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Kansas City Metropolitan Health Access Policy Assessment Final Report

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Background

The Mid-America Regional Council (MARC) engaged Health Management Associates (HMA) to investigate the feasibility of establishing and sustaining both a broad health care policy planning and coordination forum and a regional program or programs related to financing and access to indigent health care. HMA, in close consultation with MARC, the MARC Technical Advisory Committee and the newly formed Chamber Health Council, was asked to provide expertise and guidance, research national and local health care access initiatives, and engage the health care community in a discussion of possible solutions. This project is jointly funded through grants from the Health Care Foundation of Greater Kansas City and the REACH Healthcare Foundation.

This report includes:

- An “inventory” of existing local initiatives that are in place or under development to improve access to care for uninsured and underinsured populations;
- A review of existing research and data sources on the uninsured in the Kansas City metropolitan area and the regional safety net¹;
- Discussions with over 55 local providers, health plan representatives, business and civic leaders and other stakeholders about the strengths and weaknesses of the regional safety net, options for improving access, and the feasibility of a regional approach to providing an insurance product for the uninsured and coordinating care for the uninsured;
- Research on dozens of models that have been tried and implemented elsewhere in the country to improve access to care for underserved populations.
- A framework, or set of criteria, on which to evaluate various models and their likelihood of success in the Kansas City region.

This report also includes HMA’s preliminary recommendations on several models that we believe should be carefully considered in the Kansas City metropolitan area. These models were presented to MARC’s Technical Advisory Committee, as well as the Chamber Health Council, in an effort to arrive at a set of options that were then vetted with a wide range of stakeholders in the region.

The Uninsured in the Kansas City Region

Because of the socioeconomic diversity across the Kansas City region, it is important to try to paint a picture of the uninsured at both the local, or county, and regional levels. Unfortunately, reliable, consistent measurements of the uninsured at the local level are not always available. The following tables summarize the most recent data available on the uninsured in the eight-county area and provide a reasonable range of estimates regarding the uninsured in the region. Where necessary, extrapolations from state-level census data were used to present the data in a consistent manner across both states. It is

¹ Safety net providers are those providers that organize and deliver a significant level of health care and other health-related services to uninsured, Medicaid, and other vulnerable populations.

important to note that the Missouri uninsured data do not reflect the impact of the recent Missouri Medicaid cuts and, therefore, likely present an underestimate of the actual number of uninsured.

Uninsured by FPL -- Kansas City (Missouri) Region

County	Total Uninsured (1)(2)	Total Uninsured Rate (3)
Cass County Total Uninsured	7,709	8.30%
<100% FPL	979	18.30%
100-199% FPL	1,649	13.57%
200%+ FPL	5,081	6.74%
Clay County Total Uninsured	17,359	8.72%
<100% FPL	2,121	19.51%
100-199% FPL	3,375	14.47%
200%+ FPL	11,862	7.19%
Jackson County Total Uninsured	84,511	12.96%
<100% FPL	19,897	25.59%
100-199% FPL	20,822	18.97%
200%+ FPL	43,792	9.43%
Platte County Total Uninsured	6,339	7.82%
<100% FPL	697	18.01%
100-199% FPL	1,036	13.36%
200%+ FPL	4,606	6.64%
Ray County Total Uninsured	2,121	8.95%
<100% FPL	300	18.67%
100-199% FPL	599	13.85%
200%+ FPL	1,222	6.88%
Missouri 5-County Total Uninsured	118,039	11.08%

Notes and Sources:

(1)Uninsured population taken from Small Area Health Insurance Estimates

(SAHIE) Methodology; U.S. Census Bureau, Housing and Household Economic Statistics Division, Small Area Estimates Branch; Last Revised: July 21, 2005

(2) Uninsured population by poverty line was calculated from 2000 Census County and State uninsured by poverty level data. Consideration was given to the trends of uninsured in the State, as well as to the demographic makeup of each individual county.

(3)Uninsurance rates calculated using the estimated uninsured by poverty level and projected poverty level population estimates. Population is taken from Source: U.S. Census Bureau, 2005 Population Estimates; Poverty line breakdowns based on growth projections using Census data.

The data on the uninsured in the Kansas City region provides much valuable information with which to assess the potential impact of various strategies to improve access to care

for the uninsured. For example, several recent studies indicate a significant number of uninsured individuals are likely eligible for Medicaid or SCHIP coverage in their home state of Missouri or Kansas.² Any option(s) ultimately adopted in the region should include a strong eligibility component to ensure that all who are eligible for existing public coverage receive that coverage.

In addition, approximately 43% of the uninsured in the five-county Missouri area fall below 200% of the Federal Poverty Level (FPL). Strategies aimed at this income group – whether access-based strategies or public or private coverage expansions – would have a large overall impact but would not capture all or even the majority of the uninsured. Those in middle income groups may be more receptive to employment-based strategies than lower-income groups that have a more tenuous link to the workforce.

Uninsured by FPL -- Kansas City (Kansas) Region

County	Total Uninsured	Total Uninsured Rate
Johnson County Total Uninsured	40,856	9.06%
<100% FPL	5,373	34.66%
100-199% FPL	5,797	17.41%
200%+ FPL	29,686	7.38%
Leavenworth County Total Uninsured	7,280	10.60%
<100% FPL	1,531	33.52%
100-199% FPL	1,562	17.24%
200%+ FPL	4,187	7.60%
Wyandotte County Total Uninsured	24,688	15.64%
<100% FPL	9,840	37.69%
100-199% FPL	6,549	19.12%
200%+ FPL	8,299	8.51%
Kansas 3- County Total Uninsured	72,824	10.75%

Source: Lewin Uninsured Study, 2000

The income distribution of the uninsured is quite different in Kansas. In Wyandotte County, for example, those under 200% FPL make up nearly 70% of the uninsured. However, this is not the case in Johnson County, where those under 200% FPL make up less than 30% of the uninsured, nor is it the case in Leavenworth County, where those under 200% FPL make up approximately 42% of the uninsured.

² See, for example, *2004 Missouri Health Care Insurance and Access Survey: Select Results*, prepared by the State Health Access Data Assistance Center. February 2005; or Kansas Health Institute, *Uninsured Children in Kansas: Who Are They and How Could They Be Reached?* October 2003.

When the income distribution of the uninsured is aggregated for the Greater Kansas City region, 57% of the uninsured population lives above 200% FPL as outlined in the table below. Furthermore, the data presented does not include the impact of recent Missouri Medicaid cuts.

Uninsured by Federal Poverty Level - Kansas City Missouri and Kansas regions

	Under 100% FPL	100 - 199% FPL	200% + FPL	Total
Kansas	23,994	27,481	66,563	118,038
Missouri	16,744	13,908	42,172	72,824
Total	40,738	41,389	108,735	190,862

Source: Consolidation of Tables above

Taken together, the picture of the uninsured in the Kansas City region indicates that a single approach applied on a regional basis is likely to be far more effective in some areas than in others. As such, the recommendations at the end of this report include not one but several strategies that, taken together, will have a meaningful impact on the entire region.

Health Status in the Kansas City Region

Data from the 2000 Health Assessment conducted as part of Ford Motor Company's Community Health Initiative indicate that Greater Kansas City's health status is comparable to national benchmarks but with more profound racial disparities between African American and white residents than are observed nationally.³ Specifically:

- The Greater Kansas City Area's infant mortality rate exceeded the national average and the Healthy People 2010 objective.
- The proportion of low birth weight and very low birth weight births were 30 percent and 44 percent higher than the Healthy People 2010 objectives, respectively.
- The admission rate and days of care for respiratory system disorders and cardiovascular disease far exceeded national benchmarks.
- African Americans are more likely to lose years of life due to chronic conditions and experience worse maternal and child health outcomes than white residents. These disparities are more pronounced than national benchmarks.

While some of this information is now a bit dated, more recent data that look at specific parts of the Kansas City region indicate that the same health status issues remain a concern. For example:

³ The Lewin Group, "Greater Kansas City Area Factbook," 2000. This report defined Greater Kansas City as Clay, Jackson and Platte counties in Missouri and Johnson and Wyandotte counties in Kansas.

- Pregnant women in Jackson County are significantly more likely to receive no or inadequate prenatal care when compared to the statewide average. The percentage of low birthweight infants and infant mortality rates in Jackson County are significantly higher than statewide rates.⁴
- The hospital admission rate for asthma in Jackson County is 16.8 per 10,000, compared to 13.3 per 10,000 statewide. Approximately 13 percent of African Americans in Missouri have asthma compared to 10 percent of whites. The racial disparity in asthma incidence is particularly pronounced among children. Approximately 10 percent of African American children in Missouri have asthma, compared to 6 percent from all other racial groups.⁵
- The overall heart disease mortality rate for Jackson County was notably higher than the overall U.S. rate.⁶
- African Americans in Wyandotte and Johnson counties have age-adjusted death rates from all causes that are substantially greater than those for whites.⁷

These data indicate an ongoing need for access to primary care and coordinated access to specialty care, especially for those suffering from chronic conditions. Without sufficient primary care management, many unnecessary hospitalizations are due to ambulatory sensitive conditions, admissions that can be significantly reduced in a well coordinated system of continuity of care.

The Safety Net in the Kansas City Region

One of the strengths of the regional safety net in Kansas City, according to the stakeholders we spoke with, is its capacity to care for low-income children. With the exception of dental, children were widely believed to have good access to both primary and specialty care. Children enjoy much higher levels of public insurance coverage than adults through the Medicaid and SCHIP programs. The individuals we spoke with believe that uninsured children also have relatively good access to care, primarily through Children's Mercy Hospital and its clinics, but also through local FQHCs and other safety net clinics.

Among adults, the stakeholders we spoke with consistently cited access to specialty care as the biggest concern in the region, though certain geographic pockets appear to have inadequate access to primary care as well. For example, Johnson County and the Northland area were cited by several as having poor access to primary care for adults, as were rural areas on the fringes of the eight-county region encompassed by this report. A

⁴ Health Care Foundation of Greater Kansas City, "Health Assessment of Cass, Jackson and Lafayette Counties," January 4, 2005.

⁵ Ibid

⁶ Ibid

⁷ The REACH Foundation, "Allen, Johnson and Wyandotte Counties Health Assessment," August 2004.

report recently released by the Northland Community Foundation notes that two of the major hospitals in that region are reporting a 40 percent increase in the number of individuals who cannot pay their medical bills and who use the emergency room for primary care.⁸ A separate study completed by Northland Health Care Access found that Clay and Platte counties will require between 22 and 31 full-time primary care physicians and between 20 and 29 specialty care physicians by 2010 to meet the needs of the Medicaid and uninsured population in these two counties.⁹

Access to dental care was cited as a significant hole in the safety net on both sides of the state line, for children and adults, for the uninsured and those with Medicaid. In the nine-county metropolitan area on the Missouri side of the state line, only 15 percent of dentists accept children on MC+/Medicaid (1 dentist per 923 children).¹⁰ In Wyandotte County, the population to provider ratio is 3,450 persons per full-time equivalent dentist.¹¹ Approximately one in five persons in Wyandotte County has not seen a dentist in the last two years.

In addition, access to mental health services was also frequently cited by stakeholders as a significant weakness in the current safety net, on both sides of the state line.

Hospital Providers

One of the dominant features of the health care safety net in the Kansas City region is the presence of a large, “community public hospital” on the Missouri side of the state line and the absence of a parallel institution on the Kansas side. The Institute of Medicine defines “core safety net providers” as having two distinguishing characteristics: (1) by legal mandate or explicitly adopted mission they maintain an ‘open door’, offering access to services and patients regardless of their ability to pay; and (2) a substantial share of their patient mix is uninsured, Medicaid, and other vulnerable populations.

While not truly “public” from a technical perspective, Truman truly fulfills the definition of a core safety net provider with a predominantly public mission to serve the poor. Truman also receives significant municipal and county tax support to fulfill their mission. Across the state line, Kansas University Medical Center, while public according to the technical definition, does not fulfill the traditional community public hospital role as a core safety net provider. As a large academic medical center, KUMC fills multiple roles including teaching, research and patient care that are often paired with a community public hospital.

It is often difficult to quantify the impact the uninsured may have on a given community. One measurement frequently utilized to document the magnitude is to refer to the level of

⁸ Northland Community Foundation, “Vision North 2005.”

⁹ Northland Health Care Access, “Strategic Plan,” prepared by the Buckley Group, LLC. April 2006.

¹⁰ Health Care Foundation of Greater Kansas City, “Health Assessment of Cass, Jackson and Lafayette Counties,” January 4, 2005.

¹¹ ¹¹ The REACH Foundation, “Allen, Johnson and Wyandotte Counties Health Assessment,” August 2004.

¹¹ Northland Community Foundation, “Vision North 2005.”

charity care and bad debt provided by local hospitals.¹² In the Kansas City region, the total uncompensated care provided by hospitals in 2004 was \$158,429,452. Of that, \$72,561,454 was charity care and \$85,867,998 was reported as bad debt.¹³

These figures do not include the amount of care provided by private physicians, Federally Qualified Health Centers, public health departments or free clinics throughout the area. It is important to note that the dollars above do not reflect the impact of the recent Missouri Medicaid cuts and, therefore, are likely to present an underestimate of the actual total uncompensated care provided more recently in the Kansas City region. For example, Truman's uncompensated care has gone from a 2004 level of \$45,686,480 to over \$75,000,000 after the Missouri Medicaid cuts were enacted.

See Appendix A, Kansas City Metropolitan Area Hospital Charity Care and Uncompensated Bad Debt (2004) for individual hospital charity care and bad debt dollars.

