirely through local tax revenues. Revenue generated from a local, half-cent sales tax finances Hillsborough HealthCare, a comprehensive managed care plan for low-income uninsured county residents. Where possible, Hillsborough HealthCare payments are used in conjunction with DSH and other programs to facilitate additional matching funds for providers.
- **Miami-Dade County, Florida.** Tax-generated revenues (from a local half-cent sales tax and property taxes) constitute a large part of the county's annual contribution ($220 million in 2002) to support local health care services for the medically needy at Jackson Memorial Hospital and its clinics.

- **Palm Beach County, Florida.** The Health Care District of Palm Beach County is an independent taxing district charged with advancing access to health care services. A core responsibility of the Health Care District is to improve health coverage for low-income residents. This is accomplished through a locally funded health initiative called Coordinated Care and includes a network of physicians, hospitals, pharmacies, and ancillary health care providers. This program serves approximately 30,000 members on an annual basis who are not eligible for full Medicaid, Medicare or private insurance.
- **Cuyahoga County, Ohio.** Cuyahoga County uses two separate health and human services (HHS) property tax levies to support a wide variety of HHS initiatives. A portion of the tax-generated revenue subsidizes providers of uncompensated health care services within the county. The county also serves as the "payer of last resort" for indigent care. In FY 2003, Cuyahoga County generated approximately $135.1 million in revenue through property tax levies.
- **Bexar County (San Antonio), Texas.** The Bexar County Hospital Taxing District conducts business as the University Health System. The Health System administers a local property tax at a rate of $0.24 per $100 property valuation to support health care services for the county's uninsured population. The financing mechanism generates more than $145 million per year in property tax dollars, most of which are used to support Carelink, the local coverage/access program for the uninsured.

State Financing Mechanisms

Although many communities draw funding from local sources, state dollars are also an important revenue source. State funding can be a more reliable flow of funds to support the local provision of health care services for the medically indigent. In addition to tax-based revenues, state financing mechanisms may be based on:

- mandatory or incentive-based state/local matching funding mechanisms
- tobacco settlement dollars and/or revenues from special state fees, such as a vehicle licensing and registration fees

Mandatory or incentive-based matching funding

- **California.** Counties in California assume primary responsibility for providing health care for their uninsured population and, by law, serve as the providers of last resort for medically indigent residents.[2] In 1991, the state set up a dedicated funding stream for this care, financed by an increase in the state sales tax and a portion of the state vehicle license fee.[3]

[2] Long, M.H.S., Peter. County Efforts to Expand Health Coverage among the Uninsured in Six California Counties. Oakland CA: Medi-Cal Policy Institute, February 2002.
[3] Refer to http://www.rwjf.org/publications/publicationsPdfs/community-init.pdf for a more detailed description of these programs.

- **Alameda County** leveraged $1 million in county tobacco Master Settlement Agreement funding and $500,000 from the Alameda County Social Services Agency to draw down $5.5 million in state and federal matching funds to provide coverage for in-home supportive services workers.
- **Contra Costa County** relies on a diversified funding stream to support the Contra Costa Basic Health Care (BHC) program, an enrollment-based, care financing program for the county's low-income, medically indigent population. The state provides two-thirds of the total budget (approximately $19 million) through a state/local match financed by vehicle licensing fees and tobacco settlement funds. The state also levies a cigarette tax to help support local efforts. Contra Costa County contributes approximately $9.5 million in general revenue dollars, and Basic Health Care also receives some DSH funding through the Contra Costa Regional Medical Center.[4]

Tobacco Settlement Dollars/Revenues from Special State Fees

- **New York State.** In 1996, New York passed the Health Care Reform Act (HCRA) of 1996. Among HCRA's features were the establishment of Healthy New York and Family Health Plus, two new comprehensive programs to expand affordable health coverage among the uninsured population. In addition to expanding coverage for the uninsured, HCRA and its successor, HCRA 2000, support antismoking efforts, strengthen hospital and clinic care for the poor, and address rural health care and graduate medical education needs.
- **Santa Clara County, California.** Like Alameda County, Santa Clara County and the city of San Jose CA decided to use a portion of state-allocated tobacco settlement funds to help provide health insurance coverage to the county's uninsured children. Other sources of revenue that support the Healthy Kids program include contributions from the Santa Clara Family Health Plan, foundations, local hospitals, and revenues from a special state-levied tobacco tax.

