COMMUNITY VOICES:

Lessons for National Health Policy

A Series of Community Voices Publications

FEBRUARY 2004

BY

Jack A. Meyer • Sharon Silow-Carroll • Emily Waldman

Economic and Social Research Institute, Washington, DC

Community Voices

HEALTHCARE FOR THE UNDERSERVED

www.communityvoices.org

W.K. KELLOGG FOUNDATION

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Community Voices began with 13 learning laboratories across the nation and is targeted at ensuring the survival of safety-net providers and strengthening community support services. The program is a multi-year initiative of the W.K. Kellogg Foundation designed to improve health care access and quality. As of August 2003, the National Center for Primary Care at the Morehouse School of Medicine (www.msm.edu/ncpc) is the program office for the eight communities currently involved in the initiative. For more information on Community Voices publications, please visit www.communityvoices.org.

Community Voices
HEALTHCARE FOR THE UNDERSERVED

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ABSTRACT

A number of forces — federal and state budget deficits, severe stresses on the safety net, and rising numbers of people losing private health coverage — have been pushing responsibility for improving access to health care for vulnerable populations onto local communities, while at the same time impinging on communities' capacity to meet the growing needs. Some communities, including the 13 sites initially part of the W.K. Kellogg Foundation's Community Voices project, have been developing innovative ways to meet the growing challenges they face. Such projects are often best suited to *fill in health service gaps, link people to coverage and care,* and *develop new community relationships and skills* because local stakeholders have a keen awareness of community issues and needs. These local efforts also serve as "learning laboratories;" the more successful strategies provide models for larger-scale state or federal reforms. This brief highlights some of these promising approaches. It then describes ways that states and the federal government can directly support local efforts, as well as reduce the burden on communities by expanding public and private coverage on a state-wide basis. It concludes by emphasizing the importance of community initiatives while pointing to the need for broader, multi-level, fundamental reform of the U.S. health care system in the long run.

INTRODUCTION

Several strong forces are combining to push responsibility for improving access to health care for vulnerable populations onto local communities. First, the federal government has moved, in the space of four years, from a position of projecting a $5.6 trillion ten-year budget surplus to a roughly $4.4 trillion ten-year deficit.[1] This swing of $10 trillion has been a setback for comprehensive health reform in the United States that would necessarily involve some new federal spending.

Second, virtually all of the states are facing budget deficits, as rising costs interact with sharp declines in personal and corporate income tax revenue along with sales tax revenue. States are forced to devise some combination of spending reductions and tax increases to avoid fiscal catastrophe. Many states are cutting Medicaid eligibility, reducing payments to health care providers, and scaling back important optional health care services such as prescription drugs. Countless Americans are seeing their health and social services cut back. States are also reacting by shifting responsibility for health care and other social spending to counties.

Third, the health care safety net is under severe stress. Community health centers (CHCs), both public and private health systems, and state and local health departments are seeing more uninsured and indigent patients. Further, it is more difficult for many safety net providers to get reimbursed for serving these patients. Substantial funding for this purpose has come from upper payment limit (UPL) funds in recent years, which take the form of add-ons to Medicaid payments to health centers. These hidden, cost-based subsidies have been criticized as an inefficient way to subsidize the uninsured, and the Bush administration proposes phasing out UPL. Such cutbacks, however, would exacerbate the cost squeeze on CHCs if there were no direct subsidies to take their place. Moreover, many hospital emergency departments serving large numbers of low-income people are stretched to their capacity and are sometimes "on diversion," sending patients to other facilities.

Fourth, a combination of high unemployment and sharply rising health care premiums is exacerbating health care access problems. Some 2.7 million people lost their jobs in the economic downturn, and, according to the Census Bureau, about 46 percent of unemployed workers lack health coverage. Premiums for employment-based health insurance increased by 12.7 percent between 2001 and 2002,[2] with some smaller companies experiencing annual increases of 30-50 percent. As a result, employers face pressure to cut back their health benefit packages, shift more of the cost to workers, drop health coverage entirely, or lay off higher-risk employees.

Thus, local communities are facing reductions in public coverage, dwindling support for community health centers and hospitals, and rising numbers of people who

1 This figure assumes that the federal income tax cuts enacted in 2001 and set to expire under current law in 2011 will not be allowed to expire and that changes will be made in the Alternative Minimum Tax to keep it from increasing taxes paid by large numbers of taxpayers.

2 Bradley Strunk, et. al., "Tracking Health Care Cost Growth: Growth Accelerates Again in 2001," Health Affairs Web Exclusive: http://www.healthaffairs.org/WebExclusives/Strunk_Web_Excl_092502.htm.

have lost private coverage. Proposed policy reforms that promise to alleviate stress on the safety net—refundable tax credits from one camp and Medicaid/SCHIP expansion from another—are being debated but not enacted. This policy void impinges on the capacity of the local health care delivery system to meet the needs of the community's most vulnerable residents.

