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National
Association of
County & City
Health Officials

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"Medicaid Managed Care Arrangements: Local Health Dept and Community and Migrant Health Center Experiences"-Indiana

Medicaid Managed Care Arrangements: Local Health Department and Community and Migrant Health Center Experiences

This is the third in a series of case studies addressing Medicaid managed care. For more information, please contact Robin Shillman Rosenblum at NACCHO.

Locality Description

The following case study addresses Medicaid managed care in Marion County, Indiana, a large, urbanized county which includes the city of Indianapolis and several suburbs. The County's population is about 797,000; the Indianapolis metropolitan statistical area is nearly 1.25 million. Marion County is approximately 77% white and 22% African American; and 1% other; refugee and other ethnic populations are not significant numerically. Approximately 12% of the population is classified as "Below Poverty." The state health agency reports that 14.2% of the County's population is uninsured (1990 estimate), and that as of June 1992, 9.4% were Medicaid recipients*.

The Marion County Health Department is a unit of the Health & Hospital Corporation of Marion County, a municipal corporation directed by a president/executive director and guided by a 7-member Board of Trustees. Three trustees are appointed by the Mayor, two by the City-County Council, and two by the County Commissioners. In addition to the Health Department and a Corporate Headquarters organization, the Corporation includes Wishard Memorial Hospital, the County's public hospital. Wishard Memorial Hospital is managed by the Indiana University School of Medicine.

Site-specific patient services are provided through 31 WIC Program locations; the Adolescent Health Program's comprehensive health center; immunization clinics; 3 school-based clinics; Bellflower Clinic, which provides STD and HIV early intervention services; and the Dental Health Program. The Health Department manages a range of population-based and environmental health programs. Some examples include: HIV/AIDS Prevention; Acute & Chronic Disease Control; Immunization; Public Health Nursing; Health Promotion; Adolescent Health; Dental Health; and the County's community infant mortality reduction initiative. Other programs include: Food Borne Disease Prevention; Housing and Neighborhood Health; Occupational Health; Water Quality and Hazardous Materials Management; and Mosquito, Rodent, and Environmental Control.

*Except as noted, data is based upon 1990 Census information.

In Marion County, there are five community health centers which are federally qualified health centers (FQHCs) and receive Section 330 funding. Barrington, Southeast, and Southwest health centers are administratively linked through HealthNet, an umbrella organization affiliated with Methodist Hospital of Indiana. The two other centers, People's and Citizen's, are administratively independent.

Indianapolis's community health centers and its health department have developed and maintained a strong, collaborative relationship. Examples of joint, complementary efforts include: care coordination; immunization follow-up; coordination of HIV early intervention activities through the Ryan White III(b) project; the development of a health department-health center immunization data network. The Indiana Primary Health Care Association (IPHCA) has been instrumental in developing and nurturing this collaboration, and has played a particularly vital role in managed care development through its training activities and through identifying and coordinating action on issues affecting the community care infrastructure. Finally, the health centers have actively collaborated in the application for homeless initiative funding (the program is currently administered by People's).

I. Description of State Level Medicaid Managed Care

Indiana initiated its Medicaid managed care program, Hoosier Healthwise, in 1993, through a 1915(b) waiver. Indiana has officially defined the purpose of the program as follows: (1) to increase access to primary and preventive care services; (2) to improve access to all health care services; and (3) to encourage continuity and appropriateness of health care services. Hoosier Healthwise is mandatory for Medicaid recipients who receive cash assistance through AFDC and pregnant women and children whose family incomes are at or below 150% of the Federal poverty level.

Hoosier Healthwise enrollees may choose between participation in one of the program's two separate delivery systems: Primary Care Case Management (PCCM), and Risk-Based Managed Care (RBMC). See Attachment A for information on these managed care models.

PCCM

Marion County was among eight pilot counties in which PCCM was implemented in July, 1994; the balance of Indiana's counties will be added to the program during 1995 and 1996. Physicians participating in PCCM are reimbursed under the existing Indiana Medicaid fee-for-service schedule and receive a $3-per-month gatekeeping fee for each enrolled recipient.

RBMC

HMO contracts for the RBMC network have been awarded for the northern, central, and southern regions of the state. One HMO was selected to administer the program

for the central region, which includes Indianapolis. Recipient enrollment was initiated in January of 1995. The State has subcontracted management information services and enrollee education (benefits advocacy).

