



Measuring the Return on a Community's Investment
(ROCI) Resulting from Providing Access to
Affordable Health Coverage

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Abstract

Purpose of This Document

This document addresses how a community can measure the ROCI from addressing health care access for the underinsured, as well as how the findings can be most profitably presented to key stakeholder groups.

Access to Affordable Health Care is Not Only Socially the Right Thing to Do But Also Makes Good Financial Sense

In order to sustain funding for programs that increase access to affordable health coverage, it is necessary to show that this access is not just socially the right thing to do but also that it makes good financial sense. The resolution of the issue of the vast numbers of people who do not have access to affordable health coverage has been deterred by too much emphasis on the value-laden question whether health care is a right or a privilege rather than looking at the aggregate financial impact on the community of people not being insured (the “uninsured”) or not having adequate insurance (the “underinsured”). Another deterrent to the resolution of the issue of affordable health coverage has been the focus on who should pay for the resolution of the problem, before there is actual agreement that it is a community problem.

The Business Case Stresses Return on Community Investment (ROCI) Then Shows Returns to Individual Stakeholders

The business case for meeting the needs of the underinsured must emphasize that there is an aggregate return on the community’s investment (ROCI). Unless all stakeholders believe that what is good for the community on the whole is good for the individual stakeholders, the business case must also show that the desired distribution of expenses between key stakeholders is accomplished and that individual stakeholders receive a return on their investment as well. It is relatively easy to demonstrate benefits to the broader community when stakeholders agree that it is in everyone’s best interest to make the investment. However, the typical situation is that the individual stakeholders, particularly those funding the effort, must first be shown that there is a return on their investment and that their expectations are met.

Financial Impact Includes More Than Just Direct Cost Savings

In the past, organizations measuring their return have focused only on the direct cost savings. To address the complete picture, the indirect cost savings, the ability to bring funds into the community, and changes in the quality of life must also be measured.

Guiding Principles in Measuring ROCI

The guiding principles for the measurement of the return on community investment (ROCI) for access to affordable health coverage are:

- Address the benefits to the community and the return to individual stakeholders' investments.
- View ROCI as part of the business case.
- Attempt to quantify the financial impacts of as many factors as possible.
- Be conservative.
- Set up ongoing measurements of ROCI.
- Measurement of the financial benefits of a program should be compared to how the community would be without the program.
- The measurement of the ROCI includes more than just the direct health care cost savings. It includes indirect cost savings, the value of money brought into the community, and the value of improved quality of life such as improved morbidity, mortality, and productivity.
- The document provides additional explanations of the above principles and specific guidance, including examples, on how actually to measure the ROCI.



Introduction

Have you ever stated or heard someone else state that investment in access to affordable health care for the low-income population is not only socially the right thing to do but that it makes good business sense? Then, were you asked to prove it? Could you do so? In order to obtain initial funding for programs, and to it, it is critical that you can prove that there is a return on the community's investment.

It is true that obtaining affordable health care coverage has become a serious problem for many Americans, resulting in vast numbers of people who do not have insurance (the "uninsured") or have inadequate insurance (the "underinsured"). Many communities across the country are debating why this problem has developed, how it can be rectified, and who should pay for its resolution.

Historically, we have created a problem for sustaining funding by focusing just on the social issues, asking only the fundamental question whether health care is a right or a privilege. Assessing the importance of access to health care by starting with the value-laden question has been a deterrent to resolving the issue. When there is agreement that access to health care makes financial sense, however, cooperation toward finding solutions develops regardless if it is determined to be a right, a privilege, or something else entirely.

Another deterrent to the resolution of the issue of affordable health coverage has been the focus on who should pay for the resolution of the problem, before there is actual agreement that it is a community problem. Therefore, this document will address how a community can measure the return on its investment in addressing health care access for the underinsured as well as how the findings can be most profitably presented to key stakeholder groups.

The federal Health Resource Services Administration (HRSA) has supplied seed money to communities in the form of grants such as the Healthier Communities Access Program (HCAP), formerly known as the Community Access Program (CAP). While the CAP recipients have successfully implemented programs, they too are now faced with the challenge of obtaining sustaining funding when their HCAP or CAP grants period is over.

When this ROCI model was first developed several years ago, in the "pre-9/11" days, it was presented in the context that although the economy was good, there were many who were uninsured. The economy was sound enough to address the issue. Then, we cited that 1 out of 6 Americans were uninsured, totaling over 40 million people. We now hear the argument that the economy has softened and that society does not have the money to address affordable health coverage. However, society must still address affordable health coverage in order to rebuild the economy and it must be through partnerships. To compound the challenge, the

weak economy and rapidly increasing health coverage costs have increased the number of uninsured and underinsured people.

In order to obtain sustaining funding, the business case for investing in affordable health care for the low-income population must be shown. It is relatively easy to demonstrate benefits to the broader community when stakeholders agree that it is in everyone's best interest to make the investment. However, the typical situation is that the individual stakeholders, particularly those funding the effort, must first be shown that there is a return on their investment and that their expectations are met. In the past, organizations measuring their return have focused only on the direct cost savings. To address the complete picture, the indirect cost savings, the ability to bring funds into the community, and changes in the quality of life must also be measured.

Therefore, the first financial goal of meeting the needs of the underinsured is that there will be aggregate return on the community's investment (ROCI), while the second financial goal is that a desired distribution of expenses between key stakeholders is accomplished and that individual stakeholders receive a return on their investment.

This document will describe a framework for measuring the return on a community's investment in addressing health care access as well as identifying stakeholders, their expectations, and their concerns that they receive a return on their investment. This framework will also assist in the documentation of the case for the community and stakeholders' investment.

This ROCI framework was developed over a three-year period and applied to over thirty communities and counties. With each two project or application, the approach was further refined. This document provides insight resulting from these applications.

While the main body of this document does not detail the actual group process for doing the ROCI measurement, Appendix A provides an example of a process that could be used



Guiding Principles

Before we start looking at the specifics of measuring the return on community investment (ROCI) for health care access for the underinsured, it is useful to understand key guiding principles.

Address the benefits to the community and the return to individual stakeholders' investments.

- The most convincing argument is made when there is concurrence amongst key stakeholders that money spent on improving access to health care is an investment in the community.
- With the increasing use of public-private partnerships to address care for the underinsured, it makes sense to first look at an aggregate ROCI as a means of building these partnerships but then to customize the ROCI to the expectations of individual stakeholders.

View ROCI as part of the business case.

- Identify the targets for the business case – As summarized below and further described in Exhibit 1, the four general target groups for the business case are:
 - Current funding who want accountability for their investment.
 - Clients who, although they do not make a significant dollar investment in the program directly, the quality, service, and cost performance of the services they receive are evaluated by those who do invest on their behalf.
 - Other beneficiaries who do not currently invest in the program but might do so if shown the benefit they could receive.
 - Potential funding who could be convinced to invest in the program

Exhibit 1.

STAKEHOLDER GROUPS AND THEIR EXPECTATIONS

CATEGORY	EXAMPLES	EXPECTATIONS	MEASUREMENTS
(A) CURRENT DIRECT FUNDERS	<ol style="list-style-type: none"> 1) Private and public grantors / reimbursements. 2) Taxpayers. 3) Subsidizers. 4) Insurers. 	<ul style="list-style-type: none"> • Benefits exceed risks and costs. • Return on investment. • Prudent and legal use of funds. • Process matches expectations. • Better off with program than without. 	<ol style="list-style-type: none"> 1) Return on Community Investment: <ul style="list-style-type: none"> • Direct and indirect cost impact. • Quality of life impact. • Ability to draw down funding. 2) Agreed upon financial performance. 3) Influx of funds from other sources.
(B) CUSTOMERS	<ol style="list-style-type: none"> 1) Clients. 2) Providers: <ul style="list-style-type: none"> • Hospitals. • Community Health Centers / Other Primary Care Providers. • Physicians. 	<ul style="list-style-type: none"> • Ease of access (financial, convenience). • Satisfaction -- "They seek you out." they receive what expected. • Better off with program than without. 	Quality, access, and service have financial impact that will be reflected in ROI measurement.
(C) NON- INVESTING BENEFICIARIES	<ol style="list-style-type: none"> 1) Community: <ul style="list-style-type: none"> • Business. • All people. 2) Teaching institutions. 	<ul style="list-style-type: none"> • Can access services. • Ability to understand their benefits. • Better off with program than without. 	Measurements are the same as for (A) Direct Funding and an overall funding strategy is to show that the benefits are so great that specific indirect beneficiaries should support the program and even become direct funding.
(D) POTENTIAL FUNDERS	<ol style="list-style-type: none"> 1) More funding from Group A. 2) New funding. 	Same as (A).	

NOTE: This framework was initially put together in a work session with the Arkansas River Valley Rural Health Network and has had subsequent refinement.



Program objectives should emphasize quantifiable financial results.

As illustrated in Exhibit 2, the ongoing funding for care for the underinsured typically comes from one of four sources:

- Government subsidy to providers – Could be a combination of local, state and federal subsidy.
- Out of pocket payment from recipients of care.
- The value of the care that providers give for which they are uncompensated – If the provider intentionally directs care to lower cost settings, the uncompensated care is called “voluntary”. By comparison, uncompensated care in less desirable settings is called “involuntary”. For example, providing pro bono primary care for people who would otherwise use emergency rooms for their primary care is an example of reducing total uncompensated care by providing voluntary uncompensated care as a replacement for involuntary uncompensated care.
- Subsidy from other users of services – This is what is popularly called cost shifting. Unless there are specific programs in place to surcharge insurance premiums or specific patient bills to support the underinsured, it is becoming more difficult for providers to cost shift.

