Profiles in Coverage:
Utah's Primary Care Network
SCI talks with Rod Betit, former executive director of the Utah Department of Health
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In March 2002, Utah received a first-of-its-kind Medicaid 1115 waiver to implement its Primary Care Network (PCN), which provides primary care and preventive services to low-income adults who would otherwise lack health insurance. Rod Betit, former executive director of the Utah Department of Health, was the key official responsible for the development and implementation of this program. PCN began accepting applications in July 2002, and 18,000 people are currently enrolled.

After 16 years of service to Utah citizens, Betit has accepted a position as the president of the Alaska State Hospital and Nursing Home Association. Prior to his departure, Rod answered some questions for us about the inception of the PCN, its successes and challenges, as well as the lessons he has learned through the process of designing and implementing the program.

The PCN program offers beneficiaries what Betit refers to as "front-end" services. Newly eligible beneficiaries will have access to services similar to those provided at community and rural health centers, including physician office visits, immunizations, emergency care, lab, x-ray, medical equipment and supplies, basic dental care, hearing and vision screening, and prescription drugs. Although the program does not cover inpatient care, beneficiaries can take advantage of hospital and specialty care components donated from the community.

Rationale for the Program

1. SCI: Why did Utah move forward on this project? What was the rationale behind the development of PCN?

BETIT: Utah pursued the PCN in the spirit of a 10-year commitment to reducing its number of uninsured by introducing affordable health insurance products to low-income individuals. Utah's health policy initiatives have contributed to the lowest uninsured rates among Utahns for some time. The state's uninsured rates were reported at 8.7 percent for all ages and 6.8 percent for children in 2001. The low percentage of uninsured children is due in large part to the Utah's State Children's Health Insurance Program, which covers children from families with incomes up to 200 percent of the federal poverty level (FPL).

The most worrisome uninsured group remaining in the state was adults with family incomes below 150 percent FPL. Utah's 2001 uninsured survey concluded that, among those still uninsured, approximately 85,000 are adults with family incomes below 200 percent FPL. Approximately three-fourths of these adults work, but most of their employers do not offer health insurance. The fiscal picture in Utah and most other states prevented traditional expansions of Medicaid to parents and people without children. It was simply too costly and would not gain widespread political support.

Yet Utah had some state funds to continue expanding eligibility to adults, including savings from our Utah Medical Assistance Program, Medicaid, Federal Financial Participation, and cost sharing. The policy question facing Utah was whether to wait for new federal funding to expand coverage to these low-income working adults, or to push the federal government to allow the state to offer a limited benefit plan for this population under Medicaid using the discretionary powers of the Secretary of the U.S. Department of Health and Human Services.

This limited-benefits approach had the potential to cover five times as many adults as a more traditional Medicaid expansion, assuming that they are at least as healthy as the population of adults covered by Temporary Assistance for Needy Families (TANF) in Medicaid. The per member per month cost was $75 for PCN after deducting administrative costs compared with $465 for the Medicaid adult population for Fiscal Year 2002 (when we started PCN).

Governor Leavitt and I believed it was time to partially close the coverage gap for adults with a primary care benefit that would meet their day-to-day needs and encourage them to use the health care system more appropriately until they were able to obtain employment that offered more comprehensive coverage.

Further, the limited-benefits approach could provide the stepping stone that employers needed to provide coverage that would supplement the PCN, and might stimulate the insurance industry to offer a wider range of choices to employers, such as a catastrophic benefit that PCN enrollees could purchase at an affordable price.

2. SCI: After developing PCN, you decided to discontinue your Utah Medical Assistance Program (UMAP—a state-funded program for adults who do not qualify for Medicaid). What was your rationale for that?

