Workgroup Explore Equitable Access to Primary Health Care for all Prince George's County Residents
Minutes
April 9, 2025

- Members Present

Wala Blegay, Council Member, Chair
Tiffany Hannon, Chief of Staff, Office of Vice Chair Oriadha
George Escobar, Chief of Programs & Services**,** CASA (nonprofit)
Sharon Zalewski, Executive Director, Regional Primary Care Coalition
Caitlin Murphy, Associate Director, Health & Wellness Division, Health Department
Monique Powell-Davis, MD, FACOG, Chief Medical Officer, Mary's Center
Suyanna Barker, Chief Program Officer, La Clinica del Pueblo
Miriam Hauser, VP of Behavioral Health (Mental Health)
Nick Venturini, Director of Benefits Section**,** Prince George's County Schools
Roxanne Leiba Lawrence, VP, Primary Care & Community Medicine, Luminis Health
Stephanie Slowly Little, MSW, LCSW-C, Chief of Health Policy and Innovation, Office of the Health Officer
Terra Bynum, Office of Management and Budget
Dr. Diane Young, PhD, MS, RN, Associate Director, Family Health Services Division, Health Department
Ryan Smith, Sr., Director of Administration**,** Greater Baden Medical Services

- Members Absent:

Richard Gesker, Interim CEO, Mary's Center
Wanika Fisher, Council Member
Bradford Seamon, VP of Government and Public Affairs for Prince George's County, UMD System
Sonya Bruton, CEO, CCI Health and Wellness
Elana Belon-Butler, Director, Department of Family Services

- Others Present:

Leslie Graham, Chief Executive Officer, Primary Care Coalition

- Staff Present

Sandra Eubanks, HHSPS Committee Director
Rhonda Riddick, HHSPS Committee Aide
Leroy Maddox, Legislative Attorney
Anya Makarova, Senior Advisor to the Board of Health
Ayana Crawford, Council Member Wala Blegay's Office

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Nikia McBride, GOFP Committee Aide

Welcome & Opening Remarks

Chair Blegay called the meeting to order at approximately 1:35 p.m., proceeded with the roll call, and acknowledged the planned discussion topics.

- **Consideration of Minutes**

The minutes were approved.

- **Presentation**: Sharon Zalewski, Executive Director, Regional Care Coalition
  Leslie Graham, President & CEO, Primary Care Coalition

Ms. Sharon Zalewski provided an overview comparing the healthcare landscapes of Prince George's County and Montgomery County. She mentioned that she has extensive experience working in both counties. She emphasized that no one-size-fits-all approach works for health programs targeting uninsured populations due to key differences between jurisdictions.

The discussion centered on budget disparities. Montgomery County has a larger overall budget, at $7.7 billion, compared to Prince George's County's $5.8 billion. This financial gap is reflected in each county's investment in health and human services—7.2% of the budget in Montgomery versus just 1.1% in Prince George's County.

Ms. Zalewski further explained that Prince George's County has more federally designated Medically Underserved Areas (MUAs), enabling the presence of six Federally Qualified Health Centers (FQHCs). In contrast, Montgomery County has only two MUAs, so it is not an FQHC-rich environment. Instead, it relies on a centralized system like Montgomery CARES, a well-established program with dedicated resources and infrastructure. In contrast, Prince George's County operates Health Assures, a relatively new, underfunded program with limited administrative capacity and no budget for supportive services or coordination.

Ms. Zalewski noted that there are also significant differences in healthcare infrastructure. Prince George's County has four hospitals but lacks comprehensive school-based health centers, while Montgomery County has five hospitals and 16 school-based centers. Programs for uninsured children differ in scale and scope: Prince George's County relies on slots provided by Kaiser, whereas Montgomery's Care for Kids program has broader provider networks integrated with its school-based centers. Furthermore, Prince George's County lacks a homeless health initiative, which Montgomery funds directly.

Additionally, comparisons included the availability of veteran outpatient services in both counties and notable federal health institutions, such as the NIH and Bethesda Naval Hospital in

Montgomery County, versus the University of Maryland Academic Health Center in Prince George's County.

Ms. Zalewski emphasized the disparity in access to primary care physicians, noting that Prince George's County has about one primary care physician for every 2,000 residents. In comparison, Montgomery County has approximately one primary care physician for every 750 residents – a clear indication of the access gap.

