

2. Financial Support for Safety Net Services

Background Information

Low-income individuals receive their health care in several ways. Health care services may be provided free or on a sliding-scale basis for uninsured individuals at clinics or health centers whose mission is to serve the low-income population. Hospitals and private doctors' offices may provide reduced-price or free charity care or may write off unpaid medical debts of individuals who cannot afford their services. For individuals covered by Medicaid or a State Children's Health Insurance Program, services may be provided on a fee-for-service basis or through a managed care organization. However, the waiting time for a clinic appointment can be several weeks, doctor's offices and hospitals may limit the amount of charity care they provide, and health care is a significant source of debt for many low-income families.

Financial support for safety net services comes in many forms, from insurance-type reimbursement or managed care arrangements in programs such as Medicaid, to grants that fund Community Health Centers (CHCs), to the distribution of funds from State uncompensated care pools. Additional support may come in the form of personnel, such as clinicians from the National Health Service Corps, or from drug assistance programs. Each of these types of support has a considerable influence on the health care delivery system in a local area, including the types of providers and services available to care for the low-income population.¹⁰

Indicators for determining the *Financial Support of the Safety Net Services*, as suggested by AHRQ, include:

- Medicaid Program Measures
 - Extent of Coverage
 - Percent below 200% FPL enrolled in Medicaid
- Growth in Medicaid
- Disproportionate Share Hospital Funds Per Person Below Poverty
- Relationship Between DSH Payments and Safety Net Performance
- Community Health Center in Area
- Uncompensated Care Pooling
- Prioritizing Need based on the Financial Support for Safety Net Services

Medicaid Program

Medicaid coverage is often associated with slight to moderate decreases in potentially preventable hospitalization rates and negative birth outcomes at both the place/county and MSA levels. The larger the proportion of the low-income population that is covered by Medicaid, the less likely the low-income population is to have access-related problems, including lacking a usual source of care and not having any physician visits; this association is moderate to strong.”¹¹

¹⁰ Book I, Page 18, Chapter 4, Billings and Weinick (2003).

¹¹ Book I, Page 20, Chapter 4, Billings and Weinick (2003).

Extent of Coverage for Medicaid is defined as state-level standardized index of income eligibility levels for the Medicaid program for pregnant women, children, and infants. Table 2.1 provides the current State Fiscal Year (SFY) 2005 program guidelines by federal poverty guidelines.

| Table 2.1: Federal Poverty Guidelines by Program, SFY05* | |
|---|------------------------------|
| Program | Federal Poverty Level |
| Medical Assistance for Families | 75% |
| Medicaid for Pregnant Women | 185% |
| MC+ for Kids (non SCHIP) | |
| Up to age 1 | 185% |
| Age 1 to 5 | 133% |
| Age 6 to 18 | 100% |
| MC+ for kids (SCHIP) | |
| Uninsured children up to age 19 | |
| No cost | 185% |
| \$5 co-pay | 225% |
| \$62 to \$252 monthly premium (No more than 5% of their income), plus \$10 co-pay and \$9 prescription co-pay | 300% |

Source: Family Support Division, Missouri Department of Social Services

The federal poverty guidelines by monthly income rates are provided in Table 2.2.

| Table 2.2: Federal Poverty Guidelines (FPL) | | | | | | |
|---|---------|---------|---------|---------|---------|---------|
| Percent FPL by 2005 Poverty Guidelines (Monthly Income Rates) | | | | | | |
| Family Size | 75% | 100% | 133% | 185% | 225% | 300% |
| 1 | \$599 | \$798 | \$1,061 | \$1,476 | \$1,795 | \$2,393 |
| 2 | \$802 | \$1,070 | \$1,422 | \$1,978 | \$2,406 | \$3,208 |
| 3 | \$1,006 | \$1,341 | \$1,784 | \$2,481 | \$3,017 | \$4,023 |
| 4 | \$1,210 | \$1,613 | \$2,145 | \$2,984 | \$3,629 | \$4,838 |
| 5 | \$1,414 | \$1,885 | \$2,506 | \$3,486 | \$4,240 | \$5,653 |
| * Average TANF grant = \$236/month | | | | | | |
| ** Minimum wage = \$5.15/hour = \$893/month (\$10,716 annually) | | | | | | |

Source: Family Support Division, Missouri Department of Social Services

* These eligibility guidelines are good through April 2006

Based on the coverage guidelines for Medicaid, Table 2.3 provides the number and percent of Medicaid annual enrollment for 2002-2004, by Medicaid category.

