



Innovations in Indigent Care: Strengthening the Safety Net in Texas

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Key Points

- Counties are required by law to provide health care for indigent populations.
- Indigent care programs on the county level that incorporate market-based principles can help Texas resist Medicaid expansion by demonstrating the advantages of being free from the straightjacket of federal rules and regulations.
- As Texas works to reduce government interference in the health care market, local government programs that encourage primary care and personal responsibility have been shown to reduce expensive emergency room and uncompensated care costs.

Introduction

Since the advent of Medicare and Medicaid in 1965, government control of health care for indigent and low-income populations has steadily grown, as have federal and state expenditures on these programs. In 1970, combined state and federal spending on Medicaid represented only 0.5 percent of gross domestic product (GDP). That share had grown to 2.8 percent of GDP as of 2011, and will likely continue to increase under current law.¹

The growth in Medicaid spending has mirrored overall growth in national health expenditures, which increased from \$356 per capita in 1970 to \$8,402 in 2010.² This growth trend is projected to continue under the Patient Protection and Affordable Care Act (ACA). Medicare, Medicaid, and the Children's Health Insurance Program (CHIP), which accounted for 6.6 percent of GDP in 2011³ (or almost \$1 trillion), are by 2021 estimated to make up nearly 50 percent of national health expenditures, with Medicaid and CHIP accounting for \$963 billion.⁴

At the state level, Medicaid continues to consume an ever-larger share of state budgets while producing sub-standard health outcomes and persistently inadequate access to care for Medicaid patients.⁵ Like other states, Texas is experiencing a steady long-term rise in Medicaid as a percent of state resources, and the program now accounts for more than 30 percent (\$60.2 billion) of the 2014-15 All Funds budget,⁶ despite state leaders' decision not to expand Medicaid under the ACA.

Governor Rick Perry has repeatedly affirmed that Texas will not participate in Medicaid expansion as outlined in the ACA, which requires states to cover everyone earning up to 138 percent of the federal poverty level (FPL),⁷ and in Texas would add an estimated 1.5 million people to the Medicaid rolls, mostly non-disabled parents and childless adults not currently eligible for the program. This decision to reject expansion was made with good reason. By some estimates, expansion would cause the state to spend \$7.3 billion more on Medicaid by 2020 and \$15.9 billion more by 2040 than it will without expansion.⁸ These cost increases reflect nationwide projections outlined by the Congressional Budget Office.⁹

Beyond the cost burden, the federal terms of the ACA Medicaid expansion are egregiously inflexible for states, similar to the terms of the Medicaid program itself. The U.S. Department of Health and Human Services (HHS) requires that expansion be complete and immediate, covering all mandated benefits in the current Medicaid program and taking effect January 1, 2014. Inflexible federal rules regarding benefits and cost-sharing protections for Medicaid patients mean that the only substantial cost-controlling measure available to states is to reduce Medicaid provider reimbursement rates, which now average about half of those paid by private insurers.¹⁰ The gradual reduction of provider reimbursement rates in Texas has weakened the Medicaid provider network, such that in 2012 only 31 percent of Texas physicians would accept all new Medicaid patients, down from 67 percent in 2000.¹¹

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The stated goal of Medicaid expansion under the ACA is to increase access to health care for low-income and indigent populations, reduce the number of uninsured, and thereby reduce the high costs incurred by taxpayers from emergency room (ER) overuse. However, expanding the Medicaid program without significantly reforming it will exacerbate existing access problems and likely result in greater ER use and therefore greater costs to taxpayers. Reducing uncompensated care (UC) and emergency room costs is often cited as a justification for Medicaid expansion,¹² but the experience of other states with past Medicaid expansions suggests that forcing more uninsured, low-income residents into the program will not reduce UC costs, and that the program itself will continue on an unsustainable trajectory.¹³

The goal of reforming indigent care should be to reduce, not expand, the role of government—especially at the federal level, where inflexible rules and requirements stymie attempts at even modest market-based reforms. Although the provision of health care for indigent populations from government-funded programs, whether on the local or federal level, is not ideal, the introduction of market-based policies in county indigent care programs would be a vast improvement over the status quo, as would the leveraging of charity care at the county level.

Free from the straitjacket of federal rules, county-level programs can adopt market-based policies that incentivize indigent patients to seek care in the proper setting, which will reduce uncompensated care costs by avoiding ER overuse. Moreover, local programs that rely on non-federal funding streams, such as local property taxes, are able to be more flexible and innovative than Medicaid, which prohibits the kinds of policies that can incentivize individual patient behavior. Indeed, the ability to incentivize behavior at the patient level is the key to indigent care reform, and if under-

taken carefully could lead to increased access to providers, better health outcomes, and lower costs for taxpayers.