The RBMC provider network is administered by private managed care organizations (MCOs) which enter an "at-risk" contract with the State; the program is fully capitated. The MCOs provide service through a network of primary care and multi-specialty physicians, dentists, pharmacists, and transportation services and arrange all Medicaid-covered services for recipients. RBMC contractors must be Federally-licensed health maintenance organizations (HMOs).

Finally, provider entities such as FQHCs, health department primary care clinics, and out-patient departments are eligible to participate in Hoosier Healthwise if they meet certain physician coverage requirements, such as providing a certain number of physicians, and offering 24-hour coverage, including weekends. With the exception of provisions allowing FQHCs reasonable cost-based reimbursement under PCCM, no additional special provisions for local health departments or health centers have been included in Indiana's Medicaid managed care initiative.

II. The Local Health Department and Community Health Centers Before Medicaid Managed Care Participation

1994 data describing service utilization, patient population characteristics, primary care and enabling services, and funding sources for the Health Department and Section 330 community health centers are attached (see Attachments B, C, D). On an aggregate level, Indianapolis's community health centers are located throughout the inner city and their widespread placement is reflected in diverse race/ethnicity user data. In 1994, age categories served were generally consistent among centers. Two-thirds to 90% of patients were "at or below poverty," approximately one-half were Medicaid beneficiaries, and Medicaid reimbursement accounted for one- to two-fifths of health center funding.

Health Department funding information is also attached. Please see Attachment E.

III. Process of Becoming Involved In Managed Care Arrangements

Coordination of interests between the Health Department and health centers during the development of Indiana's Medicaid managed care program has been continuous. This relationship has been supported through a variety of collaborative activities. For example, prior to the initiation of the PCCM program, the IPHCA sponsored training programs for health center staff which Health Department personnel also attended. Health Department personnel also participated in a managed care work group coordinated through IPHCA, and participated in managed care discussions with the State Medicaid and health agencies. Finally, the Health Department Director and health center directors maintained communications on strategic and tactical matters

during development of the County's Medicaid managed care program and the contract negotiation process.

The development and implementation of the risk-based program during 1994 significantly affected the position of the health centers relative to each other. The managed care organization designated as the sole administrator for Medicaid managed care in Marion County was developed as a cooperative venture of three independent and competitive hospital systems. The health centers affiliated with different hospitals, and as a consequence, became positioned in different vertically integrated networks.

While the most significant negotiations were dominated by participating hospital delivery systems, the Health Department Director and health center directors were actively involved in MCO leadership discussions, and Health Department and health center staff participated in MCO development committees. Contract negotiations required approximately eight months, and while periodic consultation occurred between the Health Department and health center directors, each organization negotiated contracts independently. Two centers are receiving technical assistance in this process through the Bureau of Primary Health Care, Health Resources and Services Administration.

The implementation of the risk-based program and the development of the MCO accelerated the Health Department's process of redefinition. For example, the importance of asserting the Health Department's essential functions of assessment, evaluation, and assurance was reemphasized through the recognition that the transition to managed care could significantly impact the community care infrastructure. The importance of these functions was also reemphasized by the identification of opportunities for improving community health status through improving provider preventive services delivery.

MCO development also stimulated the Health Department to begin reassessing and reconfiguring direct patient services in market terms: (1) those which are traditionally seen as reimbursable within the managed care network (dental and adolescent services, for example, for which contracts or agreements have been developed), or (2) those -- like STD clinic services and TB therapy -- for which network coverage should be available through the public health approach offered by the Health Department. Regarding the latter, new marketing plans emphasizing community *and* network value must be developed, so that local public health may continue to offer such services to the community and receive reimbursement.

The Health Department experienced a significant barrier in the evolution of the managed care organization because of its corporate alignment with the County hospital, which, in affiliation with Indiana University Hospital, was one of the three partnering hospital delivery systems. This organizational linkage initially resulted in the association of the Health Department with one of the three competing participating networks. It also limited the number of assignments to the committees which were established to guide managed care organization development, and compromised the independent

promotion of public health principles and community care needs in managed care design.

