Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

CHIP's Impact On Changing Service Delivery Of Federal Health Centers

Six Case Studies

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OVERVIEW

PURPOSE

To examine the experience of six Federally funded health centers during their State's early implementation of the Children's Health Insurance Program (CHIP) and/or concurrent Medicaid expansions within the context of the changing health care environment.

RESULTS IN BRIEF

With their tradition of serving low income children, Federally funded health centers have considerable potential for supporting the goals of CHIP. These centers possess great aptitude for outreach and enrollment due to the level of trust and service they have established in their communities. Recognizing the need to adapt to managed care environments, most centers have assertively joined managed care organizations or undertaken special developmental efforts, ranging from infrastructure enhancements to creation of entire managed care organizations. Not surprisingly, transition from cost-based reimbursement continues to be a challenge for centers as they seek to better manage costs and devise appropriate reimbursement formulae within their health plan contracting.

BACKGROUND

Legislation: Enacted as part of the Balanced Budget Act of 1997, CHIP was a response to increasing numbers of children lacking health coverage. The legislation gives States flexibility to institute a separate health insurance program, expand Medicaid eligibility or combine these approaches. A higher Federal match rate under CHIP than for primary Medicaid provides an incentive for States to implement the legislation. Children applying for insurance through these programs must first be screened for Medicaid eligibility.

Federally funded health centers: Generally located in communities with low to moderate family incomes, Federally funded health centers have been major safety-net providers for low income children since the 1960s. Such centers were often, and continue to be, the primary health care source for growing numbers of children without health insurance when the CHIP was passed. Centers are funded by Section 330 of the Public Health Service Act, with some receiving State and local funds as well. In addition to primary health care services, these clinics also provide enabling services such as translation, health education, and transportation which are important to serving the CHIP population. Besides CHIP implementation, Federally funded health centers have experienced other substantial and related changes in the health care system, particularly due to increased use of managed care by State Medicaid programs in the 1990s.

Methodology: This qualitative case study report describes the experiences of six health centers' involvement in CHIP implementation. We conducted site visits in August and September, 1998, during the very early implementation of the program. Using structured protocols, we interviewed executive and clinical directors, financial officers, and other staff members. Staff from State Medicaid programs, CHIP agencies, managed care organizations and Primary Care Associations (PCAs)[1] who interacted with the health centers were also interviewed. Using qualitative data analysis software, we analyzed each center as an individual case. In a second phase of this study, we will apply issues and insights from these case studies to gather additional information from a sample of Federally funded health centers concerning their involvement in CHIP implementation. Knowledgeable staff from the Health Resources and Services Administration (HRSA), the Health Care Financing Administration (HCFA), and the Office of the Assistant Secretary for Planning and Evaluation (ASPE), as well as persons interviewed in during our site visits, reviewed and commented on the draft of this document. Their suggestions and technical corrections are reflected in this final report.

The States selected represent the variety of possible CHIP model choices and geographic regions. Within each of these States we selected for study a center regarded as effective in implementing CHIP, by its State administrative agencies and area PCAs. The chart below identifies the State where the center is located, the CHIP model implemented by the State, program characteristics, and the actual center studied.

State CHIP Program Models and Center Sites

State	Model	Program Characteristics	Center Visited/City
New Mexico	Medicaid Expansion	closely followed earlier State-initiated expansion, except for a cost-sharing element for higher income families	Health Centers of Northern New Mexico Espaòola, NM
South Carolina	Medicaid Expansion	voluntary managed care with choice of HMO or one of two rural managed care alternatives	Family Health Centers Orangeburg, SC
Colorado	Freestanding CHIP Plan	preferring a private sector approach, even administrative functions often privatized	Plan de Salud de Valle Fort Lupton, CO
Connecticut	Combination Model	plans share same name, application form, and administrative agency	Fair Haven Health Center New Haven, CT
California	Combination Model	administered independently, both programs encourage inclusion of safety-net providers	La Clínica de la Raza Oakland, CA
Michigan	Combination Model	incentives to include safety-net providers in managed care via contract bidding preferences	Cherry Street Health Services Grand Rapids, MI

Benefits covered in States we visited generally were comprehensive, and based either upon standard Medicaid services (including EPSDT) or large employer group benefits. All States, except Colorado, covered dental services at the time of our visit.

CROSS-CUTTING ISSUES

The following information identifies the most salient features and issues regarding the role of Federal health centers under CHIP. These specific issues are discussed at length in the individual case studies which follow.

Health Center Services:

- Except in Colorado, all centers visited operate school-based health clinics, and consider them a key element of CHIP health service delivery. Centers we visited offer comprehensive primary and preventative services, with some offering additional service enhancements such as mental health care, asthma and diabetes management, vision and dental services.

- Dental care was identified as a critical service for children, with some centers giving children priority for appointments, since client demand often exceeds capacity. Yet, low Medicaid and dental insurance reimbursements are causing some centers to reconsider offering this service.

- Capacity to serve uninsured families was identified as a problem by the large urban health center we visited in California. Over 600 families were on a waiting list for center services at the time of our site visit, even though the center was expanding.

Outreach and Enrollment: Health centers visited pursued a variety of enrollment activities.

- For existing patients, activities ranged from recruitment from families already seeking services to direct telephone contact of potentially eligible families. School-based clinics operated by the centers provided another avenue for outreach and enrollment.

- These centers also reached out to surrounding communities to identify and enroll CHIP and Medicaid eligible children. Of the centers visited, Fair Haven in Connecticut best demonstrated such "grass-roots" community outreach through a "Sign-up for CHIP Day", and "door-to-door canvassing" in a nearby housing project. Several centers were targeting schools, where they operated clinics, to provide information and application assistance to families of children attending there.

- Outreach/enrollment efforts have not been without challenges for the health centers. Policy ambiguity raised concern that CHIP benefits would be deemed a "public charge" for immigrant families, increasing their fear of government, and hindering enrollment of their eligible children, particularly in California. Although this issue was recently resolved legally, respondents believed significant effort would be required to overcome this fear. However, health centers feel they are in a strong position to work with these families due to the trust established in caring for them as patients. Translation services available at most of the centers we visited would also facilitate reaching these populations.

- Desiring to engage in more outreach efforts, center and PCA directors we interviewed expressed frustration at being hampered by a lack of resources for outreach workers. Connecticut health centers had applied for outreach contracts with the State and the Michigan center planned to apply for similar monies as well. The health center and PCA staff in California expressed concern over the inadequacy of the $25 for application assistance reimbursement due to the amount of personnel time it requires.

Planning and Implementation: The extent of direct health center involvement in the planning and implementation of the CHIP plans in their States varied widely.

- Some centers testified at input forums and legislative hearings, while others participated exclusively through their PCA. Despite direct representation on planning committees, Plan de Salud in Colorado did not believe it heavily influenced the outcome. Advocacy for including a dental benefit did not secure its inclusion in the final plan.

- Most centers visited noted that their primary role in CHIP planning and implementation was through their PCAs. In New Mexico, the PCA director is a member of the Medicaid Advisory Committee. The PCA director in California presented issues to the CHIP governing board and reported success in the managed care contracting system, which favors contracts that include safety-net providers, such as health centers. The Michigan PCA aided its legislature's decision to include Medicaid expansions in their plan.

- All health center directors we spoke to expressed a preference for Medicaid expansions to implement CHIP in their States. Their reasons focused on Medicaid's comprehensive child health benefits plus its pre-existing infrastructure. New Mexico and South Carolina selected a Medicaid expansion model only. Center directors from most other States stated that preferences for privatization influenced their State's decision to adopt a combination model or a free-standing program.

- Three States we visited, California, Michigan and New Mexico, had provisions either requiring managed care organizations to contract with health centers or providing incentives to include them in their contract bidding process.

Adapting to a Changing Healthcare Environment: Of the centers visited, all but one operate in States which employ mandatory managed care for their health delivery system. Valuable strategies pursued by these centers to adapt to an environment in flux included use of managed care organizations, consolidation, networking and shared services.

- **Formation of or participation in health center-based managed care organizations -** Usually with assistance of Integrated Service Network funds from HRSA, these efforts are teaching health centers the managed care business and allowing participation in decision-making which affects them. The exception is the center in New Mexico, which contracts with the Medicaid managed care plans in its service area.

- **Consolidation, networking and shared services -** The health center in New Mexico grew from the consolidation of free-standing clinics from a seven-county service area. To enhance productivity, PCAs in Connecticut and South Carolina and the county-based health center network in California are coordinating such shared services as an auto-dial telephone contact system, payroll, pharmacy purchasing, auditing, laboratory contracting, and consulting services.

- **Infrastructure adjustments -** Pervasive among health centers we saw, adjustments include upgrades to Management Information Systems, either made or planned, and addition of staff positions for financial management, managed care coordination and assistance to clinicians. Redesign or consultant projects to enhance productivity are also underway in centers visited in Connecticut, California and South Carolina.

Medicaid reimbursement structures remain a major challenge for most health centers:

- Most health center directors expressed concern over the phase-out of cost-based reimbursement by 2003, as stipulated by the Balanced Budget Act of 1997, particularly regarding the funding of enabling services they provide. Centers in South Carolina and Connecticut have undergone periods with and without caps on cost-based reimbursement rates which resulted in financial difficulties, requiring loans or financial recovery plans. Health centers in Michigan had agreed to a methodology to allow a phase-in to risk assumption, although HCFA approval was pending when we visited.

- The health centers visited in California and Connecticut were assuming some risk for health services costs for managed care patients. The South Carolina center was starting a pilot project with the Medicaid program to capitate primary care services. Other centers were also considering assuming some risk as part of their strategy for transitioning from cost-based reimbursement.

CASE STUDIES

The Health Resources and Services Administration and the Office of the Assistant Secretary for Planning and Evaluation expressed strong interest in this study of health centers' early involvement in CHIP implementation. To meet their needs, we prepared the following resource document consisting of case studies of health centers we visited in six different States. In it, the issues described above are outlined in greater depth as they relate to specific centers.

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INTRODUCTION

PURPOSE

To examine the experience of six Federally funded health centers during their State's early implementation of the Children's Health Insurance Program (CHIP) and/or concurrent Medicaid expansions within the context of the changing health care environment.

BACKGROUND

For the past three decades, Federally funded health centers have been a critical part of the health care safety-net for low income families. These centers have struggled in the 1990s to continue to fulfill this mission as States have moved to managed care for their Medicaid programs. Adaptation is also needed as States adopt a variety of approaches to implementing CHIP. Since services for children are a large component of their programs, these health centers hold considerable promise in helping realize the goals of the CHIP legislation. Thus, the Health Resources and Services Administration (HRSA) and the Office of the Assistant Secretary for Planning and Evaluation (ASPE) have expressed strong interest in looking at the involvement of centers in the early implementation of CHIP.

Children's Health Insurance Program

As of 1999, an estimated ten million children in the United States were uninsured.[2] The Balanced Budget Act of 1997, in a new Title XXI of the Social Security Act, created CHIP. Authorized for ten years, and funded at $20.3 billion from 1998-2002,[3] the CHIP program targets children in low-income families (generally under 200% of the Federal poverty level) with the intent of providing them with the same quality health care enjoyed by most privately insured children.

The legislation gives States flexibility in designing their programs. They may simply expand Medicaid eligibility for children, institute a separate health insurance program or use a combination of these approaches. If Medicaid expansions are used, the same benefits and administrative rules used by the existing Medicaid program apply. States which previously expanded Medicaid for children, or created State-specific programs, are allowed to expand eligibility beyond 200 percent of the Federal poverty level to 50 percentage points higher than their existing eligibility limits.[4] If a State creates a new health insurance program for children, they may establish different benefits within Federally legislated minimum standards. For example, preventative services are required, but dental services are optional. These new programs may also establish a separate agency to administer the program. The Health Care Financing Administration (HCFA) is responsible for administering CHIP, with joint oversight by HRSA.

Because the CHIP legislation provides higher rates of Federal matching funds than the existing Medicaid program, the Medicaid benefits package frequently is richer than most private insurance. In addition, since Medicaid is an entitlement, screening children for Medicaid eligibility first is required. Studies have shown that the percentage of eligible children enrolled in the Medicaid program has been low (about 70% nationally [5]) and is even lower in some States and among minority children. Consequently, policy makers and analysts anticipate large numbers of children applying for CHIP will actually enroll in existing Medicaid programs.

Federally Funded Health Centers and CHIP

Health Centers and Provider Networks

Federally funded health centers are an integral part of the "safety net" of health providers for uninsured children and adults. These health centers, under the Public Health Services Act, Section 330, are generally located in neighborhoods or communities near low and moderate income families. They have long been the traditional health service provider for many of the children now eligible for CHIP. These clinics also provide enabling services such as translation, transportation, health education, case management and other social services important to meeting the needs of this population.

Medicaid program contracting with managed care organizations has been developing since the early 1990s. Currently, the majority of States require managed care enrollment for at least some of their child and young adult populations. The CHIP legislation is expected to accelerate these changes in both Medicaid service delivery and reimbursement structures. However, some policy makers and analysts have expressed concern regarding the extent to which Federally funded health centers are incorporated into the provider networks for Medicaid managed care organizations.[6] An analysis of Medicaid managed care contracts found substantial variance in whether States require or encourage managed care organizations to incorporate safety-net providers into their networks.[7]

Adapting to Managed Care

Assisting centers in the adaptation to health care systems changes is the focus of the HRSA's Center for Managed Care. Created in 1996, it provides technical assistance and training opportunities for the health centers. HRSA commissioned a study of the impact of managed care on the health centers. The study described numerous adjustments and emerging issues for the centers in adapting to these changes, including strategic decision-making regarding managed care, formation of "safety-net" provider owned and operated managed care organizations, financing and reimbursement, contracting, staffing, patient care management and relationships with State governments.[8]

The financial viability of "safety net" providers, including the health centers, has been of considerable concern to policy analysts beyond HRSA. Studies in several States

have shown centers to be under considerable pressure to compete with private providers for inclusion in managed care provider networks, and to gain or retain patients, and from cost competition.[9,10] In order to meet contract requirements and operate effectively in managed care organizations, health centers need to make infrastructure and operational changes in areas such as management information, financial management, staffing, patient management, and quality assurance reporting.[11,12]

Reimbursement is a major issue in health center viability due to managed care organizations' preference for capitation of primary care providers. Since health centers often provide enabling services, typically not provided by private primary care providers, these services are not generally built into reimbursement methodologies, and recovery of the associated costs becomes a concern. The risk assumption implicit in capitation is very new to most health centers who may lack the necessary management information and financial management infrastructure to manage risk. Risk assumption also concerns centers, many of whom operate with small cash reserves. Cost-based reimbursement to health centers, currently required of Medicaid programs, is being phased-out by 2003. Furthermore, State CHIP Programs are not bound by this requirement and may not always provide cost-based reimbursement to the centers.[13]

METHODOLOGY AND SCOPE

This study provides a description of the early experiences of Federally funded health centers in the implementation of State CHIP and/or Medicaid expansions. We conducted the study in two phases. The first phase, reported here, involved case studies of six selected Community Health Centers and their interaction with State programs and their Primary Care Associations (PCAs). From this Phase I report we are designing a follow-up study to obtain representative, national information on centers' experiences and issues regarding their participation in the implementation of CHIP and Medicaid children's expansions.

Site Selection

We purposively selected six case study States: California, Colorado, Connecticut, Michigan, New Mexico, and South Carolina. The following criteria were used, resulting in the sample characteristics described below.

- Type of Grantee: A combination of health centers which included funding for Community Health Centers and Migrant Health Centers.[14]

- State Program Type: The States selected are using a combination of a CHIP program and Medicaid expansions, a CHIP program only, or Medicaid expansions only.

- Service Delivery: Although most States are primarily using managed care delivery systems (also true in our sample), one State used a fee-for-service delivery system for a small voluntary managed care component.

- Geography: States represented include the east and west coast, the midwest, the inter-mountain west, the southwest and southeast regions of the country. The health centers are located in large and small cites, as well as rural areas.