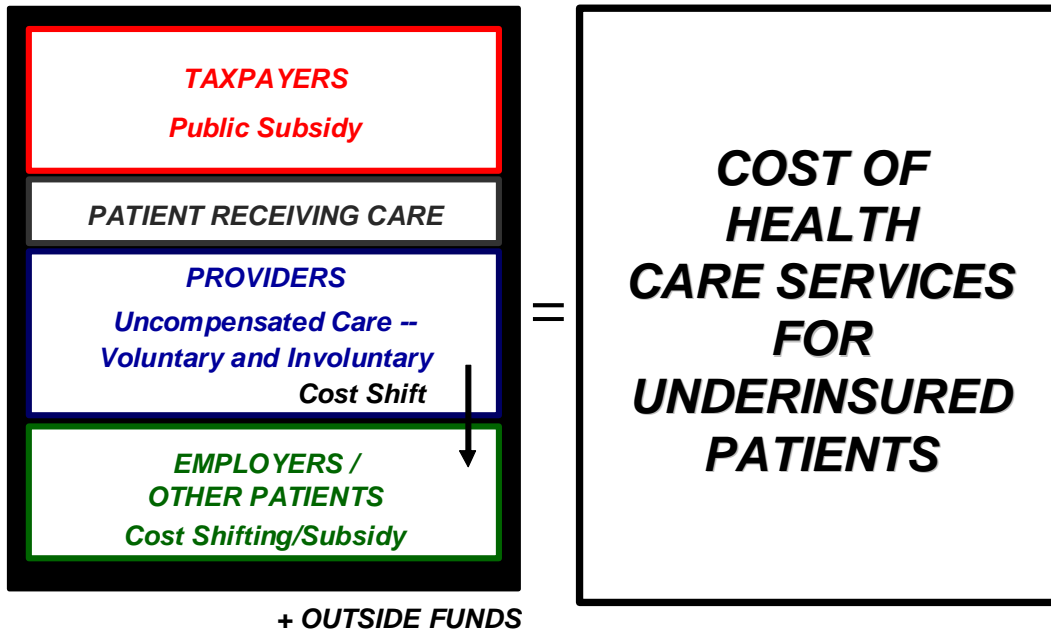
With some exceptions, while private sector philanthropy or government grants can be used to start up programs for improving health care access, these outside funds cannot be relied upon for ongoing funding. Examples of exceptions are when a private source endows the fund to pay for services for the underinsured.

Attempt to quantify the financial impacts of as many factors as possible.

- Financial quantification is the most objective and least value-laden measure. Individuals may differ in their perceptions of the social importance of health care for the underinsured and its qualitative link to the community, but should agree with the quantification of financial impact if it is supportable by data.
- If impacts cannot be financially measured directly, measure a proxy for the financial outcome or quantify non-financial returns to the community. This is particularly true when it is too early to measure financial outcome but a process and structure has been put in place that would indicate that the outcome would be achieved. For example, access to health care alone is not a financial measure; the measure of the value of the access is a proxy for financial outcome.

- Exhibit 2.

**ACHIEVE DESIRED
DISTRIBUTION OF FISCAL RESPONSIBILITY**



Be conservative.

- Use the highest, most accurate, and broadly accepted values. Often times the goal of measurement is to find a financial benefit with which the targets for the business case will agree.
- If this conservative number is adequate to make the case, additional time and effort that will result in showing additional financial benefit may not be needed.



Set up ongoing measurements of ROCI.

- The measurement of ROCI should not be viewed as a one time study. You will continually be challenged to prove a return on the investment in care for the under insured. Setting up an ongoing measurement of ROCI will allow you to prove the ROCI whenever you are challenged.
- Over time, expect improved accuracy.
- Initially, components of the ROCI will be projected using the results of national studies and experience at similar programs. Then the ROCI component should be measured to confirm or adjust the projection.
- If the measurement is conservative from the beginning there should be the ability to show increased ROCI with more accuracy. It is important that you are sure the financial impact is “at least the amount measured even if it means sacrificing some of the ROCI.

Measurement of the financial benefits of a program should be compared to how the community would be without the program.

- This is a more meaningful measurement than a comparison to how society was before the program was implemented.
- It can be difficult and time-consuming to reconstruct the way it was before the program and may not contribute any useful information.

The measurement of the ROCI includes more than just the direct health care cost savings.

It includes indirect cost savings, the value of money brought into the community, and the value of improved quality of life such as improved morbidity, mortality, and productivity.

Guided by these principles, we can now look at the specifics of a measurement of the return on a community’s investment in addressing health care access



The Phases of Measurement

Ultimately, the principal financial measure of the effectiveness of a program to improve access to health care is improved quality of life accompanied by reduced direct cost of health care. It is initially difficult to measure these outcomes in the early life of a program, and if a program has been in existence for a period of time, it is difficult to assess outcomes if the measurement tools are not in place. The three phases of measuring the ROCI are further described below.

Phase 1: Identification and measurement of actual and projected financial benefits to date.

A mistake that is often made when it is decided to measure ROCI is to wait until the perfect measurements are done to release findings. It should be remembered that if the objective is to prove that there is a positive ROCI, the most important consideration is whether there is agreement that the ROCI is what is indicated. Therefore, it is recommended that an initial ROCI be determined as rapidly as possible using conservative assumptions that are agreed upon. It should be presented as “at least” and that as the process continues a more refined ROCI can be measured.

Unless there has already been progress toward the measurement of specific outcomes, the first phase will focus on the measurement of the impact of process measures such as the value of additional funds brought into the community and indirect and administrative savings due to improved coordination. The initial ROCI may also include a projection of the financial impact of direct cost savings and quality of life.

In many cases, data on ROCI has already begun to be collected. In these situations, Phase 1 can be abbreviated.

Phase 1 also sets the stage for future ROCI measurements by including the identification of ongoing measurement activities that need to be put in place as well as the identification of the audiences for the ROCI analysis and customization of the ROCI presentation to meet target audiences' expectations

Often times, a program has been set up with initial grant funding or investment by providers, government, etc. Therefore, the target audience for Phase 1 is often current investors and potential investors.

Phase 1 should be completed quickly, often within two to three months. The process data to be collected in usually available or conservative projections can be made. The results of Phase



1 are clearly labeled as conservative, with the emphasis made that over time the results will be expanded and fine-tuned.

Phase 2: Completion of activities started in Phase 1 and commencement of outcome measurements.

Phase 2 includes finishing initial measurements started but not completed at Phase 1 deadline as well as commencing more detailed measurement of outcome measurements (direct costs and quality of life) including applying the more rigorous measurements that were designed in Phase 1. Phase 2 will also include updating the+6 measurements conducted in Phase 1.

The amount of time for Phase 2 will typically be longer than Phase 1. At the beginning of Phase 2, the expected completion date should be identified. As noted earlier, in many cases, data on ROCI has already begun to be collected. In these situations, Phase 1 could be abbreviated and work started on Phase 2.

Phase 3: Ongoing calculation of the ROCI.

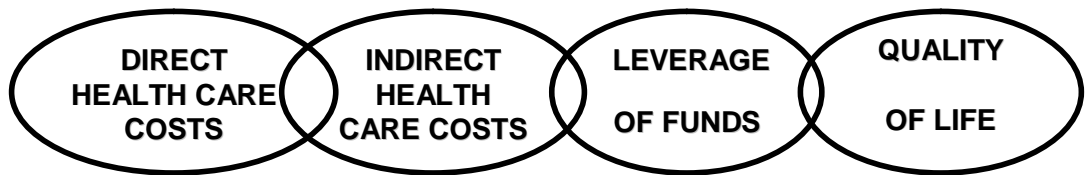
After Phase 2, the mechanism for the ongoing measurement of the ROCI should be put in place. Frequency of the measurement will be determined as well as ongoing refinement of methodologies.

In addition, the ROCI will begin to be used as a performance tool. For example, if initially project outcome is not achieved, the reasons would be identified and adjustments made.

Examples of the use of project phasing will be illustrated in later sections of this document.

Exhibit 3.

EXAMPLES OF BUILDING ON CURRENT ROCI WORK



PHASE 1. PROCESS MEASURES AND PROJEC- TIONS	<ul style="list-style-type: none"> • Project potential impact. 	<ul style="list-style-type: none"> • Admin. cost savings. 	<ul style="list-style-type: none"> • Add value of: <ul style="list-style-type: none"> -- State / fed. subsidized services. -- Enhanced payments. 	<ul style="list-style-type: none"> • Project potential impact.
PHASE 2. EXPAND / ENACT OUTCOME MEASURES	<ul style="list-style-type: none"> • Compare actual to “control group”. • Compare to projections. 	<ul style="list-style-type: none"> • Continue above. • Impact on other programs and support costs. 		<ul style="list-style-type: none"> • Compare actual to “control group”. • Compare to projections.
PHASE 3. ONGOING	Continue and further develop the above measures.			



Specific Measurements:

Exhibit 4 illustrates the factors to be considered under each of the four categories of financial benefits:

- Decreased direct health care costs.
- Decreased indirect costs.
- Improved influx of funds into the community.
- Improved quality of life.

The rest of this section will describe how these factors could be measured and how the measurement may differ during the three phases of work.