This barrier was overcome through efforts directed toward increasing the visibility of public health principles and concepts. This included the persistent and assertive advocacy of the Health Department Director, who stressed the importance of public health in managed care during meetings with hospital directors/CEOs and MCO directors. Intensive Health Department staff efforts also helped to create a coordinating role in the development of the MCO's quality assurance program and its prevention activities. Current emphases include:

- implementing enrollee behavioral risk-factor identification and referral for intervention;
- creating uniform prevention-related practice standards across Medicaid managed care providers;
- implementing a uniform preventive services assessment instrument supporting linked evaluation of preventive guidelines utilization, preventive guidelines effectiveness, patient outcome, and community health status within participating delivery systems; and
- directing the community health promotion resources of each of the three hospital systems into one coordinated community health education program.

IV. Description of the Local Health Department and Community Health Centers as Medicaid Managed Care Participants

Within the PCCM framework, the Health Department submits claims for lead testing (laboratory), immunization (injection administration), adolescent primary and prenatal care and related mental health counseling, dental services, selected school-based health services, and family planning services. The Health Department's direct participation in the risk-based program is currently limited to dental services, though participation by its adolescent health center is being sought.

Covered services provided by the health centers include primary and preventive physician services, laboratory and x-ray, EPSDT, and dental services. Protocols for referral between health centers have not been established, though it is anticipated that referral practice will not be extensive as a consequence of the centers' alignments with competing delivery systems.

Referrals to the Health Department for non-reimbursable services such as public health nursing have continued, with the Health Department absorbing the cost. The role of the Health Department in quality assurance and the development of preventive services has been previously described.

Little information on the enrollee population and its characteristics is available from the State Medicaid program at this time. In Marion County, as of March 15, over 25,000

clients were reported to have been enrolled in PCCM and approximately 12,000 were participating in RBMC. The State has informed the MCO that approximately 92,000 clients will be enrolled in both managed care programs by the end of 1995. No provider-specific data within delivery systems is currently available.

Because of its recent implementation and significant delays in reimbursement which have developed at the state level, the impact of Indiana's Medicaid managed care program on Health Department and health center funding cannot be accurately assessed at this time. As patient enrollment in PCCM-like programs -- which reimburse on a fee-for-service basis -- declines, more patients will become part of risk-based programs, as is common in today's health care environment. In such a climate, it is of even greater importance that local health departments be able to market their services as reimbursable through managed care organizations. Otherwise, health departments run the risk of absorbing more of the cost of care to risk-based patients, affecting their financial viability.

In Marion County, targets for marketing public health services are the three hospital systems. The Health Department Director has been working individually with the medical directors of each hospital to emphasize the value of reimbursing for certain local health department services. Primarily, the Health Department has focused on marketing such nursing services as postpartum follow-up currently reimbursable under Medicaid.

Elements of the PCCM program which have adversely affected the health centers can be identified. For example, significant cash-flow problems for the health centers have developed because billing is currently based on codes which, even with an additional monthly "settlement," do not cover all FQHC services.

V. Experienced and Predicted Impact of Medicaid Managed Care Arrangements on the Medicaid Population

Assessment data of the ability of patients to access services and information on the quality of care provided enrollees is not available. Anecdotal information suggests that many Medicaid recipients are receiving less than adequate orientation by welfare department-associated benefit advocates, do not understand the implications of auto-assignment of patients to providers, and are confused about accessing services. Numerous instances of patients returning to providers where they previously obtained services (although they have been auto-assigned elsewhere) have been reported. Several recent informal surveys suggest that inappropriate emergency room utilization has not notably decreased.

The public health implications of Medicaid managed care in Indianapolis are significant.

(1) The transition to a managed care environment is stimulating the Health Department to redefine its mission and goals in the context of ensuring necessary and essential public health functions and is providing new opportunities to shift resources previously associated with patient care to population-based initiatives.

(2) Medicaid managed care is also providing opportunities to impact substantially on community health status through standardizing utilization of clinical preventive services, provider behavioral risking and referral, and implementing standardized quality assurance tools across delivery systems.

(3) Other opportunities include enhancing the coordination and effectiveness of community health promotion efforts.

(4) The health centers have new incentives to increase their competitiveness, improve responsiveness to client needs, and develop new and alternative funding sources -- all critical to ensuring the long-term viability of the community care infrastructure.

