Medicaid Testimony
On Behalf of Community Voices

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The National Center for Primary Care at the Morehouse School of Medicine is the program office for the Community Voices initiative. Community Voices is designed to improve health care access and quality. The initiative involves eight learning laboratories across the nation and is targeted at ensuring the survival of the safety-net providers and strengthening community support services. For more information on Community Voices, please visit **www.communityvoices.org.**

Community Voices
HEALTHCARE FOR THE UNDERSERVED

Table of Contents

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Introduction

In developing recommendations for achieving reductions in spending growth for the Medicaid program, it would be beneficial to consider the lessons learned from the W.K. Kellogg Foundation initiative, *Community Voices: Health Care for the Underserved*, which sponsored thirteen "learning laboratories" in communities across the United States, beginning in 1998. Each of these communities developed creative strategies for organizing health care for the underserved (that includes the uninsured and underinsured), and made important discoveries pertinent to issues that the Commission seeks to address, namely:

- The expansion of coverage while being fiscally responsible;
- Eligibility, benefits design, and delivery; and
- Quality of care and beneficiary satisfaction

I. Expansion of Coverage

In order to give a sense of the breadth and diversity of the work accomplished through *Community Voices*, three very different initiatives to expand coverage must be reviewed. One of these was led by a not-for-profit health care system (FirstHealth of the Carolinas), one by a university (University of New Mexico), and one by a public health agency (Ingham County Health Department). Each of these endeavors demonstrates some capacity of public-private partnerships to ameliorate, at the local level, the national crisis of health care coverage. They also demonstrate, in their limitations, the need for national policy to support the application of these approaches on a broader scale.

Above all, however, these initiatives illuminate the importance of developing health care coverage strategies through the community's experience and insights rather than through the very limited lens of the marketplace or conventional political debate. In each case, the lead entity carefully assessed its community's needs, convened necessary public and private partners, and collaboratively designed appropriate benefits. But what made them truly unique was the addition of a fourth activity: the active engagement and constant involvement of the community in the development and initial implementation phase. The story told at the national level about access to health care is a tired and bleak one. Accelerating costs, bureaucratic inefficiencies, and universal self-interest have yet to allow quality and affordable health care for all. The Community Voices initiatives tell a different story, and the reason it is different is that the community itself was involved in telling it.

- In Moore County, North Carolina, First Health of the Carolinas developed and launched **FirstPlan**, a new group of health care coverage products for small businesses. First Health offers subsidies to low-income workers, and premium discounts if employers meet certain criteria. Launched in 2002, the plan had enrolled 1,375 workers in 132 businesses after two and a half years of operation. FirstPlan was specifically designed to enroll and mainstream the working

uninsured, and toward that end, emphasized disease management for high-risk enrollees and a strong educational component to teach them how to use the system effectively. With First Health of the Carolinas acting as convener, this plan was forged around the principle of shared responsibility and participation, and would not have succeeded without strong partnerships in the community to develop one-on-one relationships with the small businesses whose employees it was meant to help.

- In Bernalillo County, New Mexico, the University of New Mexico created the **UNM Care Program** in partnership with a network of Federally Qualified Health Centers in that county. Its purpose was to establish a managed care plan and case management services for uninsured people who were not eligible for Medicaid and who sought care through hospital emergency departments. Enrollment in the plan began with 7,500 uninsured people with incomes under 235% of the Federal Poverty Level (FPL) and soon grew to 15,000—a level that the plan has maintained for several years. Enrollees are served through a unique "health commons" delivery strategy that facilitates access to many services not formally covered by the program, including dental care, behavioral health services, and non-health related case management. As with FirstPlan in North Carolina, this patient-centered approach would not likely have emerged without UNM's intentional convening of a broad array of community stakeholders to participate in creating the plan. Limitations in the plan's growth are tied to available provider capacity and ability to meet rising demand; still, the model can inform Medicaid, COBRA coverage, and other forms of public insurance in delivering services to this population.

- In Ingham County, Michigan, the Ingham County Health Department (ICHD) took the lead in creating the **Ingham Health Plan**. Again the key to success was the engagement of diverse public-private partners, this time with a strong emphasis on engagement of the community at large in owning and informing the approach. In this case, partners formed a new, independent not-for-profit corporation to manage the plan, which provided health care benefits to uninsured people earning up to 250% FPL. Enrollment patterns were remarkably similar to that of the UNM Care Program, beginning with 6,000 initial enrollees and rising to a peak of 16,600 within four years of operation. Since its inception, however, over 31,000 different individuals have been enrolled in the plan—an indication of its value to people who are temporarily without health care due to unemployment or other life crises. By developing the internal capacity to manage the plan within the health department, ICHD supports the 50 other counties in Michigan who have replicated the Ingham Health Plan model.

