TABLE OF CONTENTS

VIII. Exhibits

I. Key Informant Interview Tool
II. Stakeholder Interview List
III. A. FQHC/Health Home Survey and B. CEO Survey
IV. Maps
V. Components of the Safety Net
VI. Health Home Uninsured Penetration Rates
VII. FQHC State Comparison
VIII. State Safety Net Financing Models

I. EXECUTIVE SUMMARY

The Delaware Health Care Commission (DHCC) contracted with John Snow Inc. (JSI) to analyze the health care safety net serving Delaware's low-income uninsured residents. The goals of the project were to:

- identify and describe the components of the safety net;
- preserve and stabilize the safety net; and,
- expand the safety net.

JSI conducted the project between April and September 2002, utilizing both qualitative and quantitative analyses.

Key Findings

- Delaware's safety net is made up of several different categories of providers including Federally Qualified Health Centers (FQHCs), other primary care centers, mobile vans, private practice physicians enrolled in the State's VIP II program, Division of Public Health Service Center sites, school-based Wellness Centers, oral health providers, HIV providers, mental health and substance abuse centers, and hospitals. The various components of the safety net provide an excellent range of services but could be better coordinated to create a true safety net system.

- Safety net providers are geographically dispersed throughout the State, although there is a greater concentration of services in the more urban New Castle County, which also is home to the largest number of uninsured people. Some specific service gaps exist in the more rural Sussex and Kent counties related to oral health, behavioral health and prenatal care.

- Among the various components of the safety net, the core consists of primary care providers that function as health homes, ensuring access to continuous, comprehensive and coordinated care. FQHCs, a few other hospitals and community based primary care centers, and primary care providers within the Medical Society of Delaware's Volunteer Physician Initiative Program (VIP II) network all serve as health homes. The health homes currently serve approximately 10% of the State's uninsured population with FQHCs providing the majority of services to uninsured patients. There is both the potential and need to expand capacity within the health home components of the safety net. Doubling the number of uninsured patients served in the next five years is a reasonable goal. There is also the potential and need to better link health homes to a full continuum of services.

- The Delaware safety net is substantially supported by federal funds and contributions from safety net organizations and providers. The State does not currently provide direct financial support for the health home components within the safety net. In order to ensure stability of the safety net and stimulate expansion, additional funding will

be required, particularly since provider contributions are unlikely to expand and may be reduced. Funding opportunities currently exist within the Health Resources and Services Administration of the federal government as well as private foundations, but State funding should be considered for stability and to achieve expansion objectives.

- The Community Healthcare Access Program (CHAP) is an important statewide initiative that serves as a key mechanism for: facilitating access to health services for the State's low income and uninsured residents; developing the foundation for more expansive coverage programs; and, encouraging communication and collaboration across the components of the safety net.

Key Recommendations

1. Expand capacity of health homes within the safety net to double the number of uninsured people served in the next five years, from 9,000 to 18,000.

    - Maximize federal dollars through additional FQHC sites
    - Allocate State funds to support health homes
    - Develop additional coverage programs
    - Expand and market CHAP to increase enrollment
    - Collect data on current utilization patterns of uninsured residents

2. Ensure all health homes have access to a comprehensive array of services either in-house or through referral, for the patients they serve.

    - Maximize federal dollars to expand scope of services
    - Develop linkages to remove financial barriers for referred services
    - Share best practices and lessons learned to replicate successful programs
    - Develop streamlined procedures to facilitate access to referred services

3. Enhance collaboration among components of the safety net to create a better system, avoid redundancy and incorporate best practices.

    - Support and expand CHAP structure as forum to bring together components of the safety net
    - Maintain a technical assistance resource, including peer advisors to transfer knowledge

The full project report more fully describes the project methodology, findings, environmental influences on the safety net and recommendations.

II. BACKGROUND & INTRODUCTION

The Delaware Health Care Commission (DHCC) is an independent, public, policy setting body that reports to the Governor and to the General Assembly with the mission of promoting accessible, affordable, quality health care for all Delawareans. The DHCC conducts a range of activities in pursuit of this mission, including conducting research and strategic planning projects that allow them to promote appropriate health care policy, predict long-term trends, assess consumer and provider needs, facilitate strong public-private collaboration, and test new ideas.

The DHCC is currently in the process of developing and refining a comprehensive "Uninsured Action Plan" (UAP), which will help focus the State's efforts to significantly reduce the number of uninsured people in Delaware and improve access to a full continuum of health services for this population. The UAP has two major components: 1) a planning and policy initiative, and 2) implementation of direct service delivery initiatives. Both initiatives have been substantially supported through Community Access Program (CAP) grants; funded by the Health Resources and Services Administration (HRSA). The following are more detailed descriptions of these two efforts.

> State Planning Program: The goal of the State Planning Program (SPP) is to develop a comprehensive plan to expand coverage to the uninsured. The SPP has focused on creating a broad forum of stakeholders from the public and private sectors throughout the State with the objective of identifying feasible, cost-effective options to expand coverage for the uninsured. Key milestones in this process have been a series of Summit Meetings, including a statewide Kick-Off Summit and a set of reports and presentations to high level state and federal agencies.
>
> The Community Healthcare Access Program (CHAP): The goal of CHAP is to strengthen and coordinate health services and to link uninsured individuals to 'health homes'. To accomplish these goals CHAP has developed a highly coordinated but decentralized screening and enrollment system that assesses participant's eligibility for existing state insurance programs. Those who are eligible are enrolled in the appropriate state programs and are entitled to the health benefits that are part of those programs. Those who are not eligible for these programs are registered in CHAP. Trained advocates (care coordinators) assist these individuals in navigating the health care system and identifying a health home drawn from a geographically dispersed pool of participating community health centers, hospital-based clinics and VIP II primary care providers throughout the State. The major objectives of this effort are to ensure access to primary and preventive care services, decrease the burden on the safety net system, and reduce the need for expensive, avoidable visits to hospital emergency departments.

The DHCC recognizes that successful implementation of both components of the UAP depends on a strong, stable network of safety net providers with the capacity to provide a

full spectrum of primary, specialty, and in-patient care, including health education and preventive services. Accordingly, in February 2002 the DHCC contracted with John Snow, Inc. (JSI) a public health research and consulting firm, to conduct an analysis of the capacity and overall strength of Delaware's Safety Net System. The goals of this effort were to:

1. Identify and describe the components of the safety net,

2. Preserve and stabilize the safety net through an assessment of its current capacity, scope, and overall strength, and

3. Expand the safety net through better integration and utilization of existing services as well as the development of new services and opportunities, if appropriate.

Importance of a Strong Safety Net

The importance of maintaining a strong health care safety net can not be overstated. Roughly 88,000 Delawareans go without health insurance every year and many face additional barriers to accessing health services including language, culture and transportation. The health care safety net, those providers who serve people regardless of their ability to pay and strive to eliminate other access barriers, provide a critical resource to both the State and the individuals they serve. Often, the safety net is the only source of care for the State's most vulnerable residents.

Ensuring access to health care services through a strong safety net is a critical part of an overall strategy to address the needs of the State's uninsured population. An extensive body of research has demonstrated that those who do not have adequate health insurance are much less likely to have regular access to the health care services they need. Uninsured people are less likely to receive regular preventive care and screening services, less likely to receive appropriate treatment for chronic illnesses and more likely to experience adverse outcomes from illness than those with insurance. While Delaware should strive to provide insurance coverage to as many people as possible, universal coverage is a long-term goal. For the foreseeable future, the State can expect that thousands of people will remain uninsured. For them, a strong safety net system offers the best chance to attain health status comparable to their insured counterparts.

This report summarizes JSI's analysis and findings related to the safety net in Delaware. Specifically, the report summarizes: the approach and the methods that were applied to achieve the project's goals; presents the findings from these efforts; and provides recommendations to guide DHCC as it develops its plans to preserve, stabilize, and strengthen the State's safety net. In addition to these findings and recommendations, additional information regarding related issues that were raised during the project have been included. These issues are clearly relevant to the safety net and to Delaware's health care policy debate but they were not directly related to the specific goals of this project. Accordingly, they have been included in a series of appendices.

III. METHODOLOGY

JSI designed a two-phase approach for its analysis of the Delaware safety net. The two phased approach enabled JSI to gain a broad understanding of the safety net in Phase I, and to focus on key issues and providers in Phase II. Both phases incorporated a combination of quantitative and qualitative methods. Both phases also involved a broad group of stakeholders in discussions about preliminary findings and results.

During Phase I, JSI identified and described the different components of the safety net and highlighted issues needing further discussion. In Phase II, JSI conducted additional, more detailed analyses related to key providers and issues, resulting in concrete and relevant recommendations. Outlined below are the specific components of the methodology:

- **Key Informant Interviews:** Key informant interviews were conducted throughout both phases of this project. JSI worked with the DHCC to identify an initial group of key stakeholders to be interviewed. Interviews included an open discussion of the safety net, and were guided by an interview tool that JSI developed (Exhibit I). Most interviews were conducted in-person, though depending on the interviewee's preference and schedule some were conducted by phone. Questions addressed the individuals' perceptions regarding the State's safety net system including its strengths, weaknesses, opportunities for change and improvement and ideas for where future efforts should be focused. Additionally, in an effort to ensure that JSI was obtaining input from as many key stakeholders and venues as possible, in each interview, individuals were asked if there was anyone else with whom JSI should speak. Additional interviews were conducted whenever appropriate. More than 40 people were interviewed over the course of the project. A list of people interviewed is included in Exhibit II.