After selecting sample States, we contacted State officials and PCA directors in these areas for recommendations of health centers they considered to be successfully involved in the early implementation of CHIP and Medicaid expansions. One health center per State was chosen as the focus of Phase I of our study. The following health centers were selected: Fair Haven Health Center, New Haven, Connecticut; La Clínica de La Raza, Oakland, California; Cherry Street Health Services, Grand Rapids, Michigan; Plan De Salud Del Valle, Inc., Fort Lupton, Colorado, Health Centers of Northern New Mexico, Española, New Mexico; Family Health Centers, Inc., Orangeburg, South Carolina.

Data Collection and Analysis

We used three methods of obtaining data for our study. First, we conducted structured, in-person interviews at the Federally funded health center, the PCA, the State Medicaid and/or CHIP agency and, if applicable, a managed care organization which had a CHIP and/or Medicaid contract with the health center.[15] We also analyzed data from the Uniform Data System of the Bureau of Primary Health Care for each of the health centers we visited. These interviews were conducted in August and September, 1998, during the very early in the implementation of CHIP. Finally, we reviewed documents requested from the interviewees concerning the implementation of CHIP and Medicaid expansions in their States.

Structured interview protocols were developed to collect qualitative data from the health centers and the other actors. For the health center interviews, separate protocols were developed for the Executive Director, the Chief Financial Officer, and the Medical Director or senior pediatric medical staff member. In a few health centers we were fortunate to be able to interview an outreach worker or migrant health worker. We pretested our protocols in a site visit to Connecticut, with excellent results, and were thus able to fully use this site visit in our study.[16] Site visits were then conducted in the remaining five States. All interviews were audio-taped with the permission of the persons interviewed.

In addition to the interviews, we asked each health center to provide selected tables from their most recent Uniform Data System annual report for background information regarding patient demographics, revenue sources, services provided and staffing. Furthermore, we asked each entity we visited to provide documents which would help

us understand the CHIP and/or Medicaid program in their States, their role in the implementation of the program, and significant issues regarding the program. As a result, a considerable range of documents was collected and reviewed in the analysis of each case in this study. Examples of documents collected included general health center and CHIP outreach materials, application forms, State legislation and regulations, managed care contract templates, managed care provider and member manuals, and State guidance memoranda. A complete listing of these materials is found in Appendix A.

To analyze the information obtained in our interviews, each tape was transcribed.[17] We then used a qualitative data analysis software package[18] to code each transcript using descriptive and analytic categories developed by the study team. Reports were generated for each category, linking the responses of all interviewees in each State. Thus, we are able to summarize, compare and contrast a number of perspectives on each category or issue we identified. This report consists of a case description for each of the health centers within the context of their respective States.

Since health system changes for children's health care are expected to accelerate as a result of CHIP, we refer to necessary adjustments of health centers as "CHIP Readiness". This report addresses these readiness issues, as well as health center involvement in CHIP implementation, outreach activities, and provision of children's health care services. It also includes our assessment of the key factors underlying the health centers successful involvement in CHIP and/or Medicaid expansions.

HRSA, HCFA, ASPE, and those we interviewed at the sites reviewed and commented on the material in this report. Their suggestions and technical corrections are reflected in this final report. None voiced any substantive objection to the material. A request was made for additional information on enrollment numbers at the time of our visits. Although these numbers were not always available, they were incorporated in the report where we had the information.

A second phase of this study applies issues and insights from these case studies to developing a national survey of Federally funded health centers and CHIP implementation. In early 2000, we plan to release a report based on this survey and the insights gathered through the case studies. Due to comments regarding the draft of this report, we plan to explicitly ask for information on outstationing of Medicaid eligibility workers.

We conducted our study in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

FAIR HAVEN HEALTH CENTER
New Haven, Connecticut

State Model: *Combines Medicaid expansions with a free-standing program. Programs share name, application form, and administrative agency for easy client transition/welfare stigma reduction.*

Center Highlights:

- *Prior experience with managed care; developer and member of a managed care organization of Federally funded health centers;*
- *Added managed care coordinator to staff, and plans future MIS upgrades;*
- *Aggressive and creative outreach activities, largely self-funded with grant applications pending;*

Challenge: *The center faces reduced reimbursement rates due to the capitation level for primary care versus the higher, fee-for-service rate received from another managed care plan. This disparity possibly threatens funds which subsidize enabling services and care for the uninsured.*

Connecticut CHIP Model

Several of those interviewed stated that various legislative and administrative components have been very supportive of health insurance for children in recent years. In fact, prior to the national Children's Health Insurance Program (CHIP) legislation, Connecticut had instituted a set of optional Medicaid children's expansions. This program, entitled "Healthy Start" (not a HRSA Healthy Start program), expanded Medicaid for pregnant women and children, through age 11, to 185 percent of the Federal poverty level (FPL).

To implement the CHIP legislation, Connecticut utilizes a combination model of Medicaid children's expansions, and a separate Children's Health Insurance Program. Both parts of the model use continuous eligibility for 12 months before re-application is necessary, and are administered by the Department of Social Services. The Medicaid portion, called HUSKY A, expands Medicaid eligibility to children in families with incomes up to 200 percent of the FPL. Benefits for HUSKY A children match those of traditional Medicaid recipients. HUSKY B, the separate CHIP portion, is for children in families at incomes between 200 percent and 300 percent of the FPL and is State-specific. Families at incomes greater than 300 percent of the FPL may purchase HUSKY B for their children for an unsubsidized premium.

The HUSKY B benefits are based upon those of three State employee options. Benefits include required services, as well as mental health and substance abuse, prescription drugs, durable medical equipment and dental services.[19] Service delivery is provided by contracting with managed care organizations, as has been the case for the majority of Connecticut Medicaid recipients since 1995.

Health Center Background

Fair Haven Health Center is a medium sized center, which served about 10,000 patients in 1997, and has been in operation for over 25 years**.** The health center consists of one main clinic, three school health clinics, and a site at a housing project for the elderly. The main clinic is located in a largely Hispanic area of New Haven. Since nearly 60 percent of the center's patients are Hispanic, about half of the centers' patients are estimated to need bilingual services or translation. Children and adolescents comprise a substantial portion of the patient population (about 50%).[20] As described later, a full range of preventative and primary care services, as well as some specialty services, are provided to children. Our visit was conducted in August 1998, during the early implementation of the Connecticut program.

Planning and Implementation

Fair Haven and its Primary Care Association (PCA) reported that they had little influence on the final model chosen in Connecticut. However, all parties acknowledged that the required opportunities for input through legislative testimony were provided. The Connecticut Primary Care Association (CPCA) was in the process of hiring a new Executive Director during the period of CHIP deliberations and this may have decreased their level of influence. Both the health center and the PCA indicated that their preference was to use a Medicaid expansion for all children. Their rationale was that the administrative infrastructure was already in place, and Medicaid benefits are the most comprehensive. However, much of the State's consultation regarding the development of the plan was with the legislatively funded Children's Health Council, of which the CPCA is a member.

Collaboration between the HUSKY Program and the Federally funded health centers appears to be growing. The CPCA annual meeting in June 1998 focused on collaboration generally, and "Planning for HUSKY" was the focus of one of the meeting sessions. The Deputy Commissioner of the Department of Social Services addressed the health centers regarding implementation and outreach for the program and provided applications and outreach materials for center use at that session. The CPCA has also submitted a grant proposal for HUSKY outreach, as discussed in the next section.

Outreach for CHIP

Utilizing its existing resources, Fair Haven Health Center initiated HUSKY outreach activities from the very beginning of the program. These activities were good examples of local, "grass-roots" outreach in action. The health center outreach worker "blanketed" the business area of the Fair Haven neighborhood with a bilingual flier, specifically aimed at their potential patient population,[21] and alerted them to the HUSKY insurance program and services offered by the health center. At a local housing project, door-to-door canvassing was also conducted to disseminate HUSKY program information and to take some "on-the-spot" applications, which an outreach worker would mail in. Area businesses were involved at the request of the health center, with a local branch bank co-sponsoring a "Sign-Up for HUSKY Day" in the bank

lobby on the busiest day of the month. The health center noted plans to conduct outreach and applications for the HUSKY program at their school sites, when the school year started. Although numerous applications were being submitted, only about 50 children had been added to the Community Health Network, the plan formed by the health centers, at the time of our site visit when outreach activities were in an initial stage.

State resources for HUSKY outreach include an allocation for community grants of $450,000.[22] Shortly before our site visit, responses were due to a Request for Applications for outreach grants ranging from $20,000 to $100,000. Fair Haven is part of a local coalition in New Haven which is applying for a $20,000 grant to do local advertising and outreach activities to augment its activities described above. The CPCA also submitted a proposal to do a Statewide media campaign for HUSKY, that would target adolescents and young parents, a very hard to reach group. The CPCA also plans to utilize their "auto-dialer" phone system, a PCA shared service for the health centers, to tailor "customized" telephone messages to the existing clientele of the health centers. The Connecticut Children's Health Council had also applied for $500,000 from the Robert Wood Johnson Foundation, "Covering Kids Initiative".

The Department of Social Services has contracted with Benova, an enrollment broker, to provide outreach and enrollment services. This is the same enrollment broker Connecticut uses for its regular Medicaid managed care program. Outreach materials and applications were printed and distributed Statewide. The health center indicated an early problem in obtaining application forms in Spanish from the enrollment broker. However, this was resolved by the direct distribution by DSS to the PCA. The enrollment broker accepts telephone applications via a 1 - 800 number as well.

Some problems with outreach and enrollment were identified by the health center personnel. One was the interface between HUSKY A (Medicaid) and HUSKY B (the separate CHIP program) enrollment processes**.** Applications for HUSKY B are screened for Medicaid eligibility by the enrollment broker. If Medicaid eligibility is deemed likely, the application is referred to DSS for processing. This often requires additional documentation for the application, which is forwarded to the family for response. Concern was expressed that this procedure made it easier for families to get lost in the process.

A second critical concern was expressed regarding children of immigrants and migrant workers engaged in seasonal farmwork. Some families may have children born in the U.S., and thus eligible for Medicaid or CHIP, whereas older children and parents are undocumented. The HUSKY application form does request citizenship status, but for the children only. However, some felt the concept that children of undocumented parents might be eligible for such benefits is hard to convey to the immigrant population. This issue was identified for additional training of outreach workers and application assistants.

Health Center Services for Children

Primary/Preventive Services

Fair Haven Health Center offers a comprehensive range of primary and preventative services to the children they serve. These services include well-child care, immunizations, pre-natal and delivery care by certified nurse midwives, pre-natal and other health education, family planning, and primary care for illnesses. This care is delivered at the main clinic and three school health clinics operated by the health center. The operation of the local Women, Infants and Children (WIC) program by the health center at their main clinic allows families to centralize most of their health care needs. Food vouchers and nutritional education are also provided by the WIC program.

The health center operates three school-based health clinics, which are a key component of their delivery of health care to children. Connecticut strongly supports school-based health care. In this case, school-based clinics are funded through a State program under which the City of New Haven contracts with the health center. The main clinic's child care is staffed by pediatricians and nurse practitioners, since their affiliated hospital does not grant admitting privileges to family practitioners. The school-based clinics, located in an elementary, middle, and high school, also provide preventative care and health education, as well as some episodic care for illness, such as nebulizer treatments for asthma. These clinics are staffed by nurse practitioners.

Enabling and Specialty Services

Several enabling services are also available to the families of children served by Fair Haven. The health center has a strong social service department which provides case management and outreach services. A particularly strong outreach program for well-child care has contributed to the 98 percent immunization rate by this center for children under age two. This successful outreach effort also includes transportation, when necessary, by the outreach worker. Bilingual medical staff and translators at the clinic are also an important enabling service of the center, which serves a largely Hispanic population. This combination of bilingual staff and translation was reported to work well, with occasional difficulty encountered during after-hours telephone contacts where client family members or neighbors needed to assist.

Fair Haven is able to provide some specialty services to children at the main clinic in addition to its central preventative and primary care services. With a board certified developmental pediatrician on staff, comprehensive developmental assessments can be conducted at the clinic which, otherwise, would require referral to a child guidance center, often with considerable waits. Mental health services are not provided by health center staff; however, child guidance center staff conduct evaluations at the clinic weekly. Obstetrical and gynecological services, including family planning and pre-natal education, are also provided by certified nurse midwives at the clinic. Dental services are not offered, although the other Federally funded health center in New Haven does offer them. Dental care was noted as a problem for children served by the center, since very few local dentists accept Medicaid patients. As a result, dental

service capacity was viewed as inadequate for the needs of poor children. The health center staff indicated that referral networks for children's specialties are quite good, since most of these services are provided by the Yale faculty, who are members of local managed care organizations.

Fair Haven staff were confident that many of the children already served by the health center would obtain HUSKY. The significance of this coverage, beyond additional revenue, was an improvement in the treatment options available for these children. For example, the medical staff indicated that concerns about prescribing some costly medications would be alleviated, as would delays in non-emergency specialty care due to waiting times to obtain subsidized care. However, availability of prosthetics, orthotics and durable medical equipment for disabled children was still perceived to be problematic.

CHIP Readiness

Managed care participation is a critical component of the Federal health centers' readiness for CHIP and prior events in the Medicaid program had well-prepared Fair Haven. The State implemented a mandatory Medicaid managed care waiver for younger adults and children in 1995. In the words of the health center director, "...I think CHIP will all flow from this. So, I think that in some ways Medicaid managed care has prepared us for CHIP."[23] Connecticut Federally funded health centers responded to the introduction of Medicaid managed care through a strategy of forming their own managed care organizations. The Community Health Network (CHN) is the plan formed by the health centers and includes the New Haven area. This strategy was developed largely through a HRSA Integrated Service Network project coordinated by the PCA. Each of the original health centers contributed financially to the start-up costs as well. The PCA director at that time became the director of CHN. The health center and the PCA rationale for creating their own plan was to assure continuity and quality of care for their patients, as well as a desire for the care to be managed by the centers and their clinicians, rather than an insurance company. This health center also participates in a local managed care plan operated by Yale University.

Although Fair Haven was already providing after-hours coverage and emergency room triage, they cited several adjustments necessary for managed care. The foremost of these was to augment staffing associated with referral management, a function of medical assistants in this center. Fair Haven is one of several health centers participating in a patient visit re-design project on the East coast. This project has identified a significant need for the center to augment their ancillary medical staff to achieve greater efficiency of clinician time. This center is also pursuing Joint Commission accreditation to strengthen its market position. In addition, substantial administrative adjustments are being made, as described below.

Business infrastructure improvements in this health center largely focus on a new management information system (MIS)**.** Fair Haven has issued a Request for Proposals to replace its current system, which is over 12 years old, although some upgrades have been made over the years. A key feature of the new MIS will be integration of

software modules and databases, many of which are now separate. An appointment component, billing, patient information and report writing capabilities are integral to the new system. Although a clinical information component will not be initially included in the system, it may be added in the future.

Administrative staffing adjustments were necessitated, largely in the billing area. For example, considerable time of the billing coordinator is now allocated to coordination with the managed care organizations. Additionally, the center has added a managed care coordinator, who also has considerable interaction with the managed care organizations, particularly in credentialing activities.

Reimbursement for health care services was the most critical concern identified by both Fair Haven and the PCA**.** When the Connecticut Medicaid program implemented managed care in 1995, they initially stopped payment of cost-based reimbursement for health centers in their contracts with managed care organizations. The health center and the PCA emphasized that this policy drastically reduced their Medicaid revenues, causing Fair Haven to deplete all its cash reserves, and take out a line of credit to cover operating expenses while this policy was disputed by the centers and the PCA.

The HCFA and HRSA intervened to resolve this problem, resulting in the State Medicaid program negotiating a settlement for these disputed reimbursements in April, 1998. The payments were made retroactive to April, 1996 when the centers first asserted their right to cost-based reimbursement under Medicaid managed care. The negotiated payment amounts to approximately 64 percent of the disputed payments.[24] The wrap-around payments for cost-based reimbursement, supplemental to capitation or fee-for-service payments, were initially paid to the managed care organization for pass-through distribution to the health centers. However, effective September 1998 the Medicaid program began distributing these payments directly to the health centers, based upon submitted encounter data.

Community Health Network is currently paying their health centers a capitated rate for primary care services, and fee-for-service for specialty care. Fair Haven's other managed care plan reimburses all services on a fee-for-service basis. The health center emphasized that these wrap-around payments primarily support the enabling services offered by health centers, and subsidize their care for the uninsured.