| Table 2.3. Medicaid Statistics for the State of Missouri | | | | | | | | |
|--|----------------|--------------|----------------|--------------|----------------|--------------|----------------|--------------|
| Month: May | | | | | | | | |
| Medicaid Category | Year | | | | | | | |
| | 2002 | | 2003 | | 2004 | | 2005 | |
| | Number | % of total | Number | % of total | Number | % of total | Number | % of total |
| MC+ For Pregnant Women | 12,798 | 1.4 | 13,673 | 1.4 | 14,113 | 1.4 | 15,099 | 1.5 |
| Extended Women's Health Services | 13,602 | 1.5 | 9,864 | 1.0 | 9,599 | 1.0 | 10,137 | 1.0 |
| MC+ Family Healthcare | 649,670 | 71.4 | 680,799 | 70.5 | 691,532 | 69.7 | 686,239 | 68.7 |
| Old Age Assistance | 68,681 | 7.6 | 76,939 | 8.0 | 80,436 | 8.1 | 83,084 | 8.3 |
| Permanently and Totally Disabled | 116,121 | 12.8 | 139,040 | 14.4 | 153,293 | 15.5 | 162,641 | 16.3 |
| Assistance for the Blind | 3,786 | 0.4 | 3,807 | 0.4 | 3,804 | 0.4 | 3,792 | 0.4 |
| General Relief | 2,634 | 0.3 | 3,017 | 0.3 | 2,966 | 0.3 | 2,787 | 0.3 |
| Medicare Cost Savings Programs | 18,006 | 2.0 | 13,289 | 1.4 | 10,270 | 1.0 | 8,495 | 0.9 |
| Other Children Eligibility Types | 23,038 | 2.5 | 23,373 | 2.4 | 23,911 | 2.4 | 24,536 | 2.5 |
| Other Eligibility Categories | 1,341 | 0.1 | 1,308 | 0.1 | 1,536 | 0.2 | 2,116 | 0.2 |
| Total for Selection | 909,677 | 100.0 | 965,109 | 100.0 | 991,460 | 100.0 | 998,926 | 100.0 |

Note: This data is provided to CHIME by Missouri Department of Social Services on monthly basis. This point in time data is for the month of May for each of the years 2002-2005

Source: Missouri Information for Community Assessment (MICA) 2002-05, Missouri Department of Health and Senior Services

Percent Below 200% FPL Enrolled in Medicaid Program is defined as the number of individuals under age 65 with family incomes less than 200% FPL enrolled in Medicaid, divided by the number of individuals under age 65 with family incomes less than 200% FPL. Based on the 1999-2001 Current Population Survey, 48% of the state's population with incomes less than 200% FPL were enrolled in Medicaid. Of the total Medicaid enrollees under age 65, 80% were low income (<200% FPL). County level data for this indicator were not readily available.