- **Secondary Data Analysis:** Delaware is rich with existing data related to the status of health insurance in the State. Numerous reports have also been conducted that relate directly and indirectly to aspects of health services delivery to low income and uninsured residents, such as the Dental Care Access Improvement Committee Report completed in 2000, the Report on Primary Care Physicians in Delaware completed in 2000 and 2001, and the Delawareans without Insurance Report completed in 2000 and 2001. JSI did not collect any primary quantitative data about the target population. Instead, JSI reviewed existing data available in the State related to the safety net and the targeted low-income uninsured population. Data sources reviewed included: Census data on population demographics; University of Delaware insurance and health cost reports; CHAP activity reports; portions of the actuarial analysis projecting numbers using the safety net based on income distributions; the Bureau of Primary Health Care's Uniform Data Set (UDS) reports for Federally Qualified Health Centers (FQHCs) in Delaware; reports from other federal programs such as WIC, Ryan White, Title X and Maternal and Child Health; data and trends included in the Delaware Community Health Centers Marketplace Analysis; ER and hospital

discharge data related to low-income patients; and, health status and epidemiological information from the Delaware Division of Public Health.

- **Primary Data Collection of Components of the Safety Net:** In both stages of the project, JSI collected data describing the various component parts of the safety net. In Phase I, data was collected during the key informant interviews. During this phase, JSI collected basic descriptive data to obtain a comprehensive picture of the safety net, as well as preliminary data to assess capacity. This descriptive data included: organization type and governance, services offered, service locations and geographic area covered, population served, and any specific policies that impacted on services to the uninsured. The capacity data collected included: facilities, staff and financial resources. In Phase II, JSI focused data collection on health centers and clinics that had been identified as "health homes". Using a brief written survey (Exhibit III) that was reviewed during a site visit, JSI sought to update and verify information collected in Phase I. Additional data was also collected relating to the organization's financial position, organizational vision, and strategy related to expansion. JSI also conducted a qualitative assessment of each organization's strengths, potential to expand and potential to collaborate.

- **Geo-mapping:** JSI used GIS mapping software to develop maps that located and displayed the locations of safety net providers throughout Delaware, as well as displayed the demographic and socioeconomic distribution of the target populations. JSI also mapped roads and major public transportation routes. These maps delineated patterns allowing JSI to more clearly understand and interpret some of the collected data. (Exhibit IV).

- **Collect Information on Other Models:** JSI conducted research using web-sites, printed reports, and key informant interviews with people outside Delaware to identify relevant models used for strengthening and sustaining the safety net system in other states. For selected models, JSI collected additional descriptive information.

- **Facilitate Meetings and Discussions:** Throughout the project, JSI organized and participated in working sessions with members of the DHCC and other stakeholders. Meetings with DHCC and its Working Group were designed to provide progress updates and interim results for discussion and consideration. Meetings with the broader stakeholder group had similar goals and were also designed to foster collaboration among the stakeholders. Two key meetings were held with the broader stakeholder community. The stakeholder meeting held at the close of Phase I was designed to reach consensus regarding the definition of the safety net and the work plan for Phase II of the project. The meeting held at the close of Phase II was used to gain input and suggestions regarding the final presentation and report to the DHCC.

- **Comparison to National Averages and Benchmarks:** JSI collected and summarized financial and utilization data for most health homes within the Delaware safety net system and compared and/or benchmarked these data against national and regional averages from the Bureau of Primary Health Care's Uniform Data System.

These comparisons helped JSI understand the strengths and vulnerability of the health home components of the Delaware safety net and assess their capacity to serve additional people.

IV. FINDINGS

This section details our findings and analyses based on the project's data collection efforts. The first segment of our findings provides a comprehensive description and inventory of the State's safety net system. Following this description are detailed discussions and analyses based on a review of the information and data collected from the 'health homes' identified in the inventory. Included in these findings are discussions regarding safety net service gaps, barriers, and system capacity. The section concludes with a summary of other state approaches to financing the safety net.

Description of the Safety Net

Throughout the key informant interview process, JSI asked interviewees to define the safety net – both as a system and its relevant components. Aggregating the data from these interviews, JSI compiled a comprehensive list of safety net providers by category. JSI presented this list for discussion at the DHCC Working Committee meeting and at the stakeholder meeting held at the close of Phase I. The list was modified to reflect input received in these meetings. JSI worked with stakeholders to reach consensus on the definition and parameters of the State's safety net. Stakeholders agreed on a broad definition of the safety net to encompass (See Exhibit V for a full listing):

- Federally Qualified Health Centers
- AI duPont Pediatric Practices
- Other Primary Care Clinics
- VIP II Primary Care Providers
- VIP II Specialty Providers
- Prenatal Care Providers & Family Planning Clinics
- Other Specialty Providers
- Mobile Primary Care Clinic Services
- Division of Public Health State Service Centers
- Delaware School-Based Wellness Centers
- State Dental Clinic Sites
- Other Dental Providers
- Mental Health & Substance Abuse Outpatient Providers
- HIV Title II, III, and IV Clinic Sites
- Hospitals

The Stakeholder group recognized that all segments contributed to a complete safety net system, but agreed that the components of the safety net that provided a full spectrum of primary care and served as "health homes" should receive priority for additional consideration and analysis.

Incorporating this input, JSI, with the help of the stakeholders, developed a definition of a "health home" to serve as the cornerstone for defining and expanding Delaware's safety net system. The agreed upon definition of a health home is:

> ***A health home provides primary care and collaborates with patients and other providers to ensure that care is accessible, continuous, comprehensive, coordinated, compassionate and delivered. Care is available 24 hours a day, seven days a week.***

By consensus of the stakeholders, health homes in the Delaware Safety Net include Federally Qualified Health Centers (FQHC), the Nemours (AI duPont) Pediatric Practices, other hospital-based and freestanding health centers, and primary care physicians who are participating in the VIP II Program. Included in the other safety net provider category are specialty providers, OB/Prenatal care providers, mobile care providers, Division of Public Health Service Center Sites, School-Based Wellness Centers, dental clinics, mental health and substance abuse providers, HIV/Title II, III, and IV Clinic Sites and the hospitals.

Health Homes

Federally Qualified Health Centers (FQHC)

At the time of this analysis Delaware had three FQHCs and one health center that was about to apply for FQHC status. For purposes of this report, all four are referred to as FQHCs. Delaware's four FQHCs provide health homes for a majority of the State's uninsured population. They also serve a substantial number of non-English speaking patients.

Henrietta Johnson Medical Center and Westside Health, both of which have two clinic sites, are long-standing FQHCs located in the City of Wilmington. Kent Community Health Center, an enterprise of Delmarva Rural Ministries, Inc., is located in Dover and is also an established FQHC. Historically, Delmarva Rural Ministries, Inc. served migrant and seasonal farmworkers but has recently received funding to expand services to the underserved population of Kent County via the Kent Community Health Center. In addition to its health center, Delmarva Rural Ministries, Inc. operates mobile health vans that provide limited primary care services at designated sites in Kent and Sussex Counties. La Red Health Center, which is poised to become the State's newest FQHC, is located in Georgetown in Sussex County.

There are more than 800 FQHCs throughout the United States and together they serve as the backbone of the country's primary care safety net. FQHCs all meet Delaware's agreed upon definition of a health home. In addition, FQHCs must satisfy several federally mandated requirements to maintain their designation and receive federal funds. These criteria include:

- Creating/maintaining a board of directors comprised of at least 51% of people who utilize health center services
- Providing services in a federally designated Medically Underserved Area (MUA) or to a Medically Underserved Population (MUP)
- Accepting all patients, regardless of their ability to pay; applying a sliding fee schedule for people up to 200% of the Federal Poverty Level (FPL). Additionally, FQHCs agree to charge all patients with insurance.
- Providing and/or referring for a specific list of primary care, preventive and enabling services
- Serving all ages
- Employing a core management and clinical staff
- Providing culturally and linguistically competent services
- Adhering to rigorous requirements and fiscal and clinical monitoring by the federal government

Combined, the above four health centers serve approximately 13,000 people each year of whom about 5,100 (40%) are low-income and uninsured. This represents approximately 14% of the low income uninsured population in the State.

AI duPont Pediatric Practices

The AI duPont Pediatric Practices are located throughout the State and serve approximately 850 uninsured children per year. Not including the hospital, there are ten AI duPont Pediatric Practices, three of which are located in Wilmington, with others located in Newark, New Castle, Middletown, Dover, Milford, Georgetown and Seaford. Additionally, there is one clinic that provides limited services (e.g., vision, dental, and pharmacy) to Delaware's uninsured elderly. This one, Nemours Health Clinic, is located in Wilmington, adjacent to the hospital.

Other Primary Care Clinic Sites

There are four other organizations serving as health homes, three of which are located in New Castle County. These include the Claymont Family Health Services, the Wilmington Health Center, the Delaware Park Clinic, and clinics owned and/or operated by St. Francis Hospital, The Claymont Family Health Services, located in Claymont, Delaware, is staffed solely by volunteer physicians and serves only uninsured patients, seeing about 1,400 per year. The Wilmington Health Center, located within the Christiana Care Wilmington Hospital campus, is operated as part of the hospital's internal medicine residency program and offers a multitude of services including pediatric, adolescent and adult primary care, women's health, pharmacy, and dental. The adult medicine and women's health practices at Wilmington Health Center serve approximately 900 uninsured patients per year[1]. Also located in Wilmington, the Delaware Park Racetrack offers on-site primary care services to employees of the track

[1] JSI made certain assumptions to arrive at this approximation as Wilmington Health Center had difficulty identifying unduplicated users for these two practices.

who do not have health insurance. The clinic serves roughly 300 uninsured employees per year. Data from St. Francis Hospital was not available for this report.

