



# issue brief

## State and Community Collaboration: Lessons from the Communities in Charge Program and Other Local Initiatives

*by Isabel Friedenjohn and Terry Stoller*

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**T**he saying “all health care is local” not only reflects the importance of local infrastructure in the delivery of health care, but also a growing trend: communities coming together to more effectively finance and deliver care to the uninsured. With little comprehensive action at the federal level in the past few years, the problem of the uninsured has been pushed to the front line, compelling states and communities to work together to find and implement solutions.

States have always been recognized as laboratories for innovation, particularly with regard to Medicaid and the State Children's Health Insurance Program (SCHIP). This nexus of innovation, however, may hold further potential when communities are part of the equation. Committed communities are capable of leveraging significant dollars (including state-level investments), brokering public/private partnerships, institutionalizing coalitions, responding to local needs, accessing local resources, and building and sustaining new safety net infrastructures.

The organizations and individuals involved in the Communities in Charge (CIC) program, a Robert Wood Johnson Foundation-sponsored initiative, have learned first-hand the complexities of developing sustainable community pro-

grams. CIC began in 2000 to assist broad-based, community coalitions in designing and implementing sustainable health care delivery systems to improve access for low-income, uninsured individuals. Financial and technical assistance was provided through grants to support community models that demonstrated fresh approaches to the organization and financing of local care delivery. These communities developed models applying various strategies including managed care, promotion of prevention and early intervention, and integration of a full continuum of health care services.

The 12 communities “graduated” from the program in 2004 with valuable experience and new knowledge of critical concepts that are fundamental to state-local collaboration. Although the idea of states and communities working together is not a new one, recent experience highlighted by the CIC program and other local initiatives exemplifies the value of coalescing local and state infrastructure.

### **Fostering Stronger Relationships**

#### **Education and Dialogue**

*Louisiana Department of Health and Hospitals*

Opportunities that foster greater dialogue between states and communities can provide necessary information to move initiatives for-



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AcademyHealth is the national program office for SCI, an initiative of The Robert Wood Johnson Foundation.

ward. States can share information with communities on the complexities of Medicaid/SCHIP programs, including their financing structures, as well as the legislative review and approval process. Communities can in turn share local strategies being used to address access and coverage. Sharing information can curtail both the perpetuation of misinformation and the investment of finite resources toward models that do not work.

Providing an opportunity to align state and local interests and develop a more consistent understanding of terms can lead to the development of “win-win” strategies for communities and states. For example, the Louisiana Department of Health and Hospitals became aware of several communities working on local coverage and access programs independently and decided to convene a series of meetings to better understand local efforts. The meetings were developed to help the communities learn about state financing of health services, coverage, and the legislative process, while creating a forum where communities could learn from one another. Several communities continue development of community-based coverage models and are working with the state in this effort.

“Not only did these forums provide an opportunity for the state to develop relationships with the communities and harness their energy, but they also allowed leaders from different sectors to have an honest dialogue with state policymakers about access to affordable health care,” says Eric Baumgartner, director of policy and program planning for the Louisiana Public Health Institute.

#### **Implementing State-Level Changes**

*Hinds County Health Alliance—Jackson, Miss.*

Community involvement in state initiatives can make a difference in fast-tracking or promoting state policies and programs by helping identify leaders and community coalitions that can help the process move forward. Likewise, community involvement can infuse some state initiatives that have become stagnant with new energy to promote the program and get the message out to a greater number of people. This involve-

ment can also provide community leaders with opportunities to influence and shape implementation strategies while concurrently ensuring that programs are consistent with state policy objectives.

In Jackson, Miss., the Medicaid agency understood the value of the Hinds County Health Alliance (HCHA), which helped disseminate information about the state’s new Medicaid disease management program to hospital and physician providers, social service agencies, and consumer groups in central Mississippi. HCHA consists of leaders of key safety net providers and numerous consumer groups. These leaders understood and supported the state’s initiative and, in the vein of a “train the trainer” approach, they educated the staff within their organizations, as well as other important stakeholders, on the program’s benefits. HCHA has become a respected and trusted organization among providers, social service agencies, and consumer coalition members. The state’s ability to leverage the valuable relationships established by HCHA had a significant impact on the use of the disease management program.

