



# Safety Net Assessment November, 2004

prepared for the  
Health Insurance  
for  
Indiana Families  
Committee



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## **FOREWARD**

Hoosiers and people around the United States are paying more for health care than ever before. Increases in health care premiums have left some Hoosiers without insurance, underinsured, or on the verge of losing coverage. Employers face double-digit increases in premiums. Rising health care costs undermine the ability of individuals, businesses, and the state to purchase health care coverage.

There are approximately 45 million uninsured Americans. In Indiana, the percentage of Hoosiers without coverage is lower than the national average. The Family and Social Services Administration (FSSA) telephone survey reached more than 10,000 people and showed an uninsured rate of 9.2%. National studies put Indiana's rate at 12.9%. This means more than 600,000 Indiana citizens do not have health insurance.

The face of the uninsured has changed. It includes mostly working families and larger numbers of the middle class. Being uninsured has a great impact on individuals, families, communities and the economic vitality of the state. People without health insurance often have poorer health status, which affects their ability to work. Lack of health insurance is one of the leading causes of personal bankruptcy. Uninsured patients often delay care ultimately receiving costly emergency room treatment. Safety net hospitals and other institutions created to provide care for the indigent are struggling.

With great concern for these issues, the Indiana Family and Social Services Administration (FSSA) competed for and was awarded a \$1.1 million State Planning Grant from the Health Resources and Services Administration (HRSA) in July 2002. The grant provided Indiana the opportunity to study its uninsured population and develop viable policy options for providing access to affordable coverage.

The Indiana State Planning Grant work was guided by the Health Insurance for Indiana Families committee, a bi-partisan group that included public and private officials, representatives from small and large businesses, insurers, physicians, hospitals, the Indiana University School of Medicine, safety net providers, and advocates that developed options to address the needs of uninsured Hoosiers.

State Planning Grant funds were used to support data collection to aid committee members in their deliberations. The data collected was unparalleled in its scope and depth in providing information on the uninsured and the Indiana health care system.

The following reports were received by the committee. The contents are not endorsed or recommended by the committee.

### **I. 10,000 Person Household Survey**

Over 10,000 Indiana residents were surveyed between February and April 2003 to understand key characteristics of the uninsured. The survey identified who the uninsured

are, where they live, where they receive care, their age, race, employment and health status.

## **II. Focus Groups of Businesses, Uninsured, Brokers, and Providers**

The purpose of the focus groups was to gain insight from those affected by this issue and to understand the local dynamics of how people access care or experience barriers. Forty-seven focus groups were conducted throughout the state with more than 350 individuals. The stakeholder groups included uninsured and underinsured individuals, physicians, hospital administrators, businesses, insurance brokers, and community group. They were asked about cost, the consequences of no coverage, what should be in a basic plan, and their experience with government health programs.

## **III. Assessment of Indiana Health Funding**

This report attempts to catalogue the major funding sources, eligibility requirements, and restrictions on funding. It also examines Indiana's current financing mechanisms and outlines additional opportunities for leveraging federal dollars. The report lays out issues that must be considered in determining whether the options presented are feasible.

## **IV. Safety Net Assessment**

This report is intended to broadly identify and assess the major providers of safety net services in Indiana. It reviews the availability of primary, specialty, mental health, hospital and dental health care services and their financing. The information in the report was derived, in part, from the results of a survey of the Indiana Step Ahead Councils, as well as from interviews with the Indiana Primary Health Care Association (IPHCA), the Rural Health Association, and others. The report also discusses the Indiana Medicaid program and its significance to safety net providers.

## **V. Assessment of National & State Efforts to Address the Uninsured**

This report focuses on the variety of options most commonly used by other states to expand health coverage. The report examines public program expansions, health insurance market reforms and initiatives, tax-based reforms, community-based programs, and strengthening the safety net.

## **VI. Indiana Market Assessment and Drivers of Health Care Costs**

This report examines Indiana's demographic and economic changes that have affected the affordability and structure of private health insurance. The report provides an overview of Indiana's health care sector, the economic impact of cost reduction, Indiana's health insurance market, employer coverage, and cost drivers.



## **VII. Indiana Market Assessment & Drivers of Health Care Costs**

### **A. Indiana's Health Care Sector and Insurance Market: Summary Report**

This report examines Indiana's demographic and economic changes that have affected the affordability and structure of private health insurance. The report provides an overview of Indiana's health care market place including its impact on the overall economy. The report compares Indiana to neighboring states and identifies cost drivers.