Federal Financing Mechanisms

Some communities use federal funding mechanisms to supplement state and local dollars earmarked for indigent health care. Disproportionate Share Hospital (DSH) and Upper Payment Limit (UPL) arrangements are two such mechanisms.

[4] Andrulis, Dennis and Michael Gusmano. Community Initiatives for the Uninsured: How Far Can Innovative Partnerships Take Us? New York: The New York Academy of Medicine, Division of Health and Science Policy, Office of Urban Populations, August 2000.

- **DSH** dollars compensate hospitals that provide a "disproportionate share" of health care services to low-income, uninsured individuals and/or those enrolled in the Medicaid program. Hospitals typically receive DSH payments directly from the state. In return, the federal government reimburses the state dollar-for-dollar or sometimes substantially more than this amount. Most states receive substantial DSH funding, and the federal government affords states great flexibility in determining how to distribute these dollars. Some states create DSH revenues are dedicated to specific services.
  - **Georgia** had created a DSH set-aside program for primary care. In 2004 the amount is 15 percent of DSH funds. Macon's Communities in Charge initiative used a small portion of these dollars from two area hospitals to fund the cost of prescription drugs for Community Health Works enrollees.
- **UPL** is a supplemental payment mechanism that enables a state to draw down matching federal dollars. This mechanism allows a state to pay state or local government-owned medical institutions an amount exceeding prescribed Medicaid reimbursements. The resulting higher payment rate is used to draw down a proportionally larger share of federal dollars. Local recipients of these payments return an equal or slightly lesser amount to the state. Under this arrangement, the medical institutions incur no financial loss and the state keeps the matching federal dollars to use at its discretion. While a state may use UPL dollars to support the provision of health care services for the uninsured, it has the flexibility to use these funds for other purposes.[5] Because of the potential to abuse the UPL provision, the current federal administration has implemented regulations intended to significantly restrict state use of UPL dollars. For this reason, the potential for communities to successfully implement UPL as a sustainable financing strategy is quite limited.

Other Government Financed Models

Some communities are running projects to test the effectiveness and sustainability of creative financing mechanisms for local coverage/access programs. Many of these are funded through tax revenue.

Local Demonstration Financing Mechanisms

- **Montgomery County, Maryland,** was the first county in the country to pass a local *earned income tax credit* (EITC) that provides tax refunds to low-income working individuals. The credit, which began in 1999, was part of the county executive's "Rewarding Work" proposal to improve the lives of the county's working poor. Some experts believe that such tax relief provides low-income individuals more after-tax dollars to purchase needed health insurance coverage, while others

[5] Ku, Leighton. Limiting Abuses of Medicaid Financing. Washington, DC: Center on Budget and Policy Priorities, September 27, 2000. Available http://www.cbpp.org/9-27-00health.htm.

remain skeptical about the overall effectiveness of this model in reducing the number of uninsured. The latter suggest that, despite supplemental tax relief, low-income individuals still lack access to affordable coverage and the "cash flow" necessary to purchase health insurance.