Ms. Zalewski also highlighted socioeconomic indicators: while both counties have similar population sizes, Prince George's County has higher poverty rates, more Medicaid participants, and nearly double the number of children living below 250% of the federal poverty level. Uninsured rates, particularly among children, are also higher in Prince George's County, with an estimated 16,000 uninsured children, likely higher than officially reported figures.

Ms. Zalewski provided a budget comparison analysis, highlighting how Prince George's allocates a more significant portion of its budget to public schools and public safety but significantly less to health and human services than Montgomery County. These fiscal and structural differences form the foundation for why different program models and funding approaches are necessary in each jurisdiction.

Ms. Zalewski concluded the presentation by emphasizing that Montgomery CARES, the county's longstanding primary care program for uninsured residents, is the product of two decades of gradual development. She expressed that it did not emerge fully formed but grew organically through ongoing adjustments, lessons learned, and collaborative efforts.

Ms. Leslie Graham, President and CEO of the Primary Care Coalition (PCC) gave a detailed presentation on Montgomery CARES. She clarified that Montgomery CARES is not a health insurance product but rather a county-supported program that provides a network of care for uninsured adults aged 18 and older who meet residency and income criteria. It exists alongside a separate initiative, Care for Kids, which serves over 11,000 children annually and operates with a slightly overlapping provider network.

Montgomery CARES comprises twelve healthcare organizations, only three of which are Federally Qualified Health Centers (FQHCs), distinguishing it from Prince George's County, which has a higher concentration of FQHCs. The participating providers include nonprofit clinics, faith-based organizations, culturally specific services, and a hospital-operated site. Altogether, these groups offer care at over 25 locations across Montgomery County.

Ms. Graham discussed the history and evolution of the program, tracing it back to 1995 when a lack of specialty care access for uninsured patients led to the creation of Project Access, a referral program managed by PCC in partnership with the Montgomery County Medical Society. Recognizing the need for more comprehensive care, PCC also developed a medication access

program, allowing providers to obtain both generic and brand-name drugs, now accounting for nearly $6-8 million annually in prescription support, plus an additional $4.4 million in generic purchasing, including vaccines and diabetic supplies.

As part of the ongoing development of Montgomery CARES, Ms. Graham noted that the program was officially launched in 2005 as a public-nonprofit partnership, building upon existing infrastructure. The county began by contributing funds for medication access in 2003 and expanded its investment over time. The official formation of Montgomery CARES added a visit subsidy model, offering financial support to clinics for patient visits and reducing their need to rely on private fundraising. This was an intentional shift to ensure that these organizations could prioritize delivering health care over sustaining their operations through constant fundraising. The Program's strength lies in its ongoing collaboration between local government and nonprofit providers, adapting to meet the needs of the uninsured sustainably and strategically.

In 2007, as the population of uninsured residents continued to grow, behavioral health was integrated into the program using a collaborative care model. This allowed behavioral health providers to be embedded within each participating Montgomery CARES clinic. Ms. Graham expressed that at the same time, a clinical quality program was introduced to monitor and improve care delivery, using data measured against HEDIS standards due to the program's unique structure outside the traditional FQHC framework.

Ms. Graham noted that by 2013, the program had adopted a shared electronic health record system, eClinicalWorks, to enhance provider coordination and consistency. In 2017, additional operational standards were established, including requirements for provider responsibilities, co-pay guidelines, and sliding fee scales, to bring more significant equity and standardization across the participating organizations.

Ms. Graham then shared data showing the program's growth. From its launch in 2005, Montgomery CARES saw consistent increases in patients served and healthcare visits until 2013, when the Affordable Care Act expanded Medicaid access. This caused a temporary decline in the number of uninsured individuals in the program. Ms. Graham indicated that the visits and enrollment rose again before dropping due to the COVID-19 pandemic, followed by renewed and rapid growth. In FY24, nearly 70,000 visits were recorded for around 25,000 unduplicated patients, and projections for FY25 are even higher, with around 77,000 encounters expected.

Ms. Graham clarified that Montgomery CARES is not an enrollment-based program. Instead, the health centers "deem eligible" patients based on income and residency documentation, with PCC providing training, documents, and audit support to maintain quality control.