BETIT: The idea was to make a clean break from UMAP because it was a different type of program; it focused on specialty and emergency care rather than primary health care. UMAP also targeted the very poorest of the adult population (those who made less than $300 in income per month) and, as a result, mostly ignored other working poor with family incomes below 150 percent FPL. However, we did accommodate those who were interested in transitioning into PCN. UMAP recipients were given notice of the new PCN program, and they had the first opportunity to transfer into it.

3. SCI: Utah approved reductions in benefits for part of the Medicaid mandatory population as a result of budgetary constraints, not solely to fund PCN. What prompted such cuts? Were there any unanticipated consequences?

BETIT: The PCN-related reductions were minor, and I have seen no documented adverse impact as a result of them. A supplementary chart indicates which reductions were made as part of the PCN waiver and which were made by the Utah legislature to balance the Medicaid budget.

Far more significant were the Medicaid cuts made by the Utah legislature in response to the revenue shortfalls that most states were experiencing. Utah had six special sessions in Fiscal Year 2003 alone to adjust budgets to fit revenues.

We have heard anecdotally about adverse impacts although no research has been conducted. The Department of Health is in the process of developing a study to address this issue.

Building Support

4. SCI: Where did find your primary political support? What were your major selling points to the health care advocates who had concerns about the PCN proposal?

BETIT: Primary support came from two key people: Governor Mike Leavitt (R) and Secretary of the U.S. Department of Health and Human Services Tommy Thompson. Both saw the value of moving forward with some coverage for adults who had no financial capacity to purchase their own health insurance. The governor saw this as a precedent-setting endeavor. Secretary Thompson referred to Utah's PCN as a program that he hoped could be adopted in some form by other states wanting to do something short of a full expansion. Over time, additional support came from Utah's legislative leadership, low-income advocates, employer groups, the Utah Hospital Association, and others.

5. SCI: You negotiated a voluntary arrangement with Utah's hospital systems to provide $10 million in donated hospital care? How do the hospitals benefit from this arrangement? Why did they participate?

BETIT: This is a non-binding arrangement between the Utah Department of Health and the Utah Hospital Association (UHA). It was negotiated between myself and Rick Kinnersley, UHA President, and ultimately approved by the UHA Board. The agreement dates back to 1990, when the UHA consented to provide charity care connected to the UMAP in the amount of $2.5 million annually. Today, the agreement covers up to $10 million annually. UHA agreed to transition the agreement from UMAP to PCN. The longstanding relationship between Department of Health and the UHA had created a degree of credibility and trust between the two parties.

The hospitals benefit from the agreement in several non-financial ways:

- Acute care needs are being met by Utah's hospitals already, and collection for the services provided to this low-income population is often unsuccessful. Thus, this would formalize the "giving" and take much of the frustration out of the process.
- The state would uniformly certify the uninsured Utahns who were least able to pay by qualifying them for PCN. This would allow hospitals to focus their collection efforts in more productive areas.

- The state agreed to triage patients who needed immediate hospital care and to direct those referrals as evenly as possible to Utah's hospitals.
- UHA is also interested in the impact that PCN will have on the amount of uncompensated care that is provided by their members, both inpatient and emergency services. By participating, the hospitals became a partner in the demonstration program and the evaluation of its impact.
- The state agreed to provide reimbursement for inpatient physician care, so this would not be an issue to participating hospitals.
- Utah's hospitals, both for-profit and not-for-profit, have a long tradition of working with the state to provide charity care; this allowed them to continue that tradition in a major way.

At this point, the hospital component of PCN is working very well. Approximately half of the $10 million line of credit has been committed for Fiscal Year 2003, with ample reserve remaining to provide needed hospital care for the remainder of the year. These cost estimates are based on "charges," not Medicaid prices.

6. SCI: Safety net providers frequently discuss how difficult it is to find specialist care for their patients. How are you addressing that issue?

