Healthy Communities Cook County

HC3

Components of a Direct Access Health Program

- A centralized system of administration
- Community-based outreach and enrollment assistance
- Community-based patient navigation and support
- A universal set of eligibility requirements and enrollment application so that enrollees can apply once and gain access to the entire network
- An ID indicating enrollment in the program
- An extensive network outpatient facilities, FQHCs, and free clinics sufficient to provide geographically convenient prevention, primary care, behavioral health, dental, vision, and pharmacy services to the uninsured
- A more limited network of public and nonprofit hospitals to provide specialty care, inpatient care, surgeries, and diagnostics.
- A predictable and affordable cost structure for enrollees accessing care through network providers
- Assignment of a medical home and PCP
- A simple electronic information sharing system that allows network providers to access enrollment status, contact info, PCP, and recent health utilization data

Draft Cook County TF Recommendations

Input is needed from Cook County health care stakeholders, including Health Care Taskforce members, on how to design and implement a direct access health program. We offer the following as a starting point, with the expectation that alternative approaches may be preferred.

Recommendations for: Administration and structure of HC3 recommended direct access health program (the program)

- Establish 'the program' through a County ordinance in 2016.
- Use 2017 to develop the back-end structures, hire staff, contract with providers – begin to conduct outreach and enrollment for a January 2018 launch.
- Recommend starting with the areas in the County with the highest number of uninsured residents. These were identified as the 'North', 'South Central', and 'South Side' neighborhoods in the UHP. 'The program' would then expand to other parts of the County over time.
- 'The program' could be administered as an independent body like the UHP, housed in CCHHS, or as an expansion of CareLink or Access to Care.
- Eligibility for 'the program' will be those under 400% FPL who are uninsured and ineligible for public programs such as Medicaid and Medicare. Access to Employer Sponsored Insurance or Marketplace coverage should not make anyone ineligible. Potential enrollees should be educated about their options, encouraged to enroll in full health insurance if it is available to them, and informed of the tax penalty for not having health insurance under the ACA, but if they choose not to enroll in insurance, they should be able to enroll in 'the program.'

Recommendations for: Outreach and enrollment (OE)

- Incorporate OE assistance for 'the program' into the work of existing OE efforts for County Care, Certified Application Counselors (CACs), etc. The timing of the launch will ensure Marketplace Open Enrollment will coincide and eligible residents will have the opportunity to enroll in full health insurance if they are eligible.
- Engage community-based organizations to promote 'the program' at health fairs, churches, etc.
- Hire community health workers (CHWs) or contract with existing CHW programs to provide additional community OE assistance and ongoing patient support and navigation.
- Patient Support Center staff at CCHHS should be familiar with the program and can provide call center support.
- One unified application and set of needed documents to enroll in 'the program' – should limit number and type of documents as much as possible while still maintaining program integrity. This application could eventually be integrated into existing Medicaid and other benefit application systems.
- All network providers should be able to assist with and submit enrollment applications onsite.
- Explore building off of current County Care or MHN systems to develop an enrollment database that is accessible to all network providers. Enrollment database should include at a minimum: enrollment status, enrollee contact info, PCP and CHW information.
- Receive an ID card once enrolled and must re-enroll annually

Recommendations for: Provider network

- 'The program' shall build a network consisting of CCHHS facilities, additional nonprofit hospital systems to cover the remainder of the County areas (maybe one for the 'North' area and two for the 'Southside' area), and additional FQHCs and free clinics needed for convenient access and sufficient numbers of PCPs, dentists, etc.
- Enrollees will not have to reapply for sliding fee scale copays, charity care, etc. once they have applied for 'the program'.
- The network will grow as more sections of the County are added.
- Network providers will participate voluntarily and program staff will spend the prep year developing these contracts.
- Medical homes will receive a per member per month rate (PMPM) for participating. Those that can provide behavioral health, dental, pharmacy, etc. will receive higher PMPM rate. The PMPM rates for other programs ranges from $9-$28 and the rate proposed in the UHP was ~$15 for medical homes ($200 per year, specifically).
- Hospital systems will receive a flat fee for participating.
- Enrollees in the program under 250% FPL should have no copays when accessing their PCP or other needed services in network (like My Health LA). Current fee scales and copays at network providers should be lowered voluntarily and the County could make up the difference if needed during negotiations for the PMPM.
- No reimbursement for services outside of the flat hospital fee and the PMPM PCP rate will be provided by 'the program.'

Recommendations for: Back-end systems and care coordination

- Assign a PCP medical home for each enrollee and have all care coordinated through them. Use CHWs to provide community-based support and system navigation.
- Use MHN for a limited health information sharing system – at the least some sort of alert for the PCP/CHW when an enrollee accesses in-network services from a hospital or specialist.
- Use MHN to incorporate an evaluation component and use basic info sharing system to track health service utilization, patient experience, etc.
- CCHHS is already exploring a system to improve access to specialty care so some of the care coordination for this program has already begun.

Recommendations for: Costs

- 2017: UHP estimated the first year setup to be $5 million – we are not proposing anything dramatically different for the first year setup.
- 2018: UHP estimated $3-5 million in operating costs the first year. We are proposing additional services (dental, behavioral health, etc.), additional participating nonprofit hospital systems and lower costs for enrollees. This could lead to slightly higher operating costs depending on the negotiated rates agreed to by providers, but not dramatically higher than the $3-5 million.

Recommendations for: Financing

- Considering the dramatic reduction provided by the County to support serving the uninsured at CCHHS, it is reasonable to ask for some allocation of County Health Fund dollars to 'the program.'
- The inclusion of additional nonprofit hospitals in the network could reduce uncompensated care costs at CCHHS and nonprofit hospitals, as will improved health care coordination for the uninsured.
- Nonprofit hospital systems should contribute in-kind contributions of services and even funding for the program. Such funding could be counted towards their Community Health Benefit requirement under the IRS, and charity care services provided on-site (specialty care, etc.) would count towards their Illinois tax exemption requirement – regardless of the outcome of the current charity care supreme court case.

Sample Chart for use in the Task Force

Recommendation	Reason for Rec	Estimated cost	Data still needed	Responsible party