Federally Qualified Health Centers (FQHC)

Kansas City is home to two Federally Qualified Health Centers operating in multiple sites throughout the region. Swope Health Services serves more than 58,000 low-to-moderate income men, women and children in the Greater Kansas City area from five clinic locations (2 in Kansas City, Kansas; 2 in Kansas City, Missouri; 1 in Independence). More than 90% of patients live below the poverty level. Samuel U. Rodgers Health Center serves approximately 17,000 low-income patients at three area sites, including its main location in Kansas City, Missouri and satellite locations in Lexington and Independence (dental only).

The goal of the FQHC program is to maintain, expand and improve the availability and accessibility of essential primary and preventive health care services (and related enabling services) for low income, medically underserved and vulnerable populations that have traditionally had limited access to affordable services and face the greatest barriers to accessing care. FQHCs must see all patients, regardless of ability to pay and must have a sliding fee scale in place for uninsured patients. FQHCs must also be located in and/or serve areas in the greatest need; must serve the full "life cycle" of care (prenatal, pediatrics, adolescent, adult, geriatric) through a core staff of primary care providers; and must be governed by a community board with a majority of members who are users of the health center.

In exchange for meeting rigorous federal requirements, FQHCs are entitled to a range of benefits, including favorable cost-based reimbursement from Medicare and Medicaid, federal grants to offset the costs of caring for the uninsured, free federal tort protection for providers and other benefits.

¹² Charity care is defined as the amount of free care (at cost) provided by the hospital to individuals qualifying for that hospital's charity care policy. Bad debt is defined as unpaid out-of-pocket costs incurred by insured or uninsured patients. These two figures combine to make up the total uncompensated care provided by the hospital.

¹³ Missouri Hospital Association Community Benefit Report - May 2006 (data from 2004 fiscal year)

Free Clinics, Local Public Health Departments and Other Safety Net Clinics

In addition to area hospitals, health systems and FQHCs, the Kansas City region has a number of free clinics and other safety net providers that see significant numbers of uninsured patients on a no-fee or sliding fee scale basis. Some of these clinics are closely affiliated with area hospitals, while others are free-standing. A complete listing of free and reduced fee clinics may be found at <http://downloads.kclinc.org/HealthResourceGuide2006.pdf>. In addition, most local health departments offer some level of primary care and preventive services, including immunizations and maternal and child health services, while some offer full-service primary care clinics. The tables below list the Kansas and Missouri safety net clinics and the corresponding number of patients registered with KC CareLink. These numbers do not reflect the total number of patients served merely those utilizing referral and other services through KC CareLink.

Unduplicated patients registered in KC CareLink August 2006

<i>Kansas Safety Net Clinics</i>	<i>Registered Patients</i>
Duchesne Clinic	1,105
Partnership Clinic of Johnson County	NA
Silver City Health Center	574
Southwest Boulevard Family Health Center	54
Turner House Children's Clinic	2,446

Unduplicated patients registered in KC CareLink August 2006

<i>Missouri Safety Net Clinics</i>	<i>Registered Patients</i>
Cabot Clinic	9,869
Seton Family Health Center	5,104
Kansas City Free Clinic	8,610

Local Public Health Departments

- Public Health Department of Wyandotte County/Kansas City, Kansas
- Johnson County Health Department
- Leavenworth County Health Department
- Kansas City (MO) Health Department
- Jackson County Health Department
- Clay County Health Department
- Platte County Health Department
- Cass County Health Department

Local Initiatives to Improve Access

The Kansas City Metropolitan area has responded to the need for access to health care through a variety of initiatives designed to better manage how the indigent access services and at least one low-cost coverage product. The tables below summarize these initiatives into the following categories:

Access Initiatives

- Voucher/Donated Care Programs
- IT/Referral Systems
- Community Health Record (CHR) Initiatives

Coverage Initiatives

Innovative Funding Measures

In addition, the Kansas City region has a variety of funding measures in place to support access to care provided by safety net hospitals and clinics.¹⁴ These measures fund the care provided but do not manage or coordinate that care. They are listed here, however, because they represent potential sources of ongoing support as Kansas City looks to move toward an organized, rational system of care for its uninsured and underinsured.

Increased efforts have been started to improve coordination between programs and initiatives. In addition, the Chamber of Commerce of Greater Kansas City has formed a Health Council with representatives of hospitals, payers, and other providers to address access to health care.

¹⁴ Unless otherwise noted, all information on current local initiatives comes from the initiatives' web sites, discussions with initiative leadership and documents provided by initiative leadership.

Summary – Access Initiatives

Initiative	Description
Voucher/Donated Care Programs	
WyCare (Community Health Council of Wyandotte County)	The Community Health Council of Wyandotte County, Inc. is a 501(c)(3), not-for-profit, public/private collaborative, which exists to improve access to healthcare for the uninsured and the underinsured, to enhance health maintenance and prevention of health problems, and to facilitate coordination of community health services and health education initiatives. Formed in 2002, the Community Health Council's primary focus is to implement the key recommendations and vision of the Report of the Mayor's Access to Healthcare Commission, Wyandotte County, Kansas City, Kansas. Activities include implementation of the KC CareLink system in Wyandotte County safety net providers to facilitate electronic exchange and referrals, establishment of a voucher program for lab and pharmacy services, and conversion of the existing radiology voucher program to electronic format.
WyJo Care	The Medical Society of Johnson and Wyandotte Counties in collaboration with the Community Health Council of Wyandotte County launched a specialty care referral program in Wyandotte and Johnson Counties (WyJo Care), which is now fully operational and being managed by the Medical Society of Johnson and Wyandotte Counties. This initiative, which was initially financed with nearly \$180,000 in seed money from the Health Council's HCAP grant, began making referrals in the Summer of 2006.
Metropolitan Medical Society Referral Project / Specialty Healthcare Referral Network (formerly the Medical Outreach Project of the Center for Practical Bioethics)	<p>The goal of the Metropolitan Medical Society Referral Project/Specialty Healthcare Referral Network is to establish a fully functioning and collaborative metro-wide specialty care referral network facilitating free specialty healthcare referrals to patients who do not have access to coverage.</p> <p>A business plan is complete as of June 2006 for the Specialty Healthcare Referral Network (SHRN). The plan calls for implementation, contingent on funding, beginning in August 2006, with operations under the auspices of the Metropolitan Medical Society. Referrals would begin in early 2007, probably to volunteer cardiologists, ophthalmologists and ENTs. The project currently is analyzing electronic platforms for the referral network, including KC CareLink, Cerner and Blue Cross and Blue Shield of Kansas City. The intent is to facilitate movement toward an IT infrastructure that fits within a future regional community health record system and one that will include the uninsured. The project continues to work collaboratively on a potential physician recruitment barrier grounded in limited liability coverage for charitable providers by the Missouri state legal expense fund.</p>
Northland Health Access Project	<p>Northland Health Care Access (NHCA) has recently implemented a strategic plan that includes four main goals:</p> <ol style="list-style-type: none"> 1) To expand primary/preventive care services to include additional providers, 2) To increase the community investment from individuals, corporations, the faith community, and public and private foundations, ensuring increased access to health and dental care for the uninsured, 3) To increase the community awareness of NHCA mission and services made available through community partnerships, 4) To offer appropriate governance and staffing to support the mission of NHCA, its fundraising efforts, and health care programs

Initiative	Description
	<p>and services.</p> <p>NHCAs current activities include direct financial support to build primary care capacity within the Clay and Platte County health departments, as well as direct financial support to build capacity for prenatal care in the region through a contract with a large women’s health practice. NHCA is also planning to launch a “Project Access-like” program in the near future to enhance access to primary care in the region.</p>
IT/Referral Systems	
<p>KC CareLink</p>	<p>KC CareLink is a shared electronic information network linking Kansas City's major healthcare safety-net providers. KC CareLink facilitates electronic information exchange and referrals among providers, but is not an EMR.</p> <p>KC CareLink's mission is to ensure that providers across safety-net organizations can better coordinate and deliver healthcare to uninsured and underinsured patients that they jointly serve.</p> <p>20 organizations (more than 40 sites) currently use KC CareLink. There are approximately 130,000 unique patient records in the system.</p>

Community Health Record (CHR) Initiatives	
Ascension/Cerner Community Health Record Initiative	The Ascension Health System is in the early stages of discussions with Cerner about establishing a Community Health Record for the uninsured in the metropolitan area. The initiative would build on the long-standing business relationship between the two entities, which includes the development of a successful Community Health Record initiative in the Austin, Texas region. Details of the initiative are still under development, but Ascension representatives stress that it is their desire to work with Cerner to cooperate with rather than compete with existing initiatives in the region designed to improve the flow of information among safety net providers.
Healthe Mid-America	An independent non-profit designed to serve as a trusted agent for exchange of health information in the Kansas City region. Started in late 2005, Healthe is currently funded by approximately 20 area companies. The employees and dependents of those sponsors benefit from creation of personal entries in a Community Health Record (CHR) designed to help coordinate their care. The CHR contains patient information including demographics, claims, medications, allergies and lab results. Employers pay for Healthe, and employees and dependents are given the opportunity to opt out of participation. Cerner is providing its health care information technology for the program.
Kansas City Regional Electronic Exchange (KCREE)	Blue Cross and Blue Shield of Kansas City, St. Luke's Health System and Commerce Bank are currently piloting the KCREE system to electronically validate insurance coverage and process claims. It is envisioned that this system could evolve into a community health record.
Kansas Medicaid EMR Pilot – Sedgwick County ¹⁵	<p>The state of Kansas, Cerner Corp. and FirstGuard Health Plan Inc. have partnered to launch a new state program for sharing electronic medical records for Medicaid patients in Sedgwick County. The pilot is being funded by a \$750,000 state contract with FirstGuard, which has selected Cerner as a subcontractor. North Kansas City-based Cerner is providing its health care information technology for the program, which is expected to be extended to other Kansas Medicaid members in 2007.</p> <p>The Sedgwick County Community Health Record will collect patient demographic information, claimed clinician visits, dispensed medications and immunizations. In addition, all allergies are documented and KanBeHealthy screening forms are available to participants.</p>

Summary – Coverage Initiatives

Initiative	Description
BCBSKC CommunityBlue	<p>A high-deductible health insurance plan with a health savings account option in which employers agree to contribute at least 50 percent of the premium cost for each employee. Premiums are approximately 30% lower than traditional products.</p> <p>Employers must meet the following criteria:</p>

¹⁵ Kansas City Business Journal, “Cerner, others partner for electronic medical records,” April 7, 2006.

	<ul style="list-style-type: none"> • The employer group must have 99 or fewer employees. • Seventy-five percent of their employees must make less than \$30,000 per year. • The employer must not have offered health insurance to employees in the past 12 months. • Ninety percent of employees must live in the BCBSKC service area. <p>The Community Health Fund, a donor-advised fund within the Greater Kansas City Community Foundation established and funded by Blue Cross and Blue Shield of Kansas City, will help reimburse qualified employees for healthcare expenses incurred before they have met their deductibles if they have no other health coverage and their household income is less than 150% of the federal poverty level.</p>
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Summary – Indigent Care Financing Measures

Initiative	Description
Kansas City Indigent Care Tax Levy ¹⁶	<p>In 2005, Kansas City voters approved a nine-year increase in the tax levy of \$0.22 per \$100,000 of assessed value, bringing the total levy to \$0.72 per \$100,000 of assessed value, or approximately \$43 million in 2006.</p> <p>The levy funds are distributed as follows:</p> <p>FQHCs and other safety net clinics = \$3.9 million Children’s Mercy = \$1.2 million Truman Medical Center = \$24.9 million Ambulance Services = \$14.2 million (includes some \$ from public safety tax)</p>
Jackson County Support for Safety Net Providers ¹⁷	<p>The Jackson County safety net tax levy is distributed as follows:</p> <p>\$6.4 million for Truman Medical Centers for hospital operations, indigent care, and the Jackson County Health Department \$1.8 million for Inmate health care at the Jackson County Detention Center County also provides support for Children’s (\$500,000), Swope (\$280,000), Sam Rodgers (\$247,000) and other safety net clinics.</p> <p>In addition, Jackson County also has a separate Mental Health Tax Levy that supports the provision of mental health services.</p>
Kansas Health Insurance Tax Credit Program	<p>The 2005 Kansas Legislature approved a plan to enhance the tax credits given to small employers that begin offering health insurance.</p> <p>As a condition to participation as a member of any small employer health benefit plan, an employer shall have not contributed within the preceding two years to any health insurance premium or health savings account on behalf of an employee who is to be covered by the employer’s contribution other than a contribution by an employer to a health insurance premium or health savings account within the preceding two years solely for the benefit of the employer or the employer’s dependents.</p> <p>The credit is \$70 per month per eligible covered employee for the first 12 months of participation, \$50 per month per eligible covered employee for the</p>

¹⁶ 2006 Kansas City Budget documents.

¹⁷ 2006 Jackson County Budget documents.