Addressing the financial component of the Montgomery CARES program, Ms. Graham explained that the current encounter rate, the amount the county pays health centers per visit, is

$102.50 as of the current fiscal year. That amount only covers about 45% of the actual average cost of a visit. Ms. Graham expressed that this funding balance has shifted unfavorably over time, with nonprofits now carrying a much greater share of the financial burden. She emphasized that efforts are underway to restore balance.

Ms. Graham highlighted the PCC's broader role in supporting the Montgomery CARES network. Beyond coordination, PCC secures grant funding for programs that enhance the quality of services, such as cancer screenings and other quality improvement initiatives.

PCC also operates several centralized support programs. Ms. Graham emphasized that one of the most significant is the MedBank Prescription Assistant Program, which secures between $6 million and 8.5 million annually in brand-name medications. These medications are distributed directly to patients through the participating clinics.

In addition, PCC coordinates group purchasing of about $1.4 million of medications annually, ensuring lower costs through pooled procurement. This model is essential in Montgomery County, where many participating providers are not FQHCs and lack access to the federal 340B drug pricing program.

Regarding specialty care access, Ms. Graham noted that the county contributes about $480,000 annually to specialty services. PCC supplements this amount by facilitating an additional $1 million or more in donated (pro bono) specialty care through its network, further maximizing limited public funds.

Continuing with the presentation, Ms. Graham emphasized that while clinical encounters are the most significant budget component, they are part of a broader financial ecosystem that supports a comprehensive primary care infrastructure. This includes behavioral health and on-site specialty services, funded through the $102.50 encounter rate, and targeted investments in cancer screenings, specialty care, medications, and vaccines.

Ms. Graham described capacity building as a foundational pillar of Montgomery CARES. The program supports the delivery of health services and the long-term sustainability and growth of its provider network. She described how the PCC takes a hands-on role in developing and sustaining the care network, which includes primary care and specialist networks, imaging services, and a shared electronic health record system.

Ms. Graham noted that part of PCC's contribution is its behavioral health integration work. PCC deploys a team of 11 behavioral health staff directly into clinics. These staff help deliver collaborative behavioral health care, embedding services in the primary care setting. PCC also conducts program-wide data analysis.

Lastly, Ms. Graham acknowledged the County Council's crucial role in this ecosystem. The Council listens to the community and providers, determines whether additional or supplemental funding is warranted, and responds to the program's evolving needs. Ms. Graham's closing remarks were that together, these partners form a 20-year-old, deeply integrated network designed to support uninsured residents with high-quality, community-based care.

- Q & A

The discussion focused on the structure, administration, and community awareness of the Montgomery CARES program. The PCC administers the program, which includes 12 nonprofit healthcare providers contracting with the PCC to deliver services to eligible patients. These organizations serve Montgomery CARES patients and others and submit monthly invoices for reimbursement based on eligible patient encounters.

It was clarified that uninsured residents typically access services through these nonprofit health centers, which are known in the community via word-of-mouth, outreach by the center, local events, referrals through 311, and behavioral health providers. The health centers often promote themselves as accessible, low-cost care providers, although many patients may not even realize they are part of the Montgomery CARES program. A modest co-pay of up to $35 may be charged.

While Montgomery County does not operate a centralized government-led outreach campaign for the program, it funds three minority health initiatives (Asian American, Latino, and African American Health Initiatives), incorporating outreach about Montgomery CARES into their broader community engagement strategies.

The discussion also touched on the impact of the Affordable Care Act (ACA) and Medicaid expansion. From 2011 to 2013, in preparation for the ACA, PCC worked to ensure all health centers could accept Medicaid, enabling continuity of care for those transitioning to coverage. The PCC collaborated with navigator groups to help uninsured families explore qualified health plans or Medicaid and refer those who didn't qualify to Montgomery CARES or Care for Kids.

It was emphasized that Montgomery CARES is not an insurance product; while it offers robust primary and specialty care, it does not cover hospitalization, oncology, or other high-cost services. Therefore, the program prioritizes helping residents secure Medicaid or other insurance whenever possible.

Questions were raised about how nonprofits engage with the program and whether they receive a set allocation or submit documentation for reimbursement. It was clarified that Montgomery CARES operates as a cost reimbursement program. Participating clinics submit monthly invoices for patients seen the previous month who qualify under the program. An invoicing system is in place, including a quarterly reconciliation process for any claims ineligible for payment. The program functions with its internal claims processing department to manage these transactions efficiently.