BETIT: Several community efforts are in place to create a referral charity system to obtain needed specialty physician services. Utah's physician community wants to give back to the community as well. As a result, several physician groups have come together to provide some referral capacity for this demand. It remains unclear whether this will prove adequate in the long run. Enrollee demand may exceed capacity. If that happens, enrollees must arrange and pay for any necessary specialty care that their PCN provider cannot provide. Due to the limited funds we had to work with, we made a conscious program design decision that some adults would have to seek specialty coverage on their own.

The state expects specialty physician charity participation to continue to increase. A barrier to past participation has been specialists' concern that they would have to take on primary care for individuals, rather than just specialty care. Primary care is not generally their strong suit or area of interest. PCN allows them to provide their specialty component and then refer patients back to their primary care provider for ongoing care requirements.

7. SCI: Utah has large rural areas. How did this play into the design of the PCN?

BETIT: It is important to take rural areas into account when designing an access initiative. Generally, there are only a small number of large employers in rural communities (e.g., school, local government, hospital, etc.), leaving many people without employer-based coverage. This contributes to a high number of uninsured in many rural towns.

PCN provides an option to these rural residents for an affordable price. PCN enrollment underscores this point, as evidenced by the high percentage of rural residents in the total enrollee count. As of May 2003, 45 percent of all enrollees in the PCN were from rural communities.

Rural enrollees have access to the providers in the Medicaid network. We haven't had difficulty getting physicians to participate, in part because they are paid 12 percent more than urban Medicaid providers.

Having this limited benefit option is also beneficial to the long-term sustainability of health care providers, including physicians, dentists, and pharmacists. This additional coverage addresses a critical economic need for these providers and helps ensure that they will have adequate business to survive.

General Program Information

8. SCI: Who is eligible for the PCN? How do you verify eligibility?

BETIT: The eligible populations includes adults (both with and without children) aged 19 to 54 who have not had health coverage for six months or more, who have annual family incomes less than 150 percent FPL, and whose employers pay less than 50 percent of their health care benefit. PCN is open to both working and non-working adults. As of May 2003, approximately 46 percent of those enrolled are employed. The lower percentage of employed enrollees at this stage of implementation is probably due to the limited outreach that has been done to the employed target group.

PCN eligibility is handled by Utah Department of Health Medicaid eligibility staff who look for the same traditional kinds of income verification used for Medicaid eligibility.

The goal of PCN is to encourage people to be proactive about getting coverage and enroll before they need to be hospitalized. So, we made an arrangement with hospitals that inpatient care would be free for those who took the time to enroll in PCN as a primary care customer. If, on the other hand, they just show up in the emergency room without having applied for PCN previously, they don't qualify. There is no retroactivity for PCN. You have to think about it, enroll, and pay your premium and co-pays.

9. SCI: How did you determine cost-sharing requirements? Do you think they are set at an appropriate level?

BETIT: Cost sharing was patterned after the State Children's Health Insurance Program's cost-sharing policy, which requires people to pay approximately half of what would be required by the average employer plan. We believed that requiring significant rather than nominal cost-sharing would help the public and providers to perceive the program as more akin to a commercial insurance product, and was administratively easier to operate than collecting monthly premiums.

We're currently evaluating at what level cost sharing begins to affect utilization. We didn't see any significant change in utilization when we changed co-pays from $2 to $3, so now we're considering what the impact would be of making a switch from $3 to $5. Some anecdotal information suggests that the $5 co-pay is more of an incentive than $3 to use services appropriately. However, we haven't figured out how to model the question of

whether to move to a $5 co-pay in a way that we're comfortable in order to draw firm conclusions.

10. SCI: Although this program has created a formal entry into the delivery system, how do enrollees maneuvers through the system once they have been identified as needing immediate hospital/specialty care?

BETIT: Most enrollees present themselves to the hospital emergency room and are then admitted for inpatient care. We confirm PCN eligibility and the admission is then tracked by our department. We collect the needed financial information to monitor the $10 million line of credit and the impact on individual hospitals.

If self-directed hospital admission does not occur, providers generally contact the Department of Health and we negotiate the arrangements with the appropriate hospital. The process seems to work well.