The reliance of the health centers on cost-based reimbursement, which is being phased out as a Federal requirement as of 2003, is a continuing issue for the Medicaid portion of the HUSKY plan. HUSKY B (the separate CHIP program) does not require cost-based reimbursement to these centers.

Key Factors for Success

Fair Haven was identified to our study team as a health center which is successful in its early implementation of the CHIP program in Connecticut. Several reasons for its success are identified in the case study described here. Foremost of these elements

of success is the strong primary care program they offer for children in their community, since this positions them well to serve client needs under CHIP. Outreach to children, a vital factor, has been integral to their health care delivery model. This outreach includes three school-based clinics, well-child and immunization services, and recent, enthusiastic grass-roots efforts to enroll children in the HUSKY program.

Another significant success factor for Fair Haven has been its commitment to making a broad range of adjustments to accommodate the changing health care environment in which it operates. These adjustments include active participation in a health center operated managed care organization, initiated when Connecticut made the transition to Medicaid managed care in 1995. Staffing realignments, participation in a patient visit re-design project, and upgrades to the management information system have also been essential adjustments.

Challenges to continued success for the health center remain. The most pressing of these centers on reimbursement issues. When cost-based reimbursement for Medicaid patients was temporarily ended, a financial crisis arose which depleted the health center's cash reserves and required a line of credit to maintain existing operating levels. Since cost-based reimbursement for Medicaid is being phased out and reimbursement for HUSKY B children will not be cost-based, the question remains whether this, and other health centers, can make the necessary adjustments to their revenues and costs. Lack of reimbursement for enabling services, such as outreach, health education, and translation have yet to be addressed.

LA CLÍNICA DE LA RAZA
Oakland, California

State Model: *Combines Medicaid expansions with a freestanding CHIP program. Administered by separate agencies; both include mechanisms to encourage inclusion of safety-net providers.*

Center Highlights:

- *Use of extensive personal contact for CHIP outreach, to potentially eligible client families;*
- *Affiliation with a local organization of health centers yielded shared resources, including payroll, hardware and software systems, and a patient database. Consolidation of MIS functions is a future consideration.*

Challenge: *Difficulties have emerged in the recruitment of eligible children of undocumented parents, with prior ambiguous INS policies creating a "fear factor" within this community.*

California CHIP Model

To implement CHIP, California utilizes a combination model of Medicaid children's expansions, and a separate CHIP program which is called Healthy Families. The Medicaid children's expansion, administered by the Department of Health Services, is only a small portion of the State CHIP Plan in California. Medicaid eligibility was increased to 100 percent of FPL for all children up to age 19, 200 percent FPL for children up to age one, and 133 FPL for children up to age six, and benefits match those of traditional Medicaid recipients.

Eligible children, whose family income is between 100 and 200 percent of the FPL, will be enrolled in the separate Healthy Families Program which is administered by a free-standing State Agency called the Managed Risk Medical Insurance Board (MRMIB). The Board also administers a small business and other health insurance programs for California. Benefits for children in the Healthy Families Program are modeled after private employer health plans and include required services, as well as mental health and substance abuse services, prescription drugs, dental, vision, home health care services, and durable medical equipment. Co-payments are required for some services, but are limited to $5. Families pay a monthly premium of $4 to $9 per child with a maximum of $27 per family.[25]

Prior to the CHIP legislation a small private program called Cal Kids was available for uninsured children. This program, has a limited benefits package, yet continues to be available for undocumented immigrant children since no public funds are used.

Of particular interest to this study is that both the Medicaid and Healthy Families Programs employ managed care for service delivery in all major population areas. The Medicaid Program has a "two plan" requirement currently operating in 12 of the 26 counties where managed care is available. The two plans required in each service area

are a commercial plan and a "local initiative" plan which must include traditional and safety-net providers such as health centers, county hospitals and county clinics. The Healthy Families Program uses a market-oriented approach which reduces the monthly premium to $4 for the "local initiative" plan in each service area, thus encouraging enrollment in those plans. A comprehensive methodology is used to weight providers based upon their actual experience in delivering services to low income children.

Health Center Background

La Clínica de la Raza in Oakland (Alameda County) California is a medium sized health center, which served about 13,000 patients in 1997, and has been in operation over 27 years. The health center consists of three clinic sites and two school-based health programs. The main clinic is located in a largely Latino area of Oakland. Another clinic site is located in an ethnically diverse area of Oakland and serves Latinos, African-Americans, Asians, and Africans. The third site is a teen clinic. Although the center is expanding its programs, over 600 families were on a waiting list for center services at the time of our visit, due to the large numbers of uninsured individuals in the area. Since 84 percent of the center's patients are Latino or other ethnic groups, the health center employs many bilingual or multi-lingual staff. Children and adolescents comprise a significant portion of the patient population (about 54%).[26] As described later, a full range of preventative and primary care services, as well as several specialty services, are provided to these children. We conducted our site visit in California early in the implementation of CHIP in September 1998.

Planning and Implementation

La Clínica and the California Primary Care Association (CPCA) were actively involved in the planning and implementation of the Healthy Families Program. The Chief Executive Officer of La Clínica is currently Chairman of the CPCA. Largely through this affiliation, she and other health center directors testified in support of the program during the legislative process and later oversight hearings. The position of the CPCA was to support an expansion of Medi-Cal, the State's Medicaid program, since the infrastructure was in place and the health centers were major providers for the Medi-Cal Program. However, those interviewed acknowledged that implementing CHIP solely by a Medicaid expansion was unlikely in California at the time the enabling legislation was passed due to the State's preference for market-oriented programs.

Since the formation of the Healthy Families Program, the CPCA has actively collaborated with the MRMIB on program planning and implementation. A health center director is on the MRMIB advisory panel and the CPCA frequently presents issues to the Board. One primary health center concern has been the inclusion of health centers in the provider networks of managed care plans which contract with the Healthy Families Program. In addition to the local initiative plans, the CPCA arranged for all health centers to be offered managed care contracts with Blue Cross, HealthNet and Omni where available. Another success for the health centers was obtaining a waiver from Vision Services Plan (VSP), the Statewide vision plan for Healthy Families. The waiver allows health centers to contract with VSP, when historically, it has

contracted with provider-owned practices only.

Remaining implementation concerns of the health centers include capitation rates for dental providers, cultural and linguistic competency requirements for health plans, and implementation of the Special Populations Project and outreach. Although a fee-for-service dental plan is available Statewide, several health centers have noted that they have been unable to obtain a fee-for-service dental contract and that the capitation rates offered by the managed dental plans are too low for health centers to participate. The CPCA has been working with the California Dental Association on this issue. Medicaid cultural and linguisitic competency requirements for managed care plans in California are considered to be good, and efforts are being made to strengthen requirements in the Healthy Families Program in line with the Medicaid requirements. The CPCA also expressed concern regarding the implementation of a State-funded Special Population Project, under Healthy Families, which they hope will include migrant farm worker clinics, although they have currently been omitted. State outreach resources are discussed in the following section.

Outreach for CHIP

La Clínica de la Raza is actively engaged in outreach for Healthy Families and the Medicaid program. The health center has sponsored and participated in health fairs where information and applications for these programs were distributed. However, the major outreach activity of this health center is personal contact, via telephone, with families who are on the waiting list for health center services. The waiting list is due to the extensive need for services among the uninsured, although La Clínica continues to expand its capacity and clinic hours. Health center staff are working evening hours to telephone these families and notify them of the Medicaid expansions and Healthy Families Program, and to offer them assistance in completing applications. Unfortunately, due to the mobility of this population, many of the families no longer have the same telephone number. Nevertheless, contacting those recently placed on the waiting list has yielded a better response rate. Since our visit was early in the program, La Clínica knew of only three children served by their clinics who were enrolled in Healthy Families, although numerous applications were pending.

The Community Health Center Network (CHCN), a local organization of health centers, is very active in outreach for the Medicaid and Healthy Families Programs. They have assisted the health centers in developing a patient database for use with letters, phone calls, and health center specific fliers explaining the new children's programs. Community Health Network staff have also provided training to health center staff on the application process. Other local outreach activities, noted by CPCA, include distributing fliers in schools, malls, shopping centers, and daycare centers, and public service announcements and media releases.

The most significant problem identified regarding outreach and enrollment is the fear among immigrant families with eligible children about whether receiving CHIP benefits will be considered a "public charge." Public charge refers to Immigration and Naturalization Service policies regarding receiving legal immigration status and

sponsorship of family member immigration. Such sponsorship may be precluded if someone is deemed a "public charge" due to receipt of public benefits.[27] Additionally, in California, a State program which monitored ports of entry for immigrants returning to California has previously requested repayment of benefits, including Medicaid, for re-entry. This practice has been stopped, monies were returned by the Medicaid program, and the program was ended in April 1999.[28,29] However, immigration attorneys throughout the State have advised immigrants not to sign up for any public benefits. Fortunately, on May 25, 1999, the INS issued a policy statement explicitly stating that receipt of Medicaid and CHIP benefits will not lead to a public charge designation, except for certain Medicaid nursing facility services.[30] However, due to the lengthy period of policy ambiguity and the hesitancy of the Latino community to trust such pronouncements, it will take time to overcome this former barrier.

Because of these issues, all California respondents said the "fear factor" among immigrant families is the primary barrier to outreach and enrollment of their eligible children. Enrollment numbers were lower than anticipated, at the time of our visit, particularly among Latino children.[31] The application for Medicaid and Healthy Families only requests information regarding the child's immigration status and assures that information provided is confidential. However, income verification requirements for the parents continue to raise concerns among these families. La Clínica and CHCN staff verified the reality of this fear among their patient populations, and were very concerned about the lack of a clear INS policy regarding Healthy Families and public charge when assisting families with applications. Even with a clear policy, they felt the "fear factor" would remain a problem until immigrant families start to trust the programs after observing families enroll their children without repercussions.

Allocation of State resources and procedures for Medicaid and Healthy Families outreach has been controversial in California. The Medicaid program is responsible for outreach for both programs. Although the health centers strongly supported allocation of grants for outreach, the State's approach is to pay $25 per completed application to those providing certified application assistance to families. Certification is obtained by completing a one day training on application assistance. This policy is intended to diversify the sources of outreach and application assistance. Some outreach money will also be allocated to counties and health centers which may be able to sub-contract for these resources.

La Clínica and the CPCA felt that $25 was inadequate payment for application assistance due to the length and complexity of the joint application. The application booklet is 28 pages; however, this includes detailed program information, and worksheets for pre-screening for program eligibility. The application is available in 10 languages. The CHCN director emphasized the increasing need for an eligibility assistance function at each health center; yet some centers lack the resources to do this. Another concern expressed by the health center and CHCN was the requirement that the first month's premium be paid at the time of application by cashier check or money order, an inconvenience to many of the families applying for the program.

After our site visit, the Medicaid program provided updated information regarding

outreach resources. The application assistance reimbursement has been increased to $50. In fiscal year 1998/99 the State provided $1 million in mini-contracts to organizations and in fiscal year 1999/2000 the State recently released a Request for Proposals for $6 million in funds for outreach. Additionally, the State changed its policy that required the first month's premium to be paid by cashier check or money order to also allow personal checks. In April 1999, a revised application was released which is only four pages long and which is available in 11 languages.

Health Center Services for Children

Primary/Preventive Services

La Clínica de la Raza offers a comprehensive range of primary and preventive services to children. Adolescent patients are also served at the health center's Teen Clinic. Provided services include well-child care, immunizations, primary care for illness, pre-natal care and delivery, and a strong health education program which uses health promotion volunteers and community health workers. In addition to the two major clinic sites and the teen clinic, the health center operates two school-based clinics, one in an elementary school and the other at a high school. A major focus of the school-based clinics is prevention. At the high school, reproductive health education, parenting skills, dealing with peer pressure, and involving parents in health education programs are components of the prevention activity.

Enabling and Specialty Services

Preventive and community health workers conduct outreach, as well as health education, through a strong community health education program. In addition to health education, translation services are key enabling services provided by La Clínica de la Raza. The San Antonio clinic site is referred to as the International Clinic by health center staff. Languages spoken by patients of the health center include Spanish, Ethiopian, Chinese, and Korean, plus others. Most translation is provided through bi-lingual staff with occasional contractual assistance from a language center in Oakland, which also provides signing services for the hearing impaired.

La Clínica also provides a sizeable range of specialty services to children. The health center has a mental health clinic which serves its patients, as well as referrals from other providers. Psychiatrists and psychologists are on staff and their mental health clinic has a contract to provide these specialty services for health plans. Staff noted that their clinic is the largest Spanish/English bi-lingual mental health provider in the area. Full vision services, including opthalmology, optometry and eye glasses, are also available at the health center. Individual providers from the health center have contracted with the Vision Services Plan as Healthy Families providers and the health center is expecting to secure a clinic contract as a result of the recent VSP policy change explained above.

Dental services are provided by La Clínica at the main clinic site. A long waiting list for dental services has resulted in the health center giving children and pregnant

women priority for services. The health center also partners with the Colgate toothpaste company three times a year to provide mass dental triage screenings for children. They have found that about one third of the children just need preventive services, another third require priority services, and the remaining third are in need of specialty intervention. The health center currently has five dental chairs, serving 800 to 900, cases a month, and they plan to add five more chairs soon. The health center has a periodontist on staff and hosts an orthodontal clinic staffed by dental residents bi-weekly.

CHIP Readiness

La Clínica de la Raza, and the local Community Health Network, have been in the forefront of California health centers ready for CHIP by virtue of their their proactive engagement in managed care. The Alameda Alliance Health Plan is the "local initiative plan" in Alameda County. It was formed under the two-plan model when the California Medicaid Program introduced managed care contracting. They were the first local initiative plan in the State, becoming operational in January, 1996. Community Health Center Network (CHCN) was formed as a Management Service Organization (MSO) by a 25 year old local association of clinics, whose member centers are key provider of primary care for the Alameda Alliance Health Plan. CHCN is the contracting entity for the health centers with this plan. When the Healthy Families Program was implemented, the Alameda Alliance was able to obtain reduced premium status based on having the most traditional and safety-net providers in their network.[32] CHCN passes on primary care capitation to health centers which participate in CHCN and pays for specialist services from the remaining capitation funds.

La Clínica management staff described several adjustments made by the health center in response to managed care. They are undergoing a re-design process, examining their administrative processes, health center procedures, staffing and management information system. Staff training has been an important component in adjusting to managed care. The health center is attempting to institutionalize training through regular staff meetings, video training tapes, and cross-training of front desk and billing personnel. Using a shared hand-held device purchased by CHCN, the health center has conducted waiting room surveys of their patient population to monitor satisfaction and reactions to changes in their operations.

Clinic management has exerted considerable effort to involve clinical staff in decisions required by managed care. Changes implemented with clinician input include moving health education and psycho-social responsibilities from physicians and mid-level providers to nurses, health educators and social workers. Nursing staff, in particular, have been added. Additionally, the health center's chief pharmacist has aggressively pursued pharmacy managed care contracts and drug price discounts.

Business infrastructure improvements have also been made by La Clìnica and Community Health Network. Included are extensive revisions of their management information system. Since 1996 numerous software programming changes have been made to accommodate billing requirements, referral management and staff access to

multiple databases. Discussions are also underway regarding consolidation of management information functions through CHCN to include joint purchase of new hardware and software. Shared services, also through CHCN, currently include payroll, auditing, laboratory and pharmacy contracts. The health center has hired additional administrative staff, including a patient omsbudsman, a managed care coordinator for credentialing and patient record audits, and more front desk staff. A managed care committee, consisting of health center staff, has been formed to address issues regarding the managed care contracts.

Our interviews identified some reimbursement issues which pose challenges for health centers. The California Medicaid program sets interim rates for the health centers based upon their most recent cost reports and will continue to provide retroactive cost settlements until cost-based reimbursement is phased out according to Federal legislation. The Healthy Families Program does not use cost-based reimbursement, which leaves reimbursement rate negotiations up to health plans and their contracting health centers. In preparation for the phase-out of cost-based reimbursement, La Clínica has accepted full risk professional services capitation, excluding hospital services, to gain experience in managing finances for primary and specialty care for commercial patients. As mentioned earlier, inadequate dental reimbursement from managed dental care plans is also an issue raised by La Clínica and the CPCA for the Healthy Families Program. Because of the low rates, La Clínica has decided to only contract with the fee-for-service dental plan. CPCA is working with the California Dental Association to address this issue on a Statewide basis.