The rising level of need in communities is complicated by the widespread imbalances in resource allocation and the fragmentation of health care. Acute care is frequently favored over chronic care despite the growing number of people with chronic conditions. Expensive advanced medical technology with sometimes unproven effectiveness is driving up health care spending even as we under-invest in proven, relatively inexpensive primary and preventive care. Local hospital systems are frequently over-built in the aggregate even though certain sections of cities may be bereft of inpatient services. At the same time, insufficient resources are devoted to community health centers, mobile vans to deliver care to underserved areas; training of culturally competent physicians, dentists, and allied medical personnel; and substance abuse treatment. More resources and technical assistance are needed to improve information systems that could facilitate enrollment in public health insurance products and assess quality of care. And both health care and coverage are fragmented, with separate systems for physical, mental, and dental health. In this patchwork, there is little recognition of how these various aspects of health are intertwined.

Ultimately, the United States needs to achieve universal health coverage supplemented by effective direct outreach strategies that address barriers to access and the social determinants of poor health. To move us in that direction, we need a multi-pronged strategy to improve access to health care — one that helps individuals and providers/health systems. Stable funding streams need to be developed to reach and enroll eligible people in existing public coverage programs, provide medical homes to the indigent who remain uninsured, bolster a culturally competent health care workforce in underserved areas, and assist low-income people in obtaining affordable private coverage. Such funding streams also can help lower-income people navigate the health care system and maintain their health. Community-based organizations are best situated to perform many of these tasks and receive such funds. They should be held accountable both for managing costs and providing high-quality care. In this way, scarce resources can be stretched to achieve the best possible health outcomes at a reasonable cost.

Many communities have been filling in the gaps in the safety net and are trying to develop innovative ways to meet the growing challenges they face. A variety of entities – academic health institutions, public health departments, community health centers, and health providers are addressing the health crisis through collaboration and partnership. The Community Voices project, funded by the W.K. Kellogg Foundation, has produced and/or nurtured a number of promising, collaborative models for improving access to health care in 13 communities across the country. These models provide effective strategies through which local communities can weather the current storms and improve the delivery of appropriate and timely health services to vulnerable people. These efforts also serve as "learning laboratories;" the more successful strategies provide models for larger-scale state or federal reforms. This brief highlights some of these promising approaches, and describes ways that states and the federal government can support local efforts, while also making the case for longer-term fundamental reform of the U.S. health care system.

Importance of Community Action and Role of Community Voices

Given the context outlined above, the Community Voices sites have all been faced with how to allocate limited resources to help their communities. Motivated by similar values and goals – to maintain or improve access to health care for vulnerable populations — each site has chosen to focus on different aspects of the problem, with the solutions falling along a continuum. At one end of the spectrum, sites have been working "on the ground" to *fill in health service gaps,* by providing direct services, such as dental care, or bolstering the health care workforce. The next step is slightly removed from the provision of direct services, but nevertheless involves *linking people to coverage and care.* This occurs, for example, by referring consumers to direct services though outreach workers or linking them to health coverage through facilitated enrollment in public programs such as Medicaid or the State Children's Health Insurance Program (SCHIP). This level

also includes developing new health coverage products to encourage access to health care by providing financing and care management mechanisms. Even further along the continuum are efforts to *develop new community relationships and skills.* This includes forming integrated networks of providers to serve vulnerable populations, and developing political and technical skills that are necessary to be successful on an ongoing basis.

All of the communities' choices have been prompted by the need to maximize limited resources and each involves trade-offs. For example, providing direct services fills an immediate need and may be immensely helpful in the short term to the people served, but may have a more limited long-term impact in terms of reducing the *need* for such a safety net. In contrast, establishing networks and collaboratives among local providers may not yield such an immediate benefit, but may set the stage more effectively for larger, long-term improvements in health care delivery.

All of the initiatives provide lessons for policymakers at the local, state, and national levels by illustrating the level of need, by exploring which entities (local, state or federal government, or the private sector) may be best suited for implementing different approaches, and by demonstrating varying levels of success for different models pursued. The more successful initiatives offer a set of "best practices" that, with state or federal support, could be replicated and expanded. Below, we describe some examples of the models implemented by Community Voices sites and present recommendations drawn from their experiences.

Filling in Health Service Gaps

Direct Service Provision

One way to fill in health care gaps is to provide direct services to populations who otherwise would not have access to those services. Projects working at the community level, such as Community Voices, are often best suited to provide these types of services because local stakeholders have a better awareness of local issues and needs than do state or national projects that necessarily have a broader focus. The Baltimore and North Carolina Community Voices sites have identified and addressed gaps in direct services for men's health care and children's dental care, respectively.

Direct service provision is important in its own right as a means of serving the uninsured. But it will also be an important addition to a national health care reform strategy. Even if we are successful in covering more of the uninsured, there will still be pockets of people facing substantial access barriers related to language, transportation, and a shortage of personnel in under-served areas.