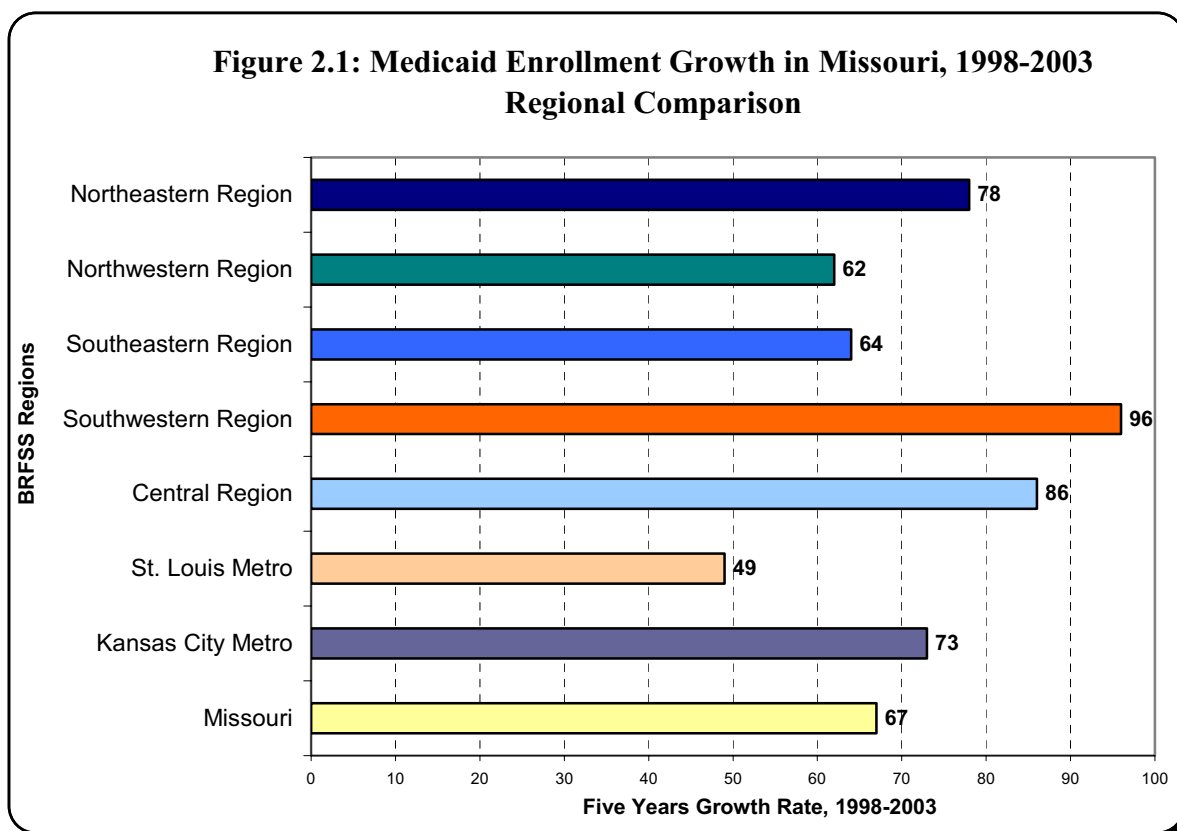
Growth in Medicaid

Regional and county level Medicaid enrollment data for June 30 of the respective year for the years 1998-2003 were provided by the Missouri Department of Social Services and are presented in Table 2.4 and Figure 2.1. The data indicated that there was a 67% growth in the Medicaid enrollment in Missouri between 1998 and 2003. The highest growth was noticed in the southwestern region where it almost doubled (increase of 96%). The growth in Medicaid correlates with the expansion of the State Children's Health Insurance Program (SCHIP) in 1998

as well as the downturn in the economy and loss of jobs, income, and employer-sponsored insurance for many residents.

| BRFSS Regions | Percent of Annual Growth | | | | | 5-Year Growth (%) |
|---------------------|--------------------------|---------|---------|---------|---------|-------------------|
| | 1998-99 | 1999-00 | 2000-01 | 2001-02 | 2002-03 | |
| Missouri | 19 | 11 | 11 | 8 | 6 | 67 |
| Kansas City Metro | 16 | 12 | 13 | 10 | 8 | 73 |
| St. Louis Metro | 13 | 10 | 9 | 6 | 3 | 49 |
| Central Region | 25 | 13 | 13 | 9 | 6 | 86 |
| Southwestern Region | 29 | 13 | 14 | 9 | 9 | 96 |
| Southeastern Region | 22 | 8 | 9 | 7 | 6 | 64 |
| Northwestern Region | 20 | 8 | 10 | 7 | 6 | 62 |
| Northeastern Region | 23 | 11 | 13 | 9 | 7 | 78 |

Source: Missouri Department of Social Services



Calculating the annual and five-year growth rates of Medicaid enrollment can be used to monitor the financial support for the vulnerable population at the county level. The county-level Medicaid growth for the time period 1998 - 2003 is provided in Appendix 2(a).

Disproportionate Share Hospital Funds (\$) per Person Below Poverty

Disproportionate Share Hospital funds are defined as the total Medicare Disproportionate Share Hospital (DSH) payments to hospitals, divided by the number of individuals with family incomes less than 100% FPL. The numerator is from the Centers for Medicare and Medicaid Services and the denominator is based on U.S. Census 2000 Medicaid DSH payments. According to the data provided by AHRQ, for every person in Missouri below 100% FPL, the state received about \$89 in DSH payments in 2001 and that amounts to the total of \$455,068,490. These payments were distributed to health care facilities including hospitals, mental health facilities, and rehabilitative centers. Of the \$455 million received by the state in DSH payment, hospitals received almost \$282 million. For the same time period, hospitals provided almost \$238 million in charity care and accrued over \$500 million in bad debt. The DSH payments received, by hospital and county, for 2001 are provided in Appendix 2(b).