Key Factors for Success

La Clínica de la Raza was identified to our study team as a health center which has been successful in early implementation of the CHIP program in California. Our interviews confirmed that the Community Health Center Network and the Alameda Alliance Health Plan are also in the forefront of traditional and safety-net managed care plans. In fact, they were the first to become operational in the State. Several reasons for this joint success are identified in this case study. Foremost of these elements of success is their proactive approach to entering the managed care market environment in California. A significant part of their approach has been partnering with the Community Health Center Network, negotiating provider contracts as a group instead of as individual health centers, accepting risk for specialty services as a group, and sharing services provided through CHCN. The Executive Director of La Clínica, when describing what makes an individual health center successful stated, "Networking. I don't know ... how they could possibly survive outside of a network right now."[33]

Another aspect of La Clínica's proactive approach to managed care is working extensively with their administrative and clinical staff to identify operational adjustments necessary for managed care work in their health center and involving the staff in the implementation of these adjustments. Examples of this include formation of an internal managed care committee, a commitment to staff training, and engaging in a re-design project. Expanding clinic hours and services, adding specialized staff with managed care responsibilities and realigning clínical staff responsibilities are also

important adjustments which La Clínica has made.

The largest challenge to successful participation in the California CHIP program for La Clínica and other health centers is overcoming the significant barriers to outreach and enrollment described earlier. Even after clarification of the public charge policy the "fear factor" for California's immigrant population will be difficult to overcome. However, having close ties with their community and the trust of their respective patient populations positions the health centers as key allies for alleviating fears and reaching these children and their families.

CHERRY STREET HEALTH SERVICES
Grand Rapids, Michigan

State Model: *Combines Medicaid expansions with a free-standing program. Inclusion of safety-net providers in managed care not required, but default assignments of patients provide incentives to do so.*

Center Highlights:

- *Hired an outreach coordinator instead of an eligibility worker to conduct off-site recruitment and application assistance and tracking;*
- *Designated a managed care coordinator to oversee development of MIS system improvements;*

Challenge: *HCFA's rejection of original reimbursement methodology forced return to cost-based settlements. Original plan included payment for recent program expansions, so a cost-based approach puts such programming at risk.*

Michigan CHIP Model

Soon after the enactment of the CHIP legislation, Statewide forums were held, starting in October, 1997, to gather input on a CHIP proposal. With strong administrative support for privatization of governmental services, a totally free-standing program was proposed, and a plan using this model submitted to HCFA in December 1997. When the State legislature convened in January 1998, the House held hearings on this plan, and discussions ensued regarding a combined approach of Medicaid expansions along with a free-standing program. As a result, legislation was passed in March 1998 for a combination Medicaid expansion/private model. HCFA approved the revised State plan in April 1998. Implementation of the program began in May, and Statewide implementation was completed by September 1, 1998.

Income eligibility levels for the Medicaid expansion are set at 185 percent of the Federal Poverty Level (FPL) for infants up to one year of age. The remaining children up through age 18 are eligible for Medicaid if family income is less than 150 percent FPL. The free-standing program, called MIChild, covers children in families at and below 200 percent FPL who are not Medicaid eligible.[34] Both the Medicaid expansions for children and the MIChild program permit continuous eligibility for 12 months. Community health centers are among a group of providers who are allowed to deem presumptive eligibility for children.

The Medicaid program and MIChild use an enrollment broker, Maximus, to process applications and choice of managed care plans. For families who do not select a plan for their children, Maximus makes default assignments for Medicaid. Although Medicaid health plans are not required to include health centers in their provider networks, the bidding procedure grants points to plans who contract with these centers in the allocation of default assignments. The plan pays fee-for-service if there is no contract with an Federally Qualified Health Center in the county. The three plans

with the highest points in each county receive default assignments. Other health plans in the county which are not among the top three in enrollments receive no default assignments. MIChild accepts any licensed HMO or PPO provider.

Benefits for the Medicaid expansions are the same as the pre-existing Medicaid program. MIChild benefits were designed based upon the State employee benefit package and are fairly comprehensive, by including prescription drugs, vision, dental, and home health services, as well as durable medical equipment, but with limitations on some therapy services.[35] Mental health and substance abuse services are provided separately through a carve-out from the health plans whereby the MIChild program contracts directly with community mental health programs.

Health Center Background

Cherry Street Health Services, based in Grand Rapids, is a medium-sized health center which served over 17,000 patients in 1997. The health center operates six clinic sites, including school-based health clinics, in Grand Rapids and Kent County. The patients seeking care at Cherry Street clinics are ethnically diverse and include African Americans (30%), Caucasians (30%), Hispanics (15%) and 25 percent in other categories . About 10 percent of the patient population are estimated to need bilingual or translation services. The majority (54%) of patients seen at the health center are children. Although Cherry Street does not receive Migrant Health Center grant funds, they do see some children from migrant farmworker families at various sites during the three month crop picking season. As described later, the center provides a full range of preventive and primary care services, as well as several specialty services to these children. We visited Michigan in September 1998, very soon after CHIP implementation was completed Statewide.

Planning and Implementation

Cherry Street Health Services was involved in the planning and implementation of MIChild and Medicaid expansions primarily through their Primary Care Association. The PCA members had extensive discussions within the Association regarding their support of Medicaid expansions over a free-standing CHIP program. Many assumed that the free-standing model was a given, but the PCA decided to support a Medicaid expansion because it had more comprehensive benefits and a pre-existing administrative structure. Since the Medicaid program had implemented managed care over a year before the passage of the CHIP legislation, provider networks and contracts were in place to serve a low income population through managed care plans, including one formed by the Federal health centers. When members of the legislature expressed interest to include a Medicaid expansion as part of the CHIP plan, the PCA worked with legislators and other advocates to realize its inclusion.

Additionally, the health centers were represented at three or four State input forums regarding the original, free-standing plan submitted by the State. The PCA was also involved in meetings of a group of child health related agencies in Grand Rapids that commented on the State plan. When the combination plan for Medicaid expansions and

the MIChild program was ultimately developed, the PCA informed member clinics of implementation activities. In addition, it provided outreach information that assisted the health centers in enrolling their children in the appropriate CHIP program.

Outreach for CHIP

Cherry Street Health Services has actively engaged in outreach following the establishment of Medicaid expansions and MIChild. They have an outreach coordinator whose primary responsibility is to enroll children. Parents of its 2,400 self-pay children served by the health center were mailed a brochure explaining the program, eligibility requirements and how to apply. The center's medical director has asked its providers to monitor child encounter forms for an indication of self-pay status so they can then inform parents about the programs and refer them to the outreach coordinator for application assistance. The outreach coordinator also tracks applications for families she has assisted with the process to ascertain eligibility status and/or need for additional documentation. At the beginning of the school year, the coordinator gave presentations during registration activities and distributed information and applications. The outreach coordinator also distributes information and applications at neighborhood picnics, church-sponsored health fairs, job fairs and other local activities. However, with six sites to cover, the center director noted that three or four outreach workers are needed, but that more staff resources aren't available. This is, in part, due to the uncertainty regarding the amount of cost-based reimbursement which they would receive and the lack of supplemental CHIP funds being allocated to them.

The Medicaid and MIChild programs have also conducted outreach activities on a Statewide basis. Although these programs accepted applications in July 1998 the "kick-off" press conference was held in late August after changes to the original application forms were made. Radio and television advertisements were being aired by September when we visited, and plans were announced to send applications to all schools. Additionally, regional contracts for outreach activities were initially granted only to "multi-group collaborative bodies", which are county-based groups largely composed of governmental agencies. Some health centers are involved in these groups, but many are not. The health center and PCA expressed concern about restricting outreach contracts to these groups, since Federal health centers are not members of these groups in some areas. Shortly before our visit, the State program, in an effort to increase enrollments, issued a request for proposals for 30 more outreach contracts, for which health centers would independently be eligible. Applications for the MIChild program were accepted throughout the remainder of the year after April 1998 and in 1999. However, beginning in 1999, re-enrollment after failure to pay premiums will only be accepted during three open enrollment periods.

Although health centers are allowed out-stationed Medicaid eligibility workers to deem presumptive eligibility, Cherry Street had not yet implemented this option. Since the health center would need to pay half of the eligibility worker's expense they decided to employ an outreach coordinator as a member of their staff. The PCA director said health centers were wary of presumptive eligibility. They would receive capitated payments for the presumptive period, regardless of the final eligibility determination of

the child. However, if a child was initially sick and needed significant care, their costs would exceed capitated revenues if the child was subsequently deemed ineligible and these costs would be assumed through the HRSA grant resources, as though uninsured.

The health center and PCA directors also expressed concerns regarding some administrative problems with the enrollment broker for both Medicaid expansions and MIChild. One problem cited by the health center's managed care plan was that, at the time of our September site visit, the enrollment broker has been unable to transfer enrollment information to the health plans electronically. Updated information, after our site visit, indicated that electronic transfer of MIChild eligibility verification became available in October 1998 and an electronic bulletin board became operational in February 1999. Prior to October 1998, the health center indicated they expended considerable time on confirming program eligibility. Finally, although a short, four page, application form is being used, it has been revised three times since its inception, which has caused some confusion and delays.

Health Center Services for Children

Primary/Preventive Services

Cherry Street Health Services offers a comprehensive range of children's primary and preventive services, including well-child care, acute care, immunizations, prenatal care, family planning, and pharmacy services. The health center also has a Women, Infants, and Children nutrition program on-site. Services are provided at the six clinic sites, a school-based health clinic, and through a traveling school health program serving 16 schools. The traveling program offers medical and dental screening to students. The health center has one part-time pediatrician on staff. Most providers are either nurse practitioners or family practitioners.[36]

Enabling and Specialty Services

Health education is a significant enabling service provided by the health center. For pregnant women they provide a State-funded program of maternal support services which focuses on health education, coupled with case management and home visits. Bilingual providers and translation services are available to non-English speaking families by two physicians and a number of medical assistants, all of whom speak Spanish. Other enabling services provided by the health center include eligibility assistance, case management, housing assistance, outreach and some transportation.[37]

The health center also provides several specialty services to their patients. The center has a sizeable dental program consisting of five dentists, three hygienists, and ten assistants, aides and technicians. Mental health services are also provided at the clinic sites and mental health referrals for Medicaid and MIChild are available through community-based mental health providers. Limited vision services are also offered by the center.

Although still early in program implementation, the health center has begun to see MIChild eligible children assigned to their clinics. At the time of our site visit, 53 children from the health center had been enrolled in MICHILD, and 123 had become newly eligible for Medicaid. However, the director is concerned about Cherry Street's ability to maintain its current range of services, largely due to decreases in the numbers of families assigned to them with Medicaid coverage. This is, in part, due to competition for Medicaid patients as managed care was implemented in Michigan. However, the total Medicaid caseload Statewide has declined due to the effects of welfare reform. The center director noted that the total number of patients seen by the health center is not decreasing but that more families are now served under the self-pay, sliding fee category which is dependent on grant funds.

CHIP Readiness

When the Medicaid program began implementing mandatory managed care, Cherry Street Health Services joined a health center-owned and directed managed care plan. This plan, Community Choice of Michigan (CCM), was formed through efforts initiated in 1995, when a group of health centers obtained a HRSA Integrated Service Network Initiative grant. With the Medicaid program moving towards managed care, these health centers decided that creating their own health plan would best serve their patients' interests. To assure involvement in plan decisions, particularly those regarding adequate reimbursement and maintenance of clinic enabling services, health centers invested $22,000 each and obtained a seat on the Board of Directors. Since Michigan phased-in its managed care program by counties, Cherry Street was not initially in CCM when the plan became operational in 1996. However, they joined the plan as Medicaid managed care was implemented in the Grand Rapids area.

With the advent of Medicaid managed care, the health centers and CCM needed to address the issue of how cost-based reimbursement was going to be handled by the State. Initially, the Medicaid program thought managed care plans would place capitation bids which incorporated the higher reimbursement for the health centers, and then reflect this in the fees paid to the centers. However, the plans did not include these higher fees in their bids, and health centers feared this created disincentives for plans to work with them. The health centers, then, as a group, negotiated a memorandum of agreement with the Medicaid Program whereby the managed care plans would reimburse health centers at market rates, and the Medicaid program would supplement these payments[38]. The supplemental payments were based upon the 1996 cost reports, with an inflation factor of 15 percent for 1998 and 1999. The agreement also allowed health centers to be paid for service expansions planned prior to the 1997 date of the agreement. Also, health centers could assume risk in their managed care contracts. Thus, they could realize gains from savings, and lose revenue for excess costs.

However, the HCFA informed the Medicaid program that this reimbursement methodology was not acceptable under the Balanced Budget Act of 1997 (BBA), and they would need to return to cost-based settlements. Returning strictly to cost

settlements would negate any gains or losses from accepting risk. Additionally, under cost settlements, Cherry Street Health Services would not receive payments for their expansions already made. The health centers, their PCA and Michigan Medicaid have protested HCFA's ruling, and a final determination on this issue was pending at the time of our visit. The outcome of this reimbursement issue was expected to have significant impact on the health center's ability to adjust to managed care risk assumption, once cost-based reimbursement is phased out as required by the BBA, because they would have no Medicaid experience with capitated reimbursement. Cherry Street also anticipates a need to retreat from service expansions already underway if the Memorandum of Agreement is ultimately nullified by HCFA.

Cherry Street and CCM noted several adjustments being made by health centers to facilitate their viability in a managed care environment. The director of Cherry Street stated that, as their participation in managed care evolved, they had become more "thirsty for Medicaid encounter data". CCM provides them with their financial reports with costs, broken out by services and providers, as well as considerable education during their board meetings on how to use this information. CCM indicated that two of the most financially successful health centers in their plan had each hired a staff person with managed care experience to monitor financial aspects of managed care contracts. Cherry Street had designated one staff member as a managed care coordinator who was being educated to oversee this component of the center's operation. The center also was considering adding a referral coordinator, if resources allowed.

Another significant area of needed adjustment was in management information. Although Cherry Street had not yet invested in new hardware or software, the director indicated he was assessing their technical needs in this area. The PCA noted that 14 of their health centers now contract with a common software company and that this vendor had recently dedicated a staff person to support the Michigan health centers. The Medicaid staff we interviewed reiterated that good information systems and business managers were critical to health center viability in the new managed care environment.

Key Factors for Success

Cherry Street Health Services has made a concerted effort to enroll children in Medicaid expansions and MIChild. Although the director indicated that they would like to do even more outreach if resources were available, this health center has clearly made CHIP/Medicaid outreach a priority. They demonstrated this by dedicating staff to this effort, informing their providers about the program, involving them in referring families to the outreach coordinator for application assistance, and by conducting a major mail outreach to their self-pay families with children. The health center is also making an effort to track the processing and outcome of these applications to ensure that applications needing follow-up don't "fall between the cracks." Due to welfare reform, their loss of patients previously covered by Medicaid is presenting financial challenges for the health center. This reinforces their need to enroll many of these children who then become eligible for Medicaid expansions or MIChild coverage. The

school health program operated by the health center reaches over 16 schools and provides an opportunity to achieve this goal. The State programs have shown intent to partner with the health centers in this effort by issuing a request for proposals for outreach contracts with them.

Cherry Street has also partnered with several other health centers in the State in joint ownership and development of a managed care plan. This has required considerable effort to learn the business of managed care, as well as a willingness to accept financial risk for primary care patients. They have designated a staff member as a managed care coordinator and indicated desire to add a referral coordinator as well. As part of their managed care strategy for Medicaid, these centers negotiated an agreement for a modified version of cost-based reimbursement with the State, which incorporates some risk assumption, to facilitate the transition from cost-based to capitated reimbursement for services, although the agreement has not yet been signed. Several people we interviewed said that making the transition to capitation would be a major challenge if they were not allowed this intermediate step.