	<p>next 12 months of participation and \$35 per month per eligible covered employee for the next 12 months of participation.</p> <p>Despite doubling the amount of the tax credit, take-up has reportedly been very low.</p>
<p>Kansas Medicaid Disproportionate Share Hospital Program (DSH)¹⁸</p>	<p>Kansas and Missouri hospitals are eligible to receive Kansas DSH payments under the same eligibility and payment criteria.¹⁹ Any hospital with a low-income utilization rate of 25% or more, or a Medicaid inpatient utilization rate of at least one standard deviation above the mean for Kansas is eligible for DSH payments according to the State’s payment formulae. Both Children’s Mercy and St. Luke’s qualify for Kansas DSH payments; Truman does not. KUMC is the largest recipient of Kansas DSH payments, but a large portion of these payments are financed by KUMC itself through certified public expenditures. Providence also receives a relatively modest DSH payment from Kansas.</p>
<p>Missouri Medicaid Disproportionate Share Hospital (DSH) Program²⁰</p>	<p>Virtually all Missouri hospitals qualify for DSH payments, but the level of payments varies greatly based on specific qualification criteria. The DSH program is financed through Missouri’s hospital provider assessment program. The administration’s FY 2007 budget proposed implementing rules that would severely limit the use of Missouri’s Federal Reimbursement Allowance (FRA) and result in reduced federal funds available for Missouri Medicaid.</p>
<p>Missouri Tobacco Tax Ballot Initiative (pending)²¹</p>	<p>Missouri voters will approve or reject a ballot initiative in November that would raise the tax on a pack of cigarettes by \$0.80, generating an estimated \$351 million annually. Funds would be used as follows:</p> <ul style="list-style-type: none"> • \$61 million for tobacco prevention education • \$102 million improving access under the Medicaid and SCHIP programs • \$102 million for primary care and specialty care physician reimbursement in the Medicaid program • \$44 million for trauma centers and hospital EDs that serve Medicaid and the uninsured • \$38 million for safety net clinics • \$4 million for emergency ambulance services

Need for a Regional Policy Planning Platform

As the discussion of national models below reveals, no one approach has proven to be the “magic bullet” for the communities where it operates. Many of these initiatives are quite small, yet fill an important void identified by their community. The result of this research and planning process in Kansas City has resulted in a list of several different – though coordinated – approaches to improving access to care.

¹⁸ Kansas State Medicaid Plan.

¹⁹ DSH is a payment adjustment under Medicare and Medicaid for hospitals that serve large numbers of low-income patients.

²⁰ Missouri State Medicaid Plan.

²¹ Kansas City Business Journal, “Cigarette tax advocates pick November ballot”, January 13, 2006.

National Models

Following is a discussion of several models that have been attempted elsewhere, with varying degrees of success. It is important to note that we are not aware of any initiatives that have been successfully implemented on a regional basis mirroring that of the Kansas City metropolitan area. This is not to say that such models could not succeed regionally, but that the unique geographic and political boundaries of the Kansas City metropolitan area add another layer of complexity, which have been addressed in the business plan (Appendix B). Consistent with the overview of existing initiatives in the Kansas City region, these models are organized into three categories: access models, coverage models and financing measures. While some stakeholders interviewed for this project believed that coverage (i.e., insurance or an insurance-like product) should be the ultimate goal of the Kansas City region, access models remain an important option for consideration, as they are often easier to implement than coverage programs and often reach the difficult-to-insure (e.g., undocumented immigrants) that coverage programs may miss.

In addition, we have included a brief fourth category that, while somewhat outside the scope of this project, is relevant to the discussion. This category includes broad statewide reforms to either directly provide coverage or mandate access for the uninsured, or to reform the insurance market in an effort to reduce the number of uninsured. More so than most of the other models discussed below, these models are truly statewide in nature and would require broad cooperation from both states to create systems that are equitable.

Access Models

Managed Care/Safety Net Models

In this model, a safety net system (or systems) that is already serving the uninsured organizes to coordinate and manage their care.²² These programs are not insurance, but seek to apply managed care principles to caring for the uninsured. Most managed care/safety net programs offer a medical home for members, gatekeeping for referrals, defined provider networks, inpatient care management and discharge planning and, in some cases, disease management programs.

Most programs have specific eligibility criteria (usually 200% of the FPL) and require rigorous screening of enrollees to ensure they are not eligible for public coverage or other coverage. Because these programs typically manage care for patients *who are already receiving care through the public or safety net system*, enrollment is generally quite high. While early evidence suggests that these programs are effective in increasing the use of primary care, reducing inappropriate use of the emergency room and minimizing unnecessary inpatient hospital days, they are not without cost. Sponsoring organizations (usually a hospital) often have to expand their ambulatory care infrastructure (or seek outside partners) to accommodate the increased demand for primary care, disease management and post-acute care.²³

²² Moylan C., *Managing Care for Uninsured Patients: Five Success Stories from America's Public Hospitals and Health Systems*. National Association of Public Hospitals, 2005.

²³ Ibid.

At least one community (Cook County, Illinois) has effectively extended this model into a public-private partnership that manages care through a network of private physicians, FQHCs and the Cook County health system.

Public/Private IT Referral Systems

Safety net systems are increasingly recognizing the importance of “rationalizing” specialty care visits to ensure that scarce specialty care resources are utilized appropriately and no specialty care visits are “wasted.” Specialty care referral systems have varying degrees of sophistication, but the most effective use a series of rules and criteria to maximize access for uninsured patients.

Community Health Record-Enabled Initiatives

This category encompasses initiatives that grew up around the desire to link together multiple safety net providers through a shared platform in order to better coordinate care for the uninsured. Unlike managed care/safety net initiatives, which typically involve a single health system, CHR initiatives try to bring together all safety net providers in the community. The shared CHR platform allows for uniform referral protocols, as well as uniform eligibility screenings regardless of where the patient is receiving care. The shared platform also serves as a valuable repository of data on the uninsured and how and where they are getting care, which may provide some of the most useful information to date in helping design access and coverage programs for the uninsured.

Donated/Discounted Care Programs (e.g., “Project Access” model)

In this model, participating providers agree to provide a fixed number of visits for free or at a reduced fee. The goal of this model is to provide structure to charity care provided by physicians and other providers, and to provide incentives for physicians to participate by allowing them to limit how many patients they see. Because these programs rely almost entirely on donated physician care (often with some grant support for administrative operations), they tend to be quite small. Nevertheless, the Project Access model is currently operating in more than 40 U.S. communities, making it one of the most prevalent local strategies.²⁴

Expanded FQHC Scope of Services

Federally Qualified Health Centers (FQHCs) and FQHC “Look Alikes” are eligible for cost-based Medicaid and Medicare reimbursement for providing specific preventive and primary care services. The federal government has recently started to recognize the critical role that FQHCs can and often do play in providing specialty care for their patients as well. We are aware of at least one FQHC that has received federal approval to include some specialty services -- provided on-site to FQHC patients -- within the FQHC’s “scope of services,” thereby making those services eligible for favorable cost-based reimbursement. Replication of this model elsewhere, if approved by the federal

²⁴ Taylor EF et al., “Community Approaches to Providing Care For the Uninsured,” *Health Affairs* web exclusive, April 11, 2006.

government, could greatly expand access to specialty care for underserved populations while also improving continuity of care.

Coverage Models

Medicaid/SCHIP Premium Subsidy Programs

While using Medicaid and SCHIP funds to help eligibles purchase employer-sponsored coverage has long been an option available to states,²⁵ few states have implemented programs of any size, due in large part to the administrative requirements imposed by the federal government. However, new flexibilities made available by the federal government under the Health Insurance Flexibility and Accountability (HIFA) waiver program have lessened some of the requirements related to benefit and cost sharing standards, as well as cost-effectiveness, making this option more attractive to states.

These programs do not, in and of themselves, represent an eligibility expansion. Rather, they provide another option for existing eligibles that might be more attractive than traditional public coverage. They also represent a potential source of savings to the state, which could be used to improve access elsewhere, though findings on actual savings indicate that, while these programs do save money, savings are often quite small due to the scale of the programs.²⁶

Limited Benefit Coverage Programs

This model encourages the creation of local limited-benefit coverage products through changes in state insurance regulation allowing the creation of small group limited-benefit products that are exempt from some state mandates and other insurance regulations. Often the products that result are high-deductible, catastrophic coverage products, which may not be well-suited to communities whose primary interest is encouraging early preventive care and appropriate use of specialty care. However, some communities have successfully developed limited benefit coverage models with a focus on primary care.

Three-share Programs

Several communities nationwide have implemented subsidized small employer insurance programs based on the “three-share” model, with premium costs split between the employer, employee and a public subsidy.²⁷ Many of these programs have struggled to gain the support of employers and, therefore, have had limited enrollment. Nevertheless, this strategy is attractive to many because of its employer-based approach and has recently gained attention at the federal level. A bill currently pending in the U.S. House of Representatives would make federal funding available

²⁵ Section 1906 of the Social Security created the Health Insurance Premium Payment Program, which authorized states to use Medicaid funds to pay the employee share of group health premiums where cost effective. States can also implement premium assistance programs in their SCHIP programs, according to guidelines outlined in the federal SCHIP regulations.

²⁶ Alker, Joan. “Premium Assistance Programs: How are they financed and do states save money?” Kaiser Commission on Medicaid and the Uninsured, October 2005.

²⁷ Note that some communities are also considering adding a “fourth share” to their programs, in the form of deep provider discounts.

to communities seeking to implement three-share or similar programs.

Limited Benefit Medicaid Expansions

At least one state has implemented – and other states are considering – a Medicaid eligibility expansion that provides coverage for limited benefits through a limited provider network. Matching funds for the expansion are provided by public providers (or other public funding sources) and services are limited to those available through those public providers.

Taxpayer-funded Health Coverage for the Uninsured

While many counties and localities have property tax levies dedicated to improving access to care for the uninsured, we are aware of only one county that has successfully passed a *sales tax* increase dedicated solely to financing *coverage* for the uninsured. Hillsborough County (Tampa), Florida is frequently held up as the model among community-sponsored programs for the uninsured. Residents who qualify are eligible to enroll in one of several managed care plans providing a reasonably comprehensive set of benefits, including inpatient and outpatient hospital services, physician services, pharmacy, lab and diagnostics. However, the Hillsborough County program is a model that is difficult to replicate elsewhere, especially in the current fiscal climate, because of its reliance on new revenue sources. Indeed, at least three sites – Portland, Oregon; Brooklyn, New York; and Jacksonville, Florida -- have sought unsuccessfully to replicate the Hillsborough model, and have been forced into the reality of trying to have an impact within existing resources.²⁸

Small Employer Purchasing Pools

Small employer purchasing pools seek to aggregate a large number of small firm employees to achieve choice of plans and lower rates that would not normally be available to small groups on their own. To maximize administrative efficiency, pools generally centralize administrative functions such as enrollment, premium collections and customer service. Pools also create participation rules, benefit plans and premium rating methodologies that are relatively uniform across all participating plans and are designed to minimize adverse selection into the pool. These programs are intended to reach the 63 percent of the uninsured who have an employed worker in their family. They are also intended to reflect worker preferences: the majority (56 percent) of employees would prefer to obtain health insurance through their employer, compared to 20 percent, who would prefer to buy it on their own.²⁹

To date, voluntary, unsubsidized pools have not attracted enough market share to generate competition for their business and realize significantly lower costs for small employers. However, several experts have speculated that, if some form of premium assistance – perhaps in the form of a public subsidy or a tax credit – were in place and were sufficiently large to attract significant enrollment, plans might be far more

²⁸ Brown, Lawrence and Beth Stevens. “Charge of the Right Brigade? Communities, Coverage and Care for the Uninsured,” *Health Affairs.*, April 11, 2006.

²⁹ Duchon, Lisa et al., “Listening to Workers: Challenges for Employer-Sponsored Coverage in the 21st Century,” The Commonwealth Fund, Publication No. 361 (January 2000).

motivated to participate in the pool, thus generating competition and savings.³⁰ Similarly, premium rating rules must be structured to balance the needs of the small employer groups with the needs of health plans to avoid excessive adverse selection and the ensuing insurance “death spiral.”

Tax Credits

While tax credits have received much attention at the national level as a potential means to decrease the number of uninsured, this approach has received limited attention at the state level, due in large part to tight state budgets. Tax credits to incentivize health insurance coverage can take three forms:

- Subsidizing an individual’s purchase of non-group coverage;
- Subsidizing an employer’s offer of health insurance; or
- Subsidizing and employee’s purchase of employer-sponsored coverage.

Several states, including Arizona and Maryland, have considered tax credits for individuals, employers or both, but have not implemented them. At the federal level, the Health Care Tax Credit Program (HCTC) provides a credit for up to 65% of health insurance premiums for individuals displaced by international trade. Experience to date with the HCTC program has been disappointing, however, indicating that tax credits alone are an unlikely solution.

Financing Measures

Physician Upper Payment Limit Programs

Federal Medicaid regulations allow states flexibility to disburse supplemental payments to cover the difference between standard Medicaid payments to physicians and the usual and customary charges or Medicare rates for physicians. These supplemental payments are often referred to as upper payment limit (UPL) programs.

Such a program could be implemented statewide (across both states) or could be limited to an individual counties or facilities. The non-federal share of the UPL payments may be generated in several ways:

- An intergovernmental transfer from public hospitals or medical schools; or
- A portion of the current tax levy funds.

Dental Upper Payment Limit Programs

At least one state has received federal approval to pay enhanced Medicaid reimbursement to public dental clinics to improve access to these clinics for Medicaid and uninsured

³⁰ See, for example, Curtis, Rick et al., “The Potential for a Small-Employer Purchasing Pool in Wisconsin: Issues and Options for Overcoming Barriers to the Development of the Private Employer Health Care Coverage Program (PEHCCP),” Institute for Health Policy Solutions (January 2003); or Trude, Sally and Paul G. Ginsburg, “Tax Credits and Purchasing Pools: Will This Marriage Work?,” Center for Studying Health System Change, Issue Brief No. 36 (April 2001).

patients. The enhanced reimbursement is financed through intergovernmental transfers from the public clinics and does not require any new state funds.

Statewide Reform Models

State Indigent Care Mandate

Under this model, the state (or states) mandate that individual counties pay for health care services for the indigent up to a specified FPL or spend a minimum percentage of their gross tax revenue on indigent health care. Counties then establish indigent care programs subject to the minimum standards set by the state. Counties may bill each other for care provided to indigent residents from other counties. This model is currently in place in Texas. While reasonably successful, disputes have arisen among bordering counties that have established indigent care programs with widely varying eligibility criteria.