ROI could be measured for a program, a series of activities, or a specific activity, therefore, the generic term, *intervention*, will be used in this section to represent any of the above targets of measurement.

Direct Cost Measurements:

The direct health cost savings due to new programs and interventions to improved access is typically not experienced until 2 to 3 years after implementation. Methodologies should be developed to identify a per person projection of the direct cost savings as well as quality of life measurements. The actual results will then be used to project savings when enrollment numbers increase.

Projections -- Phase 1.

If there is not available data to measure the actual direct health care savings resulting from the INTERVENTION, in Phase 1, a projection can be made to identify potential savings.

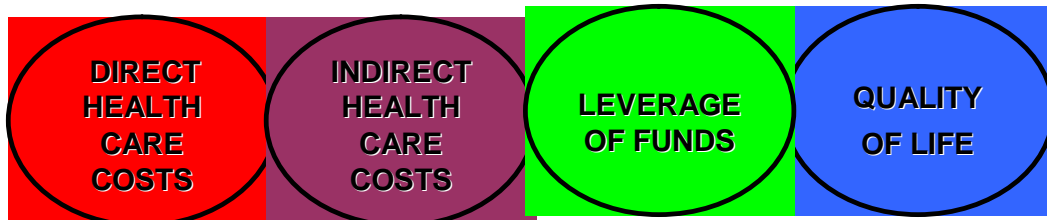
- In most situations, the reduction of direct health care costs for the low-income population is the result providing coordinated health care at the least expensive, timely location such as primary care. The primary care is the focal point for coordination of referral health care and inpatient care when needed, as well as prevention, early detection and management of health problems. For the low-income population, links to social services

are critical. Outreach is also important to make the low-income population aware of the availability of services and how to access them. The provision of health care in coordinated health care settings, as in this model, rather than ad-hoc use of expensive health care in costly settings is the most significant way to reduce direct health care costs. Exhibit 5 illustrates a primary care driven model, based upon the model that the Bureau of Primary Health Care promotes.

- Methodologies should be developed to identify a per person projection of the direct cost savings as well as quality of life measurements. The actual results from a sample of current participants could be used to project savings when enrollment numbers increase or results from other locations could be used.
- When the uninsured had access to managed care rather than ad hoc services, mostly through unscheduled care, participants tend to enroll when they have an illness or medical condition. Therefore, it is not unusual to see average \$1,000 to \$2,000 cost savings per person per year for programs that obtain access to comprehensive care.
 - Therefore, as an initial projection, if detailed data is not available, use the \$1,000 to \$2,000 per person range. The lower end of the range is the most conservative; while if your program is targeted at chronic diseases that have high resource use, the mid-range could be used.
 - It is important to set up the measurement of actual financial impact as part of Phase 2 to confirm the estimate. **This is discussed below.**

Exhibit 4

COMPONENTS OF ROI MEASUREMENT

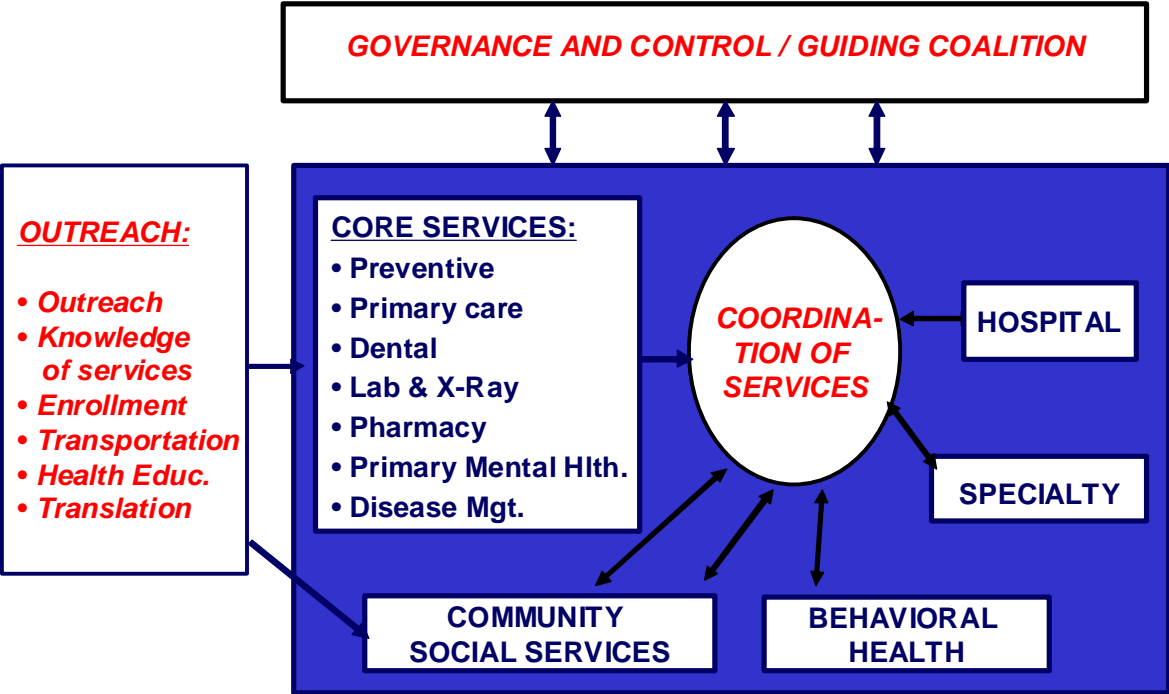


- | | | | |
|--|---|---|---|
| <ul style="list-style-type: none"> • Costs of health care for the target population. | <ul style="list-style-type: none"> • Adm. cost savings. • Support cost (such as transportation). • Adm. cost savings. • Community costs to support: <ul style="list-style-type: none"> -- Sick/injured. -- Other social services for targeted pop. | <ul style="list-style-type: none"> • Services / funds: <ul style="list-style-type: none"> -- Brought into community: <ul style="list-style-type: none"> - State. - Federal. - Private. -- Retained in community. • Coordination between payers. • Opportunities to partners • Econ. Development Factor. | <ul style="list-style-type: none"> • Improved health status. <ul style="list-style-type: none"> -- Morbidity. -- Mortality. • Improved productivity. • Benefits to future generations. • Econ. Development Factor. |
|--|---|---|---|

- Working with hospitals to identify the number of ER patients who were linked to primary care providers for ongoing care, that is, the number who was given “primary care homes.”
 - For the hospitals whose ER's are at capacity, the methodology should include the opportunity for additional revenues resulting from seeing individuals who left (reduction of the "elopement rate.") These are typically paying patients, representing lost revenue.
 - For the other ERs that are not at capacity, a methodology should be developed to measure the cost savings and revenue enhancement of patients being seen in primary care homes rather than the ER.
 - Consideration should be given to applying an ER use methodology (such as the one developed at NYU) to assess the opportunity for shifting ER patients to primary care homes, thereby adding the value of reducing the use of ERs. This measurement would be applied in Phase 2 or even Phase 3. The CAP office has been negotiating with the NYU group to provide assistance to CAP recipients. Therefore, the CAP representative may be able to assist in technical advisor support for this study.
 - These calculations will have increased importance when the ROCI is applied to provider expectations as part of Phase 2.
 - As new programs are implemented, mechanisms for measuring their direct cost impact will be put in place. Whether these activities are part of Phase 1, or later, will depend upon when they are implemented.

EXHIBIT 5

COMPREHENSIVE PRIMARY CARE BASED HEALTH CARE
(Based on Bureau of Primary Health Care Model)



Measurements – Phases 2 and 3.

Processes will be put in place to measure whether these projections were achieved. This measurement will occur in Phase 2.

- The methodology chosen will include sampling and records-review and could be a comparison to a control group based upon the Agency for Healthcare Research and Quality's Medical Expenditures Panel (AHRQ-MEPS).
 - Dr. William Custer from Georgia State University has developed this type of approach and gave a CAP TA call on this topic. Contact data and his presentation are available through CAP. See my note on page 18
 - More information about AHRQ-MEPS is available on the website: <http://www.ahrq.gov/data/mepsix.htm>. This site includes the states in which AHRQ-MEPS has been implemented and the contact in these states.
- In Phase 2 and 3, continue with measurements from Phase 1.
 - In all phases, the increased expense to operate direct care programs must be determined, as the ROCI equals incremental costs minus incremental benefits.
 - There are local programs that exist for the principal reason to enroll individuals in government subsidized health coverage. In these types of programs, direct cost is not a significant part of the return on the community investment.
 - The actual measure of the incremental direct health care reduction may be controversial. When looked at from a community perspective, the positive impact of the program is the reduction of total health care costs. This is usually the result of getting the individual coordinated health care rather than episodic care often at a level of service that is higher and more expensive than necessary and lacks prevention and ongoing management. This increment is more clearly understood as the community impact when the payers for the service are the same before and after the program is implemented. For example, provider partnerships can coordinate services as a means of reducing their expenses.

However, when the funding of health care changes but the actual cost of the service does not change, it may be harder for stakeholders to view that there has been change in the cost to the community. To illustrate this point, consider a government-subsidized program to provide coordinated care for individuals who previously did not have access to care. To agree that true community impact is just the direct cost reduction, the providers' uncompensated care should be viewed as a community expense. Therefore, when the government pays for the care, the objective is to develop coordinated care to

reduce the community's direct health care costs. Under this scenario, the expense to achieve this cost reduction is the administrative cost of the new program and the benefit is the direct cost reduction.