Indigent Care in Texas

In 1986, Congress passed the Emergency Medical Treatment and Active Labor Act (EMTALA), which requires hospitals to provide expensive emergency care to any person, regardless of their ability to pay. This law includes no promise of reimbursements for hospitals and yet it has resulted in the routine treatment of non-emergent or marginally-emergent maladies in the ER, in addition to actual emergencies. These regulations, together with Texas's high uninsured rate, force Texas hospitals to incur significant UC costs each year.

While it is difficult accurately to estimate the exact amount of hospital expenditures on UC—partly because it is difficult for hospitals to track their total expenditures—in fiscal year 2011, Texas hospitals received \$957 million in Disproportionate Share Hospital (DSH) payments from the federal government.¹⁴ These DSH payments are designed to reimburse hospitals that serve a disproportionate number of uninsured and underinsured patients, including Medicaid patients. A second federal program, the Upper Payment Limit program (UPL), provides supplemental Medicaid payments to Texas hospitals to make up the difference between Medicaid rates and what Medicare pays for the same services. In 2011, the Texas UPL program paid about \$2.7 billion to Texas hospitals. However, UPL is in the process of being phased out as a condition of expanding Medicaid managed care throughout the state, and the 1115 Transformation Waiver program is intended to make up for this loss of federal funding.¹⁵ The Texas Department of State Health Services reports that in 2011, UC charges statewide (among 539 acute care hospitals) totaled more than \$18 billion.¹⁶

Although the ACA aimed to insure more people through mandates, Medicaid expansion, and federal subsidies for the purchase of private coverage, the Texas Health and Human Services Commission (HHSC) estimates that the number of uninsured Texans will be approximately 4.2 million people after the ACA takes effect in 2014,¹⁷ leaving a significant burden on Texas hospitals to provide care for uninsured and indigent population. Even if Texas expanded Medicaid, HHSC estimates the number of uninsured would still exceed 3.1 million.¹⁸ Thus, the hope that Medicaid expansion would eliminate the need for indigent care programs

is misplaced. Whether or not the state expands Medicaid at some future date, uninsured and indigent populations will persist in Texas, and hospitals will still be required by law to care for them.

In the debate over Medicaid expansion, much attention has focused on the state's uninsured rate as a driver of UC costs. Some attribute Texas' high uninsured rate of 28.8 percent,¹⁹ the highest in the nation, to stringent Medicaid requirements and argue that Medicaid expansion will reduce the uninsured rate. However, other factors such as a sizeable illegal immigrant population, estimated to number 1.65 million in 2011,²⁰ contribute significantly to the uninsured rate.

Moreover, Medicaid enrollees themselves are a greater driver of UC than the uninsured, in part because hospitals count low Medicaid reimbursement rates as part of their UC costs, and also because Medicaid patients tend to access care in emergency room settings with greater frequency than the uninsured,²¹ whose rates of emergency room utilization have been greatly exaggerated.²² The Texas Health and Human Services Commission estimated in March that the implementation of the ACA would lower the uninsured rate in Texas to 16 percent without Medicaid expansion, and that expansion would lower the rate by another 4 points, to 12 percent.²³

The focus of reform efforts, therefore, should not be on increasing coverage through an expansion of Medicaid, but on addressing the root causes of UC costs, whether from Medicaid or from uninsured and indigent populations, and expanding programs that have been proven to divert indigent patients from unnecessary ER utilization into primary care and outpatient settings.

County Indigent Health Care Programs in Texas

Unlike the Texas Medicaid program, locally-administered county indigent care programs in Texas are free of stringent federal Medicaid rules and have the flexibility to choose eligibility requirements, recoup costs from patients according to their ability to pay, and enter mutually satisfying partnerships with the medical community. Unfortunately, most county programs currently do not make use of their full cost-saving potential and flexibility to innovate.