Volunteer Initiative Program Phase II (VIP II) – Primary Care Physicians

Launched by the Medical Society of Delaware on June 11, 2001, the Volunteer Initiative Program Phase II (VIP II) is part of the CHAP program. The VIP II program is comprised of voluntary physicians who have volunteered to treat uninsured patients for a reduced fee or free of charge. The CHAP program refers individuals to these physicians who have volunteered to see a pre-determined number of uninsured patients. The predetermined number of patients that the VIP II physicians have agreed to accept varies widely and can range from 1 to over 100 patients. As of August 2002, there were 116 primary care physicians (including OB/Gyns) participating. The physicians are widely distributed geographically and were serving approximately 230 uninsured enrollees at the time of JSI's analysis. The Medical Society of Delaware continues to recruit physicians for the VIP II as the VIP II continues to work diligently to assure that each enrolled low-income uninsured individual has a health home and is assigned to a nearby doctor.

The VIP II program also contains a subset of physicians who are here in the United States practicing under the Delaware State Conrad 20 J-1 Visa program. The physicians within the Delaware program are geographically dispersed throughout the State. Currently, 47 primary care physicians and six specialists are part of the J-1 program, eleven of whom participate in the VIP II, two of whom practice at FQHCs. At this time, there is no data available to document the volume of low-income uninsured patients that are being served through the overall J-1 Visa program.

Other Safety Net Providers

Volunteer Initiative Program Phase II (VIP II) - Specialists

The VIP II Program also has a cadre of specialists participating with CHAP. The range of specialty providers is extensive and includes cardiology, gastroenterology, otolaryngology, and OB/Gyn providers. There are 132 specialists, including fifteen OB/Gyns, who are widely distributed throughout the State and, as of August 2002, have served approximately 47 uninsured individuals (i.e., CHAP enrollees), who have been assigned to CHAP health homes. Specialty services are arranged by VIP II staff upon referral/request for a health home.

Prenatal Care Providers and Family Planning Clinics

In addition to the FQHCs[2], the Wilmington Health Center and the fifteen VIP II OB/Gyn providers, the analysis identified at least six private practices that provide prenatal care to uninsured pregnant women and one that has substantial plans to do so. These include OB/Gyn Associates in Dover, the St. Francis Hospital OB/Gyn clinic in Wilmington, and Bayside Health as well as Drs. Rupp, French, Adams, and Moise. Additionally three

[2] La Red is working to secure funding to finance a portion of a mid-wife through Dr. Rupp's practice.

Planned Parenthood of Delaware affiliated sites, located in Wilmington, Claymont, and Newark, provide prenatal care and family planning services.

OB/Gyn Associates in Dover serves a large number of low-income uninsured women and has an established referral relationship with Kent Community Health Center. This private practice is planning to expand its capacity by applying for a National Health Service Corps (NHSC) provider assignment. Additionally, St. Francis Hospital in Wilmington owns two OB/Gyn practices serving the uninsured. The last three individual private practices, along with Bayside Health, are under contract with the Delaware Division of Public Health to participate in a voucher program to provide prenatal care to uninsured women in Sussex County. This voucher program covers office visits but does not cover ancillary services such as labs and radiological testing. Dr. Rupp, who is located in Seaford, is currently working to determine his practice's capacity to serve the uninsured following the closing of the Nanticoke Midwifery Center.

The prenatal capacity within the State is difficult to determine. It appears that there is adequate prenatal capacity in New Castle County. However, in Kent and Sussex counties, the prenatal capacity is much more constrained and is in flux due to several risk factors, including the undocumented immigrants who are ineligible for Medicaid, lack of provider stability, and the financial and recruitment repercussions of rising medical malpractice premiums.

Other Specialty Providers

Similar to the VIP II program, but operating independently for approximately two years, is the Volunteer Ambulatory Surgical Program (VSAP), created and run by Dr. Raphael Zaragoza with coordination and facilities provided by Kent General Hospital. The VSAP provides free surgery to selected individuals who are low-income and uninsured. Since it's inception, the VSAP has supplied twelve surgeries to date.

Mobile Primary Care Clinic Sites

Currently within the Delaware safety net, two organizations provide primary health care services through mobile clinics. St. Francis Hospital sponsors St. Clare's Medical Outreach Van, which provided over 3,500 primary care visits during 2001. The St. Clare's Medical Outreach Van, which is operated by a physician, travels to the same eight locations each week, all in Wilmington, and serves only uninsured individuals. The other mobile units, the MATCH Vans, are operated by the Delmarva Rural Ministries (Kent Community Health Center) and visit a range of sites in both Kent and Sussex Counties.

Division of Public Health Service Center Sites and School-Based Wellness Centers

The Division of Public Health Service Centers are distributed throughout the State. These sixteen sites provide a range of services including maternal and child health, chronic disease screening and treatment services, and family planning. Augmenting these service

centers and working collaboratively with some of the health clinics are the twenty-seven school-based wellness centers, housed in high schools throughout the State. Currently, all Delaware public high schools except two have Wellness Centers[3]. The School-Based Wellness Centers provide services to students including health education and health promotion, substance abuse counseling, sports physicals, and non-acute care, through either a "medical model" or a "social work" model. The chief difference between these two models and ultimately the service focus, centers around the qualifications of the lead staff person. In the medical model it is a nurse practitioner and in the social work model it is a licensed clinical social worker.

State Dental Clinic Sites and Other Dental Providers

Five dental provider sites serve low-income uninsured individuals in New Castle and Kent Counties. These dental providers are mainly concentrated in the Wilmington area, with only one provider, the Delaware Technical and Community College, located in Dover. Two of the dental sites are part of the two Wilmington FQHCs, Henrietta Johnson Medical Center and Westside Health. A third is part of the residency program at the Wilmington Health Center. The fourth Wilmington dental provider is the Pierre Toussaint Dental Clinic, which is in part supported by a grant to serve homeless individuals through Henrietta Johnson Medical Center.

The State Dental Clinics, operated by the Division of Public Health provide preventive and restorative dental care for children covered by Medicaid. Two of the dental clinics are located in Wilmington with additional sites in Newark, New Castle, Dover, Georgetown, Milford and Seaford.

Mental Health and Substance Abuse Providers

Four mental health clinics and twelve substance abuse clinics provide outpatient services throughout the State. The mental health clinics are located in Georgetown, Dover, Newark and Wilmington and provide a broad range of outpatient services, including group and individual counseling, to those that are not severely mentally ill. The severely mentally ill are eligible for a separate program that the State has negotiated with a private contractor. The substance abuse clinics provide more targeted services in the areas of general outpatient services (7 clinic sites), methadone treatment services (3 clinic sites), and detox (2 sites). These services are well distributed through out the State. Five of the substance abuse outpatient clinics are located in Wilmington, with three others located in Dover, two in Georgetown, and one in both Smyrna and Ellendale.

HIV Title II, III, IV Clinic Sites

Five clinics, operated by the Christiana Care Health System provide primary care and specialty services for individuals living with HIV/AIDS. Three of these sites are located in Wilmington – the Porter Wellness Clinic, HIV Program at Riverfront- Brandywine

[3] Caesar Rodney HS, Wyoming, DE in Kent County and Alexis I DuPont High School Greenville, DE in New Castle County

Counseling and the HIV Community Program. The two other sites, Georgetown Wellness Clinic and the Kent County Clinic, are located in Georgetown and Smyrna, respectively.

Hospitals

Nine hospitals are located throughout the State. Since Delaware does not have a publicly funded hospital, each private hospital is a critical component of the safety net system, though, the extent of programming and services available to the uninsured and underinsured varies. Five of the hospitals are located in New Castle County. These include Christiana Care in Newark, and four hospitals in Wilmington, including AI duPont Hospital for Children, St. Francis Hospital, and Christiana's Wilmington Hospital, and the Veterans Affairs Medical and Regional Office Center. There are two hospitals, Kent General and Milford Memorial, affiliated with Bayhealth Medical Center. Kent General is in Dover, Kent County, while Milford Memorial, located in Milford is in Sussex County. In addition to Milford Memorial, Sussex County has two other hospitals, Beebe Medical Center, located in Lewes, and Nanticoke Memorial Hospital, located in Seaford. All hospitals see uninsured and underinsured patients in their emergency departments.

Safety Net Service Gaps and Barriers to Receiving Care

To provide clear insight regarding the strength of the safety net and its capacity to serve additional people, JSI explored whether there were any gaps in essential safety net services. We also identified barriers to accessing existing services (e.g. transportation, language, and culture) and assessed the adequacy of systems to support coordination of services and information flow between providers.

Gaps, barriers and systems infrastructure were explored through key informant interviews, the development of the safety net inventory, and the analysis of secondary data. In addition, a series of geo-demographic maps helped to identify existing gaps and service delivery patterns.