Problematic areas include:

(1) negative impact on health status associated with the potential unwillingness of network delivery systems to provide preventive services for which short-term cost-savings are unlikely or unsubstantiated;

(2) reduced access to care associated with reduction or elimination of enabling services, such as outreach;

(3) reduced quality of care associated with gaps between negotiated rates and the cost of providing services to populations with exceptional needs;

(4) access issues associated with the long-term commercial viability of providers located in medically underserved areas; and

(5) the financial capacity of the Health Department, health centers, and others to continue to provide population-specific services which have not been "carved out" from state managed care contracts (i.e., providing services in homeless shelters to recipients assigned to other providers).

Several Health Department Director-specific concerns have also emerged during Indianapolis's managed care transition process. Avoiding the appearance of conflict of interest and simultaneously promoting the Health Department as a neutral organization with an exclusively population-based agenda is proving challenging because the Health Department Director (as a School of Medicine faculty member and practicing university-based physician) is also a member of a participating provider network. (This conflict-of-interest issue may also arise in the course of developing health department-directed community health assessment projects utilizing "proprietary" data generated by hospitals other than those with which the Health Department Director is affiliated.) In addition, the Health Department Director's flexibility in reducing or eliminating less essential and costly direct patient services is to some degree being hindered by the perception that one must be a managed care provider to credibly negotiate managed care issues.

VI. Conclusion and Recommendations

A number of improvements in Medicaid managed care arrangements can be suggested based on the Indianapolis experience. For example, provisions should be made for the management of patients returning for care who have been auto-assigned to other providers. In addition, support of categorical and special population initiatives (examples include homeless, outreach, and school-based services) should be negotiated independently of capitation, and assurances should be obtained that reimbursable case management services will not be capped on a per-member basis.

A number of additional recommendations should be considered in the context of state-level policies and procedures (given the opportunity of health centers and health departments to influence Medicaid program design). In retrospect, involving providers *in addition to carriers* in the program design process and nurturing an environment of trust and mutual respect between the state agency and program partners appears to be absolutely necessary for adequate planning to occur. Obviously, every effort should be made to ensure that policy, enrollee education, and data support (including claims processing) are fully coordinated, and stops should be triggered by failures detected in coordination indicators.

In addition, disenrollment should be restricted (allowing for appeals and errors in auto-assignment) for a minimum of six months to support continuity of care and provider recovery of up-front costs. Finally, the advantages of developing guidance prior to program initiation that addresses the potential role of providers in enrollee orientation and education should be assessed. Some evidence suggests that hospital-based education and enrollment services -- particularly when linked to efforts by community-based organizations -- can be effective in preventing interruptions in care, particularly when the enrollee wishes to continue with his/her current provider, and that provider-based education can be done in a way that maintains the state "choice" requirements.

Additional roles and recommendations for the local health department and community health centers may include:

(1) encouraging state health agency development of preventive and primary care standards of practice for managed care organizations, and related recommendations addressing the linkage of those standards to measures of access and quality;

(2) fostering collaborative educational and advocacy efforts between state public health associations and state primary care associations; and

(3) developing cost-effectiveness data on enabling services.

Finally, local health departments should specifically assert central roles in:

(1) the development and management of data systems supporting efficient assessment of quality, access, and the relationship between delivery system performance and community health status;

(2) advocating for health centers and the community care infrastructure with the state Medicaid agency; and

(3) communicating how public health is both complementary and independent of provider networks participating in Medicaid managed care arrangements.

NACCHO would like to thank Dr. Virginia Caine, Director; and Robert Jones, Senior Policy Analyst, Marion County Health Department (IN), for preparing this case study.

Attachment A

RISK-BASED MODELS AND THE PRIMARY CARE CASE MANAGEMENT MODEL

In Medicaid managed care risk-based models, providers assume partial or full financial risk for the services they provide. Providers are reimbursed a capitated, predetermined payment per enrollee for some or all of the services provided. The payment is based on the projected costs of treating a patient. If actual treatment costs exceed the prepayment amount, the provider must absorb the cost. Two types of risk-based plans are partially and fully capitated plans.

In partially capitated plans, the provider receives a predetermined, fixed payment for a limited set of services, including no more than two ambulatory services, while other services are reimbursed on a fee-for-service basis. Therefore, the provider is not at financial risk for all services provided.

Fully capitated plans reimburse a fixed amount for all services provided, placing the provider at full financial risk. The provider absorbs the loss if the provider's expenses exceed the capitated payment. If the provider's expenses are less than the capitated payment, the provider retains the surplus.