### **B. Indiana's Health Care Sector and Economy Report**

Understanding the impacts of rising health care costs on the economy is important, but it can be difficult to measure. In this report, health care services are considered as a source of employment. Finally, this report includes two analyses: a simulation of the impacts of rising health care costs in Indiana, and estimation of the possible impact of greater insurance coverage on hospital uncompensated care.

### **C. Indiana's Health Insurance Market**

This report reviews the literature on state regulation of the small group and individual health insurance markets and describes three types of small-group insurance regulation.

### **D. Employer Sponsored Coverage in Indiana**

This report reviews coverage rates overall (including both private- and public-sector workers and their families), as well as rates of employer offer, eligibility and take up. This report considers aspects of employer-based coverage that have cost implications.

### **E. Factors That Drive Health Care Costs in Indiana**

This report examines trends in health care spending in Indiana for various types of services, changes in service utilization and price data. Several factors that may drive cost increases are considered, including changes in demographics, health insurance, service supply, and population health status.

## **VIII. Actuarial Analysis of Policy Options**

This analysis estimates the number of people eligible and enrolling in the program at various income eligibility levels up to 250 percent of the Federal Poverty Level (FPL). The report also estimates the cost of coverage under three alternative benefits packages. The actuarial analysis of alternative benefits packages addresses the selected expansions in eligibility, program costs under alternative benefits packages, minimizing crowd-out, the impact of premium contribution requirements, and buy-in.

## ACKNOWLEDGMENTS

The final report of the Health Insurance for Indiana Families represents the work of many individuals who donated their time, expertise, and energy to oversee the data collection efforts and to develop policy recommendations. The committee and subcommittees met monthly for more than two years and their efforts are sincerely appreciated. Additionally, we would like to thank members of the FSSA Technical Assistance Group which included Kathy Moses, Kari Kritenbrink, Joe Shelton, Judy Tonk and Michelle Geller.

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**The HIIF Reports and Recommendations Are Online At :**

<http://www.in.gov/fssa/programs/chip/insurance/index.html>

# **The Indiana Health Care Safety Net**

A Report to the **Health Insurance for Indiana Families Committee,**

**Indiana Family and Social Services Administration**

by

Seema Verma Consulting, Health Evolutions and Health Management Associates

April 2004



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## I. Introduction and Overview of the Safety Net

In 2003, there were approximately 500,000 Hoosiers without health insurance, and over 750,000 Hoosiers that had been uninsured at some point during the year.<sup>1</sup> For these individuals, obtaining health care services presents a multitude of challenges. Health care providers that are willing to provide services to this population for free or on a reduced fee basis are often referred to as “safety net” providers. The number and types of safety net providers vary in different parts of the State, but all are struggling to provide care to this expanding population. Faced with the rising costs of health care, growing numbers of clients with no insurance, and sometimes outdated facilities, safety net providers are able to provide varying degrees of health care services. “The safety net system is neither uniformly available...nor financially secure.”<sup>2</sup> Efforts across Indiana over the past five years have resulted in the creation of some new systems and the expansion of services, although few true safety net “systems” exist and those that do are relatively new and in their formative stages.<sup>3</sup> While these efforts have certainly made a contribution, there continue to be significant gaps in available services and the growing number of uninsured is straining the capacity of safety net providers. In the absence of health care reform or government initiatives to address the uninsured, the demands on safety net providers will continue to increase.

### ***Purpose of the Report and Summary of Recommendations***

The Health Insurance for Indiana Families Committee (the “HIIF Committee”) is a Governor-appointed task force charged with developing options to reduce the number of uninsured in Indiana. As part of this effort, the HIIF Committee is studying the Indiana health care safety net and the issues that affect its viability. The task force recognizes the important role safety net providers serve, and understands that any effort to address the uninsured in Indiana must also consider the existing safety net. The HIIF Committee has therefore commissioned this study to 1) provide baseline information of the types of safety net services that are available throughout Indiana, 2) assess the capacity and stability of the current system, and 3) provide policymakers

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<sup>1</sup> State Health Access Data Assistance Center “2003 Health Insurance for Indiana's Families Survey,” Indiana Family and Social Services Administration.”

<sup>2</sup> Institute of Medicine, “America's Health Care Safety Net, Intact But Endangered,”

<sup>3</sup> See below, “Spotlight: Innovations in Care to the Uninsured.”



with the recommendations so that interventions and strategies may be developed to address the uninsured.