#### **Understanding the State and Federal Framework**

*getCare Health Network—Louisville, Ky.*

*JaxCare—Jacksonville, Fla.*

The CIC programs developed coverage and access products that were considered financing models rather than insurance. The programs brought together financing from local government, foundations, and other sources, as well as donated services from providers to fill service gaps and better coordinate and deliver a finite set of services to low-income persons who cannot afford insurance and/or make too much to qualify for public coverage. Communities should understand early in the planning process that these financing strategies may be considered insurance under state regulation. Therefore, community and state officials need to discuss from the outset of the planning process how the community’s program fits into state and federal rules. States can demonstrate how these models interact with certain regulations and provide invaluable guidance to community planners to ensure compliance with consumer protections or solvency requirements.

Furthermore, states and local communities can work together to promote appropriate protection for consumers without tying up state resources and consuming scarce community dollars to prepare regulatory filings.

The CIC program in Kentucky had an ongoing dialogue with the state insurance department and was able to help the insurance commissioner understand that the product it offered was not insurance. On the other hand, CIC’s Jacksonville, Fla., program had communicated with the state insurance department early in its planning process and incorporated department guidance in its program design. Unfortunately, insurance department staff changed, and the new staff was not kept abreast of project plans. Despite completing a thorough business plan that had already cleared both Jacksonville’s Mayoral and City Council audit staff, the insurance department deemed Jacksonville’s coverage product insurance, requiring the community to qualify its program under the state’s HealthFlex program.<sup>1</sup> The 1,600-member pilot program had to reformat its financing, administrative, and program evaluation plan to comply with the department’s product measures and review structure for traditional insurance companies. It also had to spend almost \$50,000 in funds to produce the required documents.

### **A Springboard to Broader State Action**

#### **Local Programs Evolve into State Initiatives**

*Central Plains Regional Health Care*

*Foundation—Wichita, Kan.*

There is great potential for states to collaborate with community coalitions and test approaches to find new solutions to coverage issues. Testing at the community level allows the state to work in a more manageable and controlled environment to “fine tune” the program and operational details before implementing statewide. The Central Plains Regional Health Care Foundation in Wichita, Kan., created a case management program for uninsured persons who are frequent users of hospital emergency departments. The state Medicaid program heard about the results of this program and is in contract discussions with the foundation to pilot a similar program to be implemented across the state later this year.

## Communities in Charge Grantees

Project Name	Location	Program Design
Alameda County Access to Care Collaborative	Alameda County, Calif.	Coverage product for low-income children and their families; new managed care products for low-income adults
District of Columbia Primary Care Association	Washington, D.C.	Expand Medicaid eligibility and enrollment into a D.C.-sponsored coverage program
JaxCare	Jacksonville, Fla. (Duval County)	Managed care coverage product with donated hospital services
Community Health Works	Macon, Ga.	Donated care model providing case management for uninsured with high-risk medical conditions
Project Access/Central Plains Regional Health Care Foundation, Inc.	Wichita/Sedgwick County, Kan.	Donated care model coordinates medical care, prescription drugs, and services
getCare Health Network (Louisville/Jefferson County Communities in Charge Coalition)	Louisville, Ky.	Donated care model coordinates access to existing safety net and voluntary specialty care resources
CarePartners	Greater Portland, Kennebec and Lincoln counties, Maine	Donated care model provides access to comprehensive health care services, care management, and low-cost or free pharmaceuticals
Hinds County Health Alliance	Jackson, Miss.	ER Redirect and disease management program
Brooklyn Health Works	Brooklyn, N.Y.	Insurance subsidy program
HealthforAll of Western New York, Inc.	Buffalo and surrounding counties, N.Y.	Insurance subsidy program
Clackamas, Multnomah, and Washington Counties Safety Net Enterprise	Portland, Ore.	Regional public corporation for safety net system management and governance
Indigent Care Collaboration	Austin, Texas	Web-based regional information system/creation of health financing district

For more information, visit [www.communitiesincharge.org](http://www.communitiesincharge.org).

Communities can also demonstrate results, implement templates, communicate strategies, and create “spokespersons” to help promote programs. The Florida Healthy Kids initiative is a well-known example of a successful community model that evolved into a state program. The program started in one county as a federal Medicaid expansion demonstration in the early 1990s testing administrative simplification (subsidy determination and application), benefits design, coverage cost, and provider delivery standards. The post-demonstration model developed into a state/local/family-financed coverage program and ultimately a model for the federal creation of the SCHIP program.