Like risk-based models, the primary care case management model of Medicaid managed care controls the care of patients through an assigned primary care provider. The provider is responsible for managing a patient's access to care through the use of prior authorizations, patient referrals, and the direct provision of care. The provider is reimbursed on a fee-for-service basis, is not at risk for the services provided, and is usually provided a monthly case management fee for each enrollee. The fee is intended to serve as an incentive for providers to treat Medicaid recipients and provide compensation for the gatekeeper role they perform.

Source: "In Brief: Health Policy Studies," National Governors Association, October 21, 1993.

HEALTHNET

3401 E. Raymond Street
Indianapolis, Indiana 46203
(317) 781-4918

- **TARGET AREA:** Census Tracts in Southeast, Southcentral and Southwest Marion County
- **MUA/HPSA STATUS:** All Centers in MUAs; Southeast and Southwest in HPSA; Southeast a Dental PSA
- **TARGET POPULATION:** Poor, near poor and medically underserved

1994 USER DATA

RACE AND ETHNICITY

	#	%
WHITE, NON-HISPANIC	14,328	82.68
BLACK, NON-HISPANIC	2,562	14.78
HISPANIC, ALL RACES	281	1.61
AM. INDIAN, ETC	12	0.07
ASIAN/PACIFIC IS.	167	0.96
TOTAL	17,330	100.00

AGE

	#	%
0 - 14	6,306	36.39
15 - 19	1,356	7.82
20 - 44	6,896	39.79
45 - 65	1,880	10.85
65+	892	5.15
TOTAL	17,330	100.00

INCOME

	#	%
AT/BELOW POVERTY	9,991	57.65
101-150% POVERTY	2,382	13.74
151-200% POVERTY	793	4.58
200% + POVERTY	4,164	24.03
TOTAL	17,330	100.00

INSURANCE

	#	%
MEDICAID	8,032	46.35
MEDICARE	1,126	6.50
OTHER	2,262	13.05
NONE	5,910	34.10
TOTAL	17,330	100.00

FUNDING SOURCES

U.S. P.H.S., §330	1,555,740	30.28
MEDICAID	1,968,904	38.37
OTHER FEES	1,101,053	21.43
STATE FUNDS	144,543	2.81
LOCAL FUNDS	350,146	6.81
TOTAL FUNDS	5,138,385	100.00

OTHER

TOTAL USER POPULATION:

COMMUNITY: 17,330

TOTAL CLINIC SITES: 3

SERVICES PROVIDED

- PRIMARY AND PREVENTATIVE CARE
- PREVENTATIVE DENTAL
- PODIATRY
- SCHOOL HEALTH CLINICS
- CLINICAL COUNSELING
- DIAGNOSTIC LAB & X-RAY
- HIV TESTING AND EARLY INTERVENTION
- PRENATAL CARE COORDINATION ("BIBS")
- MIDWIFERY PROGRAM
- COMMUNITY OUTREACH/ADVOCACY
- EXTENSIVE HEALTH EDUCATION SERVICES
- CHILD ABUSE & NEGLECT PREVENTION PROGRAM
- SUBSTANCE USE PREVENTION PROGRAM ("HOPE")
- MEDICAID ELIGIBILITY DETERMINATION
- REFERRALS TO HOSPITALS AND SPECIALISTS
- TRANSPORTATION

Attachment C

PEOPLE'S HEALTH CENTER

2340 E. Tenth Street
Indianapolis, Indiana 46201-2097
(317) 633-7360

- **TARGET AREA:** Near east side Indianapolis and Indianapolis homeless
- **MUA/HPSA STATUS:** HPSA, MUA and Dental PSA
- **TARGET POPULATION:** Poor, near poor, medically underserved, homeless

1994 USER DATA

RACE AND ETHNICITY

	#	%
WHITE, NON-HISPANIC	8,013	68.84
BLACK, NON-HISPANIC	3,202	27.51
HISPANIC, ALL RACES	353	3.03
AM. INDIAN, ETC	35	0.30
ASIAN/PACIFIC IS.	37	0.32
TOTAL	11,640	100.00