PLAN DE SALUD DEL VALLE
Fort Lupton, Colorado

State Model: *Opted for a freestanding CHIP program only, in keeping with preference for privatization.*

Center Highlights:
- *Developed managed care experience prior to CHIP, through formation of an MCO, with 8 other centers and a safety-net hospital;*
- *State hopes investment in the design/implementation of an on-line enrollment/eligibility determination system will compensate for the initial lack of direct funding for center outreach;*
- *Capacity issues may arise since State funding levels will only cover half of the children estimated to be CHIP eligible;*

Challenge: *Existence of a prior indigent care program, which also serves children and charges lower copayments and no premiums for many of the same services offered through CHIP. Families tend to stay in the old program until catastrophic illness requires CHIP benefits. A much lower reimbursement schedule for services under this older plan, adversely impacts center revenues.*

Colorado CHIP Model

Early to recognize unmet healthcare needs of their citizens, Colorado had already instituted, prior to CHIP legislation, a State-only health insurance program. A specific children's coverage program, named the Child Health Plan (CHP) was also formed. The State was planning an expansion of this CHP program prior to passage of CHIP. With design teams far into the development phase of the program, the State made alterations to comply with CHIP requirements, thus allowing Colorado to submit a plan to HCFA quickly. When we conducted our site visit in September 1998, the program had been operational for several months.

As allowed under the Federal law, Colorado developed a freestanding program, called Child Health Plan Plus (CHP+), which is administered by the Office of Program Development. Operated by a separate office, the Medicaid program shares the same oversight agency as CHP+, the Colorado Department of Health Care Policy and Financing. Most interviewees describe Colorado as a fiscally conservative State, which operates under taxing and spending limits imposed by voters. They related the apprehension of legislators about expanding entitlements, preferring instead to design a program which closely mirrors private sector health insurance. Consistent with the State's philosophy, the enabling legislation requires that many CHP+ functions be privatized. The oversight agency is required to issue contracts for outreach and eligibility enrollment. This does not preclude the use of contractors already doing similar work for Medicaid, but activities must be coordinated as a separate office.

The Medicaid children's program, titled Baby Care Kids Care, covers children in families with income up to 133 percent of the Federal poverty level (FPL) through age 5. For ages 6 through 15, the eligibility drops to 100 percent FPL.[39] The separate CHP+

program covers children, up to age 18, in families with income up to 185 percent FPL who are not Medicaid eligible. Premium payments are waived for children with family incomes under 100 percent FPL, while those with families above 100 percent FPL are on a graduated premium schedule.[40] Some income levels are also assessed co-payments for office visits. The omission of dental coverage and limits on mental health, and all therapies (physical, speech, vocational) distinguish it from Medicaid's full benefit package.

Health Center Background

Plan de Salud del Valle health center in Fort Lupton, Colorado is a large center with nine service delivery sites. Salud served nearly 33,000 individuals in 1997. Surprisingly, although over 60 percent of their clients are Hispanic, the center reports only 14 percent of its patients require bilingual services or language interpretation. Nearly half (46%) of the center's patient population are children and adolescents. The center has been an owner/provider within the Colorado Access health network, a non-profit HMO providing a comprehensive medical plan for low-income individuals, since Colorado Access was formed in 1995. Salud health center provides a full range of preventative and primary care services as well as a wide array of enabling and specialty services. These will be discussed in greater depth later.

Planning and Implementation

During the design phase, Plan de Salud de Valle health center had both direct representation on planning committees, and was also represented by their PCA on all committees. Salud and its PCA had favored a Medicaid expansion from the beginning, but felt that the State political climate prevented that option from being fully explored. Although the PCA director felt that 50 percent of the resultant program was due to PCA involvement, the Salud center viewed its impact on the final CHP+ product as minimal. For example, although the center's dental director sat on the benefits committee, he was disappointed when dental care was not made a part of the CHP+ benefits package, except in emergencies. Currently, the State is exploring whether it can afford to add a dental benefit.

Although they utilize their PCA for advocacy, Salud has also joined with other health centers, using non-federal dollars, to hire a representative for the PCA to present their interests before the State Legislature. Believing that representatives were unaware of the extent to which their constituents were served by health centers like Salud, they perceived additional representation as necessary for survival in the current environment.

Implementation of CHP+ has led to interface issues with the Colorado Indigent Care Program (CICP), since the onset of CHP+ did not mark the end of this pre-existing program. Covering both children and adults, the earlier CICP plan was intended to become more of an adult program as eligible children enrolled in CHP+. In the CHP+ program, beneficiaries are likely to be faced with higher premiums and co-payments than their co-payment for services under the CICP. For example, under CHP+, a family

of four at the maximum eligibility (185% FPL) would pay $30 a month in premiums and a $5 co-payment per office visit.[41] In contrast, under the CICP plan, they would only be responsible for co-payments.

The health center predicts many families will elect the CICP for children's services during periods of good health, and enroll in CHP+ only when significant health problems emerge. At that point, most serious illnesses are likely to be referred out, so that specialists will benefit from CHP+ reimbursements, not the health center. The financial impact of this scenario on a center like Salud could be great as CICP costs are largely assumed by the clinic.[42] The double effect is to reduce the Federal funds the center would receive under CHP+, as well as the pool of funds available to their adult population under the CICP. Additionally, Salud fears that the State will try to reduce funds to the CICP, proportional to eligible CHP+ children, in order to fund some of its financial commitment to CHP+. The end result would be an overall reduction in total dollars spent on health care for the underserved in Colorado. There was no indication that the State planned any redesign of the child segment of CICP or CHP+ to prevent these conflicts.

As CHP+ enrollment increases, capacity issues may arise since the program was not funded to the level which qualifies for the maximum Federal dollars available. The PCA estimates that approximately 50,000 of the children they serve will qualify for CHP+, while the State currently has appropriated money to cover only 25,000. If such numbers were to enroll, any additional children above the 25,000 threshold would have to be placed on a waiting list until space or additional funding became available.

Outreach for CHIP

Salud health center receives no money from the State for outreach activities. As a result, they have no formal outreach program, but do attempt to enroll children when they access services in their clinics. The center views the CHIP expenditure limit of 10 percent for administration and outreach as inadequate for financing additional outreach activities. The State has allocated some resources to the development of brochures and literature promoting the program. In addition, Colorado heavily invested in an online eligibility/enrollment process which, at the time of our visit, was not yet operational. A pilot project of approximately 40 sites, not all health centers, was scheduled to come online shortly. Once operational, a site would receive a negotiated fee, from the contractor developing the system, for each Internet enrollment application completed. Realizing that getting every health center online may require some capital investment, Colorado has instituted the Essential Community Provider Grants program. The program will allocate grant funds to those essential providers in need of software, networking capability, infrastructure improvement, or direct services.

While only a few health centers currently are permitted to determine eligibility and receive compensation for it, all centers assist clients in completing and submitting enrollment applications to the State. Although Colorado prefers enrollees to fill out the applications themselves without center assistance, Salud observed that the low literacy level of many applicants prevents them from completing applications

independently. The original State plan classified all health centers as high-level eligibility determination sites which would receive training and be paid for application assistance based on a fee schedule negotiated by the contracted vendor and the center. Unfortunately, continuous mistakes by one health center resulted in the State not designating all centers as eligibility determination sites. Rather, Colorado has issued a Request for Proposals under which centers may apply to become an eligibility site. If chosen, a center would receive training at only one site, regardless of how many service locations they may have. Salud health center is a member of the PCA along with 14 other health centers for a total of 85 sites. At the time of our interview, between 3 and 5 of those 85 sites (none from Salud) had been trained to do high-level eligibility determination and were the only sites receiving reimbursement for enrollment activities. The PCA viewed this limitation on eligibility determination and lack of compensation as a serious problem in need of correction. Since our site visit, the PCA provided new information that they and the State program are conducting training sessions around the State to assist health centers in becoming CHP+ eligibility sites.

Issues of eligibility determination are compounded by the lack of presumptive eligibility. Neither CHP+ nor the Medicaid program currently has this feature. However, planners are currently trying to expand presumptive eligibility for the Medicaid plan which currently extends only to pregnant women. Both programs allow continuous eligibility for 12 months before requalification is necessary.

With health centers as the most common point of contact with potential CHP+ or Medicaid enrollees, clinics can complete an application with the client for the program for which they appear to be eligible. Yet, unless the clinic is one of the few high level eligibility determination sites, they must wait for the State to determine eligibility. At the time of our visit, this process was taking between seven and eight weeks. Updated information indicates that the processing time has been reduced to about one week. In the meantime, confusion occurs over whether and how to bill for those services which the client uses. Since CHP+ and Medicaid reimbursements are different, and the CICP program is based solely on co-payments, whether or not to charge fees at the time of service, and where to bill services while the client's eligibility is being determined for a specific program become issues.

Concern was also expressed regarding the impact of CHP+ on the children of migrant workers engaged in seasonal farmwork. While the Federal statute doesn't require a Social Security number from a CHIP applicant, Colorado's addition of this requirement on the joint CHP+/ Medicaid application is viewed as a barrier to the enrollment of migrant children. Most parents can obtain the necessary documentation, but either they don't carry it with them, or they have little motivation to produce it. Even when an application is completed, the slow eligibility determination often insures that by the time they are approved, clients will most likely no longer reside within the State. Whether these families are aggressively seeking to enroll in CHP+ is unclear. However, in Salud's view, every eligible, but unenrolled, child they treat forces them to divert scarce resources away from other uninsured persons.

Health Center Services for Children

Primary/Preventive Services

Salud health center provides a full range of primary and preventative care to the children they serve. Considering themselves primarily as a maternal and child health clinic, the center provides comprehensive care from pregnancy diagnosis through well-child and ill-child care. Salud maintains the goal of providing a majority of their care to patients under the age of 21. Currently, with 53 percent of patients age 21 and under, they seem to be reaching their goal. The center is, however, also a full-service family clinic. Fearing compartmentalization of care, Salud employs just two pediatricians, and prefers that most of their physicians be family practitioners. Other primary and preventive services include Women, Infant and Children (WIC) nutrition services, full prenatal and delivery services, and family planning. Migrant worker clinics are also operated by the health center on a seasonal basis.

Enabling and Specialty Services

Salud is able to provide enabling and specialty services in addition to their primary care offerings. Although they lack funding for translation services, the center tries to hire bilingual staff, when possible, to better serve their majority Hispanic population. Colorado Access, the managed care network of which Salud is a part, also has providers who speak Russian and Vietnamese. Regular transportation is not provided by Salud's managed care organization, and they admit this is an issue, especially in rural areas. However, limited reimbursement forces them to offer transportation only on an emergency basis. Additional enabling services provided by the health center include eligibility assistance for public programs, case management, health education, and outreach.

Plan de Salud de Valle continues to offer limited mental health care, as well as on-site dental services. An agreement with a county behavioral health provider provides a psychologist at one site. Although a similar agreement in another county was discontinued, the psychologist has decided to continue working on a *pro bono* basis. Thus, two sites are able to offer mental health services. Dental services are provided at the clinic sites and at schools, Head Start programs, and migrant centers. Children are given priority for dental appointments, since the need for these services at the health center exceeds current capacity.

CHIP Readiness

Having already participated in the formation of a managed care organization, Plan de Salud de Valle was well-positioned to deal with the implementation challenges of CHP+. Predicting that Colorado would move to Medicaid managed care, nine Federally qualified health centers, including Salud, joined to create the Colorado Community Managed Care Network (CCMCN). CCMCN then organized in conjunction with 3 hospitals and a physician's group to form Colorado Access. A private, non-profit HMO, Colorado Access began operations in December 1995 with 17,000 enrollees on the

first day. Their goals included retaining the Medicaid population, using any surpluses to serve the medically indigent, and ensuring that safety net providers remained viable. Since its formation, Colorado Access has spread from 12 to 28 counties within the State and continues to look for areas of expansion. Salud operates as a provider contracted to the Colorado Access HMO.

Having taken a proactive approach to managed care early on, Salud did not find it necessary to make significant operational changes to accommodate the CHP+ program. Determining their business infrastructure system to be adequate, the center only cites the need of an MIS manager to maximize their information capabilities. Since the new Community Health Center grant adds the MIS manager as part of the staff, Salud will be able to add this position. In addition, they are participating in a pilot project sponsored by the Federal government to test the Physician Service Practice Analysis software. Developed by a managed group medical association, it is a cost accounting software for health services which is heavily used in the private sector. The project is assessing its conversion for use in community health centers.

With five other managed care organizations approved under the CHP+ plan, Colorado Access is not the sole managed care provider. However, their ability to garner 1,000 of the 1,300 total CHP+ enrollees, at the time of our visit, attests to the effectiveness of the network they already had in place. A significant entity within Colorado Access, Salud estimates that between 400 and 500 of the network's CHP+ enrollees are patients of its own clinic system, while they speculate that several thousand more are eligible. The center expressed concern regarding the possibility that with more provider networks available, enrollees might seek out private physicians due to perceptions that private care is better, and if their insurance status changes, return to Salud. The net effect is a rise in the number of uninsured patients at the centers. Under such circumstances, the center will lose capitated funds for patients while they are insured, yet become liable for the cost of treating them when, and if, their coverage status changes. Although this has not occurred on a widespread basis, Salud has observed this shift in one county where it has provider sites.

Under CHP+ managed care, Plan de Salud de Valle health center has not experienced the reimbursement problems it did under the old Child Health Plan (CHP). Reimbursement was provided on a capitated basis, with some services "carved out" on a fee-for-service schedule. Due to delayed eligibility determinations and a slow payment system, the center would often go three to four months without receiving checks from CHP. The CHP+ plan is also capitated, but with the managed care organization rather than the center. Each managed care organization then, contracts with their providers independently. In the case of Salud, Colorado Access is giving them the same cost-based, fee-for-service they would receive under Medicaid. In addition, as an incentive to keep costs low, Colorado Access receives a designated premium from the State with the agreement that funds left over will be equally divided between themselves and Salud.

The choice to operate a freestanding commercial program has presented an unexpected issue in regard to vaccines. Health centers receive highly reduced prices

for vaccines from pharmaceutical companies for Medicaid and the uninsured, but cannot use those under the freestanding CHIP program per Federal regulation. The State's original capitation rate did not include these vaccines, so now they are trying to incorporate them into a new capitation rate. In the meantime, health centers are unclear about the reimbursement of cost for vaccines under CHP+.[43]

Key Factors for Success

Plan de Salud de Valle's previous affiliations with managed care appear to have been of great benefit as they made the transition to CHP+. Having already worked with other member providers for years, the CHP+ program was more like an add-on than a new enterprise, which allowed their managed care network, Colorado Access, to sign up more CHP+ members than the other five networks combined. Salud has been particularly successful, since nearly a third (between 400 and 500) of the initial CHP+ enrollees Statewide reside within the Salud clinic system. With its emphasis on safety net viability, Colorado Access continues to work to insure its market share, and look for areas in which to expand.

Prior to CHP+, the health center had proactively upgraded its business infrastructure. Approval of a MIS director position will further enhance their capability to manage the complex information needs associated with managed care. The progress they have made in this area is evidenced by their participation in the test pilot for service analysis software being sponsored by HRSA.

The simultaneous operation of the CICP program along with CHP+ remains a challenge for Salud and its financial future. They predict the CHP+ premiums and co-payments to be significant barriers to new members who have been accessing services under the co-payment only CICP plan. Like other insurance programs, the success of Colorado Access under CHP+ depends upon a sizeable pool of members paying premiums over time so that adequate funds will exist to cover care costs. If Salud's clients opt to utilize the CICP for general care, the center will be responsible internally for the majority of costs incurred under the CICP plan and forgo potential CHP+ reimbursements for the same care. Yet, even if the centers are able to overcome the resistance of clients to convert to the CHP+ plan, the current financing limits to 25,000 CHP+ enrollees, set by State appropriations levels, are likely to present a new barrier to success.