Individual Mandate (e.g., “Massachusetts Model”)

Under this model, which was recently signed into law in Massachusetts, business must offer health insurance to their employees or pay a fine, which will be used to partially finance coverage for the uninsured. This initiative will be closely watched as a possible model for other states. However, it is important to note that Massachusetts has a history of generously funding low-income health care through a combination of state funds, assessments on health plans and providers and matching federal dollars. As a result, the new legislative mandate is expected to be financed almost entirely with existing funds. Most other states would have to raise significant new revenues to finance such an initiative.

Statewide Small Group/Individual Insurance Reforms

This model involves broad, statewide insurance reform to encourage enrollment in small group and individual health insurance through streamlined benefits and state subsidies. The New York State’s Healthy NY program is the longest-running example of this model. All HMOs in New York State offer the streamlined, yet comprehensive Healthy NY health insurance benefit packages to eligible businesses and individuals.

In recent years, a variety of federally funded and private grant programs have led to the creation of dozens of “local laboratories” all exploring models of improved care for or coverage of the uninsured. Within a three year period (1998-2000), the Robert Wood Johnson Foundation’s Communities in Charge Program, the Kellogg Foundation’s Community Voices Program, and the federal Healthy Communities Access Program (HCAP) all came into being, directing several hundred million dollars into the development of local models to address the issue of the uninsured.

The tables below provides illustrative examples of health care access initiatives nationwide, many of which originated out of one or more of these grant programs. It is not intended to be a comprehensive listing but, rather, a representative sampling of the types of models that have been tested in recent years.

Summary – Access Models

Program/Initiative	Jurisdiction	Description
Managed Care/Safety Net Models		
Suburban Cook County Access Program	Suburban Cook County (Chicago), IL	<p>Funded significantly (but not exclusively) by a line-item in the Cook County Bureau of Health Services budget, the Suburban Primary Health Care Council operates the Access to Care program which is a unique public/private partnership that makes primary health care, pharmacy, laboratory and radiology services available to low-income, uninsured individuals in suburban Cook County and northwest Chicago. While Access to Care relies on Cook County specialty and inpatient services, the program organizes the provision of charitable primary health care services by contracting with local physicians and paying them a discounted rate (\$68 per patient per year). A modest enrollment fee and small co-payment is requested of program enrollees. Eligibility requirements include: family income below 200% of the federal poverty level, no health insurance (or a deductible of \$500 or more per person); ineligibility for Medicare or Medicaid, and; residence in suburban Cook County or northwest Chicago.</p> <p>In 2004, nearly 12,000 individuals were served by Access to Care with a total of 44,925 prescriptions dispensed, 9,917 laboratory and 919 radiology procedures conducted.</p>
Ingham Health Plan	Ingham County (Lansing), Michigan	<p>The Ingham Health Plan is an indigent care financing program that helps uninsured residents access primary care, as well as prescription drugs, diagnostics and necessary inpatient care. IHP is not insurance. Members must receive all primary care services from the primary care practice to which they are assigned. The program is financed through county and state funds, which are matched with federal Medicaid funds and pooled by local providers to support the program.</p> <p>In the past five years, enrollment in IHP has more than doubled and now includes 15,000 people, roughly half of the county's uninsured population.</p>
Boston CareNet	Massachusetts (provider network is limited to Boston area)	<p>Established in 1997, CareNet is funded primarily from the state's uncompensated care pool, which was established in 1985 to fund health care services for uninsured individuals through a combination of state, federal and provider tax dollars. Average enrollment in CareNet is 22,000. Individuals must be below 200% FPL; the eligibility period is one year.</p> <p>The provider network includes Boston Medical</p>

Program/Initiative	Jurisdiction	Description
		<p>Center and 15 community health centers. 80% of enrollees receive their primary care at one of the community health centers. Benefits include inpatient and outpatient care, as well as lab, pharmacy and diagnostics.</p> <p>The program is operated by BMC's Medicaid managed care plan, allowing it to take advantage of sophisticated information systems and other infrastructure.</p>
Indianapolis Health Advantage	Marion County, Indiana	<p>Established in 1997, Health Advantage serves uninsured individuals under 200% FPL who reside in Marion County (U.S. citizenship is not considered). The program has 48,000 enrollees and is funded through the county tax levy that supports indigent health care.</p> <p>The provider network includes Wishard Hospital (the only public hospital in Indianapolis), Indiana University Medical Group (IUMG), seven hospital-affiliated clinics and four IUMG-owned commercial sites. The program added nine additional free-standing clinics to the program in 2001 to provide additional primary care services.</p> <p>Health and Hospitals Corporation (HHC), the parent organization of Wishard and the Indianapolis Public Health Department, provides the hospital and faculty practice plan with a capped amount every year to offset the cost of caring for Health Advantage enrollees. HHC also pays the faculty practice plan to serve as the third-party administrator for the program. The expanded free-standing clinic sites are paid \$10 pmpm to compensate providers for administrative costs, including filing "shadow claims" for members to track actual utilization</p>
Public/Private IT Referral Systems		
Cook County Bureau of Health Services Internet Referral Information System (IRIS)	Cook County (Chicago), Illinois	<p>CCBHS (Bureau) has had a twenty year history of a formal affiliation with FQHCs, through its Neighborhood Referral Program, in which the Bureau deflected patients using emergency rooms for primary care to FQHCs if the patients live in communities where there are no Bureau health centers. In return for accepting these referrals (of primarily uninsured patients), the FQHC patients were provided pharmaceutical and lab support by the Bureau. In addition, the Bureau and the FQHCs have attempted to rationalize referrals into the Bureau for specialty services. This has been accomplished through the development of the Internet Referral Information System (IRIS), a decision support system developed in collaboration with the Bureau's clinical departments. The FQHCs access the IRIS software through the internet to</p>

Program/Initiative	Jurisdiction	Description
		<p>facilitate a referral. For each type of referral, a series of questions must be answered to help determine the appropriateness of the referral and to identify the prior tests/diagnostics that must be completed before an appointment can be made. This system handles approximately 11,000 referrals a month, thirty percent of which come from the FQHCs, and has virtually eliminated unnecessary referrals into coveted specialty and diagnostic appointment slots.</p>
Community Health Record-Enabled Access Models		
Indigent Care Collaboration	Travis (Austin), Hays and Williamson Counties, Texas	<p>The ICC is a coalition of safety net providers in three Texas Counties that have come together to build a master patient index/clinical data repository through which they can build shared electronic medical records. The ICC has also developed a common eligibility program through which the uninsured are screened for eligibility for medical assistance and charitable programs.</p> <p>By mid-2004, ICC had achieved several milestones, including:</p> <ul style="list-style-type: none"> • 300,000 patients and one million encounters in the system • More than 30 hospital, clinic and physician office locations participating • 100,000 uninsured patients screened for medical assistance programs • Assisting 2,000 patients in enrolling in medical assistance programs, generating more than \$2 million in new revenue for safety net providers.
Cerner Community Health Record Initiative	Tennessee; Palm Beach County, Florida	<p>Cerner Corporation is providing Community Health Records to TENNCARE and Blue Cross/Blue Shield, the state of Tennessee's Medicaid administrator. Currently 1.3 million Medicaid patient records are available in the community health record to Tennessee providers. This same infrastructure is being used by Palm Beach County Health Alliance, a coalition for the uninsured and Community Health Centers in Florida</p>
Donated/Discounted Care Models		
Health Care Connect	Maricopa County (Phoenix), Arizona	<p>HealthCare Connect is a non-profit organization that connects low-income, uninsured residents of Maricopa County to a network of participating hospitals, physicians, clinics and other providers. HealthCare Connect is a medical discount program, not insurance. Members pay an annual enrollment fee of \$50 for individuals or \$100 for families of two or more. The program was created under a federal Healthy Community Access Program (HCAP) grant. As of February 2006, HealthCare</p>

Program/Initiative	Jurisdiction	Description
		had 19 participating hospitals and 14 participating health centers in its network. Since its inception in September 2004 through December 31, 2005, the program saw 899 private professional encounters and 67 hospital encounters.
Buncombe County Medical Society Project Access	Buncombe County (Asheville), North Carolina	In 2004, BCMS Project Access, a network of 537 volunteer practitioners (85% of the practitioners in the county) provided approximately \$8 million in uncompensated care. According to the organization, the continuity of care provided through Project Access has resulted in a significant decline in unnecessary emergency room utilization, a decrease of \$10,000/month in uncompensated hospital care (by providing effective treatment to prevent hospitalization), at the same time improving the health of those patients that would otherwise be uninsured.
Expanded Scope of FQHC Services to Include Limited Specialty Care		
Access Community Health Network (ACHN)	Cook County (Chicago), Illinois and DuPage County, Illinois	The Access Community Health Network (ACHN), a large FQHC in Chicago and suburban Cook County, Illinois, has received federal approval to include specialty services within its approved scope of services. This enables ACHN to receive cost-based reimbursement from Medicare and Medicaid for these services and to better coordinate and ensure access to specialty care for its patients. To be eligible for the enhanced reimbursement, the services must be provided by ACHN or ACHN-contracted providers to patients of the FQHC at an FQHC federally recognized health center site.

Summary – Coverage Models

Program/Initiative	Jurisdiction	Description
Medicaid/SCHIP Premium Subsidy Programs		
Illinois KidCare Rebate	Illinois	The State of Illinois SCHIP program includes Family Care/All Kids Rebate as one of its options. Families may get up to \$75 per person per month to offset the family's premium cost of employer based insurance or private insurance that covers doctor and inpatient care. If a family qualifies for other SCHIP coverage, they may switch from rebate at any time. Current enrollment in the program is approximately 5,800.
Rhode Island Premium Assistance Program	Rhode Island	Rhode Island's premium assistance program covers children and pregnant women under 250% FPL and parents under 185% FPL. Enrollment is mandatory if the individual has access to approved employer-sponsored plan. Premiums are paid through a

Program/Initiative	Jurisdiction	Description
		<p>combination of employer contributions, individual contributions (for those over 150% FPL) and a Medicaid subsidy.</p> <p>2005 enrollment in the program was 6,012, making it one of the largest premium subsidy programs in the nation.</p>
Limited Benefit Coverage Programs		
Muskegon Access Health Plan	Muskegon County, Michigan	<p>Access Health is generally regarded as a successful, albeit limited, community-based approach to expanding health care coverage to uninsured workers. Access Health is known as a “three-share plan”: Employers and employees each pay 30 percent of the cost of the program. The remainder is financed through federal Medicaid Disproportionate Share Hospital (DSH) funds.</p> <p>By the end of 2004, Access Health was serving more than 420 employers and 1,150 employees and dependents. Employee and employer premiums have not increased since 2003. The community share was \$46 per member per month in 1999, and reached \$62 in 2003.</p> <p>Access Health covers a comprehensive array of health care services, but with exclusions. Inpatient and outpatient services are covered, as are primary and preventive care services, emergency room care, and prescription drugs. Health care services are provided only within Muskegon County.</p>
FlexCare	Miami, Florida	<p>FlexCare originated as a result of state legislation allowing the creation of limited benefit coverage products, but it is administered at the local level. Eligibility criteria include income below 200% FPL, state residency and no coverage for the last 6 months. The county’s property-tax financed health trust subsidizes premiums for individuals under 150% FPL. Enrollment in the program is less than 1,000.</p>
Regional Coverage Waiver	State of Iowa (though provider network is limited to Des Moines)	<p>Iowa recently received federal approval for an innovative waiver program that allows that state to implement a Medicaid expansion that limits the patient population to patients of a particular provider network and limits benefits to certain services provided only by that provider network. The expansion is funded by using previously unmatched state, county and other public provider funds. The expansion covers individuals up to 200% FPL, including childless adults.</p>
Taxpayer-Funded Health Insurance Coverage		
Hillsborough County	Hillsborough County	The Hillsborough County Health Care Plan is a

Program/Initiative	Jurisdiction	Description
Health Care Plan	(Tampa) Florida	comprehensive managed care plan for indigent residents with incomes up to 100% of the Federal Poverty Level who do not qualify for other coverage. The program is administered by the County Department of Health and Social Services and offers five health plans with access to primary care, specialists, inpatient and outpatient hospital services, diagnostics and prescription drugs. The program is funded through a ½ cent sales tax approved by the County Commission in 1991.
Portland (Oregon) Communities in Charge (CIC) Project	Multnomah, Washington and Clackamas Counties, Oregon	<p>Originally envisioned as an initiative to, among other things, create a regional taxing district to support access to indigent care in the tri-county area, this project morphed into an effort to better organize existing resources dedicated to indigent care. The regional taxing district was viewed skeptically by the two predominantly rural/suburban and conservative counties surrounding Portland as merely a means to redistribute dollars from themselves to Portland providers.</p> <p>It remains unclear to what extent the project will have an impact on access to indigent care in the region. Distrust permeated negotiations throughout the CIC project, limiting progress on even such seemingly innocuous strategies as coordinating grant seeking among safety net providers, using data to paint a picture of the uninsured and where they were getting care, and coordinating plans to leverage new federal dollars for the uninsured.</p>
Small Employer Purchasing Pools		
Kansas Business Health Partnership	State of Kansas	<p>In 2001, Kansas implemented a small employer pooling mechanism called the Kansas Business Health Partnership. The pool, a non-profit organization, purchases coverage via the private market with the stipulations of employee choice, minimizes administrative costs, and the benefits meet standards of federal and state law. The original legislation would have made subsidies available for low-income workers to purchase health insurance through the partnership, but budget troubles delayed the subsidy.</p> <p>In 2005, the Kansas Legislature authorized \$500,000 for subsidies. The original partnership has been dissolved and will be reorganized.</p>
Tax Credits		
Kansas Health Insurance Tax Credit Program	Kansas	The 2005 Kansas Legislature approved a plan to

Program/Initiative	Jurisdiction	Description
		<p>enhance the tax credits given to small employers that begin offering health insurance.</p> <p>As a condition to participation as a member of any small employer health benefit plan, an employer shall have not contributed within the preceding two years to any health insurance premium or health savings account on behalf of an employee who is to be covered by the employer's contribution other than a contribution by an employer to a health insurance premium or health savings account within the preceding two years solely for the benefit of the employer or the employer's dependents.</p> <p>The credit is \$70 per month per eligible covered employee for the first 12 months of participation, \$50 per month per eligible covered employee for the next 12 months of participation and \$35 per month per eligible covered employee for the next 12 months of participation.</p> <p>Despite doubling the amount of the tax credit, take-up has reportedly been very low.</p>

Summary – Financing Measures

Program/Initiative	Jurisdiction	Description
Physician UPL Programs		
Michigan Physician UPL Program	Michigan	Effective March 1, 2004, the Michigan Medicaid Program began reimbursing physicians affiliated with public providers at Medicare rates, financed through transfers from the public providers. This change represented a 50% increase in gross reimbursement to eligible providers.
Dental UPL Programs		
Public Dental Clinic Enhanced Reimbursement Program	Michigan	The Michigan Medicaid program received federal approval to reimburse public dental clinics at the average commercial rate for Medicaid dental services. The goal of the program is to increase access to dental services for Medicaid patients. The enhanced rate is financed through intergovernmental transfers from the public clinics and does not require any new state funds.