AGE

	#	%
0 - 14	4,534	38.95
15 - 19	969	8.32
20 - 44	4,550	39.09
45 - 65	1,214	10.43
65+	373	3.20
TOTAL	11,640	100.00

INCOME

	#	%
AT/BELOW POVERTY	10,512	90.31
101-150% POVERTY	1,128	9.69
151-200% POVERTY	0	0.00
200% + POVERTY	0	0.00
TOTAL	11,640	100.00

INSURANCE

	#	%
MEDICAID	3,608	31.00
MEDICARE	652	5.60
OTHER	710	6.10
NONE	6,670	57.30
TOTAL	11,640	100.00

FUNDING SOURCES

U.S. P.H.S., §330/340	1,272,789	27.35
MEDICAID	1,221,033	26.76
OTHER FEES	991,808	30.92
STATE FUNDS	27,151	0.59
LOCAL FUNDS	632,581	13.86
TOTAL FUNDS	4,145,270	100.00

OTHER

TOTAL USER POPULATION:	TOTAL CLINIC SITES:
COMMUNITY: 9,372	COMMUNITY: 1
HOMELESS: 2,268	HOMELESS: 13
	SCHOOL BASED: 1

SERVICES PROVIDED

- PRIMARY AND PREVENTATIVE CARE
- PREVENTATIVE DENTAL
- PODIATRY
- DIAGNOSTIC LAB
- PHARMACY
- REFERRAL TO HOSPITALS AND SPECIALISTS
- CONFIDENTIAL HIV TESTING
- FAMILY PLANNING/WALK-IN PREGNANCY TESTING
- HEALTH EDUCATION
- MEDICAID ELIGIBILITY DETERMINATION
- WALK-IN IMMUNIZATIONS
- TEEN HEALTH CARE SERVICES
- CRISIS COUNSELING

CITIZENS HEALTH CORPORATION

1650 N. College Avenue
Indianapolis, Indiana 46202
(317) 924-6351

- **TARGET AREA:** Sixteen Census Tracts in Central Indianapolis
- **MUA/HPSA STATUS:** Both
- **TARGET POPULATION:** Low-Income persons

1994 USER DATA

RACE AND ETHNICITY

	#	%
WHITE, NON-HISPANIC	1,039	12.21
BLACK, NON-HISPANIC	7,372	86.63
HISPANIC, ALL RACES	74	0.87
AM. INDIAN, ETC	0	0.00
ASIAN/PACIFIC IS.	25	0.29
TOTAL	8,510	100.00

AGE

	#	%
0 - 14	2,469	29.01
15 - 19	671	7.88
20 - 44	3,714	43.64
45 - 65	1,052	12.36
65+	604	7.10
TOTAL	8,510	100.00

INCOME

	#	%
AT/BELOW POVERTY	7,488	87.99
101-150% POVERTY	596	7.00
151-200% POVERTY	256	3.01
200% + POVERTY	170	2.00
TOTAL	8,510	100.00

INSURANCE

	#	%
MEDICAID	3,776	44.37
MEDICARE	484	5.69
OTHER	633	7.44
NONE	3,617	42.50
TOTAL	8,510	100.00

FUNDING SOURCES

U.S. P.H.S., §330	385,682	18.02
MEDICAID	379,827	17.75
OTHER FEES	731,551	34.18
STATE FUNDS	0	0.00
LOCAL FUNDS	642,992	30.05
TOTAL FUNDS	2,140,052	100.00

OTHER

TOTAL USER POPULATION:

COMMUNITY: 8,510

TOTAL CLINIC SITES: 1

SERVICES PROVIDED

- PRIMARY AND PREVENTATIVE CARE
- PREVENTATIVE DENTAL
- OPTOMETRY
- PODIATRY
- URGENT MEDICAL CARE
- DIAGNOSTIC LAB & X-RAY
- PHARMACY
- ON-SITE WIC SERVICES
- PRENATAL CARE
- NUTRITIONAL COUNSELING/WEIGHT REDUCTION
- CARE COORDINATION
- HEALTH EDUCATION
- FAMILY PLANNING
- PSYCHOLOGICAL SERVICES
- AIDS COUNSELING
- HIV TESTING & EARLY INTERVENTION

Attachment E

Marion County Health Department
Total Health Department Budget by Source
(Excluding Grants)

Taxes	$16,932,468
Licenses and Permits	$1,264,470
Intergovernmental	$531,855
Charges for Services Medicaid Other	$246,497 $84,670 $161,827
Miscellaneous	$120,777
TOTAL	$19,096,067