The concept that reduction of the number of uninsured individuals has a community impact is the main theme of a recent report from the Institute of Medicine of the National Academies: *A Shared Destiny, Community Effects of Uninsurance* (Committee on the Consequences of Uninsurance, 2003). This report summarizes its findings by saying: "The costs of care for uninsured Americans are passed down to taxpayers and consumers of health care in the forms of higher taxes and higher prices for services and insurance (p. 11)". The report uses the term, *uninsurance*, to define not having health care coverage and cites the following economic impacts of uninsurance:

- Threats to the survival of individual providers and hospitals.
- Health care providers and particular hospitals are a form of economic development and bring and maintain jobs in the community.
- Negative impacts on the public health of the community.

Therefore, although it is difficult to measure the exact impact of uninsurance on a community, it is reasonable to view public subsidy to create access as at least an offset of uncompensated care. The following example, which uses real numbers, illustrates this point.

There is a large county run health care program with a tax supported annual budget of approximately \$83M. Of this budget, \$70.5M is paid out for services per year, e.g. the annual administrative and overhead costs of the program are approximately \$12.5M. It has been calculated that the program's existence reduces direct costs by approximately \$44M. For this program:

- From a community perspective, \$12.5M is the incremental expense that resulted in a \$44M direct cost benefit. From this view, the direct cost savings alone justifies the expense and yields a 3.5 to 1 annual return.

However, if uncompensated community health care is not viewed as a community expense, and it is perceived that the return must be measured on the full government expense, then the direct cost expense is \$83M and the direct cost benefit is \$44M. From this perspective, an additional \$39M in financial benefits from indirect cost reductions, influx of funds, and quality of life improvement would need to be identified in order to claim a positive return on the \$83M investment.

Indirect Cost Measurements:

There are several factors to measuring indirect costs, such as the savings of centralizing functions, the impact of centralized negotiation of benefits and expenses, and the cost benefits to related functions (e.g. the improvement in physical health reduces the costs to the mental health and judicial systems, sayings in non-health care needs of the individuals.), among others.

The decrease in the cost of operations is calculated under indirect costs while improved outcome, increased leverage of funds, and decreased direct costs are evaluated in other sections.

Indirect costs of operations include the following activities:

- Qualifying people for government subsidized programs.
- Training and development.
- Education and marketing to make consumers aware of the programs and services available to them

In order to identify the financial benefits of centralization, compare the cost of each provider to provide the function with the cost resulting from centralizing the function. If a particular service is offered centrally, the provider may either reduce total personnel hours, or re-allocate his personnel to other activities.

If an individual provider indicates that it would not have provided the service on its own, the ROCI for that service must be justified by categories other than indirect costs.

In addition, there may be a rationale for including the indirect cost savings due to the reduction of malpractice costs.

In Phase 3, continue activities started in Phase 1 and 2.

In all phases, incremental expenses to operate the indirect care programs must be calculated.

Examples of Specific Application of Decrease in Indirect Costs:

There are several states such as Wisconsin, Minnesota, and Pennsylvania that have Medicaid waiver programs to cover the underinsured, for example, expansions of State Children's Insurance Program (S-CHIP) to cover the families of the child. Other states such as Colorado have state programs for health care for indigent populations that exceed the typical Medicaid coverage. For these states, the local challenge is to maximize their residents' enrollment in this program. By creating a central program to assist in the cost of enrollment of residents in these subsidized programs, the aggregate costs for enrollment, if handled at individual sites, is decreased. This is the result of improved processes and efficiencies. This was encountered for numerous ROCI projects in these states.

In several of these programs, the centralizing of the enrollment process facilitated the availability of individuals culturally sensitive to underserved ethnic groups. In one a Midwest-urban area, specific workers are available for Latino, Southeast Asian, Central American, and Eastern European populations. This is clearly a cost that could not have been borne by each participant.

There are several sites that are developing methodologies to measure specific types of indirect savings. For example, it is often hypothesized that there is a link between access to physical health care and mental health and a link to the cost of the judicial system. Several locations are trying to measure the financial impact of these links. Completion of these studies may demonstrate that improved access to physical health services leads to the community benefit of reduced mental health and judicial systems costs.

Improving Inflow of Funds and Leveraging Funds:

Improved inflow of funds is a measurement of dollars brought into or retained in the community as the result of the *intervention*. As relevant to an individual *intervention*, this measurement could include the value of:

- Services brought into the community.
- Pharmaceuticals acquired on behalf of participants in programs for low-income people.
- Grants acquired.
- Increased reimbursement.
- In-kind contributions and volunteers.
- Health care services retained in the community.

- An important financial impact of services brought into the community is the value of the health care for residents that enroll in state and federal government subsidized health care coverage as the result of the existence of the program. This government subsidized funding includes:
 - Medicaid.
 - State Children's Health Insurance Program (S-CHIP).
 - Expansions of Medicaid and S-CHIP such as coverage of families.
 - Social Security.
 - Other state and federally subsidized care.

- A methodology that can be used is:
 - Identify the number of people that had increased access to subsidized programs due to the existence of the intervention.
 - Determine the volume that would have not obtained access at all. For these people, multiply the total annual value of the "premium" times the number of people. "Premium" is defined as the average cost to insure the person.
 - Determine the volume of patients who access care earlier due to *intervention*. For these people, identify the number of months earlier that they obtained access. Convert to fraction of a year and multiply times the annual time value of money used by the County. Then multiple the resultant number times the annual value of premiums times the number of people.
 - The above calculations are repeated for each subsidized program.

- Also in Phase I include the value to partners of enhanced reimbursements. This will include benefits that accrue to individual partners such as any advantages of using *intervention* programs as conduits for cash flow that results in draw down or the ability to put *intervention* enrollees into individual partner's reimbursement stream (such as additional reimbursement to disproportionate share providers.) There will be a need to talk with individual partners to identify applicable examples and measurements.
- In addition, if applicable, reimbursable Medicaid administrative costs or other state incentives to appropriate placement should be added.
- As part of Phase 1, identify how to measure the draw down of other State, Federal, and private funds. In Phase 1, if the CAP grant is being used to fund the budget, there is an equal cost and benefit of draw down of the CAP federal funds.
- Partners can assist in the projection of their reduced uncompensated care as the result of *intervention* activities. Be careful not to double count by including the value of reduced uncompensated care and the payments of subsidized programs.

In Phases 2 and 3, continue with measurements from Phase 1.

In all phases, incremental expense to achieve the leverage of funds should be calculated.

- The time period of these expenses must match the time period of the financial benefits. For example, if benefits are being measured since the start of *intervention* then the expenses for the same time period should be measured.
- If outside grants are being used to support staff and operations, the expenses to run these programs offset part of the benefits of dollars brought into the community. It is easier to understand the final presentation if both entries are made.

Examples of Specific Application of Influx of Funds Measurements:

For states that have programs that expand State Children's Insurance Program (S-CHIP) to cover the families of the child or, in general, have state programs to subsidize health care for the low-income population, the local challenge is to maximize their residents' enrollment in these programs. These programs have significant, positive local financial impact that results from bringing state and federal funds into the community.

For each of these programs, the cost per month coverage for the State program was obtained. In some situations, the State knew the actual per enrollee per month cost. In other situations, per enrollee per month coverage was calculated using annual costs and average per month enrollee statistics. The calculation of the number of additional months of coverage for enrollees was determined through analysis in each case. It required making assumptions that resulted from data collection and interviews of personnel.

For many other ROCI projects, while there was less potential for additional state and federal Medicaid dollars, there was still the value of S-CHIP enrollment or enrollment in the Medically Needy Medicaid program such as in Florida. The benefits of enrollment efforts were calculated in a similar manner as described above.

In some situations, such as in the Florida Medically Needy program, if a share of cost is met then eligible individual can receive extended Medicaid benefits. If the local program pays the share of cost, the ROI calculation should include the value of the extended Medicaid benefits while the expense to receive this benefit is the share of cost.

A comprehensive program also brought dollars into the community as the result of assisting its enrollees who are legitimately disabled to become eligible for federal Social Security Disability Income (SSDI). In the case of one large coverage program, evaluation of cases indicated that, on the average, individuals were becoming SSDI eligible 6 months earlier as the result of the program. The financial impact was two-fold. First, there is the actual value of 6 additional months of SSI payments. Second, after two years on SSDI, most of these individuals became eligible for Medicare. Therefore, there was a future benefit of the value of 6 additional months of Medicare coverage brought into the community. The Medicare cost per month per disabled enrollee was then used to calculate the value brought into the community. The impact of earlier Medicare coverage had a particularly important on the program because until these individuals became eligible for Medicare, the program paid for their health care. For this program, the combined impact of additional SSDI payments and earlier Medicare was over \$3M per year.

For programs that provide access to pharmaceuticals or other medical goods, the benefits are easy to identify. The net benefit is the value of the acquired goods less the incremental cost of the program to obtain the goods. In some cases, the ROI calculation applied the conservative approach of applying the value of the good if acquired from an easy to join buyer plan while others used the actual market values.

Value of Quality of Life Improvement:

Quality of life measurements will include, as appropriate, improved morbidity and mortality. There will be an attempt to add financial quantification by identifying lost time and applying the value of the time.