Safety net providers in Indiana include a wide range of provider types. Identifying "core" safety net providers is much simpler than trying to identify the systems of care that have evolved in communities across Indiana. Often, these systems are informal and rely on private providers donating their services. This report is intended to broadly identify and assess the major providers of safety net services in Indiana while acknowledging that there are unquestionably many providers of care to the uninsured that contribute to the safety net. This report reviews the availability of primary, specialty, mental health, hospital and dental health care services and the financing of these services. The information in the report was derived, in part, from the results of a survey of the Indiana Step Ahead Councils taken in December 2003 and January 2004 (the "Step Ahead Survey"), as well as from interviews with state associations such as the Indiana Primary Health Care Association (IPHCA), the Rural Health Association, and others. The report also discusses the Indiana Medicaid program and its significance to safety net providers. The report concludes by offering recommendations to enhance Indiana's health care safety net. In summary, those recommendations are:

1. Target available state Community Health Center (CHC) funding to health centers that meet state goals and expectations (e.g., goals addressing quality of care, disease management and access provided).
2. Consider redirecting a portion of available state CHC funds to community-based initiatives to encourage local planning and development around building systems for indigent care.
3. Promote additional Federally Qualified Health Center (FQHC) designations through CHC state funding requirements.
4. Set aside a portion of the available state CHC funding to provide technical assistance to CHCs to assist them in obtaining FQHC designation.
5. As an alternative to recommendations one through four above, redirect current CHC state funding for a Medicaid program expansion.
6. Continue to preserve (and ideally expand) existing Medicaid eligibility criteria.

7. The Medicaid program should be preserved and fully supported as it is a critical support to the safety net infrastructure that the uninsured rely upon.
8. Continue to target Medicaid DSH funding to the hospitals serving the most disproportionate payer mixes.
9. Improve Indiana's ability to monitor and assess the safety net's capacity, structure and financial stability. The ISDH could assume responsibility for this role and make the data available.

### ***What Providers Compose the Safety Net and Whom Do They Serve?***

Across Indiana there is a patchwork of health care providers that compose the "safety net." These providers give care to patients who have nowhere else to go. In addition to the uninsured, safety net providers are also major providers of care to low-income populations, including Medicaid beneficiaries, and persons with limited private insurance coverage (the underinsured). "Core" safety net providers have been defined as having two distinguishing characteristics: "1) either by legal mandate or explicitly adopted mission, they offer care to patients regardless of their ability to pay for those services, and 2) a substantial share of their patient mix are uninsured, Medicaid, and other vulnerable patients." <sup>4</sup> Core safety net providers include public hospitals and a variety of health centers including Community Health Centers, Migrant Health Centers, homeless programs, and school-based health centers. In Indiana, there are many examples of safety net providers that may not meet the definition above of a core safety net provider, but nevertheless provide significant care to the uninsured, including private physicians, church-based clinics and not-for-profit hospitals. The key feature of these safety net providers is their voluntary status. This indicates that the amount of service they provide will vary based on their ability to finance care and their institutional priorities.

### ***The Safety Net System and Its Financing***

The structure, composition, service availability and financing of the health care safety net varies significantly from county to county, and from community to community across Indiana. There are a few counties that have well-organized systems, but most do not. However, even the best

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<sup>4</sup> Institute of Medicine, "America's Health Care Safety Net, Intact But Endangered," 2000 National Academy of Sciences.



safety net systems have gaps in coverage either because of long wait times or the lack of availability of comprehensive services. Vulnerable populations may have to travel long distances to receive care, especially in rural areas. The types of transportation available, the number of providers willing to accept Medicaid patients and the proportion of people who are uninsured all differ from one place to another, and therefore, the safety net system varies as well.

Financing of safety net services also varies from provider to provider. It is fair to say that all safety net providers benefit directly or indirectly from the Medicaid program which is the single largest financier of health care services for the low-income population in the United States. In Indiana, Medicaid served over 760,000 persons as of June 2003, most of whom would otherwise have had no health care coverage at all. Medicaid is also a particularly vital funding source for federally qualified health clinics (who receive cost-based reimbursement) and certain hospitals that benefit from "disproportionate share hospital" payments and other special Medicaid financing arrangements. Other state and federal grant programs, such as the federally qualified health center program, also add significant support for the safety net. In other communities, local funding, private foundations and fundraising are the core of the safety net. Many providers also "cost-shift," using dollars from privately insured patients to subsidize care to the low-income and uninsured and/or make services available on a sliding fee scale which assesses charges based on the patient's ability to pay. Despite these funding sources, increasing numbers of uninsured have threatened the viability of the safety net. Many providers have been faced with some of the toughest financial situations they have ever faced, and have had to turn patients away and ration the care they do provide.