FAMILY HEALTH CENTERS
Orangeburg, South Carolina

State Model: *Medicaid expansion with a voluntary managed care element. Providers may participate in an HMO or one of two managed care alternatives tailored for the State's rural areas.*

Center Highlights:

- *Enrollment barriers avoided with a one-page, mail-in application, and adherence to a maximum 5-day processing period;*
- *Established and funded, with other centers, a Managed care corporate structure, should managed care become mandatory;*
- *Effective mode of outreach through expansion of school-based health programs;*

Challenge: *Previous periods of capped reimbursement rates resulted in significant funding reductions to the center. While temporary, these periods raised concern over the approaching permanent phase-out of cost-based reimbursement.*

South Carolina CHIP Model

Prior to the Federal enactment of the CHIP legislation, the Governor of South Carolina, in February 1997, announced an initiative called Partners for Healthy Children, which aspired to provide health insurance to 50,000 additional children. With support from the legislature and private businesses, planning for a Medicaid expansion for children occurred as Congress deliberated the Federal legislation. The South Carolina Children's Hospital Collaborative provided $3 million in matching funds for the expansion which, together with an appropriation by the General Assembly, allowed South Carolina to start accepting applications under the expanded eligibility rules on August 1, 1997. Because of its early start, South Carolina became the second State to have a CHIP plan approved, with Colorado being approved earlier on the same day.[44] With the enhanced Federal matching rate provided by CHIP, the estimated number of newly eligible children expanded to 75,000. We conducted our site visit to South Carolina in September 1998 when their CHIP Medicaid expansion had been in operation several months.

South Carolina selected a Medicaid expansion model only for children whose family income is up to 150 percent of the Federal poverty level (FPL). These children receive all standard Medicaid benefits including Early Periodic Screening, Diagnosis and Treatment (EPSDT). Instead of instituting mandatory managed care, the State Medicaid program, in addition to its health maintenance organization option, developed two more voluntary managed care options tailored to the rural nature of the State. The first of these, called Physicians Enhanced Program (PEP), is a primary care capitation arrangement whereby physicians and health centers can contract for a bundle of primary care services, paid for by a monthly capitated fee. In this option, the primary care provider serves as a primary care case manager and must arrange referral services

for patients. The other option, called Healthy Options Program (HOP), is a model where the primary care provider agrees to serve as a "medical home" for the patient. For an enhanced office visit payment rate, the provider is available on-call to his/her patients and coordinates their care. However, this model does not include capitation or mandatory referrals for specialty care[45]. South Carolina has implemented continuous eligibility for 12 months, which should assist the process of establishing medical homes for children[46].

Health Center Background

Family Health Centers in Orangeburg, a large center located in a rural area of the State, served about 36,000 patients in 1997. The health center consists of one main clinic, six satellite offices, and school-based clinics which operate at four locations. The health center director noted that expansion of their school-based program has been a priority in recent years. Due to this emphasis on school-based health care, over 43 percent of the center's patients are children and adolescents. This is the highest percentage of children served among all the Federal health centers in South Carolina. Overall, the health center population is 82 percent African-American.[47] The main clinic provides a comprehensive range of preventive and primary care, as well as pharmacy and dental services. Additionally, for three months during the peak harvest season, the health center conducts outreach to migrant workers and provides services through use of a mobile clinic owned by the Medical University of South Carolina.

Planning and Implementation

Family Health Centers and the South Carolina Primary Care Association (PCA) reported some minor involvement in the planning and implementation of the Medicaid expansion for children. Legislative hearings were held in locations across the State, and testimony was provided by health centers in support of the expansion. The health centers were in agreement with the decision to implement CHIP by expanding the Medicaid program, since this provided the fastest and administratively easiest approach. The PCA member health centers considered pushing to expand income eligibility to 200 percent of the FPL. However, when the health centers examined their patient demographics, only small numbers of children came from families in the 150 percent to 200 percent income range. Therefore, the Association did not press this issue. PCA staff indicated that implementation of the expansions had proceeded fairly smoothly with no major issues emerging.

Outreach for CHIP

South Carolina has enrolled over 50,000 of the projected 75,000 children newly eligible for Medicaid in the first year.[48] This exceeded the State's initial goal of 37,500 for the first year of the program. To facilitate enrollment, the Medicaid program developed a one-page (two-sided) mail-in application form. Rather than using presumptive eligibility, they committed to processing eligibility applications within five days of receipt. Health centers have been a part of the State outreach effort.

Family Health Centers is serving as a site for an outreach demonstration project with the Medicaid program for targeted outreach activities. The center provided a list of all their uninsured children to the Medicaid office. Letters notifying the family of the expansions, with a mail-in application enclosed, were then sent by the Medicaid program. Of over 2,000 applications mailed only about 130 were returned. The health center director felt that a letter directly from the health center might have been more effective because of its relationship with the families and their ability to assist families in completing the applications. Beyond this project, Family Health Centers has an outstationed Medicaid intake worker at their main clinic to assist fee-for-service families with newly eligible children in completing applications for the Medicaid program. The center's community health workers at the school-based clinics are also engaged in outreach activities.

Schools were also the focus of Statewide outreach efforts. When the expansions were implemented in August 1997, the Medicaid program sent applications to all districts at the beginning of that school year. The number of submitted applications tripled to over 300 per week shortly after this mail-out. In addition to the health centers and schools, the State distributed applications to physicians' offices, pharmacies, hospitals and child care centers throughout the State. Partnerships were also formed with the Baptist Convention, the African Methodist Episcopal Church and numerous other community groups to distribute applications through their networks.

Even with the efforts described above, health center and PCA staff felt more outreach was necessary. The health center director felt without supplemental resources, centers should view these activities as short term investments with long-term payoffs. In particular, she emphasized the value of working with schools, since the health centers have established relationships there. The PCA director emphasized that families' trust for their health providers is a significant factor in successful outreach, making health centers ideal focal points. She noted that the rural culture of South Carolina is more responsive to information provided by local people and organizations than Statewide initiatives. The ability of health centers to discuss the program with families and assist them with applications is critical in her view.

However, resources for health center outreach activities are limited. No grants or application assistance payments are available. The PCA director stated that she would like to be able to assign staff to the health centers for two to three month periods. There they could devote full-time to explaining the program to children's families or assisting them with applications while awaiting clinic appointments. This staff person could also call families and schedule appointments solely for outreach and enrollment purposes.

Children in migrant and seasonal farm worker families were identified as needing intensified outreach activities. Because of South Carolina's agricultural economy in rural areas, we also interviewed the coordinator of the State Migrant Health Program. The migrant worker population is very mobile, and follow-up regarding applications can be difficult. Currently, South Carolina does not have arrangements for portability or transferability[49] of eligibility with surrounding States, and the migrant health staff we

met with would like to see this issue addressed.

Some outreach regarding the Medicaid eligibility expansion has started in Migrant Head Start programs, and respondents felt that these activities should be increased. Family Health Centers and Carolina Health Centers,[50] whose director we interviewed separately by telephone, were working with the Migrant Head Start programs on such efforts. Services to this population are often delivered by mobile clinic vans or in temporary clinics located at the migrant camps. Families in this population are now settling in the State to work in poultry processing plants, and more of their children are coming to the main clinic sites. There, language barriers need to be addressed, along with establishment of trust, since many citizen children have parents who may not be documented.

Health Center Services for Children

Primary/Preventive Services

Family Health Centers offers children a comprehensive range of primary and preventive services. The services provided include prenatal care and delivery, immunizations, well-child care and primary care for illnesses. With a full pharmacy, the health center also participates in a pharmaceutical company's cost-sharing program to assist low income, uninsured patients in receiving needed treatments.

The health center has made a concerted effort in recent years to develop and expand its program of school-based clinics. It currently has four school clinics, staffed by nurse practitioners, and two additional schools have requested clinic services. The school clinics were implemented through Rural Demonstration Project funding through fiscal year 2000. The health center director is exploring sources of seed money to expand to these additional schools. Community health workers are also located at these school-based clinics to provide health education and outreach services.

Enabling and Specialty Services

Enabling services of case management, transportation and translation are also available to children served by the health center. Case management was emphasized as an important element in providing care. In particular, scheduling and follow-up on missed appointments for preventive care was felt to be significant. Although the Medicaid program had previously reimbursed the health centers directly for case management services, these functions are now provided under contract with the Health Department. However, the need for case management of services other than immunizations and well-child visits sites remains. Located in a very rural area, many of the health center's patients have a significant need for transportation. Most specialty care for Medicaid and uninsured patients is provided by the University of South Carolina, located in Columbia, almost an hour's drive away. However, only limited transportation is provided by the center. Of particular concern for pregnant women is the ambulance service based out of Columbia. In cases of pre-term labor, the hour long wait for an ambulance to transfer them to the University hospital represents a significant delay in

receiving needed specialty care. Although the majority of the health center's patients are African American, bi-lingual staff and translation services are important to the provision of seasonal care to migrant worker families. Two physicians and one nurse speak Spanish. For translation needs in other families, and further outreach to the migrant population, the health center has an arrangement with South Carolina State University to provide additional translation services.

Health education is another key component of Family Health Center's program. For children, much of this is provided at the school-based clinic sites. The medical director indicated a desire to include substance abuse prevention education in their middle school sites. For young children, the health center staff is developing a parent's education book on basic baby care and child health needs. Family Health Centers is one of several Federal health centers participating in a diabetes management, quality improvement project recently initiated by the Bureau of Primary Health Care. Children and adults with diabetes will be part of this initiative.

The health center also provides a full dental program comprised of two dentists and four dental assistants. As we found in other health centers visited, the need for dental care by the center's population strains their current capacity. Consequently, priority for dental appointments is given to children.

CHIP Readiness

Prior activities have prepared Family Health Centers for implementation of Medicaid managed care in South Carolina. The previous governor had submitted an 1115 Waiver to implement Medicaid managed care. As the waiver application was being developed, Family Health Centers, in conjunction with other Federally funded health centers in South Carolina and the PCA, obtained an Integrated Services Network grant from the Bureau of Primary Health Care to develop a managed care strategy. A for-profit corporation, Community Network, Inc., was formed with the director of Family Health Centers as president. Each health center made an investment of $25,000 and negotiations were conducted to partner with an existing managed care company in order to obtain additional capital and administrative expertise. When the waiver application was put on hold under a new State administration, Community Network decided not to enter into any Medicaid managed care contracts at that time. The corporate structure remains in place and provides the mechanism for the health centers to enter the managed care environment should Medicaid managed care expand beyond its currently limited voluntary program.

Instead of instituting mandatory managed care, the State Medicaid program, in addition to its health maintenance organization option, developed two more voluntary managed care options tailored to the rural nature of the State. These programs, the Physicians Enhanced Program (PEP) and the Healthy Options Program (HOP) are types of primary care case management, as described in the State CHIP Model section. Family Health Centers is one of three Federal centers in South Carolina which, together with the PCA, is developing a demonstration project to experiment with PEP contracts in the Medicaid program. The Medicaid program and these health centers were, at the time

of our visit, negotiating the details of which health center services, such as transportation, outreach and social services, should be excluded from the capitation payment and billed separately to Medicaid.

Family Health Centers and the PCA have made some business infra-structure enhancements, and would like to implement others, to adjust to these managed care options. They have automated their patient accounting function, including encounter data, accounts payable, Medicaid and Medicare billing, general ledger and pharmacy. Although they are not yet billing Medicaid on-line, the electronic claims are downloaded onto diskettes and sent to the carriers. The financial officer noted further enhancements being considered are converting from a UNIX system to a PC system, and adding an in-house MIS manager, a financial management staff person, another billing staff person, and a medical coder.

The South Carolina PCA is also assisting the health centers in adjusting to the new health care environment through infra-structure assessments. They have arranged for a business consultant to assess each health center by looking for ways to decrease costs and enhance staff productivity. Each health center will be provided with a report of its assessment. The director of Carolina Health Centers whom we interviewed, also emphasized the importance of centers becoming more "business-minded." He stated that more technical assistance to health centers on business operations is needed, and suggested that HRSA contract with private trainers specializing in medical practice and financial management.

Although the health centers in South Carolina are currently receiving cost-based reimbursement, some issues were identified. During the 1990's, South Carolina has had two periods in which all Medicaid reimbursements, including those to health centers, were capped. Although the cap has recently been lifted, the Director of Family Health Centers noted that the center had lost about $14 per patient visit when the cap was in place. This caused the health center to enter a financial recovery plan to reduce costs when the cap was in effect. Dental reimbursements, at $38 per visit, were stated to be too low to cover the cost of providing these services. Currently, dental costs can be captured in the cost settlements. However, as cost-based reimbursement is phased out according to Federal requirements, further cost efficiencies will be needed.

Key Factors for Success

Family Health Centers is actively pursuing strategies to adjust to the Medicaid children's expansion and the changing health care environment in South Carolina. They have made services to children a priority for the health center in recent years through expanding their school-based clinic program and looking forward to expansion in additional schools. Their dental program makes appointments for children a priority. Health education and outreach activities to children are also part of this strategy. Although mandatory Medicaid managed care has not yet come to this State, a corporate structure has been created to enable the health centers to enter such contracts in the future. Family Health Centers has been in the forefront of this effort.

This health center is also working with the PCA and the Medicaid program to launch a demonstration project involving health centers in the partially capitated Physician Enhanced Program for primary care

Although most interviewees in South Carolina stated a need for increased outreach activities, the State has been one of the more successful in enrolling newly eligible children. By enrolling over 50,000 children in the first year of the expansion, South Carolina exceeded its program goal. Most respondents felt this success was due to simplified application processes, reaching children through the schools, and in-person contacts when families seek care for their children. Family Health Centers has engaged in these activities, as well as contacting fee-for-service families among their clientele to provide information about the expansions, encourage enrollment, and offer assistance with applications. However, the director felt that more activities, particularly in-person contacts, are needed.

Two challenges to the success of the South Carolina children's Medicaid expansions remain. One of them is to enroll children in migrant farm worker families and provide for their health care needs. Pursuing portability or transferability of eligibility was noted as one option to address this problem, but this policy change has not yet been developed. Additional bi-lingual outreach workers would also enhance the efforts to enroll this population. Family Health Centers has an opportunity to provide such outreach during the months when they operate the mobile clinic in migrant camps.

Another challenge identified is to make the adjustments required by the phase-out of cost-based reimbursement for health center services, especially considering the enabling services the health center provides. Family Health Centers encountered serious financial difficulties when the Medicaid cap was in place in South Carolina and is quite concerned about this transition. The PCA and health centers are now studying ways to improve their cost efficiency in preparation for the revenue reductions which will result from this change.

HEALTH CENTERS OF NORTHERN N.M.
Española, New Mexico

State Model: *Medicaid expansion only which closely followed an earlier State-initiated expansion, except for a cost-sharing element for families with higher incomes.*

Center Highlights:
- *Center development through the merger of small, independent clinics resulted in its continued existence and viability;*
- *Provides specialty services targeting client needs, such as their Diabetes Control Program and an asthma clinic;*
- *Demonstrates effective managed care in a rural setting;*

Challenge: *Reimbursement issues remain, since center provides specialty services not included in current health plan contracts. Additionally, low and selective dental reimbursement rates are causing the center to consider discontinuing dental services altogether.*

New Mexico CHIP Model

New Mexico had already experienced Medicaid expansion in a managed care setting when it came time to implement CHIP. In 1995, the State began expanding Medicaid eligibility for children in families with incomes up to 185 percent of the Federal poverty level (FPL), resulting in over 38,000 additional Medicaid children.[51] Somewhat later, but still before CHIP, the State legislature decided that Medicaid in New Mexico would convert to a Statewide, managed care model. For a predominantly rural State, this was an ambitious plan. All Medicaid recipients are now under managed care except for Medicare-Medicaid eligibles and people in institutional care.

As part of the Medicaid transition to managed care prior to CHIP, three managed care organizations succeeded in winning contracts with the Human Services Department. They are Presbyterian Salud, Lovelace Salud, and Cimmaron Salud, all Statewide organizations. Presbyterian and Lovelace are both Federally qualified health plans, while Cimmaron is not.[52] Operating under the optional Medicaid expansions passed by the State, these organizations are poised to implement the additional expansion outlined in the State's CHIP plan.