Summary

The positive lesson from these three experiments in community-driven coverage is that local communities can contribute to covering the uninsured however, the scope of coverage is limited and the rate of uninsured remains high. Communities are indeed talented, creative, and resourceful and can address the national crisis in access to health

care but federal and state funding, programs and partnerships are essential to ultimately address the national crisis.

II. Eligibility, Benefits Design and Delivery

The growing population of uninsured Americans stresses the fragmented health system in the most expensive venues – local emergency departments and tertiary care facilities. The Kellogg Community Voices data, confirmed by Dr. Barbara Starfield's data at Johns Hopkins, indicate that providing health insurance, case management services and a primary care home improves quality outcomes. For example, indigent populations (uninsured, Medicaid) represent 60% of University of New Mexico's Emergency Department (ED) visits. Those without an assigned primary care home – unmanaged Medicaid, and uninsured self pay, use the ED at much higher rates, and are 17.8 and 9.3 times more likely to use the ED three or more times when comparing one year to the next. Data indicate that having a primary care home, a home with primary, behavioral, oral and case management services – significantly reduces the hospitalization rate and hospital length of stay, while improving performance on prevention and chronic disease management.

When the above three coverage programs were designed, each Community Voices laboratory reflected on the needs of the community prior to designing the product; taking into consideration that reaching out to those individuals who cannot afford health care, and therefore do not get primary and preventive services, reduces costly hospital admissions and ED utilization and hospital utilization. ED usage rates, percent of uninsured, percent of population on charity care, working uninsured rates, disease states in the community, services needed and ease of accessing care were all considerations in product development.

Ingham County

When considering benefits design, Ingham County's strategy was developed with extensive community participation, through an ongoing dialogue process to produce an *Action Plan for an Organized System of Care*. After the completion of the *Action Plan* in 2001, an Access Committee monitored its implementation through periodic "community briefings," where progress in such areas as grassroots outreach, oral health, substance abuse and mental health were tracked along with enrollment in basic health care coverage. In several instances, this interactive process has had significant impact on the plan and its services. For example, briefly in 2003 the Ingham Health Plan Corporation elected to reduce its eligibility cap from 250% FPL to 150% FPL, seeking to temporarily curb enrollment and wrongly believing that the plan was used primarily by people with lower incomes. In very short order, community members who had been engaged through the dialogue process were able to communicate the consequences of this decision to the corporation's Board of Directors, in terms of real human suffering and hardship. The decision was reversed immediately and an alternative strategy for moderating enrollment was developed.

In Ingham County, mental health was altogether absent from early drafts of the original *Action Plan.* It was only through the input from African American community groups that it was eventually included. Community members repeatedly voiced concerns about suspected cultural bias built into the mental health service system, and the related over-representation of African Americans in Michigan's jails and prisons. Subsequent dialogue and planning processes have deepened the community's awareness and analysis of this issue, leading to new collaborative partnerships to assist ex-offenders in their return to the community, change the organizational culture of the court and social service systems with regard to out-of-home placement of youth, and foster the co-location of mental health services with primary care providers in health centers serving the uninsured. When developing benefit programs, it is critical to consider mental health parity. This population has special needs that are currently going unmet throughout society.

FirstHealth Community Voices

When designing FirstPlan, initially FirstCarolinaCare considered an HMO product model but realized that would limit provider choice, limit plan flexibility and only provide minor cost savings. After further input through focus groups which involved feedback from employers, employees and providers, it was determined that FirstPlan needed to be a comprehensive health plan. Therefore, FirstCarolinaCare designed a Point of Service plan that includes physician care, inpatient and outpatient hospital care, diagnostic services, behavioral health, rehabilitation services and prescription drugs. A variety of payment options are available to meet the individual financial needs of both the employer and employee. In recognition of specific disease states associated with frequent ED usage rates, FirstPlan included initial health screenings and nurse triage and case management for individuals with chronic disease states and elevated screening levels. In order to address the adverse selection risk of small business health insurance and model universal coverage on a private sector basis, FirstPlan requires 100% participation in a health plan for all employees in order for the employer to be eligible for the care credits and for low wage employees to be eligible for the subsidized premium rates.

New Mexico Community Voices

The University of New Mexico's objective when developing UNM Care Program was to establish a safety net program for uninsured individuals who were not eligible for Medicaid and who utilized the ED as a primary care facility. Therefore, when the stakeholders initiated the program design, the benefit package took a similar scope to the state's Medicaid benefit package. This was intentional in order to provide families enrolled in both programs with access to similar services and providers. The benefit package includes physician services, inpatient and outpatient hospital care, diagnostic services, limited dental care and discounted pharmaceuticals. Another benefit design emphasis was ensuring each individual enrolled in UNM Care choose a primary care provider. The primary care providers are located at the hospital or at one of the First Choice clinics. The role of the primary care provider is expanded in this model to include referrals to social services and non-health related case management. Having a primary care home is key to the success of the program and controlling costs.