- Initially, this may mean applying productivity improvement to the working segment of the target population unless there are agreed upon measurements of the value of time of people who are not working.
- Since this will require further evaluation, Phase 1 will include the identification of general quality of life measures of existing *intervention* enrollees and Phase 2 will include projections of impact under higher enrollment, as well as methods to be implemented over time to quantify financial impact.
- Methodologies should be developed to identify a per person projection of the direct cost savings as well as quality of life measurements. The actual results of current *intervention* participants will be used to project savings when enrollment numbers increase. Methodologies will include sampling and records-review, comparison to a control group base upon the Agency for Healthcare Research and Quality's Medical Expenditure Panel Survey (AHRQ-MEPS), and projecting expected savings based upon experience at other locations. Processes will then need to be put in place to measure whether these projections were achieved.

- During Phase 1, determine the gross measurement for productivity improvement due to having access to care. While the literature (such as the May 2002 report, Sicker and Poorer: The Consequences of Being Uninsured by the Kaiser Family Foundation, available at: <http://www.kff.org>) indicates that an individual who presents with a disease but does not have health care access could lose 15% to 30% earning power, initially it is more conservative to use 5% or 10%. This is then applied against an annual value of workers such as an average income of clients. This can be an actual measurement or an estimate based upon a percent of the federal poverty number.
- Another study, Care Without Coverage: Too Little, Too Late, from the Institutes of Medicine, May 2002 (available at: <http://www.iom.edu/uninsured>) indicated that the access to health care has a short term impact on daily living and in the longer term (over 5 to 17 years), these individuals have a 25% death rate.
- Over time, there should be a validation of productivity improvement by sampling or some other measurement. It is recommended that there be measurement of the client's perceptions of the impact of the program on their health. One measurement could be client's estimate on lost time due to illness. Over the longer term (Phase 3), there may be opportunities to do employer surveys.
- In economic development models, it is assumed that for every dollar of wages brought into a community, there is a multiplier due to the activity that the dollar generates. The multiplier for a specific community can be obtained from the local or regional economic development council or the Chamber of Commerce. The multiplier will typically be between 1.5 and 3.0. This can then be used to estimate the value of lost income to the community. Also, confirm if the economic development council assumes the same multiplier for retained wages in the community as for new jobs.

Ongoing outcome measurement.

- With providers, identify activities that will maximize cost impact and quality of life improvements (such as identified in May 2002 reports, Care without Coverage, Too Little Too Late by the Institute of Medicine and Sicker and Poorer: The Consequences of Being Uninsured by the Kaiser Family Foundation.) *intervention* has already begun many of these activities and could project potential savings utilizing data from these reports. These activities include:
 - Increased primary screening and prevention.
 - Improved access to cancer cares and improved outcomes.
 - Improved access to chronic disease care and outcomes. (Diabetes, cardiovascular including hypertension, renal, HIV, and mental illness were cited).
 - Trauma and decision to admit.
 - Overall negative impact.

- Continue to identify processes to measure quality of life impact. For example, measure years of lost life or lost productivity. The annual value of life is a controversial measurement but it could then be used to determine dollar value of quality of life. For interventions that utilize disease management with calculated estimates of years productivity lost there are now attempts to use this measurement. Diabetes and hypertension are two disease entities that are now beginning to yield measurable results.

Examples of Specific Application of Quality of Life Measurements:

The actual examples below illustrate two communities for which a 15% was used for the productivity factor adjusted by the economic development factor, although the reasons for using 15% differed.

In the first example, the economic development factor used by the county's economic development council and the Chamber of Commerce was almost 3X. In that case, applying the economic development factor to a very conservative 5% productivity improvement yields a 15% return. Therefore, to be ultra-conservative, this was the number used.

In the second example, the program had been in place for almost ten years. Because there had been time to measure actual positive results and a higher return had been substantiated. It had been calculated that 70% of its enrollees of the program were the working poor and that the average income of the families served was 80% of federal poverty level and the average family size in the program was approximately 3 people. In this case, the economic development council had a conservative 1.5 factor – one of the lowest encountered in ROCI work. The productivity factor was calculated by multiplying the 10% productivity improvement factor time 1.5 resulting in an overall 15%.



Presenting the Finding

There are a variety of ways to present the ROCI data. In all of them, the data should be presented in a concise manner that presents the case clearly. The extent of backup data included may range from a lengthy detailed study to a presentation with tables and explanations of methodologies to one with no written backup at all. Clearly, the audience will be the main determinant of the format of the presentation.

In most situations, a concise power point presentation with backup tables and methodologies was adequate. This section will concentrate on a presentation in this format. Even when the data is used as part of another presentation, it is good to have backup to illustrate how the ROCI was calculated.

The overall ROCI should be presented from a community perspective. It could then be adapted to individual target groups or sub-populations.

General Application:

To assist in the preparation of the final presentation, data should be compiled in a summary Excel spread sheet and illustrated graphically, consistent with the format in Attachment B. This allows ready creation of the graphic presentation of the ROCI.

The summary spread sheet is tied to more detailed spread sheets and should be broken down by individual service areas and providers as well as by specific measurements (as described above.) This allows the flexibility to later cluster data in multiple ways and to repeat the measurement periodically in a consistent format.

For the power point presentation, graphics can include:

- Summary of Components -- A summary of the impacts by each of the four categories of components of the ROCI. A list of specific measurements of each component can be listed under the oval for the components. Exhibit 6 is an example.
- ROCI Measurement Graphic – The three-bar chart in Exhibit 7 uses the same ROCI data as Exhibit 6. Exhibit 7 illustrates that the ROCI is the result of measuring benefits of the program and subtracting incremental costs. From left to right the stacked bars are the benefits from each of the ROCI components, the expenses necessary to achieve the benefits, and the resulting ROCI. If the stacked expense bar is the same height as the benefits bar the white space at the top is the difference the benefits and the expenses and equals the ROCI, which then equals the third bar. If expenses are greater than benefits then the ROCI is negative and

would be the space at the top of the benefits bar. An example of a negative ROCI is illustrated in Exhibit 8.

- Summary of ROCI Measurement Chart -- It is useful to include a table that summarizes the ROCI calculation. Exhibit 9 is an example that uses the same data as Exhibits 6 and 7.

More detailed spreadsheets can be used as background for these graphics and could be set up to actually drive the creation of the graphics.

The above sets of graphics could be repeated by scenario or by individual stakeholder. These scenarios are further discussed below. Specific applications are described for:

- Aggregate vs. specific impact measurement of ROCI.
- Measurement of ROCI by individual stakeholders or partners.
- Measurement of ROCI by specific program.
- Detailed vs. summary presentation of findings.
- Presentation of ROCI by Phases and Scenarios.

Exhibit 6.

EXAMPLE OF PHASE 1 MEASURED ROCI BENEFITS, 2001

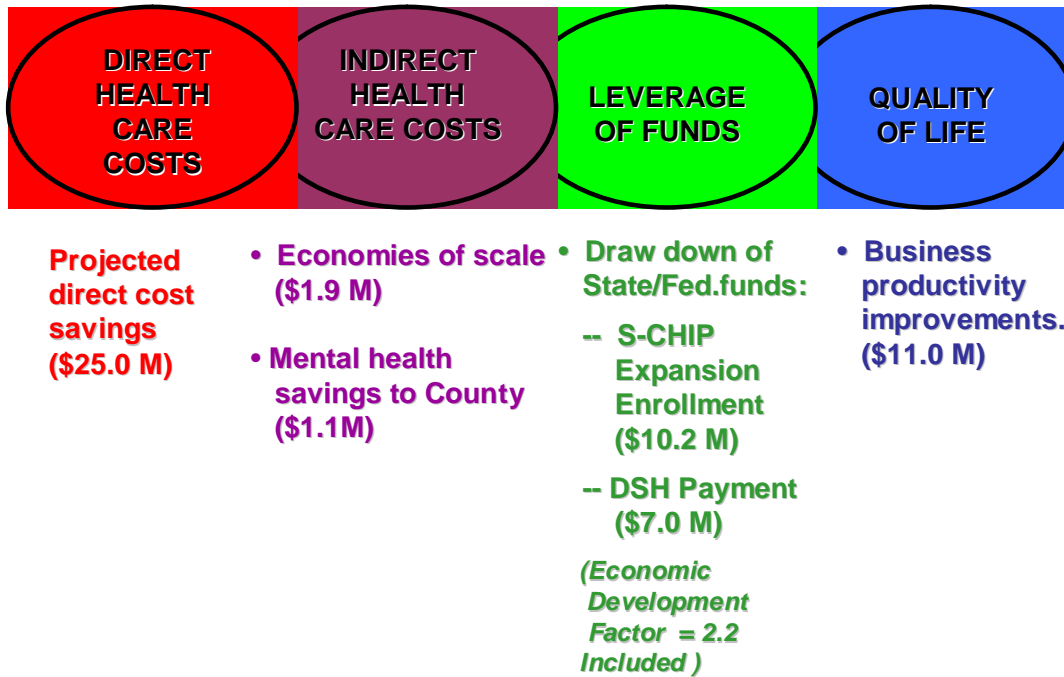


Exhibit 7.