### *Services*

There is also a significant range in the type of services that are available throughout Indiana, based on the type of provider and its funding. Primary care is more readily accessible throughout the State and is more formally organized through federally qualified health centers, rural health centers, school based clinics and other health centers. Health centers have a considerable impact on the communities they serve, and research shows a documented impact on the reduction of health disparities and improvement in health status for key health indicators. However, the range of services varies from provider to provider. Federally qualified health centers, for example, are required by law to provide physician, laboratory and X-ray, prescriptions and dental services, whereas other types of clinics exclusively provide limited primary care services through nurse practitioners and other paraprofessionals. Safety net

providers are also uniquely positioned to provide support services to vulnerable populations that are typically provided in private primary care settings. This includes services provided by social workers, translators, financial counselors, and nutritionists. This also includes general health education such as parenting, and disease management. These services provide the critical framework for comprehensive care that addresses the psychosocial issues related to improving health outcomes that are very important to marginalized populations.

Specialty care in Indiana is more limited, and represents a significant gap in service delivery, often dependent on volunteer physicians, or hospital systems. The availability of dental and mental health services also varies across the State. Mental health services are generally provided by Community Mental Health Centers strategically located across the state with exclusive geographic regions. Despite the availability of clinics, access to services is extremely difficult for uninsured individuals, unless they have an emergency or urgent need. This is primarily due to long delays in getting an appointment, which is the result of lack of sufficient mental health professionals to meet the need especially in rural areas, and lack of financing options. For dental care, there are areas of the state where few formal options exist to access dental care on a free or reduced fee basis. Where options do exist, long wait times for appointments are common. For those uninsured persons that are willing and able to pay in cash if there is an ability to enter into a payment plan, the requirement by many dental providers for payment in full up front can be a significant barrier to dental care as well. Finally, in some areas of the state, there are shortages, generally, in the number of dentists available to serve either the insured or uninsured population.

### ***Hospital Safety Net***

Different types of hospitals, ranging from public, county, not-for-profit and some for profit hospitals provide significant amounts of care to the uninsured. A substantial amount of safety net care is provided in hospital emergency departments, which as a condition of participating in the Federal Medicare program, hospitals are required to provide medical screening exams and stabilizing treatment of all patients, regardless of their ability to pay. Hospitals are often the providers that experience the greatest consequence of uninsurance, as many uninsured use the emergency room as their source of health care. They present with advanced disease states, and health issues that are often preventable or that can be managed in an outpatient setting. The care that is provided is expensive and difficult to treat.

The hospital is the final safety net. To a large extent, this institution is the barometer of the success or failure of any safety net system. If there is not sufficient primary care, the emergency

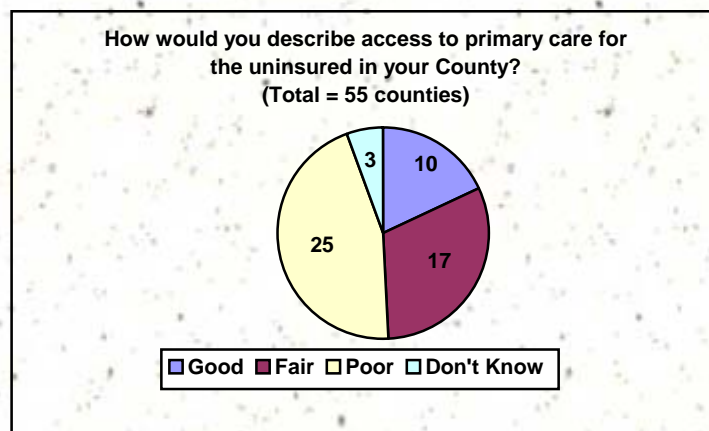


room will be filled with patients seeking primary care. If there is not sufficient specialty care, some emergency rooms will provide it to some degree as most hospitals require specialists (to the extent they are available) to take emergency room referrals as a condition for medical staff privileges (a practice that is being discontinued in some parts of the country based on physicians' refusal). When pharmaceuticals are not affordable, these patients will eventually be readmitted for stabilization of a manageable disease in the inpatient setting.