Geographic Distribution of Services: In general, services are well distributed throughout the State and correspond to the distribution of the population as a whole. Safety net services across all categories are more highly concentrated in New Castle County where nearly 60% of the State's uninsured population reside. For example, 11 of the 17 health homes and 7 of the 16 mental health and substance abuse clinics are located in New Castle. In the more rural areas downstate, where the uninsured populations are smaller, there are fewer service sites across all categories and these sites are more widely dispersed. The service sites tend to be located in more highly populated areas such as Claymont, Wilmington, Newark, Dover, Milford, Seaford, and Georgetown.

Service Gaps: With regard to health homes, JSI did not find glaring gaps in services, particularly upstate in New Castle County. This is not to say that

everyone receives the care that they need; on the contrary, capacity across all services is very constrained. The percentage of the total uninsured population that are served by a safety net 'health home' (penetration rate) ranges from roughly 5% to 13% depending on the County (Exhibit VI). These rates were calculated by aggregating the number of uninsured users across all of the safety net health homes and dividing it by the total number of uninsured persons in the State. The low-income uninsured as well as the uninsured population that is not low-income are included in this calculation. It is important to note that if we were able to calculate this rate with respect to only the low-income insured that these penetration rates would be significantly higher as safety net health homes serve a disproportionate number of low-income users. Nonetheless, if the safety net system hopes to significantly address access issues for the uninsured in the long-term in upstate and downstate regions, expansions and/or new site developments will need to take place.

With regard to specialty care services, JSI did identify clear geographic gaps in services, particularly in the areas of oral health, prenatal care, and behavioral health. These gaps are even more apparent for non-English speakers due to the lack of linguistic capabilities within the safety net providers. In Kent and Sussex Counties combined there is only one site that provides oral health services to those without insurance and there are only three or four prenatal practices that provide prenatal care to this population. Even more dramatic, is the fact that there are no inpatient behavioral health facilities and only two outpatient behavioral health serving the uninsured in Kent and Sussex Counties. There are a number of efforts underway throughout the state to address these problems, but gaps still exist.

Medical Specialty & Ancillary Services: Access to specialty care and ancillary services (e.g., labs, radiology and pharmaceuticals) are essential to ensure a continuum of care. Although the system as a whole may have the specialty and ancillary service capacity to treat the uninsured, arranging for these services has proven to be a burdensome, laborious and uncertain process. Barriers have existed, particularly for small private practitioners who participate in the VIP II program. FQHC's and the other 'health homes' have been able to put together both formal and informal systems that allow them to provide some of these services free of charge or at reduced costs for those who are uninsured. With respect to medical specialty services, co-pays are accepted where possible, volunteer provider networks have been created, and sometimes the remaining costs are absorbed by the clinics themselves. Even for FQHCs, however, developing and sustaining these systems for their patients is very challenging.

Lab tests, pharmaceuticals, and other ancillary services (e.g., physical therapy, etc.) are particularly problematic. The provision of these services has proven to be extremely difficult for VIP II physicians, with clinicians often relying on professional and/or personal relationships or connections to obtain assistance for the uninsured. With respect to medications, all of the FQHCs are eligible for

340B pharmaceutical pricing but some do not participate and conversely rely on pharmaceutical industry-sponsored compassionate use programs. At FQHC's and community clinics, lab tests and radiology are contracted at a reduced rate, or the provider absorbs the costs. However, this does not hold true for VIP II.

After working for more than two years, the Medical Society of Delaware has recently developed agreements to enable the VIP II program to have access to reduced cost ancillary services to their enrolled CHAP patients. CHAP is working to improve access to pharmacy services by streamlining access to industry-sponsored programs. Systematizing and streamlining the process by which these services are accessed will facilitate treatment and ensure that more uninsured individuals have access to a comprehensive and coordinated system of care.

Service Coordination, Integration, and Information Sharing Across Safety Net Providers: It became clear from the key informant interviews and site visits that individual health homes within the safety net are well run and provide high quality, comprehensive care. All of the health homes have good internal clinical, management, and financial systems that help to coordinate and facilitate care. This is also generally true with regard to the range of other safety net providers, such as the school-based Wellness Centers, the Division of Public Health State Service Centers.

Most safety net providers have developed mechanisms to share information and standardize care within their organization. However, there have been limited efforts to share information and knowledge among organizations, even when sites provided similar services (e.g., health homes). Recently, the FQHCs have begun working on some joint projects, but at this time, their efforts are restricted to the four FQHCs.

This "silo effect", in which providers focus on internal communication and relate externally only to other similar providers, has the potential to lead to duplication in some areas, such as purchase of technology or development of specialized services, while leaving gaps in others. It also constrains sharing of lessons learned and implementation of best practices because one part of the system does not know what the other parts are doing. One example of the "silo effect" observed in Delaware is the unnecessary time some health homes were dedicating to developing sliding fee scales and financial eligibility screening procedures, while the FQHC health homes had been operating such systems for several years. Another example is the uneven access health homes have to specialty consultation and diagnostic services for their patients. Such inefficiencies can make the safety net more expensive to develop and sustain, as well as negatively impact the comprehensiveness and continuity offered to patients. At its worst, a fragmented safety net lets people fall through the cracks and produces less than optimal health care outcomes, at greater financial cost to both providers and patients.

Several high-level efforts are working to remedy this fractionation and create a comprehensive system-wide approach to sharing information. The DHCC's State Planning Program efforts are notable but have focused primarily on larger issues of coverage and insurance eligibility. CHAP has made important strides in this area and has created a forum where providers can share information, coordinate efforts, and develop a common agenda. However, to-date the CHAP agenda has been narrowly focused on the goals and objectives of CAP, and has not always included the full spectrum of safety net stakeholders. Although this has been appropriate to get CHAP programs underway, it is time to expand the agenda and to consider planning and coordination efforts between provider types.

Capacity Analysis

One of the main goals of this project was to assess the capacity of the current safety net to serve those who are low-income and do not have adequate health insurance. The analysis in this area focused primarily on the capacity of the 'health homes' that were identified in the safety net inventory. The following analysis relied on two major sources of data. First, JSI conducted in-depth interviews and site visits with each of the 'health homes' in the safety net system.[4] During these interviews JSI collected data on services, utilization, and finances as well as information on space and facilities. Each site was also asked to estimate how many more people they would serve over the next 18 months given their existing expansion plans. Additionally, JSI reviewed information on the number of uninsured people by county and by the State as a whole from a study entitled Delawareans Without Health Insurance, 2001, conducted by the Center for Applied Demography & Survey Research at the University of Delaware.

Using these data and considering issues of space, operations, payor mix, and overall financial burden, JSI analyzed the current and future capacity of each of the 'health homes' to serve uninsured users. Additionally, JSI calculated the percentage of the State's uninsured population that is receiving care from a designated 'health home'. This percentage or penetration rate was calculated on a statewide basis and by county as well as by type of 'health home '(i.e. FQHC and Other 'Health Home') and are presented in Exhibit VI. Following is a summary of the findings.

Current Volume and Capacity to Serve the Uninsured: Currently, approximately 9,000 uninsured people receive care at safety net 'health homes'. The four FQHCs serve the majority of the uninsured and see 5,070 unduplicated users. The remaining 'health homes' serve 3,845 users. All of the 'health homes' are at or very near full capacity. Lack of space and the financial burden of serving people without insurance are the major constraints that effect their ability to serve additional uninsured patients. The uninsured represent 41% of total FQHC users while in the other 'health homes' they represent only 7%. The FQHCs are able to withstand such high percentages of uninsured users because

[4] Working with the DHCC, JSI made every effort via phone, facsimile and e-mail to obtain information regarding the location and description of the sites operated by St. Francis Hospital. However, information was not available by the project's deadline and therefore is not included in the report

they are subsidized to some extent by the federal government. The other 'health homes' have developed creative ways to shift costs, maximize efficiencies, and/or have simply taken a loss. Regardless, all 'health homes' in the system are operating extremely close to the margin and have a very limited ability to provide care to additional uninsured.

Penetration Rate: By aggregating the payor mix data collected from the 'health homes' by county and the State as a whole and combining it with the uninsurance data, JSI determined the percentage of uninsured persons that were receiving care from the designated 'health homes' (Exhibit VI). As mentioned above, all of the health homes combined were providing care to about 9,000 unduplicated uninsured users. This represents 10.2% of the estimated 88,000 people in the State without health insurance. The FQHC's serve 5.8% of the Delaware's uninsured while 4.4% are served by the other 'health homes'. As stated above, these penetration rates underestimate the percentage of the low-income uninsured that are served by the safety net health homes as safety net health homes serve a disproportionate number of low-income users. Based on the "Delawareans Without Health Insurance, 2001" study cited above about 46% of the State's uninsured population is low-income (i.e. living at 200% of the federal poverty level or below). Applying a conservative estimate that 70% of the health homes uninsured population is low-income then the penetration rates would be more like 15%.

The penetration rates vary significantly by region. In New Castle County, the 'health homes' serve a total of 6,795 uninsured users, which represents 13.1% of the uninsured population in New Castle County. In Kent and Sussex Counties, safety net 'health homes serve' a total of 2,120 uninsured users, which represents 5.9% of the uninsured population in these counties. Penetration rates are lower in more rural areas due to the lower provider density and the inherent barriers to access. In addition, the two FQHCs in Kent and Sussex county have only recently begun seeing the general uninsured population.