At the time of our visit, in September 1998, the State's CHIP proposal had been submitted to HCFA, but was still awaiting approval. Later, the plan was approved, basically as submitted, on January 11, 1999.[53] Classified only as a Medicaid expansion State under CHIP, New Mexico's approach is more creative than a standard expansion. The State proposed additional increases in Medicaid eligibility for families with incomes up to 235 percent FPL. Open to the Medicaid expansion concept, but uncomfortable with free entitlements to families above 185 percent FPL, the Governor and legislature compromised on a cost-sharing approach for families between 185 percent and 235

percent FPL. Under the proposal, each family pays a premium of 15 dollars per month regardless of household size or income level.[54] Co-payments are assessed at the time of service delivery. However, once maximum annual limits are reached, families cease to have a co-payment requirement. The New Mexico CHIP proposal includes the implementation of continuous eligibility for 12 months to insure continuity of care, regardless of changes in income. This change should also reduce current administrative challenges of verifying eligibility on a monthly basis.

Additional provisions discourage eligible families with private insurance from dropping their children's coverage and enrolling them in the new program. When the State expanded Medicaid eligibility to 185 percent FPL, it found that 16 percent of those enrolled had private health insurance at the time of enrollment. Of that group, 25 percent later dropped their private coverage.[55] Thus, the State has proposed that children will be ineligible for 12 months from the date on which creditable health coverage was dropped. Exceptions are allowed for situations beyond the insured's control.

Health Center Background

Health Centers of Northern New Mexico (HCNNM), a single health care entity with administrative offices in Española, is the result of the consolidation of various small, rural clinics. With the original Española clinic in operation since 1972, the other clinics merged with it in the 1980's and 1990's to ensure their longevity and financial stability. Today, HCNNM operates under a volunteer Board of Directors, many of whom are directors from the previously independent clinics.

The center currently consists of 13 primary care clinic sites, one of which is a university student health center, and one dental facility. Services are provided in 12 different towns, over seven counties. Despite their number of service delivery sites, HCNNM is a medium-sized health center with approximately 16,000 registered patients in 1997. Except for Las Vegas and Española, HCNNM sites are the only providers of health services in the rural communities. Since the counties served include some of the highest State rates of unemployment and families living below the Federal poverty level, HCNNM is vital to them. HCNNM also operates school-based clinics in Española at the middle and high school levels. Seventy-five percent of clients are Hispanic, with the center reporting that overall 13 percent of clients require bilingual or translation services. Approximately 40 percent of patients who receive services are children.

Planning and Implementation

HCNNM respondents felt they definitely had involvement in the CHIP planning process, but that it was almost exclusively through their Primary Care Association. Their PCA director sat on the State Medicaid advisory committee and advocated the health centers' position in that forum. Yet, the process was not without controversy in the early design stages. A State official's interpretation of regulations concluded that the State was only required to include one Federally Qualified Health Center (FQHC), a term which includes Federally funded health centers, in the managed care plan for the

whole State.[56] Fearing that the health centers would have little influence in changing this direction, the PCA involved HCFA in the plan development process. Beyond center advocacy, networking through the PCA has also proved useful in the development of additional means for centers to compete in the managed care environment. HCNNM is involved, through a spin-off of the PCA, in the New Mexico Integrated Services Network. This entity was established among the FQHCs to function as the contracting entity with the health plans on behalf of the clinics.

The end result of these involvements was a State requirement that each managed care contract with at least one FQHC within each service area. This was specifically defined as at least one FQHC per county. As a result, about three-quarters of New Mexico's health centers would be covered under this agreement, but the rest could be considered duplicates within a county and subject to non-inclusion. However, due to the large geographic size of the counties and the State's rural nature, respondents felt that more than one health center in some of these areas was needed to provide effective healthcare coverage.

Overall, the HCNNM executive director indicated that the health centers developed many program suggestions by benchmarking with other States and were able to channel those recommendations into the CHIP planning process via their PCA. Examples of their proposals to the State included parameters of reasonable geographic and financial access and a specific model for cost-based reimbursement.[57]

Outreach for CHIP

New Mexico had undertaken a comprehensive outreach campaign following the implementation of Medicaid managed care. These actions are not considered CHIP outreach, since they involved the promotion of New Mexico's Medicaid expansion prior to CHIP. However, because the State's CHIP plan proposes to build on earlier Medicaid expansions, these outreach activities can be indicative of the State's capabilities to market a new program to their population. A 24-hour phone bank was set up by the State to field calls and questions from the public regarding the Medicaid switch to managed care. Media campaigns were developed for TV, radio, and billboards to reach eligible populations. Six Statewide advocacy groups were also contracted to conduct outreach efforts to special needs populations, such as the mentally ill, American Indians, and those with HIV/AIDS. Each organization was paid between $15,000 and $20,000 to hold enrollment fairs Statewide. Since the State was continuing to mail out new paper Medicaid identification cards each month, informational mass mailings about Medicaid managed care were included with little additional effort. The Medicaid agency acknowledged that monthly identification cards are an out-dated method, which they hope to transition out of under CHIP. However, it did provide a regular communication link during the implementation of these new managed care programs.

HCNNM views the lack of both eligibility workers and compensation for enrollment activities as a hindrance to the enrollment of all eligible children into Medicaid managed care. For a time, the State only utilized about 20 out-stationed eligibility workers in hospitals. The PCA contends that placing workers in clinics is more effective for enrolling children than placing them in hospitals, since hospitals typically only see those who are very sick. However, at the time of our site visit, there were no eligibility workers, since the hospital workers had been withdrawn due to a breakdown in contract re-negotiations.[58] Rather than replace these individuals, the State hoped that the institution of presumptive eligibility, along with an aggressive training/certification program, would allow all the significant partners a role in the outreach/enrollment process. At the time of our visit, 600 individuals, against a goal of 2,000, had already been trained in the outreach and enrollment process for placement in schools, hospitals, and community centers.

The clinic director felt that HCNNM was effective in its ability to enroll the eligible children of undocumented families in managed care plans. Typically, these families first enter the system through provision of prenatal care or delivery services, and the health center is usually able to retain the child in the Medicaid program thereafter. Acknowledging parents' fears, due to their status and the INS, the State's policy of not asking for Social Security numbers from parents aids them in placing the children into the Medicaid program.

HCNNM would like to play a significant role in outreach under the current Medicaid expansion, as well as CHIP, but is unsure if it will have the resources to do so. Currently, unable to add social workers to every clinic site, they are trying to target enrollment through their school-based clinics. The fact that school-based clinics only exist in Española at this time underscores the obvious limitations to this approach. Yet, the social workers who are on staff do serve other clinic sites on a rotating basis. Since every clinic is not always staffed with a social worker, the director admits that some hit and miss of contacting potential enrollees must be occurring. However, he thought that the bulk of eligible children who visited their clinics were being signed up. Clinic staff also noted that simplifying and shortening the application materials and form would improve the process.

Health Center Services for Children

Primary/Preventive Services

HCNNM provides a full range of primary and preventative care to their children. HCNNM emphasizes family-oriented, comprehensive medical and dental health care with a focus on disease prevention and health promotion.[59] Services include well-baby/well-child care, immunizations, prenatal and OB/GYN care. The center is staffed with family practice physicians, physician assistants, family nurse practitioners, nurses, health educators, clinical social workers, dentists, dental hygienists, and dental assistants. Other primary and preventive services include nutrition counseling, communicable disease prevention, family planning, diet and weight management, and smoking cessation.

The health center operates school-based clinics at both the middle and high school in Española, and provides support for EPSDT screenings and immunizations for the elementary schools. These clinic sites operate with no Federal funding and rely instead upon the ability to bill some services to the State-supported Healthier Kids Fund. Clerical and administrative functions are funded by a small grant from the Department Of Health. Additional costs are covered by the HCNNM clinic system.

HCNNM has a strong commitment to maintaining in-school delivery sites, despite the challenges of incorporating them into managed care. In general, health plans do not contract with the school-based clinics, although children do have the option of naming a school-based clinic as their primary care provider. Refusing to adopt a policy of only seeing select children in its school clinics, the center uses their Federal grant funds to subsidize costs incurred while treating children who do not select the school site as their primary care provider. HCNNM is trying to negotiate a role for the school-based clinics in the current managed care plans. One option is to allow reimbursement for services administered in the schools. These services could be limited to a list of the most frequently used CPT codes mutually identified by the center and health plan.[60]

Enabling and Specialty Services

HCNNM offers some enabling services in addition to their primary care offerings. Formal translation services are not provided per se, but a good share of the clinical staff, including nurses and front office personnel, are bilingual. With such a large, rural area to cover, transportation barriers are a constant challenge. The health center is able to offer transportation services through the managed care organizations, who contract with independent providers of travel services. In cases requiring extensive travel, food and travel benefits may also be covered.

The center has shown a commitment to providing selective, but needed, specialty services for its patients. For example, their Diabetes Control Program has become an integral part of the HCNNM services. The center director contends that diabetes is the major medical problem, other than drugs and alcohol, among the Hispanic population. In addition, they're seeing Type II diabetes at increasingly younger ages. With two certified diabetic educators on staff, the program utilizes lay health advisors, who are diabetics themselves, to educate and train patients about life-style changes important to controlling the disease. Other innovative programs include the development of an asthma clinic for children. Although the center currently subsidizes the programs, which are not reimbursed under managed care, they are working with plans to include them as billable services. With adequate funding, they feel that these programs could be expanded. Yet, since managed care plans are often slow to recognize the benefits of services which fall outside of standard practice, HCNNM must try to "sell" the idea that such enterprises actually contain or reduce costs and improve the health status of susceptible clients.

Preventive and restorative dentistry is available from HCNNM through the dental clinic site. The only dental provider, other than the single HCNNM location, is roughly 50 miles away. Although adult dental needs in the area are great, limited capacity has

forced HCNNM to only accept children at this time. Dental conditions observed among these children are comparable to those of the general U.S. population in the 1950's.[61] Some frustration has resulted because only selective benefits are covered under the current dental plan. As an example, expensive restorative measures, such as crowns, are covered, while preventive procedures, like pulp caps, are not.[62] On another issue, the dental director believes that heavy metal amalgams should not be used for children's fillings, yet the current plan won't pay for composite fillings. Despite the obvious need, the current low dental reimbursement rates are causing HCNNM to consider discontinuance of its dental services altogether.

CHIP Readiness

To insure its viability, HCNNM had completed progressive restructuring before the introduction of managed care and CHIP. Through consolidation of free-standing clinics over the past two decades, the center now provides services from 13 sites in 12 towns. As a result, it is almost guaranteed inclusion in any significant health network in Northern New Mexico due to the large territory it serves and, in many cases, its being the only health care provider in those areas. Having already experienced a Statewide conversion of Medicaid to managed care, the center's mode of operation should not be impacted by expansions under CHIP.

HCNNM has been aggressive in its provision of specialty services to its clients. The asthma clinic and Diabetes Control Program are being utilized, and may even warrant expansion, before reimbursement agreements have been secured with the managed care organizations. Although the health center is committed to these programs, securing adequate reimbursement is needed to guarantee funding for the long term. HCNNM provides dental services, that are reimbursed through a carve-out contract, which is administered by an out-of-State entity. The center considers dental reimbursement rates too low but reported the State's intentions to provide additional dental funding with forthcoming legislation. It is hoped that raising the reimbursement level will entice other providers to offer dental services to Medicaid recipients, which will reduce the number of individuals not served due to limited capacity.

Key Factors for Success

The early foresight of HCNNM to merge with other small clinics is likely to be a significant factor in their continued existence. Well before managed care, they realized the increased stability and opportunities such action could bring. Being a larger organization, HCNNM is probably able to recruit management personnel of a higher skill and experience level than rural, free-standing clinics. This has aided them in their mission to serve their communities and maintain a significant service role under State-instituted managed care and Medicaid expansions.

HCNNM has maintained its commitment to providing quality health care to the underserved and has been aggressive in addressing emerging issues through its programming. The development of services targeting those with asthma and diabetes is a response to the increase in these diseases among their target populations. HCNNM

has also realized that, because of transportation barriers and other factors, they could reach more children through schools and, therefore, have invested resources in their school-based clinics. These ventures make HCNNM highly effective in serving its clients. However, since many of these programs have not yet been included in contracts with health plans, HCNNM is not currently being reimbursed for them. Clearly, the center cannot continue to fund a variety of programs exclusively on its own, although it appears willing to do so if necessary. The ability of HCNNM to demonstrate, to the managed care plans, the long-term benefits and savings resulting from such innovative programming and the extent to which they can be incorporated into reimbursement contracts, will greatly impact the long term success of the center and the care it provides.

Despite their own and the State's efforts, HCNNM still perceives a deficit in outreach activities. Although the HCNNM took issue with both the State's placement of eligibility workers in the hospitals, as well as the inability to settle the contract disputes, whether that loss will be compensated for by the additional 600 trained eligibility workers, and the promise of more, remains to be seen. It is likely that the training program will significantly improve outreach effectiveness. However, from the health center's standpoint, they are still unable to staff every clinic site with a full-time outreach worker. They perceive that any State outreach agenda should include aid to clinics for adding their own outreach personnel.

ENDNOTES

1. Primary Care Associations (PCAs) are State-based membership organizations that represent safety-net providers in their efforts to increase access to preventative and primary care services and to improve the health status of underserved and vulnerable populations. The major sources of funding for PCAs are membership dues and grants from the Health Resources and Services Administration (HRSA) Bureau of Primary Health Care (BPHC). In addition, PCAs receive funding from other sources including States and private foundations.

2. Sara Rosenbaum, Kay Johnson, Colleen Sonosky, Anne Markus and Chris DeGraw, "The Children's Hour: The State Children's Health Insurance Program," *Health Affairs*, January/February 1998, pp. 75-89.

3. *Ibid.*

4. Neal Halfon, Moira Inkelas, Helen DuPlessis and Paul W. Newacheck, "Challenges in Securing Access to Care for Children," *Health Affairs*, March/April 1999, pp. 48-63.

5. The 70 percent enrollment rate refers to Medicaid eligible children who do not have private insurance. Thomas M. Selden, Jessica S. Banthin, and Joel W. Cohen, "Medicaid's Problem Children: Eligible But Not Enrolled," *Health Affairs*, May/June 1998, pp. 192 -200. The authors used the 1996 data from the Medical Expenditure Panel Survey which is believed to capture the most comprehensive data available in a national survey regarding Medicaid enrollment.

6. Margaret Edmunds and Molly Joel Coyce, eds., *America's Children: Health Insurance and Access to Care,"* Institute of Medicine, National Research Council, 1998.

7. Sara Rosenbaum, Barbara M. Smith, Peter Shin, Marcie H. Zakheim, Karen Shaw, Colleen A. Sonosky and Lee Repasch, *Negotiating The New Health System: A National Study of Medicaid Managed Care Contracts,* The George Washington University Center for Health Policy Research, February 1998.

8. The Lewin Group, *Evaluation of the Impact of the Medicaid Waivers on Consumers and Services of Federally Qualified Health Centers*, November 1997.

9. Stephen A. Norton and Debra J. Lipson, *Public Policy, Market Forces, and the Viability of Safety Net Providers*, The Urban Institute, 1998.

10. Colleen M. Grogan and Michael K. Gusmano, "How Are Safety-Net Providers Faring Under Medicaid Managed Care?" *Health Affairs*, March/April 1999, pp. 233 - 237.

11. Debra J. Lipson and Naomi Naierman, "Effects of Health Systems Changes On Safety-Net Providers," *Health Affairs*, Summer 1996, pp. 33 - 47.

12. Debra J. Lipson, "Medicaid Managed Care and Community Providers: New Partnerships," *Health Affairs*, July/August 1997, pp. 91 - 107.

13. *Ibid.*

14. We originally planned to visit a seventh site where the health center also received a grant to operate a Health Care for the Homeless program. However, injury of a study team member caused us to cancel this site visit. We conducted a telephone interview with the Executive Director of this center and members of his staff. Issues and insights from this interview are incorporated in the design of the national survey.

15. Due to scheduling difficulties a few interviews were conducted by telephone with managed care organizations.

16. We are very appreciative of the time spent and feedback from the Connecticut interviewees in honing our data collection tools.

17. Due to taping problems in very few interviews, parts or all of these interviews were summarized from interviewer notes.