Criteria for Evaluation

The purpose of this project is to develop potential strategies to improve access to care for the uninsured (and underinsured) in the Kansas City region through access strategies, coverage strategies or a combination of measures. The national models presented above

provide some lessons and important insights into what may or may not be feasible in the Kansas City region. Narrowing these models to a set of options that are both feasible and effective in Kansas City required developing a set of criteria against which to measure and prioritize the models. These criteria presented to the MARC Technical Advisory Committee, the Chamber's Health Council, and included in the interim report that was widely distributed include the following:

- *Complexities of applying regionally.* Most of the models that have been implemented around the nation apply to a single community. There are successful examples of cross-community cooperation in indigent health care, including the Indigent Care Collaboration in the Austin, Texas region and KC CareLink's work on both sides of the Kansas and Missouri state line. However, those that have attempted to do large-scale reform at a regional level (e.g., Portland, Oregon Communities in Charge program) have quickly learned the complexities of such an undertaking.
- *Presence of an identifiable, sustainable revenue source.* Throughout the preparation of this report, HMA's working assumption was that few or no new state or local funds were likely to become available to support access to care for the uninsured. Thus, each of the specific recommendations below rely heavily on maximizing existing revenue sources either by generating federal matching funds, where appropriate, or better utilizing existing funds to provide more coordinated care.
- *"Fit" with the regional safety net.* As noted above, Kansas is home to a large, public academic medical center. Kansas City, Missouri is home to Truman, a not-for-profit medical center that serves predominantly Medicaid and uninsured individuals and receives significant local tax support. Kansas City, Missouri and Jackson County also support their other safety net providers through distinct tax levies dedicated to indigent health care. These public funds represent potential sources of support for an organized system of care for the indigent in the region. However, funding must also be identified to support indigent care on both sides of the state line to ensure a seamless, integrated system of care.
- *Potential for expanding access.* Many of the models that have been applied around the country are quite small; some intentionally so, while others have failed to reach the scale envisioned by their creators. Nationally, policymakers have found that programs that seek to improve access tend to be easier to implement and have a more immediate impact than programs that try to expand public or private health insurance coverage.³¹ Programs that expand coverage, however, may offer greater advantages related to care management, especially for those with chronic conditions.

Demographic data indicate that programs targeted to those below 200% FPL will

³¹ Brown, Lawrence and Beth Stevens. "Charge of the Right Brigade? Communities, Coverage and Care for the Uninsured," *Health Affairs.*, April 11, 2006.

reach the largest segment of uninsured in the region. However, programs that are highly targeted at the working uninsured with slightly higher incomes could also be very effective, especially in certain areas of Kansas, where higher income groups make up the majority of the uninsured.

- *Care management/care coordination capacity.* Stakeholders interviewed for this report consistently noted at least two significant problems in the regional safety net: 1) failure to get individuals in for regular, preventive care; and 2) lack of access to specialty care. Both of these indicate a need for a solution or set of solutions that, at a minimum, link individuals to a medical home for all primary care services and provide an organized network for specialty referrals that maximizes access by ensuring that specialty care is utilized appropriately and rationally. IT platforms for specialty care referrals and/or electronic medical records are an important component of this.
- *Likely support from provider community, health plans and business/civic leadership.* The single unifying theme from health care access initiatives around the country is that they cannot succeed without a “champion” or, ideally, multiple “champions.” This is even more likely to prove true in a region with the geopolitical complexity of Kansas City. In many cases, the provider community has successfully aligned behind the creation of programs to ensure access for the uninsured. However, as dollars for indigent health care become more and more scarce, the support of the business and civic communities has become even more critical.
- *Ability to quantify the impact of the initiative.* Whichever strategies are ultimately adopted in the Kansas City region, it will be critical to ensure that there is a system in place against which to measure actual improvements in access to care. Such data is critical to sustaining support for programs on an ongoing basis.

Recommendations

The recommendations below offer several targeted strategies that have the potential to have a significant positive impact on access to care in the Kansas City region. Each strategy is aimed at addressing one or more shortcomings in the current regional safety net as identified by recent research, demographic data, and discussions with key stakeholders. While each strategy could be implemented separately, the intention is that they be evaluated and ultimately implemented as a coordinated, regional approach. It is important to note, however, that especially where the use of public funds is concerned, the state line does pose significant – though not insurmountable – obstacles. Overcoming these obstacles will require the close coordination of providers, Medicaid officials and other stakeholders on both sides of the state line. At the same time, the Kansas City health care community has a history of collaboration on access to care issues on which to build.

As part of this project, HMA shared the interim report recommendations with both the Missouri and Kansas state Medicaid directors. Kansas Medicaid officials were very open to giving the report's recommendations strong consideration and to working with the Kansas City region on access initiatives. Missouri Medicaid officials, while also receptive to the report's recommendations, are currently focusing their efforts on restoring the devastating cuts to their program that went into effect last year.

The recommendations in this report fall into three general themes: 1) formalize coordination among the safety net and maximize the value of specialty care; 2) maximizing federal funding; and 3) targeted coverage expansions.

Formalize Coordination among Safety Net Providers and Maximize the Value of Specialty Care

- *Formalize Managed Care/Safety Net System Among Safety Net Providers.* Regardless of which coverage approaches are ultimately implemented in the Kansas City region, many individuals will remain uninsured. Thus, there will continue to be pressure on core safety net providers to provide care in a coordinated, cost-effective manner.

Safety net providers on both sides of the state line should carefully evaluate the feasibility of establishing a single virtual managed care/safety net system that assigns each uninsured individual to a medical home and manages their care. These programs are not insurance per se, but rather seek to coordinate care for the uninsured. Most managed care/safety net programs offer a medical home for members, coordinated referrals, defined provider networks, inpatient care management and discharge planning and, in some cases, disease management programs. Screening for the managed care/safety net program should be closely coordinated with eligibility screening for Medicaid and other programs, consistent with the recommendation below. Referrals within the virtual managed care network should be carefully managed through a rules-based system as also discussed below.

- *Enhance and Coordinate Eligibility Screening Functions.* Several recent studies examining the uninsured in the Kansas City region noted that both states have significant numbers of individuals who are eligible for public coverage but are not enrolled. These individuals frequently receive their primary care in emergency rooms at a substantial cost to local taxpayers.

While it is unreasonable to suggest that Kansas and Missouri completely align their Medicaid eligibility criteria and processes, both states could employ similar strategies toward maximizing enrollment of the eligible-but-uninsured. These strategies ensure that individuals are enrolled in the most comprehensive coverage for which they are eligible while also ensuring that local dollars supporting indigent health care are directed toward those who truly have no other source of coverage.

In addition, by utilizing uniform Medicaid eligibility screening forms for Medicaid as well as other insurance or access programs (e.g., a regional coverage waiver program, managed care safety net program, Project Access programs or other indigent care programs), federal Medicaid administrative matching funds may be available to offset the cost eligibility screening. Several states, including Indiana and Illinois, have established eligibility screening models that allow providers and other organizations to receive compensation for performing Medicaid eligibility functions that, in some cases, simultaneously screen for eligibility for other access or coverage programs.

- *Develop and Implement a Rules-Based Referral System.* In many safety net systems across the country, including Kansas City, specialty care has not, for the most part, been systematically approached to assure that those services are provided productively and appropriately. They have not been systematically assessed to determine: 1) the total predictable demand for each specialty; 2) the appropriateness of specialty care referrals; 3) the process for referring patients into care and assuring that they get returned to their primary care provider; and 4) capacity in the system to meet the demand.

Many area providers are currently using the KC CareLink system for referrals, but this system currently lacks a set of uniform rules to help “rationalize” the provision of specialty care. While the Kansas City region has multiple Electronic Medical Record/Community Health Record initiatives underway, management of specialty referrals is not the principle focus of these initiatives.

Kansas City safety net providers should work collectively to establish a set of uniform rules to prioritize specialty visits and ensure that no visits are wasted due to incomplete prerequisite tests or other reasons. These rules could be built into an existing electronic platform or established as a stand-alone referral system. In addition, federal Medicaid matching funds may be available to support at least some of the costs of a referral system, assuming that the same system is used for Medicaid as well as uninsured patients.

Maximize Federal Funds Coming to the Region to Expand Access

- *Physician UPL Program.* During the course of preparing this report, access to specialty physician care was consistently cited as one of the largest gaps in the regional safety net, due at least in part to insufficient reimbursement from payers. Physician upper payment limit (UPL) programs promote improved access by increasing Medicaid reimbursement rates for public providers to rates at or near commercial levels. Providers should be required to report specific metrics and demonstrate improved access in order to be eligible for enhanced reimbursement. While UPL payments are tied to Medicaid patients and do not directly support access for the uninsured, they help safety net providers remain financially sound, thus creating or at least maintaining access for the uninsured.

- *Dental UPL Program.* Poor access to dental care for both Medicaid and uninsured individuals was cited frequently by individuals interviewed and research reviewed for this report. Under this program, public dental providers would be paid rates mirroring commercial rates for services provided to Medicaid patients. The program would be financed through intergovernmental transfers or certified public expenditures from the public providers. While the payments are not directly linked to care or access for the uninsured, ensuring adequate Medicaid payments will help dental providers open up their access to the uninsured and may encourage additional providers to enter the market.

Implement Targeted Coverage Expansions

- *Implement Premium Subsidy Program Coordinated with BCBS CommunityBlue and Other Private Coverage.* With the introduction of the BCBS CommunityBlue product, the Kansas City region is uniquely positioned to implement a successful Medicaid premium subsidy program to encourage enrollment of low-income workers into private coverage. Under this program, individuals who qualify for Medicaid under current eligibility criteria and who have access to employer-sponsored insurance (ESI) could receive a subsidy to enroll in ESI in lieu of direct Medicaid coverage.³²

The addition of a Medicaid subsidy will make ESI a more affordable option for low-income workers. Any Medicaid-eligible employee with access to a qualified ESI product could participate. For employees who enroll in the new CommunityBlue product, the addition of a Medicaid subsidy could allow current BCBS subsidy dollars to be stretched further to cover additional individuals who are not Medicaid-eligible. Additionally, if a subsidy is made available the benefits may also need to be expanded to cover primary and preventative care. Office visits and routine preventive care were deductible then 100% coinsurance and 100% respectively for Indiana.

- *Regional Coverage Waiver.* HMA recommends that Missouri and Kansas pursue limited network/limited benefit Medicaid waivers that would expand eligibility up to 200% FPL for all individuals, thus capturing a significant segment of uninsured in the region. These waivers could be pursued individually by each state but we believe CMS may react favorably to a joint waiver proposal from both states that seeks to create a truly regional approach to expanding coverage for the uninsured.

Consistent with the recently approved Iowa waiver, non-federal matching funds could be provided by new or existing indigent care resources, including funds that support public providers in both states and tax levy funds that support private safety net providers. The provider network for the expansion program may be limited to those organizations financing the program. This option is more of a

³² Note: CMS may require Kansas and Missouri to offer “wrap-around” benefits to the ESI product if it determines that the benefits are not comprehensive enough.

long term objective due to the complexity of obtaining approval, as well as concerns raised by key providers who are needed to make this plan viable.

Conclusion

There is ample opportunity in Greater Kansas City for improving the coordination and continuity of care for the medically indigent population. This improvement is possible through the unique strengths of the Kansas City community. One of the greatest assets is the passion and desire of the civic leadership and health care community to solve the challenges posed by decreasing Medicaid reimbursement and increasing numbers of unfunded patients. Coupled with this desire is the development of several initiatives that have developed some infrastructure to support expanded health care access. The will exists; the coordination and execution is where Kansas City must expend its efforts.

As it stands now, there are a number of different groups in the health care community, each trying to do what it can for the benefit of the medically indigent. To effect meaningful change in the system, coordination and cooperation are going to be of paramount importance or the potential for overlapping and duplicative efforts will continue. Additionally, all groups must participate in a regional effort for sustainable progress to be made. Sometimes lost in the shuffle are the physicians, those who actually provide the clinical care. It will take the participation of the entire community, with doctors playing a prominent role, to implement the recommendations and accomplish the goals set out in this report.