In 1985, Texas passed the Indigent Health Care and Treatment Act, which requires counties that are not fully cov-

ered by a public hospital or hospital district to provide basic medical care to indigent residents through a County Indigent Health Care Program (CIHCP). The law requires counties to provide care to uninsured residents living below 21 percent FPL, although counties are free to expand their eligibility up to 50 percent FPL and still receive additional state funds.²⁴

Today, 143 of Texas' 254 counties operate CIHCPs. Many have chosen to erect community health clinics for indigent patients, but these facilities do not allow patients to receive comprehensive or specialty care. All CIHCPs are funded by local property tax revenues, although the state offers partial reimbursements when CIHCP costs exceed 8 percent of general revenue tax levy (GRTL). After that limit, the state reimburses 90 percent of the cost of additional care.²⁵ While most counties spend well below 2 percent of GRTL on their CIHCPs, others struggle to maintain their programs. In 2012, eight counties exceeded this 8 percent GRTL threshold and requested reimbursement from the state.²⁶

The counties with the greatest CIHCP burden are often rural and could benefit from less costly alternatives that leverage charity care from primary care physicians, while urban counties could realize significant savings by emulating best practices of successful programs around the country, some of which have affiliations with hospital systems while others do not.

This report details several county indigent care programs, with special attention to CareLink in Bexar County, Texas. CareLink patients have easy access to primary care and medications, so their health problems are less likely to deteriorate from neglect or lack of diagnosis and result in expensive specialty treatment or ER visits. CareLink also requires patients to pay for a portion of their health care costs on a sliding scale based on income. This market-based model encourages more efficient utilization of care, fosters personal responsibility in the community, and reduces the county's uncompensated care costs.²⁷

CareLink in Bexar County

Since 1997, Bexar County, whose public hospitals and clinics comprise the University Health System (UHS) in San Antonio, has operated an indigent health care program, CareLink, which was established according to the following six principles:²⁸

1. Promoting patient responsibility and program viability
2. Providing a medical home for members
3. Making evidence-based health care decisions
4. Paying providers on a fee-for-service basis
5. Assuring members receive medications
6. Developing community partnerships

Under the program, enrollees have an established maximum family liability rather than discounted gross charges typical of other county indigent care programs, and this approach has been shown to reduce UC costs and ER overutilization in Bexar County, where nearly 19 percent of residents were uninsured in 2012.²⁹ The program is housed entirely within the UHS, which has more than 5,000 employees, nearly 700 resident physicians, and an operating budget of \$947.6 million for 2012.³⁰

Upon enrollment in CareLink, patients are able to access comprehensive health care from providers in the UHS. Enrollees are charged for a portion of their health care costs on a fee-for-service basis at a rate that is reduced according to their income. UHS providers are always reimbursed; physicians and clinics receive Medicare rates, while hospitals receive Medicaid rates.³¹ This model provides patients a medical home, gives them greater ownership of their medical care, and provides a sustainable framework for the program.

CareLink eligibility is restricted to residents of Bexar County (but who did not move there to receive medical care) who earn up to 200 percent FPL, approximately equivalent to a yearly income of about \$23,000 for an individual or \$47,000 for a family of four. A CareLink “Plus Plan” with limited benefits is available to people up to 300 percent the FPL a pharmacy-only “MedLink” plan is available to Medicare patients. Notably, immigration status is not an eligibility factor since EMTALA requires the hospital to treat patients regardless of immigration status.

The program was developed in response to anticipated health care reform under the Clinton administration,³² and although the Clinton reforms never materialized, hospital administrators discovered that a more integrated delivery system that gave members a medical home helped to establish a more solid relationship with the hospital’s patient base, which in turn led to improved outcomes and reduced

ER costs. Today, CareLink has approximately 53,000 members, representing about 20 percent of the county’s low-income uninsured population.³³ Unlike other county indigent programs in Texas, such as Medical Access Program (MAP) operated by Central Health in Travis County, enrollment in CareLink is not capped.

Upon enrolling, members are assigned a primary care provider and are not charged a copayment when visiting this physician. They can visit the hospital and various clinics within the UHS as needed, but CareLink rates, services, and protections only apply to providers in the UHS system; if members go outside the system, they are on their own. Patients are billed on a fee-for-service basis, a payment method that differs from that used by managed care organizations (MCOs), in which a network of providers is contracted by an MCO to provide health care services to enrollees. Through CareLink, members have a monthly payment plan with charges based on household income along a sliding scale.

The program covers a range of services, including inpatient and outpatient hospital care, primary and specialist care, mental health, home health, lab tests, diagnostic radiology, durable medical equipment, prosthetics, sleep studies and therapies, ambulance, contraception and sterilization, dialysis, and solid organ transplants. Routine dental and vision care, surgical treatment of obesity, hearing aids, and cosmetic treatments are not covered. CareLink also offers subsidies for prescription drugs. Copayments for these drugs are included in monthly bills and capped at \$50.