SUMMARY OF ROCI FOR EXAMPLE, CALENDAR YEAR 2000

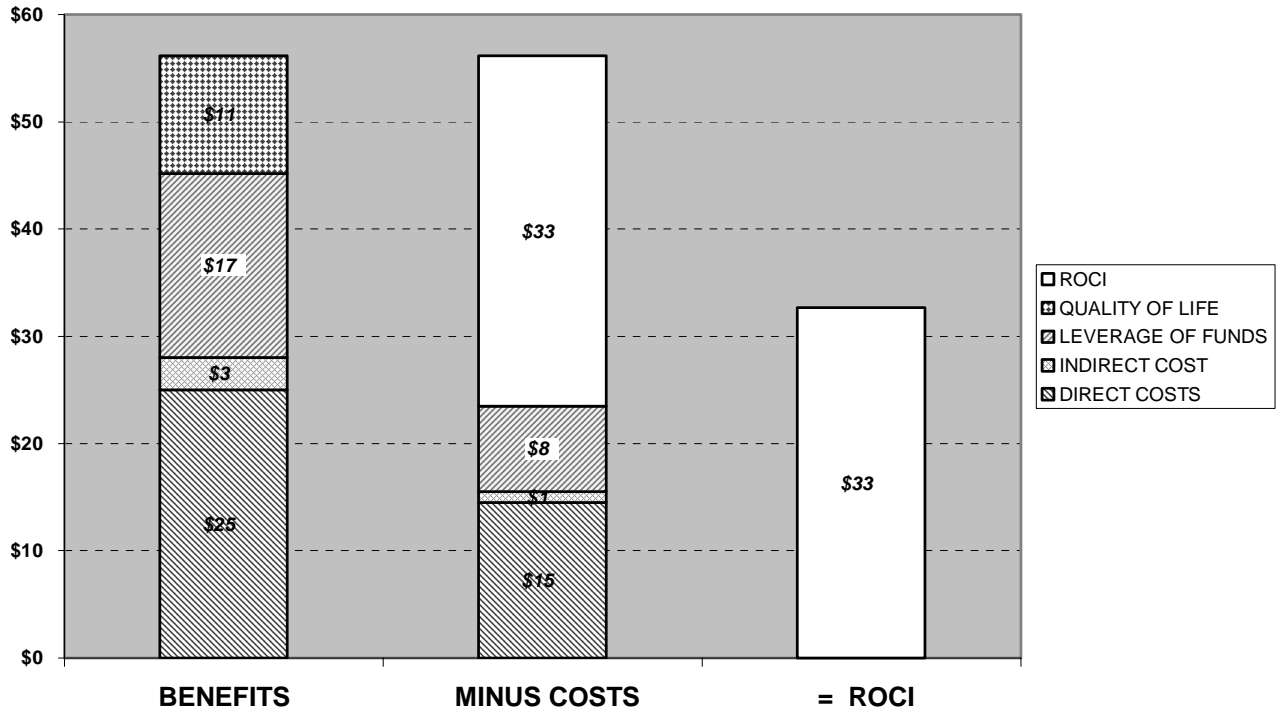


Exhibit 8.

SUMMARY OF NEGATIVE ROCI FOR EXAMPLE, CALENDAR YEAR 2000

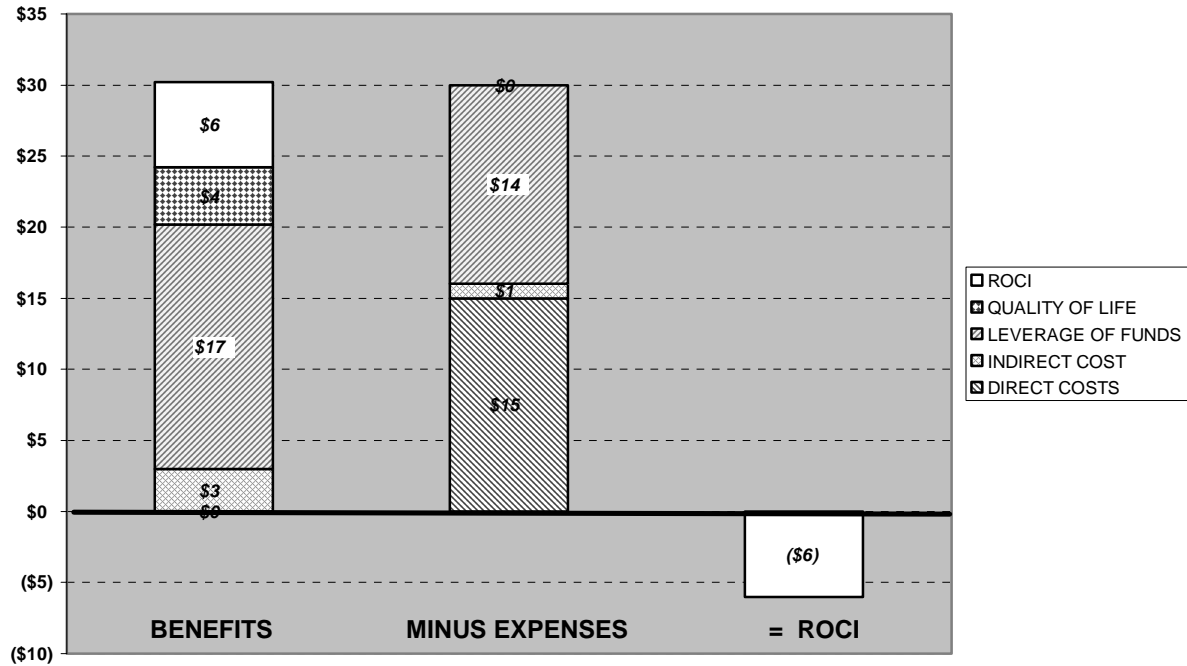


Exhibit 9.

SUMMARY OF ROCI CALCULATION

PROJECT: EXAMPLE
 TIME PERIOD: 1/1/01 to 12/31/02

MEASUREMENT COMPONENT	BENEFITS (\$ Millions)	EXPENSES (\$ Millions)
DIRECT COSTS	\$25.00	\$14.50
INDIRECT COST	\$3.00	\$1.00
LEVERAGE OF FUNDS	\$17.20	\$8.00
QUALITY OF LIFE	\$11.00	NA
TOTAL	\$56.20	\$23.50
ROCI		
= Benefits - Costs	\$32.70 M	
As Ratio to Costs	1.39	

Aggregate vs. Specific Impact Measurements:

In general, when looking at how specifically to measure programs, it should be remembered that one always add up the specific impact measurements to equal the aggregate. However, if the specific measurement is not initially collected, it is difficult to later go back and do the detailed collection.

Measurement of ROCI by Individual Stakeholders or Partners:

Often times it is important to measure the ROCI for individual stakeholders. This is particularly true if a major objective of measuring the ROCI is to sustain or further develop funding. From a financial standpoint, stakeholders include:

- Current direct funding of the program
- Customer
- Non-investing beneficiaries
- Future funding

In order to sustain funding, the objective is to show current investors that there was a ROCI and that it will continue with further investment. It is also useful to show that there would be an increased ROCI to the investor with increased investment. There is an objective to show non-investing beneficiaries why they should invest, maximize the future funding list, and, when appropriate, show customers why they should share the costs. As detailed earlier in Exhibit 1, specific stakeholder groups have specific expectations and therefore, certain components of ROCI measurement have more meaning to them than others.

Therefore, when addressing a specific stakeholder group, it is important to take the overall community ROCI and focus on the measurement that best relates to the expectations of the specific stakeholder group. For example, if the target group is local, maximizing the influx of state funds is important. However, if the target is state government, increasing their funding is viewed, as a negative while influx of federal funds is more important.

Separating ROCI for Individual Programs:

The ROCI approach can be used for a comprehensive program and / or individual interventions. Similar to setting up the ROCI measurement separately for individual partners, it is also useful to set up the ROCI for specific interventions and totaling. This approach was used for several specific programs. In some cases, certain interventions were further advanced than were others. The ROCI for these interventions are based upon actual measurements. For less advanced interventions the potential ROCI can be projected and then actual measurements put in place. Measuring intervention separately allows the impacts to be totaled while not doing separate measurements precludes the ability to later break out the comparisons.

Exhibit 10 is an example format that was used for a rural, multi-county target area with multiple hospital partners and multiple programs. These hospitals were investors in a network that emphasized getting individuals enrolled in state funded disease management programs. Oftentimes it is important to measure the ROCI for individual partners. A key objective of the partnership was to identify low-income people who would be enrolled in state-funded disease management programs. The first two diagnoses targeted by the partnership were diabetes and hypertension. Data on individual enrollees and the ROCI needed to be collected by counties. The hospital partners had service areas that included multiple counties. A Community Access Program grant was used for initial startup funding but ongoing funding will come from the four hospitals in the 10-county rural area covered.

In this case while the overall ROCI is important, it needs to be measured for each individual partner as well. This data helps show the administration and boards of each hospital that there is a return on their investment.

While this example emphasizes the measurement of the influx of outside funds, this format could be used for presenting other specific components or combinations of components of the ROCI.

As a caution, it is important that these data not be used in a manner that violates anti-trust concerns. Since the individuals impacted are underserved, by definition there is probably more leeway. Do not, however, use the data in any way that suggests “carving up territory” or excluding other providers. An opinion from your legal counsel is advised.

Detailed vs. Summary Reporting:

As noted earlier, in some situations, a report must be quite detailed while in other situations, the report can be a summary with background support available if necessary.

This section includes two actual applications for government funded programs that needed to show the return on the taxpayers’ investment. In the first example, a detailed presentation of findings was required while in the second example, the financial impact was part of a single page fact sheet, and therefore needed to be brief.