The discussion then turned to the scale and funding of the program. While $10 million was cited as the amount dedicated to direct clinical services, covering specialty care, medication, oral health, and general patient encounters, it was said that this figure does not reflect the full scope of the program. Ms. Graham said she would provide the Workgroup with a detailed cost breakdown. Noting that she would exclude components not applicable to Prince George's County.

When asked whether the program reaches the full population of uninsured residents, Ms. Graham explained that while around 30,000 individuals are eligible for services, not all seek care in a year. While not every eligible person uses the program, there is no indication of a large, underserved population being left out. Ms. Zalewski explained that the program's foundation was based on private insurance usage patterns and that understanding continues to guide the program's design and evaluation.

The issue of funding flexibility was addressed. The County Council has been responsive and collaborative, allowing for budget increases when patient encounters exceed projections. This forward-looking approach means the county does not wait for a budget shortfall—instead, data-driven forecasts prompt mid-year adjustments when necessary.

Ms. Graham expressed that at the system's center is a suite of five programs funded under the county's healthcare for the uninsured budget line: Montgomery Cares, Care for Kids, Healthcare for the Homeless, the county's own Dental Program, and the Maternity Partnership Program. This program provides healthcare access to thousands of uninsured and underinsured residents across Montgomery County.

The current investment in these services is estimated to be around $17 to $20 million annually, although the exact amount fluctuates year to year depending on need and budget cycles.

The discussion centered on the historical context and political conditions that enabled this dedicated budget line to exit Montgomery County. Political will and leadership have been identified as key drivers, particularly the County Council members who championed the initiative and played a vital role in securing ongoing funding. Equally significant was the strong response and advocacy from the community.

A question was raised about the operational side of administering healthcare programs for the uninsured in Montgomery County. Specifically, the relationship between Montgomery CARES and the Department of Health and Human Services (DHHS) and how that partnership could serve as a model for Prince George's County.

Ms. Graham responded by explaining that the programs, including Montgomery CARES, operate under the umbrella of Montgomery County DHHS, specifically within the Public Health Service division. While her organization, PCC, contracts with the county to provide services, the relationship extends beyond a simple contractual agreement. It is rooted in strong collaboration. She emphasized that PCC manages operations and partnerships with nonprofit providers and the county because it provides the core funding and retains the authority to set key policies. Ms.

Graham noted that the county's dedication is evident because these healthcare programs are a line item in the core budget, reflecting a long-term institutional commitment.

A question was raised about the funding sources behind the Montgomery Cares Program. Specifically, they inquired whether the program was supported solely by the county's general fund streams, such as fees or other sources earmarked to support it.

Ms. Graham explained that the core funding comes entirely from the Montgomery County general fund, which is supported by property taxes and the county's tax base.

Dr. Diane Young, Health Department, was asked to provide insight on whether the Montgomery Cares model could help improve the current county program. She affirmed that Montgomery Cares' structure mirrored Prince George's proposed design, particularly the principle of money following the patients. However, she emphasized that sustainable funding remains a persistent barrier in Prince George's County.

Another point of discussion focused on the longevity and consistency of the funding. Ms. Graham confirmed that while program components have evolved, such as removing the information and referral component when 311 launched, the core budget for essential services has remained intact and grown with community needs.

Dr. Young was asked if the Health Department was collecting data similarly in Prince George's County to justify annual funding needs. Dr. Young responded, citing the lack of administrative funding and staffing as key limitations. The inability to collect and analyze data impedes the ability to scale or sustain a program like Montgomery CARES.

A question was raised about Montgomery CARE's administrative and operational staffing. Ms. Graham explained that while the PCC has around 20 staff working on the program, most are engaged in programmatic rather than purely administrative tasks.

- **Identify Next Steps:**

Dr. Young was asked to follow up with Ms. Graham for a budget breakdown to explore staffing and operational requirements that could inform Prince George's County recommendations.

The FQHCs were asked to provide programmatic suggestions based on their experience to help improve the county's approach.

- **Future Meeting:**

The next regularly scheduled meeting is on Wednesday, April 23, 2025, at 1:30 PM.

- **Adjournment:**

The meeting adjourned at approximately 3:32 p.m.