- **Cuyahoga County, Ohio,** has established a county general health district to serve cities, towns and villages within the county that do not have a public health department. The general health district has established contracts with about 35 cities and towns. In exchange for providing health services, the health district applies a per capita health fee to these communities (significantly less than the per capita costs for cities that have their own public health departments). Additional funds come from private, state and federal grants and funds from the Ohio State Health Department. Although this revenue does not currently support programs for the uninsured, this mechanism of assessing local governments a per capita fee may be a viable funding source for future programs for counties looking to support all, or a portion of, indigent care services.
- In **Portland OR** the Tri-County *Communities in Charge* project managed by the Multnomah County Health Department undertook a review of the benefits of establishing a "safety net authority" with the potential to become a multicounty taxing district (the Portland region incorporates several political jurisdictions). The county boards of the tri-county metropolitan region commissioned a Blue Ribbon Panel of 25 community stakeholders. The panel's task was to make recommendations regarding the structure, financing and relationships of such a safety net authority, which would then be considered for ratification. In the summer of 2004, the three county commissions signed interagency agreements to establish the Tri-County Health Care Safety Net Enterprise (TCHCSNE). While the Enterprise does not have taxing authority, it has been charged by the community to assure the best community return on investment of private and public resources used for improvements in access to care.
- Before May 2004 **Travis County (Austin), Texas,** was one of the few major metropolitan areas in Texas without a health district. A local coalition that included the Indigent Care Collaboration (ICC) in Austin, a *Communities in Charge* initiative, then successfully obtained voter approval to establish such a health financing district. The coalition hopes ultimately to expand the district beyond Travis County to other contiguous counties, creating a regional mechanism to address the needs of the uninsured.
- **San Francisco CA** mandates that contractors providing services to the city and county or entering into leases with the city and county offer health plan benefits or make payments to partially offset the costs of services to uninsured workers. A variation on this "economic development" approach would be for a municipality to provide access to low-cost bonds or other financial incentives to businesses offering health insurance.

State Demonstration Financing Mechanisms

- **Hawaii** requires employers to pay some portion of health insurance for all employees who work more than 19 hours per week.
- **Washington, Massachusetts** and **Oregon** have unsuccessfully attempted to institute a "pay or play" mandate on businesses to encourage health care coverage for the otherwise uninsured.[6] In this case, businesses would be required to pay a tax if they chose not "play," i.e., finance some portion of employee health coverage. Such tax revenues could then be used to help support health care coverage programs for the uninsured.
- In 2004 **Oklahoma** passed several pieces legislation to increase fines and levy new fees for motor vehicle violations. The resulting revenue will be used to increase support to an underfunded statewide trauma system. A tobacco sales tax increase was approved by voters in November 2004. A portion of the new tax and the higher fines and fees will increase funding for the state's trauma care system by more than $30 million. Establishing new resources to reimburse emergency hospital and ambulance services for trauma care prevents hospitals from having to absorb these costs.[7] This may allow hospitals to support less intensive health care services to other segments of the uninsured population.
- **Maryland.** In 2002 The Maryland Citizens' Health Initiative commissioned a study to analyze the cost-savings of instituting a single-payer health care model. The statewide plan would replace all existing public and private insurance plans, including Medicare and Medicaid funding. To finance the plan, the state would draw from existing government health care funding for discontinued programs and "new taxes on employer payroll, tobacco products, alcohol products, and personal income."[8] Rather than paying monthly premiums to support the cost of individual health care coverage, residents would pay an income-based tax. Study findings showed that a single-payer system would cover all Maryland residents, including the state's estimated 760,000 uninsured, and cut the cost of statewide health spending by approximately $345.8 million or 1.7 percent.[9] A uniform and streamlined administrative system would account for a significant portion of the savings. While the implementation of such a plan is unlikely in the near term, the results of this analysis show the complexity of instituting the single-payer approach.

[6] State Employer Mandates" in State Briefing Book on Health Care. Washington, DC: National Center for Policy Analysis, September 23, 1994. Available http://www.ncpa.org/w/w24.html.