In the first example, there was a large county program in an urban area with a State Children’s Health Insurance Program expansion. The initial indicators of the success of the program are to maximize the enrollment of individuals in the state program and to minimize the costs of getting people enrolled in it, particularly comparing the advantages of centralizing the program versus each hospital’s doing its own enrollment. The county commissioners wanted a detailed study. Therefore, there was a long detailed report with a power point presentation summary with a subsequent printing of the report for distribution in the community. This level of detail in the study is atypical. However, the level of detail in the power point presentation is typical. The presentation included slides with general background about the program, the methodology used, and the results. Attachment B contains examples of key presentation slides showing study results.

In the second example, a program to support the needs of low-income populations needed state government reauthorization. While this program is paid for with local taxes, the laws of its state require that the state approve all local taxes. The desired report was a one-page bullet point presentation of the program and its impact. This one page summary would allow consistent information for individuals visiting legislators with a concise

summary of the program. The full ROI was important as backup if asked about the source of the impact measurement. The program had been in existence for over 10 years, therefore reduction of direct health care costs is relevant. Appendix C is the bullet point handout.

When the ROI is part of an overall business case there may also be a lower level of detail.

Presentation of ROI by Phases and Scenarios:

When there is a difference in the ROI during phases, the finding should be presented for each phase and then summarized over time.

This is an important presentation when the ROI is used to measure the financial impact of changes being considered as part of a business plan.

In several examples, an Excel spread sheet was developed that had links to summary tables, charts, and graphics. This allowed the ability to make changes in assumptions and generate the tables, charts, and graphics for reports. It also allowed the planning group to make changes in assumptions – the simulation of “what if” scenarios.

Incremental Changes

Setting up a measurement of the ROI of the core program allows the opportunity to measure the impact of incremental programs. The initial ROI creates the baseline and an additional program can be measured individually or their ROI can be measured by subtracting the ROI without the new program from the ROI with the new program.

For example, in the second government funded program described above and in Appendix C, the key determinants of eligibility are income level and access to other health care coverage. It is the “payer of last resort”. Exhibit 11 illustrates the current health care program eligibility.

As illustrated in Exhibit 12, strategies have been identified to expand the program, principally through partnerships. It is possible to project the ROI of potential programs to evaluate options.

Exhibit 10.

EXAMPLE: MEASURING DISTRIBUTION OF THE LEVERAGE OF FUNDS IMPACT BY PARTNER HOSPITAL AND COUNTY

PARTNER HOSPITAL	SERVICE AREA BY COUNTY	DIABETES				HYPER-TENSION	OTHER	TOTAL
		# Of Enrollees	Value Of Coverage	Pham. Value	SUB-TOTAL	(Same Columns As Diabetes)	(Same Columns As Diabetes)	(Same Columns As Diabetes)
<i>Hospital A</i>	<i>County 1</i>							
	<i>County 2, etc.</i>							
	<i>SUBTOTAL – Hospital A</i>							
<i>Hospital B</i>	<i>County 1</i>							
	<i>County 2, etc.</i>							
	<i>SUBTOTAL – Hospital B</i>							
<i>Hospital C</i>	<i>County 1</i>							
	<i>County 2, etc.</i>							
	<i>SUBTOTAL – Hospital C</i>							
<i>Hospital D</i>	<i>County 1</i>							
	<i>County 2, etc.</i>							
	<i>SUBTOTAL – Hospital D</i>							
TOTAL HEALTH PARTNERSHIP								

Exhibit 11.

LINKING OF LOCAL PROGRAM WITH STATE AND FEDERALLY SUBSIDIZED HEALTH COVERAGE

(By Age and Income)

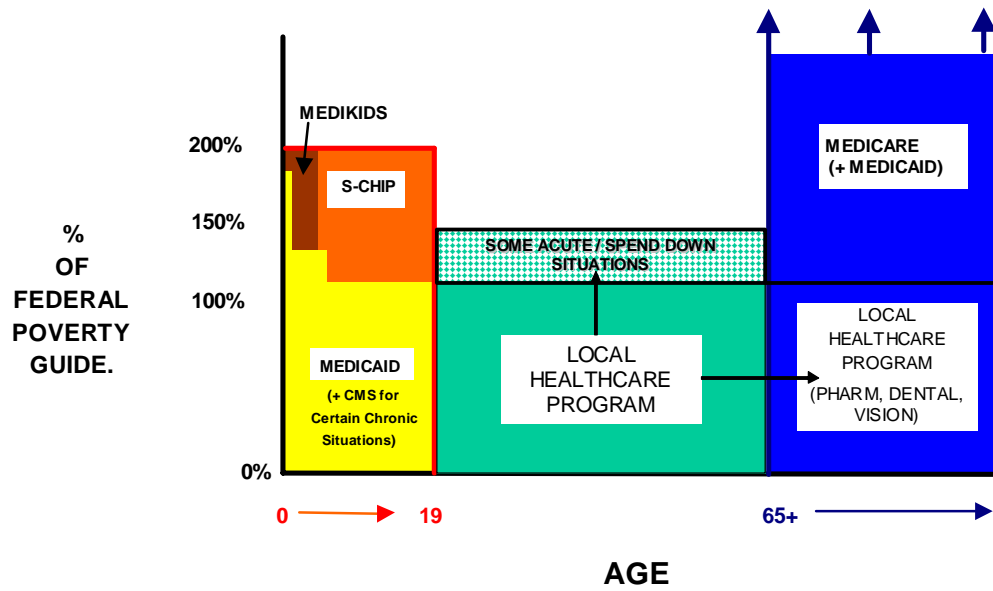
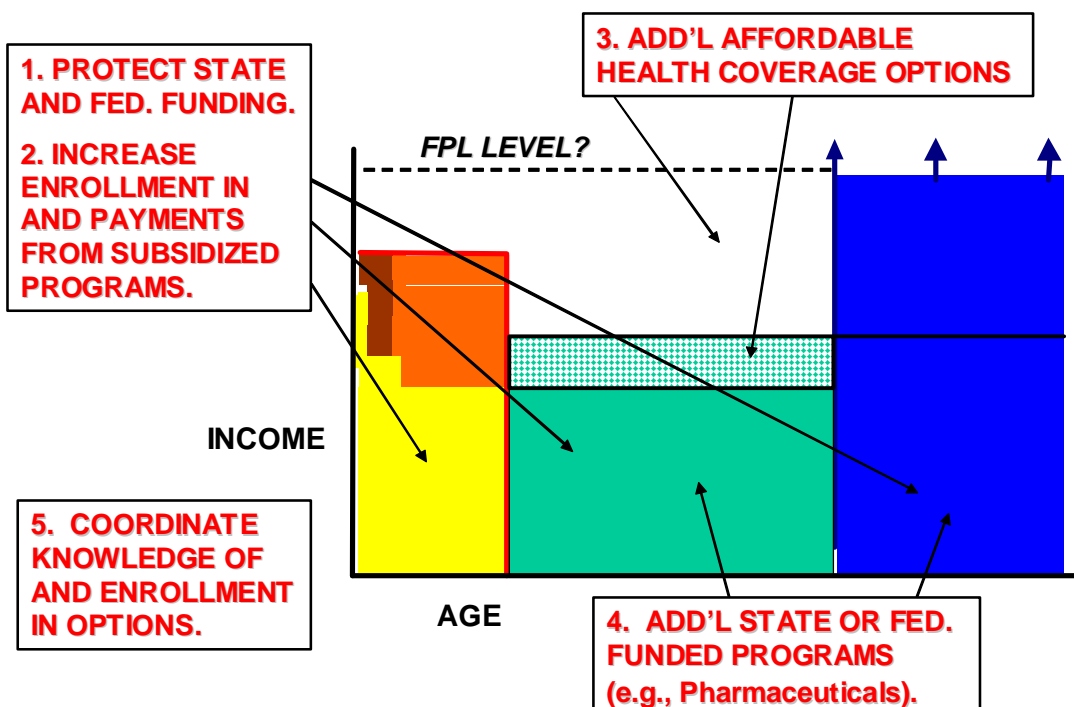


Exhibit 12.

STRATEGIES TO FILL THE GAPS IN HEALTH CARE COVERAGE AND COORDINATION





Appendix

A

Example of a group process to apply the return on community investment concept

While an individual could do the ROCI concept, there is merit to a group discussion of the concept and determination of how the concept can be applied to the specific program

Below is an example of one process that could be used. This process has a facilitator leading a series of meetings to understand the concepts and develop the specific measurements. The facilitator and staff can then implement the measurements identified. This was the process used for numerous locations.

Overall Objective:

The facilitator assists a local program in structuring how it can create a business case for its efforts in improving health care access for the underinsured and reducing health care disparities. This business case will be structured to address the community on the whole and how it would be applied to show individual stakeholders that their expectations have been met. The concept of measuring the return on the community's investment will be used.

Specific Activities

Put together a work plan to measure the return on community investment and how it can be applied to present a business plan for improving health care access for the underinsured and reducing health care disparities. This includes:

- The measurement of the current ROCI.
- A mechanism to repeat the ROCI measurement in the future.
- Identification of the current and future uses of the ROCI measurement including how it can be applied to present a business plan for its efforts in improving health care access for the underinsured and reducing health care disparities.

Identify how staff can complete the data collection or the types of additional technical assistance needed.

The next page presents a general description of the work sessions. The description of the work sessions could be amended as applicable.