Recommendation: The U.S. should target resources to directly meet the needs of vulnerable populations who are at high risk of being left out of both the employer-based health coverage system and public health care programs. This includes racial and ethnic minority populations, recent immigrants, homeless people, low-income adults without dependent children, and other groups. Services should include both mainstream medical services and supporting services that help people achieve good health.

Meeting Men's Health Care Needs

Initially, Baltimore Community Voices, known as Visions for Health (VFH), was funded to work in the Sandtown-Winchester area of Baltimore, a low-income, 72-square block community in West Baltimore with over 10,000 residents. With low rates of insurance coverage and limited access to care, one of the identified needs in the community was a place for men to receive comprehensive health services. VFH provided seed funding for a Men's Health Center, established to provide primary care, dental care, substance abuse counseling, and links to jobs for uninsured men ages 19 to 64. While VFH no longer houses the Community Voices grant, the Men's Health Center has received additional foundation funding and continues to provide direct services to the men in Sandtown-Winchester.

Addressing Gaps in Dental Care for Low-income Children

Another example of addressing gaps in the safety net by providing direct services has been the provision of dental care to low-income populations. Three children's dental health centers were established by FirstHealth of the Carolinas, a not-for-profit local health system and Community Voices grantee, in response to a shortage of pediatric dentists practicing in the area and significant barriers to dental care among low-income children. The centers provide pediatric dental services for Medicaid, SCHIP, and uninsured children in three counties. They have served about half of the underserved and uninsured children in the area; increased by 600 percent the number of children receiving dental sealants; transitioned more than 25 percent of children into preventive maintenance status; and through a strict appointment policy, have reduced the "no show" rate for appointments to about half the national average.

Bolstering the Health Care Workforce

To support the efforts of direct-service provision, some communities have been trying to address the shortage of health care providers serving vulnerable populations. These efforts include training and utilizing community health workers and "promotoras" — who promote better health behaviors and link consumers to programs and services. They also include efforts to increase the number of oral health providers through recruitment activities and establishment of dental residency programs. Some sites have supported changes in state policy to increase the number of local providers, for example through changes in licensing requirements.

Community Voices New Mexico has chosen to focus some of its efforts on increasing the number of providers in the community and the state, where shortages are acute. Its many activities in the area of oral health illustrate this commitment. The project has assisted with the recruiting of oral health providers. A dental residency program has been established at the University of New Mexico's Health Sciences Center, and the Community Voices project has worked to develop a specialty dental care program for underserved populations. It has also sponsored a dental van in Chaves County to provide oral health services in the community, and has been involved in changing licensure policy (described below).

These initiatives can not only enhance access to care for uninsured populations, but also point the way to the development of an effective complement to state and national health insurance expansion proposals designed to reduce the number of uninsured.

Recommendation: We need to assure that we have a culturally competent, multi-dimensional, health care workforce to meet the needs of vulnerable populations. This includes an adequate supply of physicians, nurses, dentists, and other practitioners working in underserved areas to reduce the gaps in available resources. It also includes people without any formal medical training who can, nonetheless, be useful in guiding people to needed health and social services.

Linking People to Coverage and Care

The goal of filling in gaps in the safety net is to ensure that when vulnerable people need health care and they have no regular means of obtaining it, the services exist for them, albeit as a "last resort." The mere existence of safety net services and programs, however, does not necessarily mean that those services are utilized, or that they are utilized in the most appropriate way. People may fail to *access* services for a variety of reasons, such as a lack of culturally competent providers, complex application processes or lack of awareness about public coverage programs, and a belief (often but not always true) that care is not affordable. Community Voices projects have been trying to address these issues by using innovative ways to reach and enroll people in existing public programs, and developing new coverage products that provide a "medical home."

Facilitating Enrollment

Since insurance coverage is one means of trying to improve access to care, many Community Voices sites have been working with states to increase enrollment among people already eligible for public programs such as Medicaid and SCHIP. More than half of all uninsured children now qualify for Medicaid or SCHIP, and many adults are going without public coverage for which they are eligi-

Recruiting Local Talent as Promotoras and Community Health Workers

Community Voices North Manhattan in New York City has developed a cadre of lay health workers and 'promotoras' (literally, health promoters) to engage in health promotion activities intended to change community attitudes and consumer and provider behavior. These lay workers have the trust of neighbors; they are trained in a specific area (such as asthma or nutrition), but are familiar with the activities and resources of the other personnel so they can make appropriate referrals.

Community Voices New Mexico has been working with promotoras in schools to educate and deliver services to high-risk and underserved populations. It has also been working with Dona Ana County (Las Cruces) on a Community Health Worker initiative. Community Voices New Mexico has tried to make community health work a "profession" through an accreditation system. This is intended to give the workers greater credibility by ensuring that they have the necessary skills and knowledge, as well enhance their ability to earn suitable wages.

ble. Effective outreach becomes particularly important as funds to care for uninsured populations are increasingly limited. Many sites have been working on facilitating enrollment using such methods as "out-stationing" (placing in various organizations around the community) enrollment workers and promotoras, awareness-raising promotional materials, developing data management tools, and reducing barriers to enrollment.