### **Financing the Safety Net and Local-State Partnerships**

*Community Health Works—Macon, Ga.*

*getCare Health Network—Louisville, Ky.*

*Alameda County Access to Care Collaborative—Alameda, Calif.*

*Indigent Care Collaboration—Austin, Texas*

*JaxCare—Jacksonville, Fla.*

State-community collaboration may focus on re-thinking investments in the safety net and re-aligning safety net funding, particularly to target individuals who are between coverage, as well as the segment of the uninsured population that historically has been difficult to enroll in public programs and who access the safety net for costly services. With the objective of achieving greater transparency in distribution of safety net funding and better aligning incentives for more efficient use of funds, some CIC grantees were able to make some changes in their safety net system.

The Community Health Works (CHW) program in Macon, Ga., is funded in part by the state’s Disproportionate Share Hospital (DSH) funds, 15 percent of which are set aside for primary care services. The two DSH hospitals in central Georgia designate a portion of their DSH primary care set-aside funding to pay for prescription drugs for CHW program enrollees. Having access to prescription drugs helps keep CHW enrollees out of the hospital emergency department and inpatient units. The CHW program, alongside three other established community programs in the state, received a proclamation from Governor Sonny Perdue’s office supporting

the development of a community-based coverage program in collaboration with the state’s HRSA State Planning Grant pilot program.

“The state of Georgia understands that in order to solve the problem of the uninsured in our state, local community action will be required,” says Greg Dent, chief executive officer of CHW. “Our program has been very successful at creating an infrastructure to help the uninsured and to improve health care outcomes.”

In Louisville, Ky., the getCare Health Network has worked with area providers and local and state government to leverage Upper Payment Limit (UPL) funding to support case managers (called Care Partners). Care Partners help enrollees use existing safety net services more effectively by securing specialist appointments and donated prescription drugs. The managers also help enrollees manage their chronic diseases. As a result, the state-financed indigent care hospital has seen more appropriate emergency department visits and better use of costly inpatient resources.

Among other activities, two of the CIC communities looked for new funds by raising and/or re-allocating revenue from local government general revenue funds, special taxes, and established taxes (e.g., sales tax). In California, state cigarette sales tax revenues (Proposition 10 funds) are dedicated to local health and education programs for young children, which are selected by local organizations.

Alameda County’s Access to Care Collaborative developed the Alliance Family Care program, which subsidizes coverage for children and adults not eligible for public coverage that are family members of SCHIP and Medicaid enrollees. The financing mechanisms for this “gap” coverage product include health plan contributions, local tobacco settlement dollars, locally controlled state cigarette tax revenue, local general revenue, provider donations, and grant funds. Enrolled low-income families pay premiums and make modest co-payments at the time of service. Alameda County also developed Alliance Group Care, a program for in-home supportive services workers. The state makes available federal matching funds for these workers when local government funds are used to purchase health coverage.

Austin’s CIC project was successful in its May 2004 referendum to allow a tax to create a health financing district in Travis County. The new law created a formal health financing authority with a board that levies a tax in the entire county. The tax will raise about \$85 million with \$5 million in new funding in 2005.

Florida hopes to take advantage of county resources through its Health Flex plan, a basic coverage model established by the Florida Legislature in 2002 in an effort to offer basic affordable health care services to low-income uninsured residents. The state approved CIC Jacksonville community’s program—JaxCare—in 2004 despite the regulatory challenges mentioned earlier. The JaxCare, Inc. Health Flex plan has significant community and local government financial support and is funded by the city of Jacksonville, grants, corporate donations, hospital contributions, and employee and employer contributions. It is employer-based coverage targeted to businesses that offer no health benefits as well as to those businesses with uninsured low-income workers who cannot afford or are not eligible for employer-sponsored coverage.

### **Community Programs Complement State Initiatives**

*Brooklyn Health Works—Brooklyn, N.Y.*  
*HealthforAll of Western New York, Inc.—Buffalo, N.Y.*

Both of the CIC communities in New York wanted to create an attractive and affordable option for uninsured small businesses. While they were designing coverage products, the state of New York unveiled a new coverage program known as Healthy NY (HNY). HNY is designed to encourage employers with 50 or fewer employees to offer health insurance coverage to their employees, dependents, and other qualified individuals by providing an affordable benefit package that uses a state-financed reinsurance mechanism to keep premiums down. After discussions with the state, both Brooklyn and Buffalo were able to fashion their own coverage “product” within the HNY program. Since both programs could access the HNY risk pool and its marketing program, the local demonstrations would help broaden coverage, increase small business enrollment, and keep the overall premium low.