There are many ways that enrollees can get referred to specialty care. The most common is to contact our health program case manager, who will steer them to a specialty physician in the network that we created. People can also go to the department of health clinics, where we have specialty physicians coming in every day for allocated time periods to provide specific services. Alternatively, they can have their primary care physician make the referral for them; he or she can contact us to make sure that the referred physician is part of the network donating specialty care.

11. SCI: How are reimbursement rates for participating providers determined? How do they compare to Medicaid? How did you convince providers to participate?

BETIT: Generally, the Medicaid rate is used for PCN. Current Medicaid providers were automatically enrolled in PCN. Others were solicited to participate. All community health centers enrolled as providers. The Utah Department of Health's four clinics were converted to PCN primary care sites. There has been adequate capacity to serve all the enrollees thus far. Utah Department of Health staff are available to help PCN enrollees find a provider if they do not have one.

12. SCI: What are the actual costs per patient and how do they compare with your budget projections?

BETIT: Initial estimates indicated that a mature program with near full enrollment would produce a per patient cost of $70 per month—$50 paid by the state and $20 paid by the enrollee through cost sharing. During the first few months, per person costs were closer to $120 per month due to heavy adverse selection. At this point in the implementation, per person costs are around $95 per month—$20 paid by the patient and $75 paid by the state. We are hopeful that these numbers will come down further as enrollment grows. If they don't, the upper-end enrollment cap of 25,000 adults will have to be adjusted downward.

The initial estimates include all federal and state costs of providing the direct health care services that enrollees are accessing, plus an administrative cost of $5. However, it does not include the $50 annual fee, which goes toward covering some of the enrollment expenses.

The annual fee is sent across as an administrative revenue source to reduce some of administrative costs of enrollment.

The initial estimates of per person costs were taken from actual experience through primary care grant programs that the state funds. Eventually, analysis will be conducted to ascertain where the differences lie in the utilization by these two populations of people.

Design and Implementation Challenges

13. SCI: What have been the most challenging operational aspects of designing and implementing the program?

BETIT: One of the main challenges was figuring out how to roll out a non-proprietary network with enough capacity to serve the PCN population. We addressed this by automatically enrolling all Medicaid providers as PCN providers, and including our four clinics and community health centers in the program. We also reached out to rural providers by promising to pay them a 12 percent higher fee for all procedures billed on a fee-for-service basis.

Another big challenge was converting our four crisis-oriented clinics at the Department of Health into clinics that focused on primary care. This involved making a cultural shift of no small measure. After having been sustained through state budgets, these clinics had to become financially self-sufficient and compete for PCN clients on the same level as everyone else. I worked directly with clinic staff to ensure that they were up to the transition.

Initially, we were not sure how to meet the needs of very low-income individuals who could not afford the $50 annual enrollment fee (i.e., those who made less than $300 per month). To address this, we approached the legislature for funding to reduce their enrollment fee to $15 annually instead of $50. The legislature agreed, and provided state funds to cover the remaining $35.

Finally, it was also difficult to figure out how to promote the program in a manner that would target its availability to the intended population without drawing too much unwanted political attention. We decided to conduct outreach more subtly for PCN than for the State Children's Health Insurance Program. We avoided TV spots, billboards, and other high-visibility media forums. We have promoted it in statewide information sheets prepared by myself and Governor Leavitt. Numerous media pieces have been written on the program as well, and we have targeted our advertising to some employers such as child care providers.

14. SCI: Has implementation proceeded as expected? What surprised you? What modifications have been made to the program since implementation?

BETIT: Implementation has progressed quite well. From approval of the waiver on February 9, 2002, to implementation of the PCN program on July 1, 2002, the department had very little time to pull all of the program components together. Thanks to the preparatory work

done by department staff in designing the program and gaining waiver approval, the stage was set for a quick implementation.