Automatic withdrawals are mandatory for enrollees who earn more than 150 percent FPL and are optional for others. Account balances are capped at 48 times the monthly payment amount, after which additional charges are waived. Unlike many private insurance plans, there is no limit to the cost of health care that CareLink will provide to its enrollees, but if a member fails to keep up with their monthly payments, their membership will be dropped and their account is sent to a collection agency. Indeed, the most common reason why enrollees leave CareLink is not because they have found affordable coverage, but because they did not make their payments. Members who earn less than 75 percent FPL are excluded from this policy, and their memberships are never involuntarily dropped. Furthermore, if a

Table 1: Monthly CareLink Payments for Individuals

Federal Poverty Level	Annual Income	Monthly Payment
75%	\$7,800	\$16.55
100%	\$10,500	\$29.99
150%	\$17,600	\$84.25
200%	\$21,300	\$123.39
300% *pharmacy drugs only	\$34,340	\$320.72

patient cannot afford the drug copayment and they are under 18 years old or earn less than 75 percent FPL, CareLink covers the entire cost of their drugs. Monthly charges are calculated using a sliding scale, calculated based on income (see Table 1).³⁴

CareLink Outcomes and Cost of Care

The structure of this system results in a significant reduction in average per patient costs compared to Medicaid. A study published in *Health Affairs* in September 2011 found that adult CareLink patients under age 51 cost an estimated monthly average of \$129 compared to \$267 for Medicaid.³⁵ The study compared costs of CareLink patients directly with Medicaid patients in a managed care plan owned by the UHS. Both groups used the same providers and received care in the same system, yet the CareLink group's average cost of care was substantially less than Medicaid, and also less than private insurance.

A number of factors contribute to the lower average per patient costs in the CareLink program, but the most significant factor is the requirement that patients pay for health care services on a sliding scale based on their income. In the above-cited study, CareLink patients paid on average

19 percent of their monthly health care costs (\$34) out-of-pocket—a significant amount compared to Medicaid patients, many of whom are exempt from any out-of-pocket costs.³⁶

According to UHS, CareLink's 2012 budget was approximately \$170 million, of which about \$19 to \$20 million (more than 10 percent) were patient payments. About 26 percent of UHS's 2012 revenue (approximately \$280 million) came from property taxes,³⁷ and most of these funds are used to fund the CareLink program. Hence, although patient payments constitute only a small portion of the CareLink budget, the structure of the program itself significantly drives down overall costs per patient.

A key factor in keeping per patient costs down is the provision of a medical home for enrollees, and more than 95 percent of CareLink members have a medical home or primary care physician. As a result, CareLink patients have a fewer number of ER visits for conditions that are treatable in a primary care setting, and also have fewer non-emergent ER visits than uninsured patients, Medicaid patients, and even privately insured patients (see Table 2).³⁸

Table 2: Unnecessary Emergency Department Visits by Insurance Status

Insurance status	Ratio of non-emergent to emergent ED visits
CareLink	1.16
Private	1.40
Medicaid	1.25
Medicare	0.78
Uninsured	1.60
Total	1.34

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Operating as a department within UHS, CareLink is a “closed system,” in which administrators of the program have interests as both payer and provider—that is, in providing quality care while keeping costs down as much as possible. Since those who choose to sign up for CareLink are generally those with medical problems and in need of health care, the closed system model allows for better treatment decisions that are based on need rather than billable services.

Since CareLink is not health insurance—although it has features of health insurance and many CareLink members believe themselves to be insured—it is not subject to the same benefit mandates as Medicaid, and physicians can more efficiently target care for enrollees. The cost savings from this approach are significant; CareLink and the other similarly-structured safety net programs have been estimated to cost roughly one-quarter to one-half less than what Medicaid or private coverage would cost the same population.³⁹

To date, the CareLink model has been successful in a single urban county with an established hospital system. However, Bexar County does have similar proportions of uninsured and indigent populations to Texas as a whole, and about half of Texas counties operate public hospital districts. Thus, the CareLink model has potential to be implemented—and succeed—in densely populated urban counties throughout the state. Certainly, the program’s requirement of significant patient payments on a sliding scale is a feature that could be adapted for indigent populations elsewhere.

Project Access in Collin County, Texas

Collin County, a primarily suburban area northwest of Dallas, offers a somewhat different model for indigent care that

relies on volunteer service from physicians and specialists. Project Access Collin County (PACC) is a non-profit community referral program for indigent and uninsured county residents founded in 2011 by the Collin-Fannin County Medical Society in partnership with the private, non-profit Collin County Health Care Foundation. The goal of PACC, which is funded by the Collin County Health Care Foundation, sponsoring hospitals, and private donations, is to provide a medical home for indigent patients and reduce ER costs.