Maximizing the number of people with some form of health coverage is particularly critical for large safety net organizations like Denver Health, which has a large uncompensated care burden and would like as many of its Medicaid- and SCHIP-eligible patients to be enrolled as possible. Therefore, one of Denver Health Community Voices initiatives involves facilitating and streamlining enrollment into public coverage programs, assisted by innovative computer technology (see text box below).[3] Denver Health employs enrollment specialists and community health advisors who conduct outreach and enrollment activities. The combination of these activities has generated reimbursement for care that otherwise would have been uncompensated.

Recommendation: Government should support community organizations in developing and implementing effective outreach and enrollment strategies to bring more eligible people into Medicaid and SCHIP. This includes both out-stationing in many diverse sites where low-income people can be reached and using modern management information systems and simplified application processes to reduce access barriers.

Developing Coverage Products

In addition to facilitating enrollment for people eligible for public programs, several Community Voices sites have chosen to address the issue of health care access by developing health care coverage products for people who remain "left out."[4] These include coverage products offered directly to low-income, uninsured individuals, and small-group insurance plans marketed to firms with low-wage, uninsured workers.[5] Implementing a sustainable coverage program, however, triggers many difficult challenges and choices. Finding a stable and sufficient funding source is one of the greatest challenges, and one in which states and the federal government could play a role.

When developing a coverage program, an important set of decisions revolves around benefits or services to be included. Given limited finances, a tradeoff exists between offering fewer covered services to more people, or a richer set of services to fewer people. Some communities have addressed this tradeoff by developing "front-end" health coverage models that focus on primary and preventive care, with limited (if any) specialty or inpatient hospital services. The intent is to provide a larger number of peo-

3 For more information on this and other outreach and enrollment activities sponsored by Community Voices, see Sharon Silow-Carroll, et. al., "Reaching Out: Successful Efforts to Provide Children and Families with Health Care," A Community Voices publication prepared for the W.K. Kellogg Foundation, June 2002.

4 The following discussion draws from Sharon Silow-Carroll, et. al., "Community-Based Health Plans for the Uninsured: Expanding Access, Enhancing Dignity," A Community Voices publication prepared for the W.K. Kellogg Foundation, November 2001. Additional information will be available in a forthcoming publication by the W.K. Kellogg Foundation.

5 FirstHealth of the Carolinas, for example, has developed and is piloting a small-group insurance product that offers subsidies to low-income employees who cannot afford their share of the premium. This product is described further in a forthcoming publication by the W.K. Kellogg Foundation.

Changing State Licensing Policies to Address Workforce Shortages

The North Carolina Community Voices project has worked on encouraging more dentists to practice in the state by supporting the recently passed "licensure by credentials" policy. This law allows dentists from out-of-state who have a certain amount of experience (and meet other criteria) to be licensed in North Carolina without taking the state's clinical exam. Community Voices New Mexico has been working on a policy initiative to change the state licensing requirements to expand the role of dental hygienists by allowing them to deliver additional types of care.

ple with services that may change health-related behavior and avoid more serious ailments. Also, many enrollees who qualify for the program would also qualify for charity care at the hospitals. The Ingham Health Plan (IHP) in Ingham County, Michigan, is one such coverage product.

The development of these types of products is taking place in localities around the country, and is not unique to Community Voices. In the context of dwindling state budgets, some *states* (such as Utah) have applied for federal waivers to allow them to offer limited, front-end coverage to some Medicaid populations. In fact, larger entities – such as states with an existing infrastructure and the ability to raise funds – may be in a better position to manage and sustain these plans.

States and localities can draw several lessons from the IHP and other Community Voices sites' experiences with such plans regarding successful enrollment strategies, care management, cost-sharing, and the impact of coverage on access and health outcomes. One lesson pertains to the value of having health coverage, even if it is limited to front-end services. Providing people with a "medical home" promotes access to care in a way that respects the dignity of the individuals. Providers who participate benefit since they receive some payments for services that had been largely uncompensated. Community Voices sites' experiences also point to the importance of ensuring an adequate number of providers, for example by offering appropriate reimbursement and minimizing administrative burdens. And these types of plans both reflect and promote collaboration among safety net providers as systems and networks are developed (described in greater detail in next section). These plans also can help broaden the concept of "health professionals" by utilizing individuals such as community health workers, nurse practitioners, or dental hygienists. On a societal level, providing and managing care at the front end often results in improved health and cost savings in the long term.

Recommendation: We should continue to experiment with a variety of insurance coverage models with varying degrees of comprehensiveness in services. While fully comprehensive coverage with affordable cost-sharing is always the goal, the current budget and economic climate may warrant further experimentation with and evaluation of limited benefit insurance packages. Promising strategies feature generous coverage for primary and preventive care services and case management to help the patient navigate the health care system and use it effectively.