In Appendix D (Business Plan), HMA recommends the formation of a Health Care Safety Net Board to oversee the implementation of the initiatives in this report as well as to monitor changes in the health care industry and delivery system to enable Greater Kansas City to keep pace in meeting future demands. As the Board convenes, hard choices will inevitably arise, and it is the duty of the Board to ensure that decisions are made, and are made in the best interests of the entire community. The provider community may be tested most of all, but it is vital to the effort that they are willing to look at the big picture.

One of the key responsibilities of this Board will be to communicate to the broader community the focused attention on the issues surrounding the uninsured, the challenges funding their care presents to providers and the subsequent impact on everyone who lives in greater Kansas City. The Board must also share its vision of the future of health care in Kansas City, highlight the efforts currently underway to achieve the vision, as well as the new initiatives required to ultimately realize the vision.

This endeavor will require a long, sustained effort. Not only will many of HMA's recommendations take a good deal of time to implement, they must also be nurtured and maintained. Other cities and counties across the nation are no longer waiting for a national or a state solution, as none appears to be on the horizon. The "solutions" will be multi-faceted and will involve community and business leaders, health care providers and elected officials to use creativity and draw on the best practices of other communities to devise strategies that will be effective here. HMA firmly believes that Kansas City has

the resources, the people, and the drive to improve its access to care and to serve as a model for the rest of the country.

Appendix A - Kansas City Metropolitan Area - Hospital Charity Care and Uncompensated Bad Debt (2004)

Hospital	Type of Hospital (1)	Charity Care(2)	Uncompensated Bad Debt(3)	Total Uncompensated Care (4)	Total Expenses (5)	Local Tax Subsidy	Uncompensated Care as % of Total Expenses	Uncompensated Care as % of Total Expenses(6)
Kansas Hospitals								
Providence Medical Center	NFP	\$4,096,124	\$3,722,287	\$7,818,411	\$136,580,260		5.7%	5.7%
University of Kansas Hospital	Public	\$5,749,744	\$16,270,047	\$22,019,791	\$423,467,741		5.2%	5.2%
Overland Park Regional Medical Center	Proprietary	\$332,430	\$4,372,877	\$4,705,307	\$109,019,000		4.3%	4.3%
Shawnee Mission Medical Center	NFP	\$2,237,234	\$5,788,242	\$8,025,476	\$256,249,392		3.1%	3.1%
Saint Luke's South Hospital	NFP	\$236,000	\$1,253,000	\$1,489,000	\$68,964,910		2.2%	2.2%
Menorah Medical Center	Proprietary	\$288,661	\$1,463,225	\$1,751,886	\$113,400,000		1.5%	1.5%
Missouri Hospitals								
Truman Medical Center	NFP	\$38,455,234	\$7,231,246	\$45,686,480	\$343,681,523	\$35,000,000	13.3%	3.1%
Two Rivers Psychiatric Hospital	Proprietary	\$702,871	\$418,603	\$1,121,474	\$12,888,155		8.7%	8.7%
Saint Luke's Northland Hospital	NFP	\$1,203,000	\$2,482,000	\$3,685,000	\$59,392,721		6.2%	6.2%
Bates County Memorial Hospital	Public	\$115,065	\$1,612,281	\$1,727,346	\$27,936,302		6.2%	6.2%
Excelsior Springs Medical Center	Public	\$67,113	\$920,073	\$987,186	\$16,579,025	\$201,399	6.0%	4.7%
Research Psychiatric Center	Proprietary	\$177,529	\$693,574	\$871,103	\$17,854,710		4.9%	4.9%
Research Belton Hospital	Proprietary	\$180,154	\$1,013,461	\$1,193,615	\$30,552,709		3.9%	3.9%
Lafayette Regional Health Center	Proprietary	\$47,461	\$837,365	\$884,826	\$23,849,956		3.7%	3.7%
Cameron Regional Medical Center	NFP	\$6,525	\$938,647	\$945,172	\$26,324,488		3.6%	3.6%
Independence Regional Health Care	Proprietary	\$1,029,759	\$2,315,856	\$3,345,615	\$99,835,830		3.4%	3.4%
Cass Medical Center	Public	\$32,337	\$869,065	\$901,402	\$27,766,645	\$1,229,449	3.2%	-1.2%
Medical Center of Independence	Proprietary	\$324,154	\$1,907,802	\$2,231,956	\$71,365,949		3.1%	3.1%
Saint Luke's Hospital of Kansas City	NFP	\$5,431,000	\$5,188,000	\$10,619,000	\$350,335,139		3.0%	3.0%
Liberty Hospital	Public	\$352,631	\$3,239,508	\$3,592,139	\$120,426,810	\$775,404	3.0%	2.3%
North Kansas City Hospital	Public	\$770,986	\$6,839,287	\$7,610,273	\$273,672,931		2.8%	2.8%
St. Mary's Medical Center	NFP	\$406,653	\$1,399,905	\$1,806,558	\$65,782,944		2.7%	2.7%
Research Medical Center	Proprietary	\$1,061,413	\$6,043,251	\$7,104,664	\$273,612,110		2.6%	2.6%
Ray County Memorial Hospital	Public	\$31,074	\$357,619	\$388,693	\$15,645,422	\$409,270	2.5%	-0.1%
St. Joseph Medical Center	NFP	\$930,193	\$2,560,400	\$3,490,593	\$153,493,867		2.3%	2.3%
Children's Mercy Hospitals and Clinics	NFP	\$7,518,533	\$1,229,843	\$8,748,376	\$325,553,333	\$3,929,774	2.7%	1.5%

Baptist-Lutheran Medical Center	NFP	\$242,624	\$2,023,396	\$2,266,020	\$129,058,444		1.8%	1.8%
Lee's Summit Hospital	Proprietary	\$96,952	\$729,387	\$826,339	\$51,789,183		1.6%	1.6%
Crittenton Children's Center	NFP	\$141,000	\$79,000	\$220,000	\$17,504,876		1.3%	1.3%
Kindred Hospital	Proprietary	\$0	\$76,618	\$76,618	\$24,217,547		0.3%	0.3%
HCA Midwest Health System	Proprietary	\$0	\$1,123,133	\$1,123,133	NA			
Saint Luke's Health System	NFP	\$297,000	\$869,000	\$1,166,000	NA			
Kansas City Metro Region Total		\$72,561,454	\$85,867,998	\$158,429,452	\$3,666,801,922	\$41,545,296	4.3%	3.2%

Source: Missouri Hospital Association Community Benefit Report -- May 2006 (data is based on hospitals' 2004 fiscal year)

(1) Missouri Hospital Association

(2) Charity care is defined as the amount of free care (at cost) provided by the hospital to individuals qualifying for that hospital's charity care policy.

(3) Bad debt is defined as unpaid out-of-pocket costs incurred by insured or uninsured patients.

(4) Combination of charity care and bad debt

(5) Annual Licensing Survey, Missouri Department of Health and Senior Services (as reported on MHA "Focus On Hospitals" web site)

(6) Local Tax Subsidy taken out of Total Uncompensated Care. HMA notes that Truman Medical Center objected to deducting the local tax subsidy from Total Uncompensated Care, on the grounds that doing so presumes that the tax subsidy is intended for uncompensated care only.

NOTE: This table does not reflect the devastating impact of recent Medicaid cuts in the State of Missouri

Appendix B - Report Contacts

To prepare this report, HMA met with – via phone and in person – dozens of Kansas City area providers, health plan executives, business and civic leaders and other stakeholders. Following is a list of the individuals that HMA spoke with – both individually and in group format -- during the development of this report. This list also includes Chamber Health Council members and Chamber representatives and guests who attended one or both of the HMA presentations to the Health Council.

MARC Technical Advisory Committee Members

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Kansas City, Missouri Department of Health

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Wyandotte County Health Department

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Mid-America Regional Council

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UMKC School of Dentistry

Dr. Andreas Deyman
Silver City Health Center

Karen Dolt
Northland Health Care Access

Harriet Duff
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Amy Falk
Caritas' Duchesne and St. Vincent Clinics

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Swope Health, Wyandotte and Quidaro

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Northland Health Care Access

Liz Levin
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Dolly Lopez
Swope Health, Wyandotte and Quidaro

Joseph So
Turner House Children's Clinic

Sr. Mary Lou Stubbs
Seton Center Family & Health Services

Sherri Wood
KC Free Health Clinic

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Blue Cross and Blue Shield of Kansas City

Peter S. Levi
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Greater Kansas City Chamber of Commerce

David Oliver
Chamber Health Council Chairman
Civic Council of Greater Kansas City

Other Stakeholders

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Bridgette Williams
CEO
Greater Kansas City AFL-CIO

Kristi Wyatt
Senior Vice President
Greater Kansas City Chamber of Commerce

Stacey Daniels-Young
Executive Director
Black Health Care Coalition

Appendix C - Health Council of Greater Kansas City

Throughout this project, HMA and MARC worked closely with the newly formed Health Council of Greater Kansas City and presented both interim and final reports to the Health Council's membership. Below is a complete list of Health Council membership as provided by the Health Council. Members who attended one or both of the HMA report briefings, or who participated in individual meetings with HMA, are also listed in Appendix B.

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Tom E. Bowser
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David Carpenter
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David Warm
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Jill S. Watson
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George Wheeler
Chief Executive Officer
Coventry Health Care of Kansas Inc.

Joy D. Wheeler
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FirstGuard Health Plan

Bridgette Williams
President
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Sheridan Y. Wood
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Kansas City Free Health Clinic

Appendix D - Business Plan

HMA met with MARC's Technical Advisory Committee, the Chamber of Commerce Health Council, both Missouri and Kansas state Medicaid officials, major safety net hospitals and clinics, physician organizations and a wider variety of stakeholders to thoroughly vet the recommendations in this report. What follows is an implementation plan for the recommended strategies. In addition, as part of this project, we were also asked to evaluate and comment on establishing and sustaining an initiative coordination structure, which we have done. Finally, we have attempted to design a two-year budget that will be required to successfully implement the recommendations in this report.

Health Care Safety Net Coordinating Council

Before describing the recommended coordination structure it should be mentioned that the creation of the Health Council of Greater Kansas City at the Chamber of Commerce is an important and unique asset because it brings together leaders of key health care related institutions. It is essential that the council and its members be an integral part of implementation of the recommendations. A complete list of Health Council members can be found in Appendix C. The health access initiative cannot succeed without this cooperation. Therefore, it is appropriate to spell out in general terms the relationship between the Health Council and the coordinating structure for the health access initiative. This relationship should include:

- ⊗ The Health Council will provide leadership to the Health Care Safety Net Coordinating Council through membership on the Coordinating Council.
- ⊗ The Health Council is a unique and important resource for the Coordinating Council generating, reviewing, endorsing and advocating specific initiatives that address health access issues that the Coordinating Council is working on or that the Health Council has determined should be addressed.
- ⊗ The health access initiative will provide the Health Council with periodic reports on the progress on the specific initiatives it is undertaking and discuss how these initiatives can be more effectively implemented.

HMA recommends the formation of a Health Care Safety Net Coordinating Council to be the coordinating body for the implementation of the initiatives contained in this report and for any future health access initiatives that may be brought to it. The recommended membership of the Coordinating Council includes civic leaders, consumers, and organizations and associations that are representative of particular health care interests in the community.

This recommendation follows from HMA's interaction with various community and health care leaders in Greater Kansas City as well as what we know has been successful in other municipalities. The project is ambitious, complex, and too important for one group to be able to implement effectively on its own. It will require the cooperation and participation of a multitude of community leaders to be successful.

During HMA interviews, MARC was the organization mentioned most often as having a track record and history in addressing Greater Kansas City issues and an organization that does not have a vested interest in health care matters. HMA recommends MARC as the organization to convene the Health Care Safety Net Coordinating Council and to provide program support. MARC has appropriate administrative capacity to launch a Coordinating Council and is widely viewed as a competent, neutral party. However, those individuals that supported MARC in such a role, and MARC itself, also expressed reservations about MARC's lack of expertise in the area of health care. Contrary to expressed concern, HMA believes the lack of health care experience could be an asset and contribute to MARC's unbiased approach and perspective.

Another important issue is representation. HMA received repeated requests to keep the Coordinating Council small hence, effective. Characteristics to be considered when selecting an effective Coordinating Council should include the following criteria:

- 1) Respected members from the local community that have an ability to work collaboratively, and in particular, with impacted health care stakeholders;
- 2) Representation from both states, including business, consumers or their advocates, health care organizations at all levels, related associations, and other identified stakeholders;
- 3) Members interested in the stated goals with an ability to make the time commitment commensurate with Board expectations; and
- 4) Members with demonstrated leadership capacity.

It will be essential that the Coordinating Council include key individuals that can truly make a difference and that can effectively build partnerships across state lines. As noted in the body of the report, the state line does pose significant – though not insurmountable – obstacles, especially where the use of public funds is concerned. Overcoming these obstacles will require the close coordination of providers, Medicaid officials and other stakeholders on both sides of the state line. At the same time, the Kansas City health care community has a history of collaboration on access to care issues on which to build.