In addition to implementing UNM Care, New Mexico also implemented the use of community health workers to improve access and quality of care in populations that might otherwise be missed. Community health workers, or Promotoras, can be used to reach those who might not otherwise access care except through costly emergency department visits when things get bad, or be hospitalized for preventable complications of chronic diseases.

Summary

The above community based coverage programs give beneficiaries a choice of providers in convenient community-based sites providing the array of services most needed by uninsured populations. Health insurance alone will not make health care accessible to the uninsured. Coverage strategies must be balanced with community based access through primary care homes. Case management needs to be incorporated into benefit models for both private and public sector programs. Mental health parity must be addressed with coverage issues.

III. Quality of Care and Beneficiary Satisfaction

The Community Voices learning laboratories have been working hard to improve the health status of the communities it serves and to remove barriers to care and provide quality care. Barriers to care not only include access to care but also often times the scope of care. Through our learning laboratory experiences, we have ascertained that quality care is not only primary care but should be viewed as comprehensive care using best practice guidelines measured by clinical outcomes. Underserved individuals need access to primary care to include oral and mental health benefits. Oral health is an integral part of overall health and as such affects nutritional, behavioral, emotional, mental and physical well-being of children and adults. It is critical to address the entire individual when addressing health care coverage issues and quality of care.

Community Voices is concerned by the evidence that the burden of oral disease and disorders is falling disproportionately on lower-income families and individuals particularly in rural areas. One of the reasons for this disparity is the overall shortage of dental professionals in rural areas as well as the shortage of minority dental professionals. Minority racial and ethnic groups are severely underrepresented in the dental profession as compared to their representation in the general population. An estimated 22.5 million Americans need and cannot obtain dental care. Preventable dental disease costs the United States billions of dollars in productivity due to time lost at work and school.

This nation's oral health crisis cannot be dealt with by increasing access to benefits alone. The dental health professional pipeline crisis must be considered. Community Voices recently released "*Bridging the Gap: Partnerships Between Dental Schools and Colleges To Produce A Workforce To Fully Serve America's Diverse Communities*." This report recommends the utilization of the Sophie Davis Model in dental schools. The Sophie Davis model has been successfully implemented to increase minorities in medical

schools. Preparing the professional pipeline will increase minorities' overall access to oral health care.

Several of the learning laboratories have established local safety nets for the uninsured and underserved communities with regards to oral health.

FirstHealth Community Voices

FirstHealth of the Carolinas has been recognized as a Solucient Top 100 overall hospital and recently received the NCAFE award for excellence. FirstHealth's core purpose is "to care for people." As a health system FirstHealth believes, it is important to take a leadership role in the effort to bring the underserved in to the system, not only because it is the right thing to do, but because the burden of inappropriate utilization and uncompensated care falls squarely on FirstHealth as a safety net provider.

Three of FirstHealth's primary service counties were federally designated as dental professional shortage areas for services to low-income groups. In addition, only one in five North Carolina dentists treat 10 or more Medicaid patients per quarter. The 2001-2002 statistics indicate that 24 percent of North Carolina children entering kindergarten have untreated tooth decay. FirstHealth Community Voices addressed this void on the local level through community partnerships and grant-funded opportunities. They were able to establish three dental care centers for low-income and Medicaid-eligible children, serving an average of 1,000 children a month. Due to the high no-show rate for appointments, a system of two no shows was implemented. If a child misses two appointments, they are unable to use the dental clinics for one year unless it is an emergency situation. As a result of this strict policy, the no-show rate is 14% compared to a national no-show rate of 30% for Medicaid consumers. Customer satisfaction surveys are conducted and the dental clinics consistently score in the 90th percentile.

In addition to the dental care centers, FirstHealth established a Children's Care Fund to assist children who were in dental crisis. These funds are utilized to provide referrals to specialists for services that cannot be provided in the dental care centers. Here is an example of a special case:

> A 14-year-old female came to the dental office with a little facial swelling on the left side of her face. Antibiotics were given and she was told to call if the swelling persisted. Before an appointment could be made for a root canal procedure, a call was received to say the child was doing much worse. By the time the girl got back to the office, she came in with a cold towel pressed to her head with tears streaming down her face. Her insurance did not cover the root canal procedure. The case was so severe at this point, the child had to be referred immediately to an oral surgeon under the Children's Care Fund for intravenous antibiotics and then to an endodontist for the procedure. The next time she was seen in the office, she looked spiffy in her ROTC uniform and was smiling again.

This child would have suffered if the community did not provide a funding safety net for oral health emergencies in children. We are seeing these issues every day in children and adults.