Expanding the Safety Net

Delaware has a strong base of 'health homes' forming the core of the safety net. However, there is both the potential and need to expand the number of 'health homes' and the number of uninsured people they serve. The federal FQHC program in HRSA's Bureau of Primary Health Care provides the State with the best opportunity to secure non-state funding to expand the safety net.

Currently in Delaware, the four FQHCs (including La Red which does not yet have the formal designation but is in the process of applying) account for almost 60% of uninsured people served by the safety net. Based on national benchmarks related to costs, revenue and utilization, FQHCs in Delaware compare well to FQHCs across the country. However, Delaware has a relatively low number of FQHCs compared to other states.

Exhibit VII compares the number of FQHC sites and people served to several similar states across the country. Delaware has the lowest number of FQHC sites and the lowest proportion of patients served compared to state population of all the comparison states. Given current HRSA funding priorities, the potential exists to increase the number of FQHC sites in Delaware.

Creating new FQHC sites brings not only federal funding to serve additional uninsured people, but also additional benefits such as access to the 340b drug pricing program and Federal Torts Claim Act (FTCA) malpractice protection for FQHC providers. Given the current challenges accessing pharmaceuticals for uninsured patients as well as rising malpractice premiums, these additional benefits can help FQHCs see more uninsured patients.

Two of the existing FQHCs in Delaware, Kent Community Health Center and Westside Health have recently received additional federal grants to expand their service sites and the number of patients served. Both expect significant growth in the next 18-24 months. Other 'health homes' in the State are also projecting at least limited growth. If all the expansions take place as planned and reach expectations, the safety net health homes will be able to serve close to 5,000 additional uninsured users over the next 18-24 months. Adding the projected 5,000 additional uninsured users will increase the statewide penetration rate by more than 50% from 10.2% to 15.9%. The projections continue significant variation by county, with New Castle's rate jumping to nearly 20% and Kent and Sussex increasing to nearly 11%.

While this projected growth is important to strengthening the safety net, the potential exists to do even more. During the project, the stakeholder group agreed, that as much as capacity/funding would allow, the safety net should seek to expand the number of uninsured people served in safety net 'health homes', from 9,000 to 18,000 in the next five years. Federal funding has recently been secured to achieve about half of this growth. National FQHC data shows that it costs about $425 per year to serve each additional patient, and Delaware FQHCs' experience is very close to this national average. Very roughly, based on this figure Delaware will require about $3.8 million per year to maintain services for 9,000 additional uninsured patients. The recent HRSA grants to FQHCs have contributed about $1.2 million, leaving about $2.6 million additional resources per year required to double the number of uninsured people served by the safety net. Some of this funding can potentially come from HRSA through the development of new FQHC access points either as part of existing FQHCs or new FQHC organizations. However, multiple sources of financial support should be considered to both stimulate the development of successful FQHCs and/or to augment federal funding for specific services and locations including, potentially, State funds. The next section describes some issues and approaches Delaware may want to explore related to utilizing State resources in support of the safety net.

State Models/Case Studies for Financing the Safety Net

The DHCC is considering all options for ensuring continued strength and possible expansions, particularly in the health home components of the safety net. As part of this project, JSI reviewed and presented a range of models other states use to support their health care safety net systems, focusing on support of the primary care safety net. Five states were selected for analysis to reflect the range of approaches being used across the country. Exhibit VIII includes a summary of selected state models.

Summary data on state activities was obtained from The National Association of Community Health Centers' (NACHC) March 2002 report entitled "How Health Centers Have Fared in Recent State Budget Negotiations". Details on individual state models were extracted through state-specific reports and legislation as well as interviews with key informants in selected states.

NACHC surveyed all states and territories, receiving responses from 47 of 52 surveyed. Responses indicated that 31 of 47 states (66%) provide some direct state support for the primary care safety net; Delaware is one of the minority that does not. The report also showed that HRSA funds account for 22.2% of FQHC annual budgets nationwide while in Delaware, HRSA funds account for 44.8% of FQHC budgets. Since patient revenue in Delaware FQHCs is close to national averages (47% in Delaware, 55% nationally). The Delaware FQHCs depend to a greater extent on federal support than FQHCs in other states.

There are many different reasons that states provide support for their safety net systems. The reasons are often reflected in the diversity of their models. If Delaware decides to begin state support of the safety net, the first charge would be to clearly articulate what is to be accomplished with the funding. Listed below are some of the considerations and approaches other states have pursued.

- **Types of organizations to support** (e.g. FQHCs, rural health clinics, school-based health clinics, free clinics, health department clinics, categorical programs, general not-for-profits, and/or State defined eligible entities). Generally, if the intent is to stabilize current providers, emphasis is on supporting existing FQHCs or State defined health centers. If the intent is to stimulate the development of new entities, often with the ultimate goal of achieving FQHC status and bringing additional federal funds to the State, funds go more broadly to non-profits and developing health care programs.
- **What to support** (e.g. general operations, specific program areas, capital purchases, bricks and mortar). Though most states provide support for general primary care, some states target funds to a particular program areas such as oral health or pharmacy. This decision may be based on which areas will generate the greatest political support as well as an objective assessment of need. Several states also provide support for building and equipment purchase, though they usually limit the amount of funds that may be used for capital purchase or bricks and mortar. Also some states provide this funding only in years when they have sufficient funds.

- **How funding is provided** (e.g. contracts, grants, loans, fee-for-service reimbursement and whether funding is competitive or formula based). There is great variation in how funds are awarded and administered. Most states provide funding through existing state contract or grants mechanisms, using traditional line item budgets. However, there are many variations within this approach as well as other approaches including unit of service prospective payment or reimbursement. Similarly there is extensive variation on how funds are proportioned, either through competition or formula awards. Competition is more prevalent when a state is trying to stimulate new programs sites or services while formula allocations are used more when the state is aiming to stabilize the existing safety net.
- **Source of funding** (e.g. general fund, tobacco settlement, cigarette or provider taxes). States draw on many different resources to support the safety net and many states use a combination of resources.
- **Duration of funding** (e.g. one-time, multi-year, or on-going). Most states that support the safety net do so on a continuing basis, though some provide one-time funding for special initiatives, often in on-going support.

The descriptions of five state models (Colorado, Indiana, Massachusetts, New Hampshire and Wisconsin) included in Exhibit VIII illustrate how these states have addressed these considerations.

V. KEY OPPORTUNITIES & THREATS

Key Opportunities

Environment

The Delaware safety net system does not operate within a health care vacuum. Many factors, especially fiscal and policy decisions at the local, state and federal level, affect the strength, capacity and sustainability of the safety net system. In addition to understanding the specific components of the safety net system, JSI sought to understand selected environmental issues that might impact the system including changes in immigration policy, medical malpractice coverage, Medicaid coverage and policy as well as pharmacy benefits. These issues were selected for analysis in discussions with stakeholders. Discussion of these issues and their relevance to Delaware's safety net system are outlined in Appendices A - C.

Federal Programs and Funding

The Delaware Safety Net has a number of strengths and opportunities on which to fortify and expand the system. Currently, the safety net system is leveraging federal funds and resources through the three established FQHCs, a HRSA Rural Health Outreach grant supporting the development of La Red, two HRSA grants (i.e., a Community Access Program grant and State Planning Grant) and the use of loan repayment/forgiveness programs available to National Health Service Corps (NHSC) providers.

The FQHCs offer a stable base on which to build additional capacity through new access points and expanded services. President Bush's plan to double the number of FQHC's within five years, by creating new access points and expanding capacity and available services within existing sites, presents an opportunity to increase access to health care services for Delaware's uninsured and receive additional federal funding. This is discussed in more detail in the previous section on "expanding the safety net".

The HRSA grant programs are supporting both statewide planning to reduce the number of uninsured and CHAP. Delaware's CHAP provides a centralized and uniform mechanism by which uninsured individuals can be screened for public assistance and/or insurance eligibility and directed/assigned to a medical home. The role of CHAP in screening patients becomes even more important given the State's recent curtailment of outreach efforts for Medicaid. Also, CHAP often provides the only local bi-lingual resource for consumers seeking insurance coverage.

Not only does the CHAP facilitate access through enrollment and referral to providers, it also provides an infrastructure for communication and collaboration among members of the safety net system. This infrastructure is critical to supporting and expanding the capacity of the safety net as it encourages dialogue and can assist in connecting, if not dismantling the silos within which some of the safety net providers operate. CHAP's ability to create and sustain connectivity and dialogue among the key stakeholders and providers will aid Delaware in building and maintaining an efficient safety net *system* of care in which to serve its uninsured and underinsured residents.

Health Insurance Flexibility and Accountability (HIFA)

Building and maintaining an efficient, effective and sustainable safety net system is challenging. Federal public assistance dollars are limited and often earmarked for specific programs or restricted in how they may be spent. Rising to this challenge, some states have chosen to apply for the Health Insurance Flexibility and Accountability (HIFA) demonstration initiative. The HIFA initiative builds upon the section 1115 waiver which allows states to waive certain requirements of the law to experiment with new ideas for improving programs; thereby increasing states' programmatic flexibility to alter their usual Medicaid benefit package for the optional and expansion populations[5]. The HIFA demonstration project encourages states to develop new comprehensive approaches to increase the number of individuals with health insurance coverage using current-level Medicaid and SCHIP resources. The waiver presents a potential opportunity for Delaware to experiment with such ideas as premium assistance, consumer cost-sharing, and private insurer partnerships, to expand coverage to those who are currently low-income and uninsured.