Brooklyn Health Works worked with state and local provider and health plan partners to develop a HNY product with premiums substantially below HNY and other insurance products by negotiating discounted provider rates. Despite enrollment challenges, the program hopes that collaborative local and state marketing strategies will bring new coverage to previously uninsured workers in Brooklyn.

HealthforAll of Western New York in Buffalo worked with the state and the local health plans to create a three-share program where one-third of the premium for insurance provided under HNY is subsidized for low-income workers by the program, and the remainder is split between the employer and employee. HealthforAll advertisements have piqued the interest of small firms to explore health and prescription coverage for employees through the HNY program. More than 100 small firms enrolled between April 2003 and March 2004, insuring nearly 700 of their employees and family members.

Unfortunately, the program will run out of local subsidy funds in November 2005; current beneficiaries may continue to be insured in HNY through replacement of subsidy dollars with higher employer and employee contributions.

### Data Tools and Resources

#### *CarePartners—Portland, Maine*

In an effort to make more data-driven policy decisions, there has been a strong focus at the state and community level to access appropriate data. States often commission surveys in addition to drawing on their in-house data and data analysis expertise. Communities unfortunately do not usually have the funds for a rigorous survey, nor the ability to conduct a large study. Consequently, there is tremendous value in states making their data more available.

By publicizing and packaging their data sources more widely, states can increase the value of their resources through their use at the community level and potentially help garner legislative support for continued state investment in data resources. Furthermore, collaboration will help minimize the creation of competing data collection activities and energy spent understanding any differences in results from using different data sources.

States could also make available the opportunity for communities to pay for over-sampling in already-commissioned surveys. Over-sampling allows a demographic or geographic population to have a larger proportion of representation in the sample than that population's proportion of the overall population. For example, the CIC project leaders in Portland, Maine, were able to partner with the state on its survey of the uninsured to over-sample in three southern regions in the state. The state was supportive and incurred no costs, because the community paid the marginal costs for the additional sample.

The primary objective of Portland's survey was to access more reliable information about the demographic and geographic distribution within the region including the proportion of the uninsured with a medical home, as well as the number and types of health care visits made by this population. This information was critical for planning purposes as the community needed to determine variables such as size of the

provider network needed, types of outreach strategies that would work for the targeted population, potential utilization of services, and likely program costs.

### Conclusion

In the absence of a comprehensive federal strategy to expand health insurance coverage and the pressure on states to sustain statewide coverage, community and local initiatives are increasingly being asked to fill the gaps in insurance coverage. The CIC experience has demonstrated that local initiatives can be an important part of the safety net for the uninsured. They can promote prevention and early intervention, coordinate care and services, spread financial risk among various providers, and monitor access and quality of care. Communities have improved access by bolstering safety net capacity; however, they do not have the financial resources to expand coverage on their own.

These community models offer a simple but important lesson: the investment in developing relationships among critical stakeholders, including state officials, is essential. Whether these initiatives can have a significant impact on access to care for the uninsured and, given precarious funding, can be sustained over the long term remains to be seen. With the broad support of these stakeholders, the operational, political, and funding challenges inherent in community-based programs may be overcome.

### Endnotes

<sup>1</sup> The Health Flex pilot program was established by the Florida Legislature in 2002 in an effort to offer basic affordable health care services to low-income uninsured residents.

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## CommunitiesInCharge

Financing and Delivering Health Care to the Uninsured

Communities in Charge was a \$16.8 million, multi-phase, competitive grants program funded by The Robert Wood Johnson Foundation that provided funding and technical assistance to help 12 communities design and implement new, or significantly expand existing, community-based approaches to financing and delivering health care to the uninsured.

### The program's goals were to:

- ◆ Create system-wide change to improve access to care for low-income, uninsured individuals;
- ◆ Develop broad-based community consortia to address local coverage issues; and
- ◆ Implement sustainable delivery systems that manage care, promote prevention and early intervention and integrate services for the uninsured.

For more information on Communities in Charge, contact Terry Stoller at 216.523.1300, x 3039, or visit [www.communitiesincharge.org](http://www.communitiesincharge.org).



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