The following groups, in no particular order, comprise HMA's recommended board:

- 1) Greater Kansas City Chamber of Commerce
- 2) Representative from a Federally Qualified Health Center
- 3) Kansas City Chamber Health Council
- 4) Civic Council of Greater Kansas City
- 5) Kansas-side Chamber of Commerce
- 6) MOHAKCA (Health Department Directors) representatives from each state
- 7) Missouri safety net hospital representative
- 8) Kansas safety net hospital representative
- 9) Free clinic representative
- 10) Large employer

- 11) Large employer
- 12) Safety net clinic patient or patient advocacy group
- 13) Representative Metropolitan Medical Society
- 14) Medical Society of Wyandotte and Johnson Counties
- 15) Payers

Liaisons: MARC, REACH Healthcare Foundation, Healthcare Foundation of Greater Kansas City, KC Metropolitan Health Care Council representative, Medical School representative(s), Nursing School representative, state Medicaid representatives

HMA recognizes the size of the Coordinating Council does not allow for participation from a very broad set of direct stakeholders. However, it will be essential to work closely with organizations that have demonstrated a commitment to the health care access issue and have extensive ties in the health care community, such as the Center for Practical Bioethics, the Mid-America Coalition on Health Care, and the UAW-Ford Community Health Care Initiative. HMA also recommends the use of steering committees to implement the specific initiatives the Coordinating Council believes will further its mission. The steering committees would be comprised of a Chair (from the Coordinating Council) and key stakeholders interested in moving the initiative forward. The steering committee structure will encourage the participation of a wider circle of stakeholders than can be directly represented on the Coordinating Council.

Initially, HMA recommends the formation of three steering committees to implement the three initiatives in this report.

- 1) Formalize Coordination among Safety Net Providers and Maximize the Value of Specialty Care
- 2) Physician and Dental Upper Payment Limit (UPL)
- 3) Targeted Coverage Expansions

The Coordinating Council should convene as a whole at least monthly during the first year. Subcommittee scheduling will be left to the subcommittee chairs, but HMA recommends they meet at least twice a month. Most of the detailed planning will take place in the subcommittees. The Coordinating Council meeting will serve as a forum for updates on current initiatives and a launching pad for new initiatives. The subcommittees should report their progress to the other members of the Coordinating Council, and ask for help or direction as needed. Staff support for Subcommittees and the Coordinating Council shall come from the convening organization, MARC.

INITIATIVES

1) Formalize Coordination among Safety Net Providers and Maximize the Value of Specialty Care

Formalize Managed Care/Safety Net System Among Safety Net Providers.

Regardless of which coverage approaches are ultimately implemented in the Kansas City region, many individuals will remain uninsured. Thus, there will continue to be pressure on core safety net providers to provide care in a coordinated, cost-effective manner.

Safety net providers on both sides of the state line should carefully evaluate the feasibility of establishing a single virtual managed care/safety net system that assigns each uninsured individual to a medical home and manages their care. Most managed care/safety net programs offer a medical home for members, coordinated referrals, defined provider networks, inpatient care management and discharge planning and, in some cases, disease management programs. Screening for the managed care/safety net program should be closely coordinated with eligibility screening for Medicaid and other programs, consistent with the recommendation below. Referrals within the virtual managed care network should be carefully managed through a rules-based system as also discussed below.

One of the strengths in the Kansas City region is current level of formal and informal partnerships among the safety net providers as a result of the current initiatives underway. Examples of such initiatives include KC CareLink, Northland Health Access Project, WYJO Care, and the Metropolitan Medical Society Referral Project / Specialty Healthcare Referral Network (formerly the Medical Outreach Project of the Center for Practical Bioethics) (as described on page 12) . To ensure coordination among projects it is essential to understand that only a formal structure can assure that scarce resources are utilized most effectively, that duplication of services is minimized, and that gaps are filled in the continuum of care offered by these various providers. Therefore, the region should consider utilizing the Indianapolis Health Advantage program as a model while designing a Kansas City version of a “virtual health plan” for uninsured patients.

Established in 1997, Indianapolis Health Advantage serves uninsured individuals under 200% FPL who reside in Marion County IN (U.S. citizenship is not considered). The program has 48,000 enrollees and is funded through the county tax levy that supports indigent health care. The provider network includes Wishard Hospital (the only public hospital in Indianapolis), Indiana University Medical Group (IUMG), seven hospital-affiliated clinics and four IUMG-owned commercial sites. The program added nine additional free-standing clinics to the program in 2001 to provide additional primary care services.

Health and Hospitals Corporation, the parent organization of Wishard Hospital and the Indianapolis Public Health Department, pays the faculty practice plan to serve as the third-party administrator for the program. Primary care sites submit “shadow claims” that are processed for the purpose of determining the cost of providing care and to provide reporting on the health status and utilization patterns of the members.

The proposed Health Care Safety Net Board’s Subcommittee should assemble key provider partners that have a history of serving the uninsured—hospitals, the Health Departments, SWOPE and Sam Rogers, the free clinics, physician organizations, and other stakeholders—to have an open dialogue about the feasibility of establishing a health plan. Criteria for provider and client participation would need to be decided and a multitude of additional operational issues. This process should also identify clinical service gaps in this “network,” identify additional partners to meet growing and changing need, explore how to include community involvement and set goals and implementation strategies through the establishment of a formal health plan structure.

Enhance and Coordinate Eligibility Screening Functions

Several recent studies examining the uninsured in the Kansas City region noted that both states have significant numbers of individuals who are eligible for public coverage but are not enrolled. These individuals frequently receive their primary care in emergency rooms at a substantial cost to local taxpayers.

While it is unreasonable to suggest that Kansas and Missouri completely align their Medicaid eligibility criteria and processes, both states could employ similar strategies toward maximizing enrollment of the eligible-but-uninsured. These strategies ensure that individuals are enrolled in the most comprehensive coverage for which they are eligible while also ensuring that local dollars supporting indigent health care are directed toward those who truly have no other source of coverage.

In addition, by utilizing uniform Medicaid eligibility screening forms for Medicaid as well as other insurance or access programs (e.g., a regional coverage waiver program, managed care safety net program, Project Access programs or other indigent care programs), federal Medicaid administrative matching funds may be available to offset the cost eligibility screening. Several states, including Indiana and Illinois, have established eligibility screening models that allow providers and other organizations to receive compensation for performing Medicaid eligibility functions that, in some cases, simultaneously screen for eligibility for other access or coverage programs.

This universal screening process becomes essential once a “health plan” for the uninsured is established with a set of criteria for participation. There must be an investment in the people and the systems needed to assure that everyone who comes to free clinics, health centers, physician offices, and hospitals for services is enrolled in any program for which they might be eligible. Many public systems and private hospitals, and most FQHCs in the country, have intake workers using standard prioritized approaches as part of an

intake process that evaluates available payment resources in an efficient and persistent—but respectful—way. This process is integrated, and does not interfere with, service delivery. The point is to help the patient identify resources to offset the cost of the treatment they will receive, not to determine whether they “pass a test” on resources. However, it is understood that patients will be expected to financially contribute to their cost of their health care. The determination of the amount of cost sharing should continue to be left to individual providers. It appears there are simply not the people or systems or standardized policies in place to assure an effective approach to eligibility screening in many health care settings in Kansas City.

Additionally, clinical settings must also institute a way to assure routine follow-up and confirmation. Information gathered about a patient’s ability to pay something for their care—or his or her eligibility for coverage—must be verified. Opportunities not explored at initial assessment may need to be pursued to the extent the initial information was not complete or accurate. Timeliness is essential to maximize the extent that documentation is obtained. Follow up with patients still in the system is certainly easier than trying to track individuals down in subsequent weeks or months. Private vendors are used by many large public and private health systems to perform this function. The most likely place for external contractor involvement is in hospital post-discharge activities that are apt to be labor intensive. In situations where provider payment for services was less than anticipated, reassessment of eligibility, particularly for Medicaid coverage is appropriate. If pursued in the Kansas City region, the approach should be positive and comprehensive without presenting barriers to patients seeking care.

Develop and Implement a Rules-Based Referral System

In many safety net systems across the country, including Kansas City, specialty care has not, for the most part, been systematically approached to assure that those services are provided productively and appropriately. They have not been systematically assessed to determine: 1) the total predictable demand for each specialty; 2) the appropriateness of specialty care referrals; 3) the process for referring patients into care and assuring that they get returned to their primary care provider; and 4) capacity in the system to meet the demand.

Many area providers are currently using the KC CareLink system for referrals, but this system currently lacks a set of uniform rules to help “rationalize” the provision of specialty care. While the Kansas City region has multiple Electronic Medical Record/Community Health Record initiatives underway, management of specialty referrals is not the principle focus of these initiatives.

During HMA meetings with representatives of Truman Medical Center, University of Kansas Hospital, FQHCs and free clinics, there was serious interest expressed in pursuing a rules based referral system. Kansas City safety net providers should work collectively to establish a set of uniform rules to prioritize specialty visits and ensure that no visits are wasted due to incomplete prerequisite tests or other reasons. These rules could be built into an existing electronic platform or established as a stand-alone referral system. In

addition, federal Medicaid matching funds may be available to support at least some of the costs of a referral system, assuming that the same system is used for Medicaid as well as uninsured patients.

A model to consider exists in Cook County, Illinois where the public hospital system has had a twenty year history of a formal affiliation with community health centers. The relationship initially started as a mechanism by the public hospital to deflect patients, using emergency rooms for primary care, to community based health centers if the patients lived in communities where there were no county sponsored primary care clinics. In return for accepting these referrals (of primarily uninsured patients), the referred patients were provided pharmaceutical and lab support by the public hospital system.

In addition, the public hospital and the community health centers have attempted to rationalize referrals into the public hospital for specialty services. This has been accomplished through the development of the Internet Referral Information System (IRIS), a decision support system developed in collaboration with the clinical departments at the public hospital. The community health centers access the IRIS software through the internet to facilitate a referral. For each type of referral, a series of questions must be answered to help determine the appropriateness of the referral and to identify the prior tests/diagnostics that must be completed before an appointment can be made. This system handles approximately 11,000 referrals a month, thirty percent of which come from the community health centers and the remaining from the public hospital's outlying primary care clinics, and has virtually eliminated unnecessary referrals into coveted specialty and diagnostic appointment slots.

Currently, the public hospital system, Cook County Bureau of Health Services (Bureau,) is in the process of exploring the feasibility of establish a consortium of interested public hospital systems to mutually operate and maintain the IRIS rules based referral system (after multiple inquiries from around the country). The vision of the consortium is that respective affiliated medical schools would institute a process to modify and agree on the set of "referral rules" to be used by all consortium members. The costs of maintaining the system would be shared and/or supported by grant funding. Meanwhile, HMA understands the Bureau will share the *system code* (rules) with any interested public entity.

2) Maximize Federal Funds Coming to the Region to Expand Access

Upper Payment Limit Programs

During the course of preparing this report, access to specialty physician care was consistently cited as one of the largest gaps in the regional safety net, due at least in part to insufficient reimbursement from payers. Additionally, poor access to dental care for both Medicaid and uninsured individuals was cited frequently by individuals and research reviewed for this report.

Federal Medicaid regulations allow states flexibility to disburse supplemental payments to cover the difference between standard Medicaid payments to physicians and dentists and the usual and customary charges or Medicare rates for physicians and commercial rates for dentists. These supplemental payments are often referred to as upper payment limit (UPL) programs. While UPL payments are tied to Medicaid patients and do not directly support access for the uninsured, they help safety net providers remain financially sound, thus creating or at least maintaining access for the uninsured.

A physician UPL program is already in place in Missouri. However, a dental UPL program could be implemented statewide (across both states) or could be limited to individual counties or facilities. In Kansas the same is true for a physician UPL program. The non-federal share of the UPL payments may be generated in several ways:

- An intergovernmental transfer from public hospitals or medical schools; or
- A portion of the current tax levy funds.

The CEOs from Truman Medical Center and University of Kansas Hospital both expressed interest in the UPL program during discussions with HMA. Specifically, Truman was interested in Dental UPL program and University of Kansas in physician UPL. Cooperation would be required from the corresponding Medicaid state agencies who would be the entities receiving approval from federal CMS and making enhanced payments to physicians and dentists.

HMA is aware of one state that required providers to report specific metrics and demonstrate improved access in order to be eligible for enhanced reimbursement under UPL. HMA recommends that both states require some reporting from providers to measure improved access for the medically indigent, for both physician and dental UPL programs.

3) Targeted Coverage Expansions

Implement Premium Subsidy Program Coordinated with BCBS CommunityBlue and Other Private Coverage

Several communities nationwide have implemented subsidized small employer insurance programs based on a "three share model", with premium costs split between the employer, employee and a public subsidy. The concept behind a three-share plan is to make healthcare affordable for low-income workers. With the introduction of the Blue Cross and Blue Shield CommunityBlue program, the Kansas City region is uniquely positioned to implement a successful Medicaid premium or other publicly funded subsidy program to enhance program attractiveness to both employers and employees. There was considerable interest in exploring the feasibility of offering such a plan in the Kansas City region.

To be successful, three share programs are low deductible plans, covering a comprehensive array of services, although there are generally some exclusions. The

plans usually cost between \$150-\$180 a month for individual coverage, translating into an affordable \$50-\$60 a month for low-income workers to enjoy health benefits. (See table below for comparative characteristics of existing three share programs in Illinois and Michigan.)

HMA recommends the Board subcommittee established to explore "targeted coverage expansions" begin their review by studying the feasibility of publicly funding a three-share program. The study should analyze the existing benefit structure, cost, and membership of the BCBS Community Plan and any other similar product currently offered to fashion a product that would be attractive in the Kansas City region. For example, according to the Lewin report, there are approximately 29,000 uninsured residents in Johnson County with incomes above 200% of the federal poverty level. One strategy may be to concentrate initial effort on employers whose workforce tends to live in Johnson County. Additionally, the BCBS Community Plan is a high-deductible plan, one feature that is contrary to other three-share plans. A customized product should be developed, taking into account the uniqueness of Kansas City's employers and uninsured population but coupled with characteristics of success from other municipalities.

Additionally, for a three-share program to be successfully implemented, a public source of funding must be identified and secured. A bill is currently pending in the U.S. House of Representatives that would make funding available to communities seeking to implement three-share or similar programs. The Subcommittee should closely monitor federal developments. Concurrently, the Subcommittee should explore possible sources of public funding that can be utilized in both Kansas and Missouri.