What surprised me most about the implementation process was the public's overwhelming response to the program. The PCN's growth has exceeded that for our SCHIP program with far less advertising.

Two key modifications have been made to PCN since its implementation. The first was to develop a waiver amendment that will allow 6,000 of the 25,000 slots to be committed to adults who have not taken up the comprehensive coverage offered by their employers. This program, called Covered at Work, would be open to the first 6,000 people who apply for it, regardless of their employers' size. Under this amendment, individuals would receive a voucher for the value of the PCN benefit, which they could use to cover part of their employee contribution for their employers' coverage plan.

We implemented Covered at Work in the beginning of August 2003. Since then, we have had very small enrollment--fewer than a hundred people. We get applications, but insurers won't allow people to select employee coverage at any time other than a narrow open enrollment period. We haven't yet found a solution for this.

We made a second modification to PCN through legislation that was passed during the 2003 Utah legislative session. It allowed the Utah Department of Health to provide a subsidy to the general assistance (GA) clients who were registering for financial and employment assistance from the Utah Department of Workforce Services (DWS). The DWS made applying for the PCN a condition of GA eligibility. To help this happen, the Department of Health worked with DWS to reduce the enrollment fee for these clients to $15 rather than $50 annually.

Marketing the Program

15. SCI: UMAP was intended for people in a medical emergency, while PCN addresses health care needs at earlier stages. How are you working to market this strategic change to potential enrollees?

BETIT: At the time of enrollment, PCN participants are oriented about the importance of this primary care benefit and how to use it effectively. As part of the program design, payment was deliberately structured on a fee-for-service basis to encourage appropriate use of services. To further educate participants, we distribute a detailed handbook explaining what the PCN program is and how to use it appropriately.

(For more information about program marketing and outreach, see the last paragraph of Betit's answer to question 13.)

Evaluation and Impact

16. SCI: What indicators have you identified to evaluate the PCN demonstration and what methodologies are being used?

The PCN outcome evaluation includes two aspects: enrollees' health status and uncompensated care for the health care systems in Utah. For the health status aspect, ten health indicators were identified to evaluate the PCN clients' health status and conditions, health care utilization, enrollee satisfaction, and risk behavior. These indicators are derived from the PCN enrollees' self-health assessment surveys.

The questions are adopted from the national standard Short Form-12 questions on health status; the NCQA's Consumer Assessment of Health Plan Survey, CDC's Behavior Risk Factor Surveillance Survey, and Utah's ongoing statewide household health status survey. These external standard surveys provide comparative measures for us to benchmark the PCN performance measures. The Year 2 health reassessments are conducted through the reenrollment and disenrollment surveys.

For the uncompensated care aspect, the evaluation plan is to measure overall hospital charity care for the uninsured population aged 19 to 64 at the pre- and post-PCN implementation stages. Ideal specific measures include overall amount of charity care, charity care by county, health care system, hospital market share, patient age, gender, race/ethnicity, and severity, etc.

Initially, we considered using the method of the State Health Access Data Assistance Center (SHADAC)—the Minnesota study conducted by Dr. Lynn Blewett and her associates (publication forthcoming in *Medical Care Research and Review)*. However, due to limited number of identifiable geographic areas in Utah, SHADAC advised Utah that its methodology is not appropriate for its PCN study. At this stage, we only plan to estimate the overall amount of charity care in 2001 from 41 acute care hospitals in Utah.

17. SCI: Who is funding these evaluations?

BETIT: The Year 1 evaluation was jointly funded by Utah's Health Resources and Services Administration (HRSA) State Planning Grant and, to a lesser extent, the Office of Health Care Systems' (OHCS) contract with the Utah Division of Health Care Finance. The OHCS' Medicaid contract is covering a majority of the cost with small supplements from the State Planning Grant for Year 2 evaluation.