[5] Optional populations are groups that can be covered under a Medicaid or SCHIP state plan. Expansion populations are individuals who can only be covered by Medicaid or SCHIP under an 1115 waiver.

Key Threats to the Safety Net System

Delaware's safety net system is relatively strong, stable and comprehensive and the State should be proud of the protection the safety net offers its most vulnerable residents. Yet, any one of many factors could easily and quickly unravel the net. A significant shift in either the provider or patient populations could upset the existing equilibrium and destabilize the system. Since the State does not directly support key components of the safety net, it is dependent on the policies and contributions of private organizations, hospitals and FQHCs particularly, to sustain the system. Several threats currently exist which may change the ability of these organizations to support the safety net including rising costs and shortages of clinical professionals. Other trends such as changes in federal legislation or funding, shifts in payer mix and changes in the Delaware Medicaid policy, are potential future threats to the stability of the safety net.

An increase in the rolls of the uninsured can adversely impact the safety net, especially in areas where there is insufficient capacity to meet existing needs. Two threats currently exist that could increase the number of people who are uninsured, including current curtailment of Medicaid outreach and the rising cost of health insurance premiums. Medicaid outreach serves to screen and enroll people in public assistance and other State-sponsored programs (e.g., SCHIP). Reducing outreach efforts can limit enrollment in these programs as potentially eligible individuals are not educated about the programs nor exposed to the screening process within their community. These same individuals may also face additional barriers (such as language) in seeking to apply and/or navigating the application process, thereby increasing the likelihood that they remain uninsured.

Since people who would qualify for State-sponsored programs must be low-income, it is unlikely that many would have sufficient means with which to purchase private health insurance and only a handful will find employers who provide coverage. Due to the rising costs of health care, health insurance carriers have consistently increased premium rates. Even those who are not low-income may not be able to afford current high premiums. Additionally, as premiums rise they become less and less affordable, especially for small employers and self-employed individuals, causing employers to reduce availability of coverage and/or the level of benefits. Ultimately, this spiral threatens to cause more individuals to be uninsured.

An increase in the number of individuals demanding services within the safety net system without a corresponding increase in the number of providers supplying services will create an imbalance within the system. Certainly, with rising health care costs and increasing financial pressures, it is unrealistic to expect providers to expand capacity without a commensurate increase in resources. Access to even the current level of resources may be threatened as even financially strong organizations confront rising costs, reduced reimbursement and pressure on their endowments or reserve funds. In addition to limited resources and rising costs, several other factors threaten the supply of services. These factors include medical malpractice issues, licensure requirements, and a general shortage of clinical professionals.

Medical malpractice premiums have increased substantially in Delaware, with a number of carriers choosing to exit the market. The medical malpractice issues influence both the capacity and type of services provided within the safety net. Increasing premiums raise the cost of doing business for providers, which in turn may decrease the number of uninsured individuals they can afford to serve. Additionally, the medical malpractice issue can hinder recruitment of new physicians and cause practicing physicians to exit the market or curtail the services they provide. The issues with medical malpractice are further exacerbating an existing shortage of Ob/Gyns and issues surrounding availability of obstetrical services, particularly downstate. Interviews conducted with Ob/Gyns, other providers and stakeholders throughout the State indicate that the risk exposure and the cost of coverage for these specialists has become so prohibitive that some physicians cannot afford to accept uninsured patients and/or have chosen to retire, move or provide only gynecological services.

Delaware may also be facing a shortage of dentists. Delaware's laws and licensure requirements are different from other states; some view these as barriers for new dentists to establish practices in the State. As dentists retire and new dentists have difficulty entering the Delaware market, dental service capacity may become severely limited. Dental and obstetrical services are just two examples of areas experiencing threats to capacity. Currently, however, there is a shortage of clinical professionals including nurses, substance abuse and behavioral health specialists, and bi-lingual clinicians. All of these professionals are needed to ensure adequate access to, and sustainability of a viable safety net system.

VI. GOALS AND RECOMMENDATIONS

The following recommendations are based on findings from the analysis of the safety net system and the current and potential future environment in which it exists and operates. Ultimately, the goal of the Delaware safety net system is to provide access to high quality health services as efficiently and to as many low-income uninsured people as possible. Expanding existing programs, developing new 'health home' sites, developing better coordination across the components of the system and sharing best practices are all necessary to approach universal access for Delaware's uninsured population. The following goals and strategies provide a guide for the Delaware Health Care Commission to stabilize the current safety net and develop and expand needed services.

Goal #1: Expand capacity to double the number of uninsured people served by health homes in the next five years (currently approximately 9,000 served; expand this to 18,000)

Strategies for Accomplishing Goal #1

1. Secure additional financial and other resources to support the Delaware safety net system, focusing on 'health homes' as the core of the system. Delaware has both the need and potential to expand resources applied to the safety net. Resources can come from several sources.

- Maximize federal dollars, particularly from the FQHC program to support the development of new access sites. Identify and provide state-sponsored support and assistance to organizations and communities interested in pursuing FQHC funds.
- Allocate State funds to support the safety net. State funds could be used to: augment funding of existing safety net 'health homes' to enable them to see more uninsured patients; stimulate the development of new 'health homes', which could then leverage additional federal funds; and/or fund services and programs such as oral health, behavioral health, pharmacy or other ancillary services that are not sufficiently funded with other sources.
- Continue the exploration of expanded insurance/coverage programs to reduce the number of uninsured residents and improve the payer mix for safety net providers.

2. Expand and market the CHAP program to increase enrollment. CHAP gives its enrolled members a 'health home' and enables them to access services similar to people with insurance. In addition, CHAP helps identify people who are eligible for Medicaid and SCHIP, reducing the number of low income uninsured people. CHAP also is developing the infrastructure on which to build more expansive coverage programs.

3. Conduct primary research on current utilization patterns for uninsured individuals. While Delaware has extensive data, which characterizes the uninsured population, it has not collected data on their health care utilization patterns. Collecting data that captures the extent of use of emergency department for primary care, the extent that private practice physicians are seeing the uninsured, the extent that the uninsured go without care as well as hospital outpatient and/or ambulatory data would be very useful. This information is necessary to set goals and plan expansion of the safety net. The data can be collected as part of current statewide data collection efforts.

Goal #2: Ensure that all health homes have access to a comprehensive array of services, either in-house or through referral, for the patients they serve.

Strategies for Accomplishing Goal #2

1. Obtain funding to fill specific service gaps. FQHCs are eligible to apply for funding for targeted service expansion, currently for oral health, behavioral health and pharmacy services. Some of these extra resources are already coming into the FQHCs, but the potential exists to secure additional funding. Furthermore, if Delaware adds new FQHCs, they will also be eligible for additional funding. Provide State support and assistance for FQHCs interested in applying for expanded funding.

2. Establish stronger linkages between components of the safety net to enable all safety net health homes to easily access specialty and ancillary services for their patients. This is a current priority of CHAP and should continue to be supported.

3. Develop streamlined procedures for all health homes that facilitate access to referred services. Structuring written agreements among providers as well as uniform policies and procedures will create efficacy within the system. This in turn will reduce barriers for patients and administrative burden for providers. CHAP has also begun to work on this issue and should continue. Once established, provide education and technical assistance on the procedures.

Share best practices and lessons learned to facilitate replication of successful programs. A number of the 'health homes' have developed very creative and successful approaches to gaining access to comprehensive services for their patients. These could be shared and replicated to create more consistent access across the system.

Goal #3: Enhance collaboration among components of the safety net to create a better system, avoid redundancy and incorporate best practices.

Strategies for Accomplishing Goal #3

1. Continue to support the CHAP structure as a forum to bring stakeholders together, as well as to enroll people in programs for which they are eligible. CHAP has already made important gains in enhancing collaboration by bringing together several components of the safety net to improve access for uninsured people. Going forward, CHAP is the best mechanism to bring together all the components of the Delaware safety net with the aim of bridging the silos that exist and creating a better-integrated system of care. Specifically, CHAP can
   - Expand membership to include representatives from all types of safety net providers, not just those participating in the current CHAP programs
   - Use the CHAP structure as a forum for complimentary strategic planning to strengthen the safety net system
   - Define an annual agenda and processes to accomplish priority tasks across the safety net
   - Establish and maintain technical assistance rosters and resources that include peer advisors to facilitate the sharing and transfer of knowledge and the development of expertise within the safety net system.

APPENDIX A

Health Care Policy for Immigrants

According to the 2000 US Census, 25,846, or 3.3% of Delaware's population are not citizens of the United States.[6] Currently, Delaware follows the standard federal requirements from the 1996 Federal Welfare Reform Law – Personal Responsibility and Work Opportunity Act (PRWORA) and does not offer any specific state-funded health care coverage to documented and undocumented immigrants. As the number of immigrants grows, so does the burden on safety net providers who disproportionately serve immigrants, many of whom are uninsured. During the course of the analysis, safety net providers requested JSI to review policies in other states as a way to inform future policies in Delaware.