Finally, many three-share programs in other communities have struggled with low enrollments. Nevertheless, this strategy is attractive because of its employer-based approach. Despite its limitations, a three-share plan should expand access to some degree. Some employers might be resistant, but others would join the plan. At this point, it is unrealistic to expect a three-share plan to cover all or even the majority of low-income workers, but it would cover a fair number of them. Every person that the plan can extend coverage to is one less uninsured person that the community must support.

Overview of Existing Three-Share Plans								
	Illinois				Michigan			
	St. Clair County	Rockford Health Access Plan	Macoupin	Springfield/Sangamon	Wayne County Four Star Health	Kent Health Plan C	Ingham County Advantage	Muskegon Access Health
Business								
<i>Business Location</i>	Primary location in St. Clair County, IL (Branch OK)	Primary location in Winnebago County, IL	Primary location in Macoupin County, IL	Primary location in Sangamon County, IL; can be a franchise	Primary location in Wayne County, MI	Primary location in Kent County, MI	Primary location in Ingham County, MI	Primary location in Muskegon County, MI
<i>Residency Requirement</i>	N/A	N/A	N/A	N/A	50%	80%	2/3	N/A
<i>Employer Size</i>	(2-50) or (2-150)	(3-25)	(2-26) or (2-50)	(2-50)	(2-100)	(4-50)	(2-20)	(2-20) originally; maximum eventually removed
<i>Duration</i>	In business at least one year	N/A	In business at least one year	In business at least one year	In business at least two years	In business at least two years	In business at least two years	13 weeks
<i>Median Hourly Wage for all Employees</i>	\$15 or less	\$12 or less	\$12 or less	\$15 or less	\$14 or less	\$10 or less for first year of plan	\$12 or less	\$11.50 or less
<i>Non-offer Requirement</i>	No health insurance offered in the past 12 months.	No health insurance offered in last six months.	Employer must have had no prior healthcare coverage for one year.	Employer must have had no prior healthcare coverage for one year.	Group health insurance cannot have been offered to uninsured employees in the past 12 months.	Employer must have had no prior healthcare coverage for the immediate past two consecutive years.	No health insurance offered in the past 12 months.	No health benefits offered in last 12 months.
Employee								
<i>Employment Duration</i>	90 days	N/A	At least 3 months	N/A	At least 90 days	None	90 days	13 weeks
<i>Minimum Hours</i>	Full time	Full or part-time	Full time (30 Hrs/week) and part time (20 hrs/week); definition at employer discretion	Full-time; part-time covered at discretion of employer, with full subsidy (20 hrs per week or 1,000 hrs a year)	Expect to work an average of 20 hours or more per week each quarter of the year	None	20 hours	15.5 hours
<i>Eligibility Requirements</i>	Not be eligible for government sponsored health insurance programs such as Medicaid, FamilyCare, AllKids or Medicare, or already be covered by private insurance							
<i>Dependents</i>	Rider attached for spouse or children, but no subsidy		One spouse; they must be ineligible for other coverage	Employer option; not covered by subsidy	One spouse	One spouse	One spouse	Varies, but dependents allowed
<i>Cost</i>	N/A	1/3 at \$50 each (\$150)	N/A	N/A	1/3 at \$58 each (\$174); 2006	1/3 at \$61 each (\$183); 2006	\$75 community (\$210); 2006	\$46 employer and employee; \$62 community (\$154)

Regional Coverage Waiver

Initially, HMA recommended that Missouri and Kansas pursue limited network/limited benefit Medicaid waivers that would expand eligibility up to 200% FPL for all individuals, thus capturing a significant segment of uninsured in the region. We pointed out these waivers could be pursued individually by each state but we believed CMS might react favorably to a joint waiver proposal from both states that sought to create a truly regional approach to expanding coverage for the uninsured.

Consistent with the recently approved Iowa regional coverage waiver, we pointed out that non-federal matching funds could be provided by new or existing indigent care resources, including funds that support public providers in both states and tax levy funds that support private safety net providers. The provider network for the expansion program may be limited to those public organizations financing the program.

HMA recommends the Subcommittee charged with *Targeted Coverage Expansions* revisit the feasibility and interest in such a program. The implementation of this program requires the cooperation of the corresponding state Medicaid agency, the entity that would actually submit the waiver to CMS for approval. Pursuing this type of waiver is extremely difficult and is dependent upon highly motivated public funders and/or publicly funded health care organizations. However, if there is not a federal or state response to the growing crisis of the uninsured, it is our belief that Kansas City will have to evaluate coverage expansion options, and HMA recommends a regional coverage waiver be considered.

Budget Discussion

Undertaking a variety of initiatives to address the issue of providing health care to the uninsured will not come cheaply. Such initiatives will require highly qualified staff, a high degree of technology investment, extensive staff time in bringing a wide range of stakeholders together, and in one case the establishment of a virtual managed health care system.

The budget will depend on the level of commitment to each of the initiatives and the exact scope of the activities and responsibilities to be undertaken by the Health Care Safety Net Board. Following is a preliminary discussion of budget elements and a range of expenditures.

The budget is divided into two broad categories: (1) Staffing and administration of the overall effort and the work of the board, and (2) implementation of specific initiatives.

Central Staffing and Administration

Staffing and administration depend on the scope of activities that the Health Care Safety Net Board determines it wants to undertake. This scope could range from providing coordination, convening and administrative support to the initiatives to taking a more active role in the implementation of the initiatives and in providing research and policy guidance for the health care community, both in support of the initiatives and in other areas of health care policy. Also, it is very likely that the wide variety of activities will be phased in over time based on the presence of an active constituency to support the individual activities. Some activities can be accomplished using contract services, but day to day coordination would be provided by hired staff.

The range for the annual cost of staffing and administrative support for the Health Care Safety Net Board and its three steering committees is estimated to be from \$400,000 to \$750,000. The larger amount would support a staff of five professionals and contractors. The lower amount would support two to three staff and consulting services. HMA recommends initially hiring three core staff to launch the Health Care Safety Net Board and phase in additional staff, when necessary. MARC's administrative costs would vary depending on the scope of the overall project. HMA has been involved in and witnessed other communities implement similar types of initiatives utilizing staff from participating organizations. We firmly believe that ultimate success depends on full-time dedicated core staffing.

Implementation

Implementation of each initiative would require staff coordination and convening of participants on the part of the central staff. This should be adequate support for the initiative to maximize federal funds using Upper Payment Limit (UPL) programs, assuming adequate central staffing.

The staff costs for Targeted Coverage Expansion are included in the central staffing costs, assuming adequate central staffing. Actual operating costs for this initiative are the projected cost of public subsidy @ \$55 per member **per month**. Year 1 2,500 members (\$1,650,000); Year 2 5,000 members (\$3,300,000). These funds will need to come from 1) matching existing public funds; or 2) the hospitals may be willing to contribute to support a broader pool of insured residents in the region.

The third initiative is the most comprehensive and expensive, the formalization of coordination among safety net providers. This initiative has three elements. The first is to formalize the safety net system into a health care system. Based on five professional staff persons the first full year of operation is estimated to cost approximately \$525,000 to \$625,000 depending upon the actual number of enrollees that drive the cost of claims processing. The second element in this initiative is the establishment of a rules-based referral system. Based on the costs to establish the Chicago program it is estimated that the development cost should not exceed \$600,000 over a two-year period. There will be additional operating costs. The final element in this initiative is to enhance and coordinate eligibility screening. The estimated cost for this initiative is \$320,000 per year for the addition of ten eligibility screeners.

Budget Summary

Staff and Administration

Staff	\$225,000 to 400,000	(3-5 professional staff)
Consultants	100,000 to 200,000	(TA, IT, grant writing)
Support	75,000 to 150,000	(Fiscal, rent, admin support)
Total	\$400,000 to 750,000	

Implementation

UPL initiative	(supported by staff from Staff and Admin)	
Coverage Expansion	\$1,650,000 to \$3,300,000	(\$55/member/month)
Safety Net Coord		
Formalize system	\$525,000 to \$625,000	(5 staff and claims processing)
Referral system	\$300,000	(per year for two years development cost)
Eligibility Screening	\$320,000	(ten eligibility screeners)
Total	\$2,795,000 to 4,545,000	

The funding for the Health Care Safety Net Board and the corresponding initiatives will primarily depend upon the interest of the local community. In other municipalities, such efforts have received funding from private foundations and corporations as well as from hospitals/health systems and corporations that are committed to solving a community problem and generally those that stand to benefit the most from program success. In Kansas City, the REACH Healthcare Foundation and the Health Care Foundation of

*Numbers shown in red corrected in May 2007 to reflect monthly fees

Greater Kansas City can act as the base of funding, supplemented by other local foundations, national foundations, and investments from the corporate and health care communities.

Nationally, the Robert Wood Johnson Foundation (RWJF) has established priorities for funding, one of which is to assure that all Americans have access to quality health care at a reasonable cost. In the recent past, RWJF has funded local and state demonstration projects that have explored the potential of various local, state and private-sector options for expanding coverage. Currently, RWJF is interested in supporting the development and evaluation of novel approaches, from one or more states (through a state governmental entity), that propose a major innovation to expand or stabilize coverage. The proposed coverage expansions in this report may possibly qualify, depending upon program design and state involvement.

Additionally, RWJF awards approximately 25 percent of its grant making funds to unsolicited proposals developed by people and organizations that help to address one or more of the Foundation's eleven key interest areas but do not fit within the specific strategy outlined in a Call for Proposal. They invite proposals that:

- Challenge traditional ways of defining health and health care issues.
- Offer creative approaches to solving problems.
- Introduce new ideas to health and health care services and policy.

The proposed budget incorporates grant development support to research and pursue funding from both local and national organizations. Fundamentally, the Health Care Safety Net Board's ability to implement worthwhile initiatives will occur through the commitment of local dollars as well as Board and staff creativity in pursuing other avenues of funding.

TASK	Months →	1	2	3	4	5	6	7	8	9	10	11	12	13-18
Convene Health Care Coordination Board														
A. MARC convene first meeting of Board 1. Approve organizational mission, structure, leadership 2. Approve Initiative Steering Committees and Chairs														
B. MARC apply for 2 yr funding from REACH, Health Care Fdn of Greater Kansas City														
C. MARC hire staff														
Maximize Federal Funding														
A. Obtain interest in UPL programs from eligible public entities														
B. Determine physician UPL eligibility (employed, medical grps, etc.)														
C. Determine criteria for participation														

TASK	Months →	1	2	3	4	5	6	7	8	9	10	11	12	13-18
D. Ongoing meetings with KS and MO Medicaid officials					■	■								
E. State submits waiver								■						
F. Program Approval													■	■
H. Program Implementation													■	■
I. Determine dental groups					■	■								
J. Determine criteria for participation					■		■							
K. Ongoing meetings with KS and MO Medicaid officials					■	■								
L. State submits waiver								■						
M. Program Implementation														■
Coordinate and Maximize the Value of Specialty Care														
<i>Formalize Managed Care Safety Net System</i>														
A. Establish standardized criteria for client participation			■	■	■	■	■							
B. Establish standardized criteria for provider participation			■	■	■	■	■							
C. Develop budget/staffing needs				■	■									
D. Determine other infrastructure needs (IT, outreach, etc.)				■	■									
E. Determine sources of funding				■	■									
F. Monitor Kansas Medicaid EMR Sedgwick Cty pilot with FirstGuard			■	■	■	■	■	■	■	■	■	■	■	■

TASK	Months →	1	2	3	4	5	6	7	8	9	10	11	12	13-18
G. Develop Clinic Network								■	■	■	■	■	■	
H. Develop Hospital Network								■	■	■	■	■	■	
I. Determine role of local health departments								■	■	■				
J. Begin client enrollment														■
<i>Enhance/Coordinate Eligibility Screening Function</i>														
A. Develop uniform screening criteria and processes			■	■	■	■	■							
B. Seek state level approval								■	■	■	■	■		
C. Develop intake forms and finalize screening process								■	■	■	■	■		
D. Program implementation														■
<i>Develop and Implement a Rules-Based Referral System</i>														
A. Contact Cook County Bureau of Health Services (CCBHS) for IRIS demonstration			■	■										
B. Obtain "code" (ie, criteria) from CCBHS for specialty appt's					■	■								
C. Convene joint Truman/KU Departmental representatives to determine "rules" for accessing appt's from safety net clinics							■	■	■	■	■	■	■	
D. Establish criteria for participation				■	■	■	■	■	■					

TASK	Months →	1	2	3	4	5	6	7	8	9	10	11	12	13-18
E. Determine who will "own" and/or "house" referral based system									█	█	█	█	█	
F. Establish Permanent Oversight Committee														█
G. Determine budget to develop/modify software and procure hardware and to sustain software re: updates, upgrades, etc														█
H. Obtain funding to develop and sustain system														█
J. Hire programmer to develop referral system														█
K. Develop network of "participating users"														█
L. Implement software/system														█
Implement Targeted Coverage Expansions														
Premium Subsidy Program														
A. Research successful "three share" programs implemented elsewhere			█	█	█	█								
B. Determine interest in program from insurers			█	█	█	█	█	█						
C. Determine/Recommend program design features					█	█	█	█	█	█				

TASK	Months →	1	2	3	4	5	6	7	8	9	10	11	12	13-18
D. Explore potential public funding entity(ies)														
E. Ongoing monitoring of federal legislation														
F. Implement program														
Regional Coverage Waiver														
A. Determine interest in program from eligible public entities														
B. Determine criteria for provider participation														
C. Determine criteria for enrollee participation														
D. Ongoing meetings with KS and MO Medicaid officials														
E. State submits waiver														
F. Program Approval														