## II. Primary Care

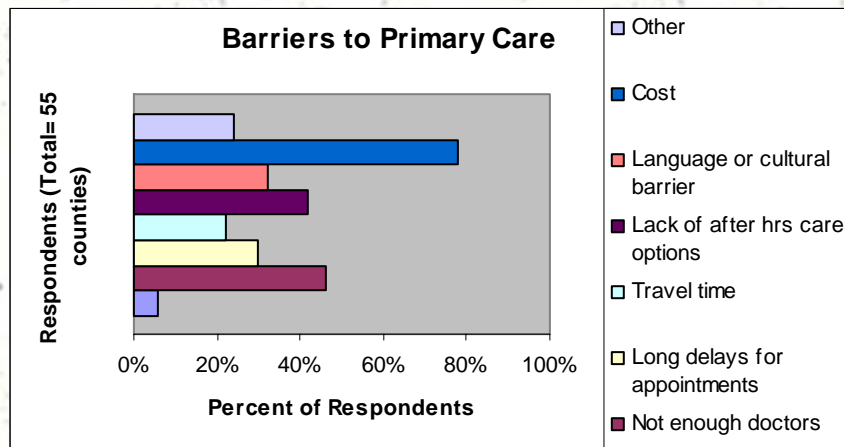
As shown in Figure 1 below, respondents to the Step Ahead Survey indicated that access to primary care for the uninsured in their respective counties was generally fair to poor.

Figure 1



Twenty-five (25) out of 55 counties that responded stated that access was poor, 17 responded that access was fair and only ten responded that access was good. (Appendix A) Based on the Step Ahead Survey data, Wells, Johnson and Tipton counties were the exception in reporting no significant barriers to primary care. For remaining counties in all regions, besides cost (which was reported as the primary barrier) the most common barriers to primary care included lack of doctors and after-hours care, followed by language and cultural barriers.

Figure 2.



In its own analysis, the Indiana Primary Health Care Association (IPHCA) has also determined that many areas of the state are “underserved” by primary health care providers, which limits health care access to populations residing in those areas, regardless of insurance status. Data from IPHCA’s market area analysis used for planning purposes shows that in 2002, all except 26 counties in Indiana had significant numbers of underserved individuals. In particular, according to the analysis Marion County had approximately 255,000 underserved residents and Lake County had approximately 139,000. Delaware, Grant and Noble Counties each had more than 40,000 underserved residents and Howard, LaGrange, St. Joseph, Tippecanoe and Vanderburgh Counties each had more than 30,000. A joint IPHCA/ISDH task force is currently conducting additional data analysis using the market area analysis as a baseline to assess service needs by county and, as necessary, by census tract. The task force will consider a number of options for increasing access, including but not limited to, development of additional community health centers in targeted areas, adding additional sites for current existing centers, seeking additional federally qualified health center designations, and coordinating with local providers to take uninsured patients. (Appendix B)

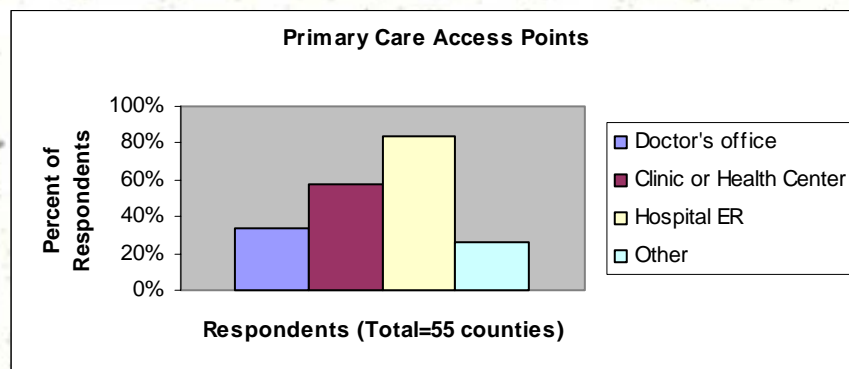
Respondents to the Step Ahead Survey also indicated that the uninsured rely heavily on hospital emergency rooms and health clinics for their primary care needs. This is consistent with the information gathered from focus groups conducted throughout the state on behalf of the HIIF Committee in 2003:

*“The uninsured are very reliant upon their local hospital emergency room, and any free clinics that may exist in the area, for their primary care needs. Without a free clinic in the county, the*



*uninsured are very reluctant to seek care due to the threat of personal bankruptcy or damage to their credit records.”<sup>5</sup>*

Figure 3.