18. SCI: What do you think your major data challenges will be?

BETIT: Three major challenges for data collection for the PCN evaluation are:

(1) Utah's Department of Health does not have sufficient authority to collect charity care data from Utah hospitals. As a result, the Department is unable to conduct a comprehensive evaluation of uncompensated care throughout Utah. Under this legal environment, any uncompensated care study has to depend on the voluntary participation of each hospital. In order to address this problem, we solicited the participation of Brigham Young University (BYU) faculty and students. Unfortunately, 11 hospitals were not able to participate in the BYU study due to individual corporate policy.
(2) Due to limited funding, the Office of Health Care Systems will only conduct re-

enrollment and disenrollment surveys once in the current fiscal year (July 2003 - June 2004).

(3) The PCN enrollee health assessments focus on the program's direct impact. Due to limited funding, indirect and statewide policy impact evaluation is not planned. Another weakness of the current research design is that we do not have a control group with which to compare PCN enrollees. Utah's Department of Health has been conducting statewide household health status surveys in 2001 and 2003. This survey also collects data on insurance status and household income level. In other words, it could help researchers to identify potential PCN-eligible candidates and provide proxy information for a control group. However, no resources are currently available for the department to conduct the study.

19. SCI: Your legislature approved a private-sector insurance package as a part of the PCN strategy. What has occurred since then? Do you have any first indications of its effect on Utah's health care marketplace?

BETIT: No insurance plan has chosen to offer a PCN-like product since the legislation was passed, although we have been having ongoing discussions with members of the health insurance industry. Hopefully, this will change if the state successfully demonstrates that people want a basic plan of this kind, that there is enough interest to make offering the product worthwhile financially, and that the absence of the specialty and hospital components of the benefit plan will not prove fatal to the long-term survival of the product. For the foreseeable future, the PCN product offered by Utah's Department of Health will be the only option available to uninsured working adults who work for employers that do not offer coverage.

20. SCI: When do you expect that the PCN will begin to meet some of its goals of reducing uncompensated care and improving health status?

BETIT: We expect to see a positive impact by 2005. Since PCN enrollees did not have health insurance for at least six months prior to enrollment in the program, we expected them to have a higher utilization of health services in Year 1 than insured individuals, regardless of whether they were covered through a public or private source. Indeed, preliminary data bear this out: Approximately 9.3 percent of enrollees reported that they were hospitalized in the six months prior to enrolling in PCN, which was three times higher than that of the general population in Utah.

In the initial health assessment, individuals in their first six months of enrollment in PCN reported more problems getting the care that they or their doctors believed to be necessary than did adult Medicaid HMO enrollees in 2002. Newly insured PCN enrollees are likely to use services more in Year 1 than in later years. Thus, it will take several years before we anticipate seeing improvements in health status and uncompensated care.

21. SCI: What are some lessons you have learned from implementing PCN?

BETIT: The demand for the PCN program, which is evident from its enrollment growth, indicates to me that we were correct to go down this road, even though there were some

complications, at both the state and community level, associated with taking a limited-benefit approach.

We learned about the importance of having a plan B through our experiences with Covered At Work.This program was added to PCN as a waiver amendment; it will allow 6,000 of the 25,000 PCN slots to be committed to adults who have not taken up the comprehensive coverage offered by their employers. When we launched Covered at Work, we thought it would be available right away to people, and that we could get around the open enrollment issues (the fact that insurers won't allow people to select employee coverage at any time other than the narrow open enrollment period). The fact that we haven't yet achieved our goals with this is a disappointment. But it will come together eventually.

We looked at financial data from other primary care programs in the state to try to predict what the PCN population's needs would be. Unfortunately, there is more demand for ongoing health care needs than we were able to glean from our analysis. This is particularly evident in the area of pharmacy. The biggest expenses for the PCN population are physician and pharmacy—even with a four prescription limit in the program. We underestimated how pharmacy-dependent this population is. We'd like to think they are a fairly healthy population, but they appear to have a lot of medical issues for a young workforce.