The program consists of about one hundred primary care and specialty physicians, all nine major hospitals in the county as well as the Baylor Heart and Vascular Hospital, and a network of outpatient clinics. Participating physicians volunteer to take on a number of PACC patients free of charge, while each hospital contributes \$25,000 per year to PACC⁴⁰ and makes their facilities available to PACC patients. Donations from private institutions and individuals help pay the cost of medications, lab work, and imaging services, while administrative costs are partially paid by Collin County, which also provides office space.⁴¹

Typically, health care providers agree to see one new indigent patient per month at their regular office. Participating providers treat PACC patients at no cost in their regular offices, alongside insured and private-pay patients. Hence, PACC patients are treated the same as privately-insured patients, and are included in the same network as the privately-insured—unlike Medicaid patients. Legal U.S. residents who are uninsured and earn less than 200 percent FPL are eligible for the program, and once the program deems a person eligible, PACC works with the patient to coordinate care with all participating medical service providers. Last year, PACC provided about \$1 million in services to enrolled patients.⁴²

The volunteer-based approach of PACC allows providers to give charity care without having to deal with the onerous red tape of Medicaid and helps hospitals keep more patients out of the ER.

CarePartners in South Coastal Maine

Like Project Access, CarePartners relies on a defined network of volunteer physicians and hospitals to provide care to indigent residents of Cumberland, Kennebec, and Lin-

coln counties in Maine.⁴³ The program was developed in 2001 by the MaineHealth hospital system in Portland as a temporary solution for indigent care until the state introduced a single-payer system.⁴⁴ Following a nonbinding referendum approved by Portland voters which called for statewide coverage via single-payer, hospital administrators anticipated such reforms to come soon. Although statewide single-payer legislation never passed, CarePartners remained—and has since become an effective, albeit limited, way to divert indigent patients from the ER.

Program enrollment is capped at approximately 1,000 participants, all of whom are uninsured adult residents of the three-county service area who earn less than 175 percent FPL, although individuals cannot enroll if they are offered insurance by their employer that costs less than 5 percent of their gross income. After enrolling, patients can visit hospital-affiliated physicians, nurse practitioners, and physician assistants, and receive hospital and home care services at no charge. Participating providers who are not affiliated with the hospital systems may charge a copayment of \$10, although many waive this fee. Patients are also charged a copayment (\$10 to \$25) for prescriptions.

Over two-thirds of local providers participate in the CarePartners program, and typically each will only have one or two patients assigned to them at any time. Freed from Medicaid mandates, providers are able to give preventative and specialty care to their patients based on need rather than a government-mandated benefits package. CarePartners patients report very high satisfaction with their level of care, with nearly 100 percent having seen their primary care provider during their first year of enrollment.⁴⁵ Most importantly, enrollees are significantly less likely to visit the ER than Medicaid patients, with a 0.37 annual utilization rate compared with 0.82 for Medicaid patients.⁴⁶

Conclusion

To control government spending and improve health outcomes, Texas lawmakers have rightly chosen to reject Medicaid expansion and the growth of government control over health care that it embodies. But rejecting expansion does not solve the problem of ER overuse by indigent patients, which is enabled by federal and state law and drives up costs for local taxpayers.

Rather than addressing the problem of indigent care and high ER costs by expanding Medicaid, state lawmakers and county officials should explore ways to provide indigent populations with medical homes and access to primary care physicians based on models that have been shown to reduce ER use and provide quality care at a lower cost to taxpayers than Medicaid.

The county-level programs described above make comprehensive care accessible to defined indigent populations, with primary and specialty care provided, in most cases, in physicians' regular office settings. Once assigned a primary care physician, enrolled patients will be less likely to go to the ER for minor issues, and unlike states' experiments with Medicaid expansion, such programs have been shown to reduce non-emergent ER rates. Counties can further minimize costs and encourage more efficient utilization of care by requiring program enrollees to contribute to the cost of their care on a sliding scale based on income.

The federal government cannot enact such cost-sharing measures with Medicaid expansion, nor can it free physicians to treat patients based on need, rather than mandated benefit. But county and city officials, together with the medical community, can create indigent care programs that align incentives for patients and providers alike. By incentivizing patients to seek care in the proper setting, and by coordinating the charity care that many physicians are willing to provide indigent patients, counties throughout Texas could see a reduction in ER costs and a reduced tax burden at the local level, all while resisting the costly growth of inferior government health care through Medicaid expansion. ★

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