Overview of federal policy

The1996 the Federal Welfare Reform Law – Personal Responsibility and Work Opportunity Act (PRWORA) restricts access to public benefits and health care programs for some immigrants by restricting eligibility. Additionally the PRWORA substantially decreased the level of federal support received by states for medical assistance and coverage provided to both documented and undocumented immigrants. States may still receive federal support for emergent medical services (including labor and delivery) provided to all immigrants (i.e., documented and undocumented). However, states are no longer eligible to receive the federal match for immigrants covered by Medicaid unless the immigrants satisfy several criteria. These criteria include legal admission to the United States and a minimum of 40 work quarters or, residency of five years with the sponsor's income included in the eligibility screening (i.e., deeming). Under the PRWORA, states may create their own eligibility rules through a formal legislative process. However, if states choose to extend coverage to those immigrants who do not satisfy the federal requirements, they must absorb the entire cost of these initiatives. Hence, many individuals who have legally entered the United States are no longer eligible for medical assistance – creating an additional burden on safety net providers and state budgets.

Contributing to the likelihood that immigrants will be uninsured and not have access to routine and preventive primary and secondary care is immigrants' confusion regarding eligibility for public benefits and fear of deportation or being categorized as a "public charge". Hence, the emergency room continues to the regular source of care for many immigrants. The reliance on emergency room care does not appear to be a reasonable long-term solution, especially for pregnant women and school-age children. Many states have opted to cover these two cohorts recognizing the long-term cost-savings of providing pre-natal care for children who will be U.S. citizens upon birth; as well as the public health risk to schools and day care facilities if children do not receive treatment to

[6] U.S. Bureau of the Census, Census 2000 – Table DP-2. Profile of Selected Social Characteristics: 2000.

prevent the spread of contagious disease. Additionally, several bills have been introduced at the national level to expand coverage to pregnant women and children. These include:

- **Federal Responsibility for Immigrant Health Act** (S.2449; May 2, 2002) would expand the emergency Medicaid exception to provide Medicaid reimbursement for pregnancy-related services, including prenatal and family planning services, and testing and treatment of communicable diseases. The bill would also expand the definition of an emergency to include chemotherapy, dialysis and services necessary to prevent an emergency. Referred to Committee on Finance.

- **Start Healthy, Stay Healthy** (H. 3729; S. 1016 March 5, 2002) would provide for an enhanced federal Medicaid medical assistance percentage for states that elect to continuously enroll infants during the first year of life without regard to the child's membership in the woman's household or the mother's eligibility status. The bill would also increase the SCHIP income eligibility level.

- **Immigrant Children's Health Improvement Act of 2001** (S.582; H.R. 1143) would allow states the option of extending health care coverage to pregnant women and children under Medicaid and/or SCHIP.

- **Legal Immigration Health Restoration Act of 2001** (H.R. 1528) would assure coverage for legal immigrant children and pregnant women under the Medicaid Program and the State's Children's Health Insurance Program (SCHIP). Referred to subcommittee on health in April 2001.

- **Legal Immigration Children's Health Improvement Act of 2000** (H.R. 4707) would permit States the option of coverage of legal immigrants under the Medicaid Program and the State's Children Health Insurance Program.

Another factor influencing state's decision(s) to offer coverage to immigrants who are not currently eligible under the PRWORA are lawsuits. In 2001, the *Lewis V. Grinker* decision, in which the U.S. Court of Appeals for the Second Circuit overturned a previous New York district court finding that the PRWORA withholding pre-natal care violated the equal protection rights of U.S. born children. The latest ruling in this case stated that Congress acted constitutionally in banning states from using federal Medicaid to provide prenatal care to women who are not "qualified" immigrants. However, a more recent ruling on another case may be indicative of changing trends. The New York Department of Health (NYDH) has extended coverage to individuals residing in the United States under the color of law (PRUCOLS[7]) and "qualified" immigrants, regardless of date of entry. This extension was influenced by the New York Court of Appeals decision in *Aliessa v Novello*, in which the court decided that the state's failure to provide health coverage to all legal immigrants violated the equal protection clauses of the federal and state constitutions.

[7] Permanently Residing Under Color of Law (PRUCOL

Although there appear to be numerous "irons in the fire" regarding the reinstatement of coverage for immigrant children and pregnant women, federal and state budgetary constraints may prove to be too difficult to overcome. It is too early to determine the impact of the New York Court of Appeals decision on other state and federal access and coverage initiatives; most likely, however, if any coverage is reinstated at the federal level it will probably be limited to these two cohorts.

Delaware and Other States' Health Care Policies for Immigrants

JSI sought to understand other states policies on coverage for immigrants. In particular, JSI reviewed policies from states that have similar demographics (e.g., % of Hispanic residents, migrant workers, etc.) and/or neighbor Delaware-- Georgia, Indiana, Maryland, Massachusetts, New Jersey, North Carolina, Rhode Island, and Virginia. Four of the reviewed states (Georgia, Indiana, North Carolina and Virginia) have similar policies to Delaware. They adhere to the federal regulations and have no special health care coverage provisions in place for immigrants who do not qualify under the PWORA.

As explained in the previous section, funding would have to come from a source other than the federal government, if Delaware wished to extend coverage for health care services (other than emergent) to immigrants who do not qualify under the PWORA. Some organizations, within the safety net, currently 'fund' such services. Certainly, as part of their mandate for Section 330 funding, all Federally Qualified Health Centers provide a continuum of care to individuals, regardless of their immigration status. This is also true for enrollees in the CHAP program, where individuals are eligible to be assigned to a health home regardless of their immigration status. Additionally, although eligibility policies outlined for the charity care funds at two major institutions within the safety net specify that beneficiaries must be citizens, actually, these organizations do not discriminate between citizens and non-citizens. In order to qualify for these two charity care funding programs, immigrants must meet the same requirements as citizen and present a valid denial of Medicaid eligibility. However, it should be noted, that both of these charity care screening programs do require some formal documentation of income, which is often difficult for an undocumented immigrant to supply. One organization, however, explained that even if documentation is not available, every effort is made to determine the individual's ability to pay and subsidize care through auxiliary methods.

Other states (Maryland, Massachusetts, New Jersey and Rhode Island) have formal policies in place to augment payment to organizations that provide health care services to immigrants. Half of these four states extend coverage only to documented immigrants (i.e., mainly those who have not met the PWORA's five year residency requirement), who are individuals who would most likely have been covered had the PWORA not been instituted. Massachusetts' coverage programs, Children's Medical Security Program and Healthy Start, are available to all children and pregnant immigrants regardless of legal status, though it should be noted that some of these programs do require individual cost-sharing (e.g., premium and co-payments). Rhode Island, through its Medicaid R.I.te Care Program offers coverage to all children regardless of immigration status.

All states, except Massachusetts, extend coverage solely to either children, pregnant women or both. In Massachusetts a myriad of programs make coverage available to documented families and/or disabled adults (i.e., MassHealth Commonhealth, MassHealth Limited), documented and undocumented pregnant women (i.e., Healthy Start) and undocumented and documented children (i.e., Children's Medical Security Plan), all with varying income eligibility criteria. The level of coverage as well as the income eligibility varies widely within and between these states, though the reasons for extending this coverage and the mechanisms for funding it seem similar. For instance, in Maryland, coverage is extended for prenatal and post-partum care for immigrant women who have incomes below 50% of the Federal Policy Level (FPL). While in New Jersey, FamilyCare provides full benefits for documented and undocumented infants (< 185% FPL for infants), children and pregnant women (< 133% FPL).

Most states chose to extend coverage because the state, advocates, and policy makers believed that it was good policy and made sense. In addition, community organizations and safety net providers advocated for coverage extension as the PWORA created an unfair financial burden on those organizations that continued to serve this cohort. Massachusetts, the only state to extend coverage to non-pregnant adults, chose to dedicate resources in order to avoid episodic, emergent care. Instead, Massachusetts decided to create a comprehensive model that stresses prevention and encourages appropriate access to services, which policy makers believe is less expensive and more effective in the long-term.

Although at the time of each state's decision, a cost-benefit analysis had not been conducted, every person who was interviewed explained that common sense dictated that preventive care for children and pregnant women would reduce costs in the long-term. Providing pre-natal care to pregnant women who would be giving birth to citizens, all of whom would then be eligible for public assistance, would produce healthier babies. Obviously, healthier babies require less care and medical assistance than unhealthy, potentially low birth weight, premature babies. The fact that prenatal care directly contributes to healthier babies has been proven. A California study found that every $1 spent on prenatal care, $3.33 was saved in the cost of post-natal care; and $4.63 was saved in incremental long-term costs (health care, childcare, special education, and grade repetition).[8]Additionally, policy makers recognized that providing care for children, especially those, who are school-aged, was a public health necessity. Children without access to care/coverage posed a public health risk as they could easily carry and transmit communicable diseases.

Generally, these four states fund the coverage extension through general revenue, tobacco settlement funds and/or a state imposed cigarette tax. A review of the increase rates of State Excise Tax Rates on Cigarettes shows that the reviewed states that have extended coverage to immigrants after the PWORA have increased their tax rate between $0.30 and $0.63 per cigarette pack, in the last ten years. Likewise, none of reviewed states that

[8] Lu MC, Lin YG, Prieto NM, et al. Elimination of public funding for prenatal care for undocumented immigrants in California: A cost/benefit analysis. Ma J Obstet Gynecol 2000; 182(1): 233-239.

did not extend coverage have increased this tax[9]. This may be indicative of willingness to look at new revenue sources to cover health care for residents.

[9] 2002: Federation of Tax Administrators, 1992: U.S. Advisory Commission on Intergovernmental Relations, *Significant Features of Fiscal Federalisms*, 1993, p. 118. Taxes as of 10/1/92 and 1/1/02.