Out-stationing and Promotional Products

The West Virginia Community Voices project has developed some innovative methods for increasing enrollment in public programs. They have out-stationed enrollment workers at nursing homes to enroll uninsured nursing home employees (and/or their dependents) who qualify for public programs. Also, some nursing home residents are eligible for both Medicaid and Medicare. In addition, nursing home residents can provide information to their children and grandchildren and encourage them to enroll.

West Virginia Community Voices has also developed a wide range of promotional materials for SCHIP, including back-to-school backpacks given to children who return health insurance questionnaires or who have physicals in outreach clinics. Promotional black bear (the state's animal) beanie babies and SCHIP t-shirts, hats, sunglasses, toothbrushes, pencils, flyers/brochures, posters, and yo-yos raise awareness and acceptance of the public programs.

Streamlining Enrollment Through Computer Technology

Denver Health has hired enrollment specialists who are located at provider sites and throughout the community — for example, in libraries or schools. These enrollment specialists use a computer program called "HealthTrack" that allows workers to track applications from "intake to eligibility determination." HealthTrack holds information for a variety of public programs and allows outreach workers to access information on an individual's enrollment status, documentation, and reasons for pending or denied applications.

Developing New Community Relationships and Skills

Building Networks of Providers

For a health plan or program such as those just described to be successful, there must be a network of providers available to serve the enrolled populations. These networks also can serve the remaining uninsured. While all of the Community Voices sites have worked hard to develop collaborations among stakeholders, including providers, two sites have focused very specifically on developing networks of providers to serve the underserved populations in their communities. The Voices of Detroit Initiative's (VODI) integrated service delivery network and New Mexico's health commons are not insurance products, but rather models for organizing an existing but fragmented system of care so that people who rely on those services are able to access them more effectively.

In addition to developing networks of providers, many Community Voices-related activities have had a favorable impact on the delivery system. In general, as partnerships develop to support the initiatives described above, there are ripple effects that have a positive impact on the delivery system as a whole.

Recommendation: Community leaders should help build networks of providers who will serve indigent patients in a way that simulates a good insurance plan enjoyed by the insured population. We must develop alternatives to expensive emergency room care for non-emergency situations. This requires identifying existing networks of primary care physicians in either clinics or office-based settings who are willing to serve indigent patients. The next step is assuring corresponding access to prescription drugs, diagnostic tests, and hospital care when it is medically indicated. This strategy will require some combination of earmarked funding streams, such as a dedicated local tax or reallocated

A "Front End" Community Coverage Model

The Ingham Health Plan (IHP) provides outpatient services and limited pharmacy services to more than 15,000 low-income uninsured residents and former State Medical Plan (SMP) enrollees.[6] Members are assigned a "medical home," given a membership card, and introduced to managed care principles. IHP was not established as an "insurance plan," and therefore is not required to offer the state-mandated set of benefits or adhere to state insurance regulations. As a result, IHP is less expensive to operate. Other features keep the cost down as well: services must be provided by participating providers (unless otherwise authorized), and they may be limited if funding is not available.[7] Innovative financing supports IHP; funds come from a combination of local government health care money previously used to finance indigent care at the county clinics, state funds designated for former SMP enrollees, and federal Medicaid Disproportionate Share Hospital (DSH) matching funds.

6 SMP is a general assistance-type program for very low-income adults. Former SMP members receive a broader benefit package with no copayments, and cannot be denied services due to lack of funding.

7 The coverage products that provide *only* front-end coverage can serve more people (as noted above), but do have some limitations. For example, they may raise expectations of those newly insured who do not understand the limits of their coverage. Also, health care practitioners may be placed in a difficult position if they have patients whom they want to refer to specialty or tertiary care that is not covered by the health product.

Disproportionate Share Hospital (DSH) funds, and a willingness by providers to serve indigent patients at greatly reduced fees.

Developing Political and Technical Skills

An evaluation of the Community Voices project has revealed that certain ingredients must be present and certain skill sets developed for communities to be successful agents of change. Some of the most important are the presence of strong leaders, the development of "management capacity," partnerships among community organizations, the fostering of political linkages, and effective communication strategies.[8] Leadership, for example, is a driving force behind community projects and must be nurtured at all levels, particularly neighborhoods. Important managerial activities include developing partnerships, communicating effectively, developing data systems, and implementing the project vision. Yet the projects must not be dependent on one individual; rather, they should be managed in a supportive environment, among people with shared commitment and values.

It is also critical to develop "community and political linkages" that is, relationships among grassroots leaders, patients, and local providers (clinicians, hospitals, clinics, etc.) that further project objectives, foster dialogue, and support focus groups and needs assessment processes. These are often developed through coalitions, boards, and other collaborative entities. Finally, there needs to be an effective internal and external communication strategy to inform key audiences and to turn data and knowledge into a force for health system improvement.

Recommendation: Community leaders need to develop political and managerial skills, and build linkages across our health care and government systems to enhance their ability to make meaningful improvements.

We need to invest in our "access infrastructure" at the grassroots level in much the same way as we have invested in basic medical research and new medical technology.