Relationship Between DSH Payments and Safety Net Performance

Based on studies done by AHRQ, there appears to be a slight association between the financial support of the safety net and health outcomes, “with an increasing amount of DSH funds being associated with higher potentially preventable hospitalization rates and higher rates of negative birth outcomes. At the MSA level, increasing DSH payments have a moderate association with more children’s preventable hospitalizations, and a slight to low association with more adult preventable hospitalizations. This finding likely reflects the fact that both significant quantities of uncompensated care (and associated DSH payments) and negative health outcomes are concentrated in areas where low-income populations are disproportionately represented.”¹²

Community Health Center in the Area

This indicator describes the presence or the absence of a federally qualified Community Health Center (CHC) in the area. It is based on the Health Resources and Services Administration, Uniform Data System. In 2004, there were 90 CHCs and satellite clinics, including CHC look alike clinics, in the state. It should be observed that the Community Health Centers, the primary health care access points for the uninsured, are not evenly distributed in Missouri. Although there are 90 CHCs or satellite clinics in Missouri, 74 out of 115 counties are without any.

Since CHCs serve as primary health care providers for the uninsured and the other vulnerable populations, it is important to examine the availability of CHCs in the context of the potential recipients of these services by region. Based on county level uninsurance rates from the Missouri Health Care Insurance and Access Survey (2004), and Medicaid data from the Missouri Department of Social Services, two indicators - the *Number of Uninsured and Medicaid Enrollees* and the *population density of the Uninsured and Medicaid Enrollees* - were computed for the seven regions and are provided in Table 2.5. The second indicator suggested that the two metro regions have a high density of the vulnerable population. The GIS maps for these indicators are included as Appendix 2(c).

¹² Book I, Pages 19-20, Chapter 4, Billings and Weinick (2003).

Table 2.5: Safety Net Support - Federal Qualified Health Centers, 2004

| BRFSS Regions | Number of FQHC/s or Satellite Clinic in the Area | Proportion of Counties Without FQHC/s or Satellite in the Area | Ratio of CHCs to Counties in the Area | Medicaid Enrollment in Missouri, Dec., 2004 | Percent Uninsured Missourians 2004 | Number Uninsured Missourians 2004 | Total Medicaid and Uninsured (Vulnerable Population) | Number and % of Vulnerable Population Served by CHCs 2003 | Density of Vulnerable Population |
|---------------------|--|--|---------------------------------------|---|------------------------------------|-----------------------------------|--|---|----------------------------------|
| Missouri | 90 | 79/115 | 90 in 115 | 1,015,799 | 8.4 | 479,177 | 1,494,976 | 227,827 (15.2%) | 22 |
| Kansas City Metro | 19 | 3/7 | 19 in 7 | 174,858 | 7.9 | 86,838 | 261,696 | 47,656 (18.2%) | 68 |
| St. Louis Metro | 14 | 5/7 | 14 in 7 | 301,864 | 5.8 | 117,835 | 419,699 | 118,606 (28.3%) | 110 |
| Central Region | 5 | 19/21 | 5 in 21 | 122,575 | 9.8 | 66,400 | 188,975 | 11,234 (6%) | 14 |
| Southwestern Region | 7 | 16/21 | 7 in 21 | 168,423 | 10.4 | 87,594 | 256,017 | 7,328 (3%) | 19 |
| Southeastern Region | 22 | 12/25 | 22 in 25 | 158,131 | 11.9 | 66,221 | 224,352 | 25,051 (11%) | 14 |
| Northwestern Region | 12 | 7/13 | 12 in 13 | 39,264 | 8.9 | 21,645 | 60,909 | 10,166 (17%) | 9 |
| Northeastern Region | 11 | 17/21 | 11 in 21 | 50,684 | 13.1 | 33,295 | 83,979 | 7,786 (9%) | 7 |

Sources:

1. Regional uninsurance rates are based on Missouri Health Care Insurance and Access Survey (2004)
2. 2003 population estimates by US Census Bureau are used to estimate the regional numbers of uninsured
3. Medicaid Enrollment data is from Department of Social Services

Uncompensated Care Pooling

This indicator is defined as the presence or absence of an uncompensated care pool in the state. An uncompensated care pool helps finance hospital-based care for uninsured patients by providing financial support to hospitals and other providers to help defray the expenses of uncompensated care. Missouri does not have an uncompensated care pool. Only eight states have this pool: California, Connecticut, Iowa, Maryland, Massachusetts, New Jersey, New York, and Virginia.

Prioritizing Need based on the Financial Support for Safety Net Services

Insufficient data are available on the indicators of financial support for safety net services; therefore, identifying priority counties based on these measures is not appropriate. However, data from this section was taken into consideration when evaluating and prioritizing counties based on the safety net structure and health system context that is described in the next section.