APPENDIX B

Impact of Medical Malpractice Issues on the Safety Net System

Delaware, like most of the nation, is facing a problem. Premiums are rising significantly, and insurers are exiting the market or refusing to underwrite new policies. According to the Medical Society of Delaware, four major medical malpractice carriers have exited or will soon exit Delaware's marketplace and one major carrier has stopped writing new policies. Among the many issues created by the lack of availability of adequate malpractice insurance and the accompanied soaring cost of coverage is access to health care services. Access can be affected on multiple levels, two of which are financial and capacity. Financially, there are at least two sides to the equation -- that of providers and that of consumers. Increasing premiums may limit practitioners ability to provide uncompensated care to those who are uninsured and/or underinsured, as they need to maximize revenue in order to cover the cost of their premium. Ultimately, the cost of higher malpractice insurance premiums will be passed along to the consumer in the form of higher health insurance premiums. Most likely, health insurance carriers will need to charge more to cover the requisite higher reimbursement paid to practitioners which is necessary to cover the provider's increasing overhead costs. Increased health insurance premiums potentially results in more Delawareans remaining and/or becoming uninsured as health insurance becomes even less affordable.

Additionally, the provider's increased financial burden may result in the closing of practices and/or services. Ultimately, this will adversely impact consumers access to care as there will be limited available capacity, especially for those who cannot afford to pay. A recent example of this resulted from a multi-million dollar jury award against a Milford-based OB/Gyn, apparently attaching this physician's personal assets as the medical malpractice insurer went bankrupt before this jury award, leaving no monies to pay the claim. Unless this decision is overturned upon appeal, this provider may not be able to afford to continue to practice, which threatens obstetrical and gynecological care and access, especially for those who are uninsured and reside downstate.
In support of medical malpractice reform, a coalition of hospitals, physicians, health insurers and the business community supported House Bill 502 calling for a $250,000 cap on non-economic damages in medical malpractice cases. In June, House Bill 502 was rejected. Instead, House Resolution 66 was passed to establish a task force to explore current and future Delaware Medical Malpractice issues. Specifically the task force has been asked to address and review medical negligence insurance issues, and to consider measures not currently in Delaware Law, and provide recommendations to the General Assembly with respect to cost and availability of insurance for medical providers.

The speaker of the house was compiling this taskforce at the time this report was prepared. The taskforce is comprised of the following and/or their designees: Chairman of the Delaware Health Care Commission, the State Insurance Commissioner, representatives of the Delaware Trial Lawyers Association, a representative of the Defense Counsel of Delaware, a representative of the Medical Society of Delaware,

representative of the Delaware Healthcare Association, a representative of the Independent Insurance Agents of Delaware, a representative of the Delaware State Chamber of Commerce, a State Representative appointed by the Speaker of the House of Representatives; two members of the general public appointed by the Speaker of the House of Representatives, one of whom will be named by the Speaker of the House to serve as the Task Force Chair. The resolution calls for a report to the General Assembly by December 15, 2002.

APPENDIX C

Pharmacy Cost Containment Programs For Safety Net Providers

Rising health care costs are one of the most significant elements stressing the safety net. These costs have indirectly led to increased rolls of uninsured and underinsured people. They have also put a greater financial burden on safety net providers and on consumers who are forced to pay higher premiums, larger co-pays or accept reduced benefits. Many factors have joined together to produce these rising costs but one of the most notable factors is increased spending on pharmaceuticals. Spending for prescription drugs nationally grew from a little over $40 billion in 1990 to almost $100 billion in 1999. Although, prescription drug costs represented only nine percent of total national health care expenditures in 2000, increases in pharmacy costs accounted for 29 percent of the total increase in health care costs between 1999 and 2000. On the upside, advances in pharmaceutical therapies have saved lives and improved the quality of life, which in turn can offset the long-term costs of care. [10]

In light of these issues, significant efforts have been made by federal and state policy makers, government agencies, and health care providers to contain pharmacy costs, particularly for safety net providers and those who are uninsured. There are a number of efforts that have been targeted at providers, prescribers, and consumers and have direct effects on reducing health care costs for safety net providers and those with limited to no ability to pay for drugs. There are also a number of strategies that have reduced costs more globally for states, managed care organizations, and large health care systems (e.g. provider networks and large hospital systems). These cost cutting efforts often do not have direct impacts on safety net providers, but rather, free up resources throughout states or within provider networks that can be used to enhance services for the uninsured or to provide greater supports for safety net providers.

There are three basic types of cost containment strategies. The following is a brief summary and discussion of these strategies.

Strategies that Reduce Unnecessary Utilization

The first set of strategies is aimed at reducing unnecessary utilization of pharmaceuticals. These strategies primarily reduce costs for purchasers and managed care organizations and only indirectly affect safety net providers and the uninsured. These strategies typically rely on managing provider behavior to ensure that, whenever possible, they are prescribing the lowest priced drugs. These strategies also try to encourage the use of evidence-based practices and disease protocols that often reduce unnecessary utilization.

Use of Formularies or Preferred Drug Lists (PDL): Some state agencies and managed care organizations are turning to tiered formularies in which consumers

[10] Kaye, Neva. Affording Prescription Drugs: State Initiatives to Contain Cost and Improve Access. National Academy for State Health Policy. July 3, 2002

pay the lowest (out-of-pocket expenses) amount for generic drugs, more for preferred brand-name drugs and the most for non-preferred drugs. These programs have allowed purchasers, managed care organizations, and to some extent providers to shift some of the expense of the most costly drugs onto consumers. Formularies also encourage providers to use generics and lower cost drugs whenever possible. Preferred Drug Lists are a similar strategy that, like formularies, encourages the use of lower priced drugs whenever possible. Drugs that are not on the PDL require prior authorization for use.

Use of Pharmacy Benefit Managers: Some states and purchasers have hired Pharmacy Benefits Management (PBM) companies to help them manage their pharmacy programs. PBMs can help organizations to reduce costs by reducing utilization and by creating management efficiencies. They can also assist providers in identifying and avoiding harmful drug interactions, which ultimately can improve the quality of care delivered. PBMs are most notably used to control provider behavior through prior authorization and by enforcing the use of formularies. PBMs also conduct provider drug use reviews, which allows purchasers and payers to identify pharmacists and prescribers with inappropriate or inefficient prescribing patterns. Some states and organizations have joined together to strengthen their purchasing power and negotiate better prices with PBMs thus further reducing administrative costs.

Use of Disease Management Programs & Limits on the Number of Prescriptions: Some states and purchasers have established disease management programs that have allowed them to encourage the use of evidenced-based treatment protocols. In addition, some states and purchasers have established limits on the number of prescriptions providers may prescribe for a patient without prior authorization. This is another method to control prescribing patterns and reduce inefficient or unnecessarily cost.

Strategies that Reduce Pharmaceutical Wholesale Costs

The second set of strategies is aimed at actually reducing the wholesale prices that pharmaceutical companies charge for medications for certain eligible types of providers or for specific, organized groups of providers. Many of these efforts are aimed primarily at states, large health care systems, and purchasers. However, a few of these efforts are geared specifically to safety net providers and the uninsured and allow certain eligible providers to reduce their costs.

Joint Purchasing: States, and agencies within states, have increasingly started to work together to strengthen their purchasing power and negotiate lower prices with pharmaceutical companies. These efforts have allowed states to reduce their health care costs, which has freed up additional resources that can be used to strengthen programs for low income and uninsured people as well as to provide better supports to safety net providers.

Pharmaceutical Rebate Programs and the Federal 340 B Program: The Omnibus Reconciliation Act of 1990 requires pharmaceutical companies to provide their best prices to the federal government. Vendors who want to sell to State Medicaid Offices and federally funded health care programs must submit bids that designate their best price for each medicine they sell. These prices are offered to State Medicaid offices enabling the State to reduce its pharmacy costs. These prices are also offered to a range of federally funded programs (e.g. FQHCs, RHCs, HCH, Migrant HC, HIV/AIDS Title II, III, and IV Clinic Sites, MCH/FP Clinics, hemophilia clinics, etc.) through an effort called the 340 B Program. Through the 340 B Program eligible entities are able to buy drugs at these reduced rates and can either buy or dispense the medicines themselves or contract with a local pharmacist. These efforts allow providers that serve the uninsured to reduce their overall costs so that they can, in turn, provide more uncompensated care. These savings can also be passed on directly to patients who pay for medications out-of-pocket.

Providers have also joined together or negotiated bulk discounts on their own. Once again, these efforts have allowed providers to provide more uncompensated care and have been passed onto patients who pay for medications out-of-pocket.

Pharmaceutical Industry Compassionate Use Programs.

Another method used to support the safety net and reduce drug costs for consumers is the pharmaceutical industries Compassionate Use Programs. All of the pharmaceutical companies have these programs, which provide free medications to those who are low income and have no coverage for prescribed medications. These programs are widely used but are very cumbersome to administer. They can be accessed by individuals or by organizations on behalf of individuals. Most established safety net providers have staff who assist their uninsured consumers with navigating these administrative systems but often the administrative burden is too high for sites to provide these services to the fullest extent possible to all consumers in need. Non-profit compassionate use consolidators exist that assist people and organizations in accessing these programs but there are usually fees associated with the use of these programs and they are still too onerous for many consumers and providers.