8 These competencies were developed and assessed by Abt Associates, Inc., as part of its evaluation of the Community Voices project. This discussion is drawn largely from a slide presentation, "Preliminary Cross-Site Findings," presented by Abt Associates, Inc., at the Community Voices Project Directors Meeting, Albuquerque, New Mexico, June 9-11, 2003.

Federal and State Governments Can Promote, Nurture, and Support Community-Based Reforms

There are many steps the federal government and states can take to promote and facilitate community-based health care reforms. They include federal funding for state and local health planning efforts, incentives to bring health care providers to underserved areas, financial support for community health centers, and other activities. This section describes some of these mechanisms, many of which are administered by the federal government's Health Resources and Services Administration (HRSA).

Federal Support for State and Local Planning to Develop New Approaches to Improving Health Care Access

The federal government can help states develop a planning process that combines insurance expansion with direct service outreach and lays out a vision and a phased-in plan for improving access to care. An example is the HRSA state planning grant (SPG) program, which now serves 40 states. Under year-long planning grants, states are conducting surveys and focus groups with employers and households to assess barriers to coverage, and to determine levels of support for various types of reforms. The grantee states convene broad-based stakeholder groups to obtain their feedback and buy-in to new approaches to health care delivery and financing. The SPG grants are also used to develop new strategies to reduce the number of uninsured, with a particular emphasis on leveraging employer contributions to group health insurance and supporting lower-income workers with access to employer coverage.

The Community Access Program (CAP) is another HRSA initiative, and this program is aimed directly at local communities. CAP grants provide localities with support for restructuring the health care delivery system to promote better access to primary and preventive health care services, facilitate enrollment in Medicaid and SCHIP, enhance coordination of health and social services, and reduce inappropriate care.

The CAP program has produced a number of results. First, a web-based network among the CAP partners has been developed that provides a universal intake questionnaire referring the potential enrollee to the different programs for which they qualify. This network also provides

information about prevention services, care coordination, and other support systems in the community. Second, the program features a concentrated effort to provide a medical home and disease management programs (diabetes, hypertension, respiratory disease, and depression) to help guide patients through the health care system and manage their chronic conditions. A third component involves sending outreach workers directly into the community to identify and link residents to available services, refer people to the CAP program, and recruit community volunteers.

A new CAP initiative, encouraged by HRSA, involves CAP grantees within a state sharing information to determine needs, goals, and program ideas that they might have in common. At the present time, this information sharing is occurring mainly through periodic conference calls. Florida, Texas, Virginia, and Pennsylvania are trying to develop linkages and share best practices. This could be an initial step toward trying to scale up promising programs to augment their impact.

Federal Support and State Policies to Bring Health Care Providers to Underserved Areas

HRSA tries to address the mismatch between the need for and supply of health care personnel in underserved areas. The agency conducts labor market surveillance providing feedback that identifies the location and magnitude of shortages. HRSA's Bureau of Health Professions helps steer practitioners to shortage areas through its support of primary care, residencies, and training programs. The Bureau's National Health Service Corps provides a scholarship program for physicians, nurses, dentists, and physicians' assistants in return for their agreement to practice for a specified period of time in underserved areas, with a minimum two-year obligation.

The federal government also assists localities through support for Community Health Centers (CHCs). CHCs provide family-oriented primary and preventive health care services for people living in rural and urban medically underserved communities. As of FY 2000, there were 670 community and migrant health centers funded under Section 330 of the Public Health Service Act—serving over 11 million people nationwide, of whom 66 percent live below the Federal Poverty Level.[9] The Bush administration has established a goal of doubling this number, which would reduce the number of areas without a center or with an insufficient number of centers. There is also a need to support those centers that now exist. Many health centers have only one physician who is severely overburdened. They may be short on nursing, clerical, and dental staff. And many need vital repairs and modernized equipment and information systems.

States, too, can play a role in bringing needed health care providers to underserved areas. With appropriate safeguards, states can change licensing requirements to make it easier for providers licensed in other states, but who have critical experience and credentials, to practice in the state. States with severe shortages of physicians or dentists could also work with medical and dental associations to expand roles for mid-level practitioners such as nurse practitioners and dental hygienists.

Other State Efforts to Support Community Initiatives

There are additional mechanisms for states to support community health initiatives. They can "partner" with counties by making DSH or tobacco settlement money available for local health programs. Michigan, for example, has allowed DSH funds to match local contributions to the Ingham Health Plan and other county coverage programs in the state. California has allowed a portion of its tobacco settlement funds to help support a two-year coverage program for small businesses and low-wage workers in Sacramento County.

States can provide grants to communities to pilot and evaluate innovative programs, and to replicate successful initiatives. States can provide localities with technical assistance by convening community leaders and experts, or establishing a clearinghouse for local "best practices." Finally, states can help public program enrollment efforts at the community level by simplifying enrollment and recertification processes for Medicaid and SCHIP.