Recently a physician within the FirstHealth Montgomery Memorial Hospital Emergency Department recognized that over 400 adults were seen in the emergency department over the course of a year for oral health issues. The adults were uninsured and underserved. The physician contacted the health system Foundation to implement an oral health voucher program specifically for his community. The fund has recently been established. This will allow physicians in the emergency department to provide adults in oral health crisis with a $250 voucher to seek treatment with a local dental professional. Three out of four local dentists have agreed to participate in the voucher program. If the costs exceed the $250 limit, the Foundation must provide prior approval. The patient has a two-week period in which to utilize the voucher. This program was established as a local safety net to provide funding for oral health crisis situations. If this fund was not available, imagine the pain and the further health deterioration that would be caused by the oral health crisis. There is a substantial need for adult oral health care.

New Mexico Community Voices

The New Mexico Department of Health used grant funds to develop the current New Mexico Oral Health Surveillance System (NM OHSS). The NM OHSS is gathering data including state-level data on water fluoridation, dental visits and teeth cleaning and tooth loss among adults, incidence of cancer of oral cavity and pharynx, and the status of caries experience, sealants and untreated decay in third graders from a variety of collaborating agencies. This data has been used in special reports on oral health of children, the oral health of pregnant women, and oral health in the border area.

New Mexico Community Voices has worked with community partners and stakeholders to establish the Early Childhood Caries Prevention Program protocol to develop primary and secondary prevention targeted to infants, toddlers and pre-school children aged six months to five years. Key stakeholders to establish such a model included the Early Start and Head Start programs, the WIC programs, child development centers serving low income parents and other identified populations organized around a child development mission of serving low income children. A combination of services are offered to include oral health screening and risk assessment, identifying risk factors, education and anticipatory guidance for parents, plaque removal, topical fluoride application/varnish, written findings and recommendations for the parents, oral findings and recommendations for the center based caregiver, and referral to an oral health care facility/provider for more intensive therapy.

To improve overall access to oral health care, New Mexico worked with Senator Bingaman and others to begin a private public partnership to begin a dental residency program, and expand dental hygiene programs. These providers are housed in the health commons model, whereby an individual can obtain medical care, dental services, and behavioral services with one card, in the same community based facility.

Ingham County Community Voices

Ingham County Health Department also increased its capacity to meet some of the unmet oral health needs of its underserved population, first by establishing a new pediatric dental clinic, Healthy Smiles, in partnership with an area hospital. The center now provides about 5,000 pediatric dental visits per year, while the county's Adult Dental Center provides an equal number of visits for adults. Other than these two county-run clinics, there are only four dentists in Ingham County who will see new Medicaid patients, and only two of these will see adult Medicaid patients. The county's resources are still not sufficient to meet the area's needs; adult dental patients must sometimes wait up to two months to be seen by a provider.

Although coverage programs have not been able to incorporate dental care into their scope of benefits, community members have been able to focus attention to some of the unmet need for oral health services. These efforts have resulted in an annual "Give Kids a Smile Day," which organizes oral health professionals to serve children through the local community college's dental care facilities, with follow-up care arranged by the providers; a new, provider-led examination of ways to address oral health need through emergency departments; and various education campaigns to prevent tooth decay in young children.

Summary

All three of the above Community Voices learning laboratories have local level models of how to expand services to the underserved, low-income population. These models and lessons learned can be incorporated into federal programs. Oral health diseases are easily preventable and treatable. However the lack of continuous insurance coverage is an issue for many children and adults. For every person without health insurance coverage, there are as many as 2.3 persons without dental health insurance coverage. When considering quality care, there is a need to also consider the impact of oral health coverage on the low-income child and adult population.

IV. Recommendations

Expansion of Coverage

- Community-based insurance plans can contribute to solving the national crisis of access to coverage, but they are limited in scope.
- Assist communities with coverage programs for the working uninsured and individuals in crisis.
- Engage the community in shaping the delivery of care, financing and coverage.

Eligibility, Benefits Design, and Delivery

- When reevaluating the eligibility requirements and benefit packages address the issue of disparities with regards to men.

- Prison recidivism rates are correlated with lack of coverage upon reentry to society. Provide a safety net for health care to ex-offenders upon reentry to include mental health and substance abuse treatment coverage.
- To decrease cost and enhance the delivery of service, provide health insurance, case management, and educational services and establish a primary care home component.
- To meet individual and community needs in benefit design, implement flexibility into coverage options.
- Incorporate all of the key stakeholders to include communities, providers, health systems, businesses and government agencies when determining benefit packages.

Quality of Care and Beneficiary Satisfaction

- Address oral health coverage for adults and children, otherwise it will remain very costly to safety net providers.
- Implement best practice models to effectively deliver services to the Medicaid population and reduce no-show rates below the national average.
- Consider the need for additional professionals in the oral health pipeline to serve the Medicaid population and incentivize professionals to practice in rural underserved areas.