DESCRIPTION OF PROJECT MEETINGS

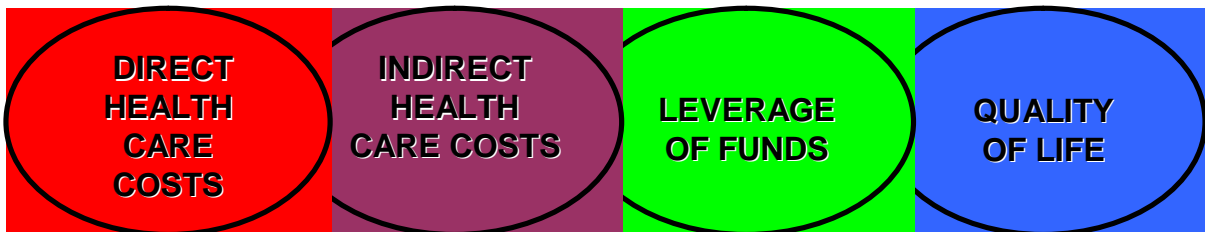
TIME	ACTIVITIES	ACTION	PARTICIPANTS
PROJECT MANAGEMENT PRE-MEETING			
30 Minutes	Clarification of Process and “Last Minute Questions.”	<ul style="list-style-type: none"> • Review schedule. • Other questions. 	<ul style="list-style-type: none"> • Project management • Facilitator
TOTAL = 1/2 Hrs.			
PROJECT OVERVIEW SESSION			
5 Minutes	Meeting Overview / Introductions	<ul style="list-style-type: none"> • Information. 	<ul style="list-style-type: none"> • Stakeholders needed for buy-in. • Key decision makers. • Project management. • Individuals with knowledge of local data sources (Data Commandos). • Facilitator.
55 – 75 Minutes	ROCI Model and the Project: <ul style="list-style-type: none"> • Project overview / goals. • ROCI model and its components. • Obtain input on: <ul style="list-style-type: none"> - Stakeholder expectations. - Project expectations. - Local applicability. 	<ul style="list-style-type: none"> • Presentation. • Discussion. • Agreement on program / service to have ROCI measured. 	
45 - 60 Minutes	Agreement on Objectives to Measure.	<ul style="list-style-type: none"> • Decision 	<ul style="list-style-type: none"> • Board Members • Project management • Facilitator.
TOTAL = 1 1/2 to 2 Hrs.			
WORKSESSION			
5 Minutes	Meeting Overview / Introductions: <ul style="list-style-type: none"> • Agenda overview. • Introductions 	<ul style="list-style-type: none"> • Information. 	<ul style="list-style-type: none"> • Project management. • Board Members (can leave after objectives session). • Individuals with knowledge of local data sources (Data Commandos). • Facilitator.
110 Minutes	Description of work plan: <ul style="list-style-type: none"> • Identification of specific data measurements and sources. • Discuss individual responsibilities and resource to complete project. 	<ul style="list-style-type: none"> • Discussion. • Agreement on: <ul style="list-style-type: none"> --Time schedule. --Responsibilities. --Other logistics. 	
5 Minutes	Wrap-Up	<ul style="list-style-type: none"> • Information. 	
TOTAL = 2 1/2 Hrs.			
PROJECT MANAGEMENT FOLLOW-UP MEETING			
30 Minutes	Project Management	<ul style="list-style-type: none"> • Wrap-up questions. 	<ul style="list-style-type: none"> • Project management • Facilitator
TOTAL = 1/2 Hrs.			



Appendix B

PRESENTATION GRAPHICS EXAMPLES:
ROCI FOR COUNTY PROGRAM EMPHASIZING
INFLUX OF STATE FUNDS

ROCI BENEFITS, 2000



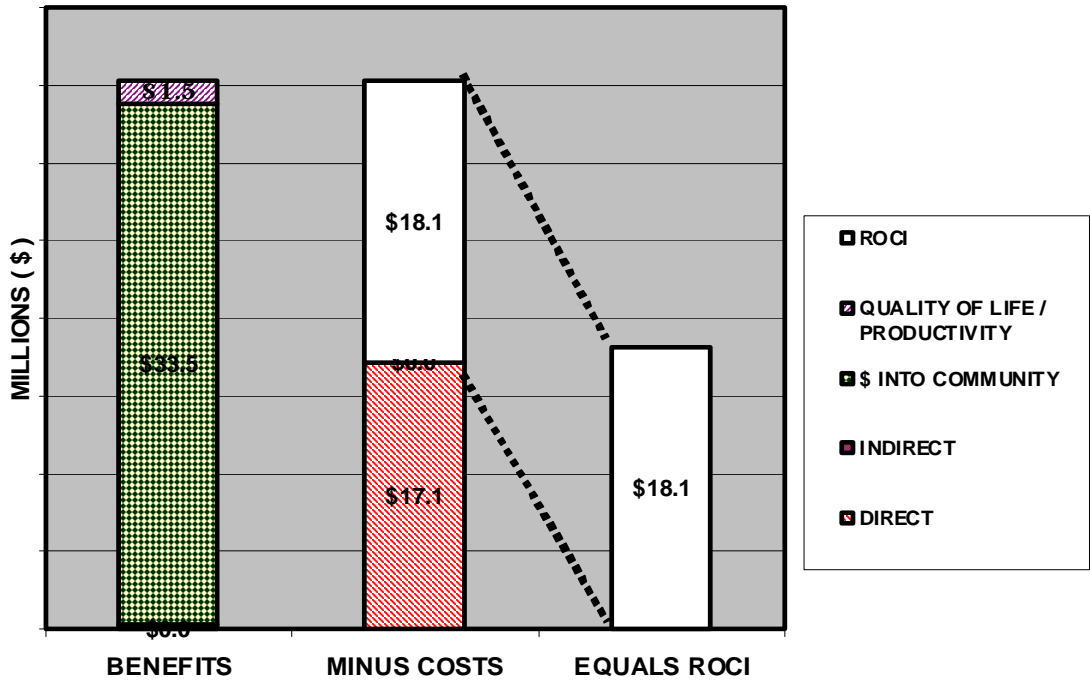
- *This ROCI does not include direct health care cost reduction (to be added.)*

- **Claims processing improvement:**
 - County (\$92,000)
 - Providers (\$230,000)
- *This ROCI does not include indirect cost reduction to other County / Municipal programs (to be added.)*

- **Draw down of State / Fed gov. funds:**
 - State Block Grant and ITP (\$31,691,000)
 - Federal CAP Grant (\$1,800,000)
- (COC econ. impact multiplier included)*

- **Business productivity improvements. (\$1,460,000)**
- *This ROCI does not include value of improving quality of life (to be added.)*

**CONSERVATIVE ROCI FOR YEAR 2000
= APPROX. 2 TO 1**



NEXT STEPS

- **Since current ROCI does not include direct cost savings calculation:**
 - **Implement activities that further actualize direct cost savings.**
 - **Evaluate the direct health costs savings.**
- **Measure indirect cost benefits to other County and municipal programs.**
- **Put in place a mechanism to measure quality of life improvement.**
- **Measure ROCI on an ongoing basis with the above additions.**



Appendix C

Talking Points Format "COUNTY HEALTHCARE PROGRAM"

THE COUNTY HealthCare Program provides access to health care for low-income residents of THE COUNTY who do not have private insurance, Medicaid or Medicare. THE COUNTY PROGRAM emphasizes:

- Primary and preventive care rather than costly emergency room services.
- Integration of health care, social services and workforce programs.
- Partnerships with local hospitals and physicians to provide services.
- Community oversight by the Health Care Advisory Board.
- Stewardship by working with stakeholders and partnering with providers to contain costs, avoid duplication, and leverage other available sources of funds to address the needs of program participants.
- Flexibility and responsiveness to changes in health care delivery.

THE COUNTY HEALTHCARE PROGRAM funds the State required local match for Medicaid payments and the special payment to Tampa General Hospital.

THE COUNTY HEALTHCARE PROGRAM has the support of the X, Y, AND Z HOSPITALS, A AND B COMMUNITY HEALTH CLINICS, as well as the COUNTY Medical Association.

COUNTY residents eligible for THE COUNTY HEALTHCARE PROGRAM are:

- At or below 100% of federal poverty level, i.e., \$8,860 single person or \$15,020 family of three.

- For some diseases, people between 100% and 150% of federal poverty guideline whose expenses for medical services cause them to have net income below 100% of poverty.
- Senior citizens receiving Medicare but needing assistance for prescription drugs, dental, and vision services.

In 2002, THE COUNTY HEALTHCARE PROGRAM served over 31,000 residents by funding 105,123 outpatient visits and 15,268 inpatient hospital days and filled 519,035 prescriptions.

THE COUNTY HEALTHCARE PROGRAM is important to local small businesses. Approximately 70% of those served by THE COUNTY HEALTHCARE PROGRAM are either employed or seeking work. The rest are disabled or on a fixed income.

Impact:

The investment in THE COUNTY HEALTHCARE PROGRAM exceeds expectations.

- Decreased direct health care costs (Over \$44M per year.)
- Strengthened hospitals and physicians by reducing unpaid bills.
- Maximized health care dollars for COUNTY residents by:
 - Increased enrollment and quicker payment from other insurers and Medicaid (\$3M per year).
 - Additional State and Federal reimbursement to hospitals and clinics (\$10M per year.).
 - Earlier federal disability assistance for COUNTY residents (\$3M to \$5M per year.)
- Improved program participants' ability to maintain employment (Value of over \$15M per year.)

Desired Action:

Reauthorization of the enabling legislation on a continuing basis.