Recommendation: Federal and state policymakers should review and assess promising programs developed and sustained under the Community Voices initiative. These programs, juxtaposed with emerging models from the CAP program and other local efforts to improve access to health care, could provide useful guidance to reforming the health care system at the state and national levels.

9 http://bphc.hrsa.gov/programs/CHCPrograminfo.asp. The FY 2002 appropriation for this program is $1.3 billion.

Organizing and Integrating Systems of Care

The Voices of Detroit Initiative (VODI) draws together safety net providers to pool resources and ideas to better serve the low-income population in Detroit. As part of this initiative, VODI has developed an Integrated Service Delivery Network, a "virtual managed care system," in which Detroit residents who meet certain income requirements but are not eligible for Medicaid are "enrolled" and given a card that allows them access to a network of providers. This virtual HMO, now called the Uninsured Health System, provides primary care, laboratory, dental, and specialty care services at 15 primary care clinics and five hospitals. Over 16,000 enrollees participate and each has been assigned a "medical home."

Prior to its Community Voices project, the University of New Mexico (UNM) had been developing the UNM Care Plan, a primary care network serving over 15,000 of Bernalillo County's (Albuquerque) uninsured. With the additional funding from Community Voices, the project has worked on building partnerships among providers, advocacy groups, and policymakers to develop a "health commons" approach. The intent is to offer an integrated set of primary care services within the community.

State-Wide Efforts to Expand Access to Health Care

In addition to directly supporting local initiatives, states can help localities improve access to health care by expanding access to public and private coverage on a state-wide basis. This relieves the pressure on communities by reducing the number of uninsured individuals who rely on an overburdened local safety net. States can also establish uncompensated care pools that reimburse local safety net providers who provide "free care" to the uninsured.

Expansions of Public Coverage

States can take a number of steps to broaden public coverage. They can expand Medicaid and SCHIP programs under existing federal program authority, obtain waivers from the federal government to broaden the reach of these programs, or use their own funds to extend health coverage to lower-income uninsured people.

Using existing program authority (e.g., Section 1931(b) of the Social Security Act), states can bring working family members into Medicaid by disregarding more of their income and assets when determining eligibility. Such disregards essentially raise the income threshold, making additional individuals eligible for mandatory Medicaid coverage. Connecticut, Massachusetts, New Jersey, New York, Rhode Island, Washington, Wisconsin, and the District of Columbia use this mechanism.

States can also develop Health Insurance Premium Payment (HIPP) programs to use Medicaid funds to provide premium assistance for Medicaid-eligible individuals who also have access to employer-sponsored insurance. The goal of HIPP programs is to help keep low-income workers with access to employer coverage in the job-based health insurance system.[10] While most states use these programs to a limited degree to serve individuals with high-cost medical conditions such as HIV/AIDS, other states are using HIPP programs to enroll families in Medicaid. Iowa currently has the largest of these programs.

Many states have used 1115 waivers to extend Medicaid coverage to new populations — usually near-poor families whose incomes are above the mandatory eligibility thresholds or other individuals who are not designated in the Medicaid statute as categorically eligible. Many states have used these waivers to increase income eligibility up the income ladder—a vertical expansion of the Medicaid program. But more than a dozen states and the District of Columbia have used either 1115 waivers or their own funds to cover a popu-

10 HIPP programs do not require federal waivers. They may expand coverage to non-categorically-eligible adults because, if a Medicaid-eligible child could not qualify for ESI coverage without the parent's enrollment, a parent who would not otherwise be deemed eligible for Medicaid may also receive premium assistance to enroll in ESI. Eligibility for HIPP program subsidies depends upon whether the state's share of the private coverage subsidy is cost effective compared to providing direct medical services.

lation that they are otherwise unable to help under existing law: adults without dependent children living in the home. This can be thought of as a kind of horizontal expansion of Medicaid in the sense that the newly-covered people are just as poor as, or poorer than, the current enrollees, but have been categorically ineligible as a result of their family status. States using federal matching funds to cover this population include New York, Maine, and Minnesota. Pennsylvania uses tobacco settlement money to run its own coverage program for this population.

States may bring parents into their SCHIP programs, also using an 1115 waiver, if they can demonstrate that the cost of covering parents in addition to children will not require the state to spend more than its given SCHIP allotment. Wisconsin, New Jersey, and Rhode Island are among the states using this approach.

Covering these poor and near-poor populations helps localities by greatly reducing the number of uninsured and the indigent care load on the health care delivery system. But the direction of influence can also run the other way. Local projects demonstrating the viability and impact of various coverage models, as illustrated earlier, can help guide states as they develop new and affordable strategies for covering the uninsured.

Insurance Market Reforms

States have undertaken a variety of insurance market reforms designed to make private health insurance more affordable and accessible for people with relatively low incomes and/or substantial health risks. One mechanism is "reinsurance," whereby the state or a private institution limits an insurer's losses on any particular individual enrollee, or aggregate losses for all enrollees. This is designed to attract insurers to markets, such as the small-group and non-group markets, and reduce their incentives to screen out high-risk people.