18. QSR NUD*IST 4, 2nd edition.

19. Connecticut State Child Health Plan Under Title XXI of the Social Security Act: The HUSKY Plan, John Rowland Governor, State of Connecticut, January 7, 1998.

20. Fair Haven Health Center Uniform Data System Annual Report, 1997.

21. The flier was targeted roughly at the estimated 4th grade reading level of their clientele.

22. Connecticut Department of Social Services Request for Proposals, Outreach for the HUSKY Program, 1998.

23. Interview of Katrina Clark, Executive Director, Fair Haven Community Health Center, August 18, 1998.

24. Memorandum of Agreement, Connecticut Department of Social Services and the Federally Qualified Health Centers, May 15, 1998.

25. *Healthy Families Handbook*, State of California, July 1998.

26. La Clínica de la Raza Uniform Data System Annual Report, 1997.

27. The public charge issue is discussed at more length in a separate OEI report regarding CHIP and Medicaid application processes, *The Children's Health Insurance Program:*

State Application and Enrollment Processes: An Early Report from the Front Lines, OEI-05-98-00310.

28. "Immigration Update," California Primary Care Association, 1998.

29. Memorandum from Pieternel Barel, July 23, 1999.

30. "Public Charge Fact Sheet," Department of Justice, Immigration and Naturalization Service, May 25, 1999.

31. Although 60 percent of the Healthy Families target population is estimated to be Latino in California, only 22 percent of early enrollees were of Latin American descent. "Immigration Update," California Primary Care Association, 1998.

32. "Healthy Families Program 1988-1999 Community Provider Plan Designation," Managed Risk Medical Insurance Board, 1998.

33. Interview of Jane Garcia, Executive Director, La Clínica de la Raza, September 3, 1998.

34. MIChild Bulletin, MIChild Eligibility 98-01, State of Michigan.

35. MIChild Contract between the Michigan Department of Community Health (template).

36. Cherry Street Health Services UDS report, February, 1998.

37. *Ibid.*

38. Memorandum of Agreement Between Medical Services Administration and a Federally Qualified Health Center (FQHC), July 1, 1997.

39. *Free & Low-Cost Health Insurance: Children You Know are Missing Out*, Donna Cohen Ross and Wendy Jacobson, Center on Budget and Policy Priorities, 1998.

40. From the State of Colorado CHP+/Baby Care Kids Care application.

41. From the State of Colorado CHP+/Baby Care Kids Care application.

42. A visit co-payment is usually five dollars. A center then submits a write-off to the State which reimburses 27 percent of the center's costs. The remaining percent (roughly 70%) is absorbed by the center internally.

43. According to the Primary Care Association director, HCFA made the decision, based on Federal law, that the health centers could not use the discounted vaccines under a freestanding commercial plan. Health centers would then need to find alternative ways to purchase vaccines for children under the CHP+ plan. The director noted that the Primary Care Association had plans to try to change the law at the national level so that States who chose a non-Medicaid approach could use these vaccines for children.

44. Partners for Healthy Children in South Carolina, Governor David M. Beasley, September 1, 1998.

45. Medicaid Managed Care materials provided by South Carolina Medicaid Program, September, 1998.

46. Informational materials provided by the South Carolina Medicaid Program, September, 1998.

47. Family Health Center Uniform Data System Annual Report, 1997.

48. Partners for Healthy Children in South Carolina, Governor David M. Beasley, September 1, 1998.

49. Portability of coverage refers to the ability of the family to use South Carolina Medicaid coverage in another State. Transferability refers to reciprocal agreements between States to accept the eligibility status as determined by the original State.

50. We conducted a telephone interview with the director of Carolina Health Center because this center has a Migrant Health Center grant to serve this population.

51. Model Application Template for State Child Health Plan Under Title XXI of the Social Security Act State Children's Health Insurance Program, State of New Mexico.

52. Cimmaron members can switch primary care providers or health plans every 30 days, while those under Presbyterian Salud or Lovelace are subject to a 6 month lock-in.

53. A Health and Human Services press release dated January 11, 1999 announced the approval of New Mexico's plan for children's health insurance.

54. *Ibid.*

55. Model Application Template for State Child Health Plan Under Title XXI of the Social Security Act State Children's Health Insurance Program, State of New Mexico.

56. According to the PCA director, a previous Secretary of Human Services Department interpreted regulations as only requiring that at least one Federally Qualified Health Center (FQHC) be involved in the State's managed care plan under CHIP. This official is no longer in the position, and HCFA got involved in the process which determined that HMOs would have to contract with one FQHC per county.

57. Interviewees referred to this as the "Wisconsin model," although we were unable to determine the specific characteristics of this "model."

58. The PCA director reported that contract negotiations broke down between the State and the hospitals. The Human Services Department stated that the contract simply couldn't be re-negotiated. However, the hospitals claim that although the Human Services Department

was receiving 50 percent reimbursement from the Federal government, for the eligibility workers, and were responsible for matching the other 50 percent, they attempted to bill the hospital for the full amount.

59. Health Centers of Northern New Mexico, *Caring For You...*, Informational Brochure.

60. CPT stands for common procedural terminology. These codes are utilized by health care providers in billing insurers.

61. This comparison was drawn by the Senior Dentist of Health Centers of Northern New Mexico.

62. A pulp cap covers an area of small exposure due to decay and prevents further damage, while a crown covers the entire tooth when too much surface damage has occurred.

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APPENDIX A

DOCUMENTS REVIEWED

Title	Author/Agency	Date
CALIFORNIA		
Expanding Healthy Horizons	California Primary Care Association	10/98
Community Health Centers and Healthy Families	CPCA - Carmela Castellano, JD, CEO	07/98
Immigration Update	California Primary Care Association	08/98
Newsletter - CPCA Strengthens Clinic Role in Rural Projects	California Primary Care Association	08/98
Letter to Sidney Trieger - California Compliance with Balanced Budget Act	CPCA - Carmela Castellano, Esq., CEO	07/98
Senate Bill - An act to amend Section 14087-325 of the Welfare and Institutions Code, relating to public social services.	Introduced by Senator Rosenthal (Principal coauthor: Senator Watson)	02/97
Healthy Families Program Subscribers Enrolled By Ethnicity	Managed Risk Medical Insurance Board Home Page	09/98
Letter to Carmela Castellano, Esq., CEO	DHHS/Health Care Financing Administration	09/98
Affordable Health Care For Children and Teens Handbooks	State of California	07/98

Title	Author/Agency	Date
CALIFORNIA continued		
Social Security Act-1902(a)(55)	Social Security Administration	N/A
Welfare and Institutions Code	State of California	N/A
42 CAR 435.904	DHSS/HCFA	N/A
OBRA 90 - Outstanding Mandate	Social Security Administration	N/A
State Medicaid Manual - Section 2905	DHSS/HCFA	06/91
Letter to Hospital/Clinic Administrator	DHSS/State of Carolina - Health and Welfare Agency	N/A
Memo to All County Welfare Directors, Administrative Officers, Medi-Cal Program Specialist/Liaisons, Outstationed Eligibility Workers Coordinators	Outstanding Eligibility Worker (EW) Program Petitions and Reporting Update	35856
Medical Service Agreement between Alameda Alliance for Health & Community Health Center Network	Community Health Center Network	N/A
Letter to Providers on Healthy Families Program	Blue Cross of California	35954
Media Release	Latino Coalition for a Healthy California	35977
California Kids Enrollment Form	La Clínica de La Raza	N/A

Title	Author/Agency	Date
FQHC Reconciliation Statement	Alameda Alliance for Health	36041
CALIFORNIA continued		
Medical Service Agreement between Alameda Alliance for Health & Alameda County Ambulatory Care	Alameda Alliance for Health	N/A
Amended and Restated Medical Service Agreement between Alameda Alliance for Health & Community Health Center Network	Alameda Alliance for Health	N/A
Quality Health Care For Your Children Brochure	Alameda Alliance for Health	
Instruction on usage of Co-Pay Card, Guidelines for Children's Checkups, Customer Complaint Forms, Provider List	Alameda Alliance for Health	N/A
Letter to Providers on Healthy Families	Alameda County Health Care Services Agency	35957
Combined Evidence of Coverage & Disclosure Form	Alameda Alliance for Health	N/A
Article 4. Risk Categories and Family Contributions	N/A	N/A
Health Plan Model Contract	Healthy Families Program	N/A

Title	Author/Agency	Date
CALIFORNIA continued		
Memorandum to Sandra Shewry, MRMIB - Re: Defining what constitutes a "community provider" under the Health Family Program	Sara Rosenbaum, GWUMC/CHPR The George Washington University Medical Center	35748
Letter to Clifford L. Allenby, Chair, Managed Risk Medical Insurance Board	Mark D. Smith, M.D., M.B.A. - California Health Care Foundation	35767
HFP Subscribers Enrolled in CPP By County	Healthy Families Program	36028
1998-99 Community Provider Plan Designation	Healthy Families Program	N/A
Hospital Providers By County	Healthy Families Program	35823
Clinic Providers By County	Healthy Families Program	N/A
COLORADO		
Parents Handbook	Child Health Plan Plus (CHP+)	N/A
Here's How To Make Your Monthly Payments...	Child Health Plan Plus (CHP+)	N/A
Benefits Booklet	Child Health Plan Plus (CHP+)	N/A
Choose An MCO - (Information Packet)	Child Health Plan Plus (CHP+)	N/A
Provider Manual	Colorado Access	05/98
Member Handbook, Provider Directory, Evidence of Coverage, Provider Bulletin	Colorado Access	N/A

Title	Author/Agency	Date
	.	
COLORADO continued		
Center/Grantee Profile - Cover Sheet	Plan de Salud del Valle, Inc	35840
Listing of Community Health Centers/Federally Qualified Health Centers	Colorado Community Health Network	N/A
10 Ways To Tell the Difference Between A Community Health Center & A Rural Health Clinic	Colorado Community Health Network	N/A
Charts on Health Center Patients	Colorado Community Health Network	N/A
Application for Health Care for Colorado Children	Child Health Plan Plus (CHP+)	N/A
CONNECTICUT		
MOA between Dept of Social Services & Community Health Network of Connecticut, Inc.	Connecticut Department of Social Services	35928
Center/Grantee Profile - Cover Sheet	Fair Haven Community Health Center	35840
Request For Application - Outreach for the HUSKY Program	Department of Social Services	N/A
Utilization and Quality Data, Directory of Members,	Connecticut Community Health Centers	N/A
Conference on Collaboration	Connecticut Primary Care Association	35969

Title	Author/Agency	Date
CONNECTICUT continued		
State Child Health Plan Under Title XXI of the Social Security Act	State of Connecticut	35801
Purchase of Service Contract Between The CT Dept of Social Services & HealthRight, Inc.	State of Connecticut	N/A
Letter to Joyce Thomas, Commissioner, DSS	DHHS/HCFA	34899
MICHIGAN		
Memorandum of Agreement Between the Medical Services Administration and Federally Qualified Health Centers	Robert M. Smedes Chief Executive Officer Medical Services Administration Michigan Department of Community Health	35611
Brochure: Cherry Street Health Services Introduces a New Opportunity for Uninsured Children in Michigan	Chris Shea Executive Director Cherry Street Health Services	1998
Testimony to House Appropriations Sub-Committee Re: MIChild Proposed Plan	Michigan Primary Care Association	35828
Letter to Althia Carr Re: MIChild Application	Katheryn Harstad Farmworker Legal Services	36019

Title	Author/Agency	Date
MICHIGAN **continued**		
Letter to Mr. Richard Fenton Re: Michigan's Response to HCFA questions regarding SCHIP application	Robert M. Smedes Chief Executive Officer Medical Services Administration Michigan Department of Community Health	35858
Substitute for Michigan House Bill No. 5532 MiChild appropriations	Michigan House of Representatives	1998
MIChild Contract	Michigan Department of Community Health	35946
MIChild Member Handbook	Community Choice Michigan	June 1998
MIChild Application	Michigan Department of Community Health	1998
MIChild Certificate of Coverage	Community Choice Michigan	June 1998
Primary Care Group Aggreement	Community Choice Michigan	October 1997
Provider Services Agreement Risk Sharing Addendum	Community Choice Michigan	August 1997
MIChild Eligibility Manual 98-01	Michigan Department of Community Health	35946
MIChild and Healthy Kids Application	Michigan Family Independence Agency	35960
NEW MEXICO		
Memo: Amendment to FQHC Agreement. From: Charles Milligan, Director	New Mexico Human Services	36055
Member Handbook (Bilingual)	Cimarron Salud (Health Plan)	N/A

Title	Author/Agency	Date
***NEW MEXICO* continued**		
Member Handbook (Bilingual)	Presbyterian Salud (Health Plan)	N/A
Member Handbook 1998 (A Salud Program)	Lovelace Community Health Plan	36068
New Mexico Managed Care Program- SALUD to Your Health: Pamplets, Newsletters	Health Centers of Northern New Mexico	N/A
Presumptive Eligibility and Medicaid On Site Application Assistance Training	Medical Assistance Division	35976
Provider Policies	Health Care Professional Services	34730
Intake/Admission Criteria	N/A	34221
Letter: Albuquerque Girl's Community Residential Facility - Admission Criteria	State of New Mexico - Children, Youth and Families Department - Juvenile Justice Division	N/A
EPSDT Psychosocial Rehabilitation Level of Care Assessment Abstract Criteria	New Mexico Child and Adolescent Mental Health Services	05/96
Memo to: Steve Smith, Executive Account Manager - Re: Request for Ad hoc (Services)	New Mexico Human Services Department	N/A
Memo to: Salud Managed Care - Re: Guidance Memorandum #8 - Native American Issues	New Mexico Human Services Department	35582

Title	Author/Agency	Date
New Mexico **continued**		
Memo to: Salud Managed Care - Re: Guidance Memorandum #7 - Questions	New Mexico Human Services Department	35572
Memo to: Salud Managed Care - Re: Guidance Memorandum #6 - MCO Client-specific Requests for Current UR Files	New Mexico Human Services Department	35571
Memo to: Salud Managed Care - Re: Guidance Memorandum #5 - Marketing Guidelines	New Mexico Human Services Department	35565
Memo to: Salud Managed Care Contractors - Re: Guidance Implementation Memorandum #4	New Mexico Human Services Department	35555
Memo to: Salud Managed Care Contractors - Re: Guidance Implementation Memorandum #3	New Mexico Human Services Department	35549
HSD Response to Benefit Questions	New Mexico Human Services Department	N/A
Memo To: Salud Managed Care Organization - Re: Guidance Implementation Memorandum #1	New Mexico Human Services Department	35535
Salud Managed Care General Program Description	N/A	35990

Title	Author/Agency	Date
NEW MEXICO continued		
SALUD Enrollees By Plan For The September 98 Capitation	N/A	36039
State Children's Health Insurance Program (SCHIP) - (Title XIX) Medicaid - Proposed Regulations	New Mexico Human Services Department	N/A
Evaluation of MCOs Performance Against NM Quality Management Standards	New Mexico Human Services Department	N/A
Model Application Template for State Child Health Plan Under Title XXI of the Social Security Act - State Children's Health Insurance Program	N/A	N/A
Medicaid Managed Care Services Agreement - Presbyterian Health Plan. Inc. of Albuquerque, New Mexico	State of New Mexico - New Mexico Human Services Department	N/A
Medicaid Managed Care Services Agreement - Cimarron Health Maintenance Organization, of Las Cruces	State of New Mexico - New Mexico Human Services Department	N/A
Medicaid Managed Care Service Agreement - Lovelace Health Plan of Albuquerque, New Mexico	State of New Mexico - New Mexico Human Services Department	N/A

Title	Author/Agency	Date
SOUTH CAROLINA.		
Medicaid Program Handbook	State of South Carolina	35550
Migrant Health Program Chart	N/A	35838
Managed Care Options	NA	N/A
A New Choice Booklet	Medicaid Managed Care Health Plans	N/A
Partners for Healthy Children Packet	Family Health Centers, Inc., Orangeburg	N/A
Packet for Applicants whose Counties do not have HMOs	S. Carolina Partners for Healthy Children	N/A
Contract Between South Carolina DHSS and _____ For Purchase and Provision of Medical Services Under the S. Carolina Medicaid HMO Program	N/A	N/A