[7] Oklahoma Hospital Association. State Legislative Report—Second Session of the 49th Legislature, July 15, 2004. Available http://www.okoha.com/StaticContent/StaticPages/MEMBERS_ONLY/Legislation/Final%20Legislative%20Report%20-%20July%202004%20-%20PDF.pdf

[8] Haught, Randall A. and John F. Sheils. Analysis of the Costs and Impact of Universal Health Care Models for the State of Maryland: The Single-Payer and Multi-Payer Models. Fall Church, VA: The Lewin Group, Inc., May 2, 2000. Available http://www.lewin.com/Lewin_Publications/Uninsured_And_Safety_Net/Publication-28.htm May 2, 2000.

[9] Ibid.

III. Voluntary Provider Models

Some communities have built networks of voluntary providers who will provide donated care to the uninsured population. Many of these communities also seek local, state and other financing to support their programs, usually to finance prescription drug costs, case management services, and the program's other administrative expenses. Sustainability and sufficient capacity are major issues for communities that use this "mixed model" financing mechanism.

- **Wichita KS,** a *Communities in Charge* community, has a physician- and dentist-led, community-based effort to coordinate donated voluntary medical and dental care for low-income uninsured people residing in Sedgwick County, Kansas. Community efforts are organized through the Central Plains Regional Health Care Foundation. Participating physicians and hospitals donate services to the project and all direct service is tracked as charges. Annual contributors to this communitywide effort also include the Sedgwick County Commissioners and the Wichita City Council. The funds are used to purchase prescription drugs and to cover some administrative costs. Central Plains also receives funding from its local United Way. Annual cash funding of more than $1.5 million supports prescription drugs and operations coordination including personnel such as service coordinators who help with program enrollment, pharmacy assistance applications, and care.
- **Portland ME's** voluntary provider model is called CarePartners. CarePartners provides eligible persons with comprehensive health care services, case management, and access to low-cost or free pharmaceuticals. The program receives direct funding from MaineHealth, an integrated delivery system serving southern and central Maine, and from key hospitals within the program's service area. These funds support prescription drug costs, staff salaries and case management services. In addition, Anthem Blue Cross and Blue Shield donates claims processing services and provides access to program utilization data to facilitate monitoring and measurement of program outcomes. Total annual cash funding to support prescription drugs and program operation is more than $1.5 million.
- **Macon GA's** voluntary model, Community Health Works, serves a multicounty region in central Georgia. Like Project Access and CarePartners, enrolled members have access to comprehensive health services, case management and low-cost or free pharmaceuticals. Hospital providers contribute disproportionate share funding or funds from general operations to pay the cost of prescription drugs. General program operations are supported through $2 million in annual grants and cash contributions from community hospitals and organizations.

Private Sector Demonstration Models

Several communities are taking an innovative approach to financing. Rather than rely on a voluntary provider network, communities are partnering with the private sector to provide needed resources, business expertise, and financial assistance with coverage initiatives.

- In **Buffalo NY** Health*for*All's vision is a local coverage program for the uninsured supported by all sectors of the community: business, individual enrollees, providers, health plans and government. The program has already secured the commitment of area hospitals to return a portion of payments for Healthy New York demonstration program enrollees. Similar arrangements are being explored with the managed care community. HFA leaders hope these hospital and HMO contributions will be matched by local and state government funds.

Conclusion

The success of a locally-based coverage/access program is largely a function of a community's ability to obtain long-term funding to support the cost of indigent medical care and program administration for individuals not supported by other state and federal health coverage initiatives.

Most communities have found that a multisource or "patchwork" funding strategy is fundamental to long-term sustainability and that, whenever possible, it is best to leverage funds from local resources to secure state and federal funding. In addition, it is important that a community adopt a long-term health care financing strategy that is responsive to the political, economic and environmental forces within which it operates.

The snapshot of financing mechanisms above is evidence that communities nationwide are confronting the political and legislative challenges of health care financing and devising innovative financing mechanisms in response. In the midst of economic uncertainty, communities are committing local dollars and capitalizing on unique funding opportunities to support medical services for the uninsured.