Another mechanism involves establishing standard benefit plans to help small companies make accurate and fair comparisons across health plans offered by different carriers, hold down costs, and increase carrier participation in this market. Guaranteed issue and renewal, modified community rating and other types of premium rate restrictions, and "mini-COBRA" laws represent additional ways state insurance departments have tried to make private health insurance more affordable and accessible, with varying levels of success.[11]

Uncompensated Care Pools

While expanding public and private coverage may help localities the most by alleviating their indigent care burden, a significant number of people are likely to remain uninsured for the foreseeable future. Communities' challenges in serving this population will be greatly assisted if more states establish a funding pool that channels money to providers that are serving indigent patients (separate from DSH funds).

Maryland, for example, operates a fund that supplements the state's rate-setting adjustments to hospitals (based on the indigent care burden of each hospital), alleviating a considerable amount of the hospital's uncompensated care burden. These policies take pressure off city and county budgets, freeing the localities to earmark their funds to primary and preventive care measures.

Recommendations: States making efforts to expand access on a state-wide basis should work with localities to implement the necessary education, communication, outreach, and enrollment activities.

Also, at a time when budget pressures are forcing many states to cut back on state-wide access programs for vulnerable populations, the federal government should provide states with additional support. This could include enhanced matching funds for Medicaid and SCHIP, greater flexibility to enroll additional vulnerable populations into these state-federal programs, and additional grants to allow states to experiment with and expand new access models, such as those pioneered in Community Voices communities and others.

Need for Both Local Action and Broader Reforms

The community-based health initiatives described in this brief play multiple, critical roles in health reform. They can inform the national debate by serving as laboratories to test various models aimed at expanding coverage,

11 "Small Group Market Options." Working Paper. Maryland State Planning Grant Working Group. 2003.

improving health-related behaviors, and reducing barriers to care. Indeed, through Community Voices and other programs, localities are developing and illuminating "best practices" that can be replicated and expanded.

Yet while local health initiatives are immensely valuable, they have limitations. Counties and community-based organizations have limited mechanisms for raising funds, and their income streams from public and private sources are generally vulnerable to political or economic fluctuations. Also, a community's ability to make lasting changes in access or delivery of health care depends on strong leadership, active constituencies, and other factors that vary from locality to locality.

Therefore, in the long term, local efforts must be undertaken in conjunction with broader health care reform at the national level. Such reform would include strategies to expand both coverage and access to care for low-income, vulnerable populations. National reform may take any number of directions.[12] At one end of the spectrum lie strategies that help lower-income people afford health coverage in the private insurance system. Under this approach, subsidies in the form of tax credits or vouchers are necessary to enable lower-income people to purchase insurance policies in the group or individual insurance markets. To avoid higher-risk people from being excluded through medical screening or exorbitant risk-based premiums, some combination of insurance regulations (guaranteed issue and renewal, rate restrictions), high-risk pools, reinsurance, and a purchasing exchange for people outside of employer-based coverage and government programs is necessary.

Toward the other end of the reform spectrum lie national health plans that rely more on public financing to ensure universal coverage and to control total health care spending. Health care providers (physicians, hospitals, etc.) may be private entities or owned/employed directly by the government. The financing mechanism could be payroll taxes, income taxes, or other revenue sources, and it may be combined with out-of-pocket payments (premiums, co-pays, deductibles). Decisions about provider reimbursement rates and capital expenditures could take place at the national, state, or even local levels. Other industrial nations offer many models of national health plans, and the United States could develop one that best meets its own values and existing infrastructure.

Any comprehensive national reform must ensure a strong safety net and social services for those individuals and families – the homeless, undocumented immigrants – who continue to "fall into the cracks."

The current movement in the U.S. toward greater flexibility for states also presents options for health care reform at the state level. In fact, Maine has recently passed a comprehensive reform plan that is intended to bring universal coverage to that state. It involves a combination of public coverage expansions for additional groups of adults, the establishment of a group health plan that would be made available to small businesses, and premium subsidies tied to workers' incomes. Other methods for states to expand coverage – Medicaid/SCHIP expansion, insurance market reforms, uncompensated care pools – were described in the previous section. While these are important, relying on state reforms alone would result in access and coverage levels that are uneven across the nation, and vulnerable to cutbacks during economic slumps. Like local initiatives, state efforts do not substitute for comprehensive national reform.

Finally, it is important to remember that both state and national reforms are ultimately *implemented at the community level.* Local assessments are most effective for understanding people's needs – the first step toward addressing those needs. Expansions in state or national coverage programs still require education, outreach, and enrollment that take place at the local level. Strengthening the safety net requires that communities attract and support an adequate number and array of practitioners. Those communities that have developed the skill sets and capacities to effect change will be in a better position to institute, nurture, and sustain broader reforms.

12 See Jack A. Meyer and Elliot K. Wicks. Covering America: Real Remedies for the Uninsured. Volumes I, II, and III. Economic and Social Research Institute. Washington, D.C. 2001-2003.

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