While the results of the Step Ahead Survey as well as the Household Survey of the Uninsured identified private physician offices as a source of primary care, it is impossible to quantify the amount of care that is likely provided from this “silent” safety net. Many physician offices provide care for free or at reduced fees. However, to protect their practices from becoming unsustainable financially, physicians do not advertise this, and they ask patients to keep it a secret for fear that the demand for free service will be greater than ever before.

The term “health clinic” can encompass a number of different categories of providers including private physician practices, federally qualified health centers (FQHCs) and FQHC look-alikes, rural health centers (RHCs), state-funded Community Health Centers, nurse-managed clinics, school clinics, and other “free clinics”. The funding sources and related requirements that govern what services are to be provided vary based on the type or designation of the provider. FQHCs, for example, provide more comprehensive services and serve a broad population by federal mandate. Targeted special populations served include homeless individuals, children at risk, and public housing residents. In contrast, RHCs receive their designation and funding based on the fact that they provide services in an underserved area, but they have fewer mandates than FQHCs with respect to required services or required populations to be served. As safety net providers, however, they all face specific challenges, some of which are unique to their locality.

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<sup>5</sup> *Voices on the Uninsured Population in Indiana,” A Report to the Health Insurance for Indiana Families Committee by Health Evolutions, November 2003.*

The major health clinic categories where information was readily available (e.g., RHCs, FQHCs, Local Health Departments and Community Health Centers, school clinics, etc.) are discussed in further detail below including a description of their services, funding, payer and patient mix, service gaps and challenges. Much of the information about adequacy and unmet need was gathered anecdotally, through informal surveys.

Appendix C and Appendix L contains the locations of a number of the Indiana primary care providers mentioned above. With the exception of FQHCs, the maps are not conclusive of health care access points statewide. For example, there may be more providers of primary care services in rural areas, however, the designation is a voluntary one and many providers may seek designation for purposes of qualifying for a state or local grant. Additionally, private providers may also contribute to providing care to the uninsured. There is no formal mandatory designation or registration of any of the other types of clinics. FQHCs, however, receive significant federal and state funding including Medicare and Medicaid, and because of the mandates attached to the designation it is safe to conclude that the only FQHCs currently are those indicated on the map.

Table 1: Primary Care Clinics

<b>Clinic Type</b>	<b>Total number of providers</b>	<b>Total clinic/sites statewide</b>
State-Funded Community Health Centers	42	68
Federally Qualified Health Centers	15	25
Rural Health Centers	52	52
Local Health Departments	92	94
Nurse-managed clinics <sup>6</sup>	4	4

### ***Federally Qualified Health Centers (FQHCs)***

The federal Public Health Service Act authorizes federal funding for the development and operation of health centers that satisfy certain statutory requirements and are located in or serve communities that have been formally designated as “medically underserved.”<sup>7</sup> Health centers

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<sup>6</sup> Nurse managed clinics are an initiative through which Advanced Practice Nurses provide clinical care in an underserved area of the State. This initiative was supported by ISDH with funding from the Preventive Services Block Grant. However, Nurse Managed Clinics were required to be self-sufficient with other funding sources within three years. These are no longer funded by ISDH.

<sup>7</sup> Sec. 330 of the Public Health Service Act, 42 U.S.C. 254b.



that receive federal grants for development and operations are known as FQHCs. Health Centers that meet all of the requirements of the federal program but do not receive federal operating grants (due to the limited availability of federal funding) are known as “FQHC look alikes.” The target population of FQHCs includes Medicaid, Medicare and uninsured individuals, regardless of their ability to pay. There are currently 15 FQHCs with 25 sites statewide, nine of which are in Marion County. (For a list of FQHCs and FQHC look alikes, see Appendix D.) Marion County, through the Health and Hospital Corporation is also in the process of applying for FQHC look alike status for the seven Wishard Health Centers. There is one FQHC in southern Indiana, which operates at three sites (in Posey, Vanderburgh and Gibson counties) with all other FQHCs spread across northern and central Indiana (Appendix C). Of the 15 FQHCs, three have only recently received their FQHC designations: Raphael Health Center (2003), Portage Township Community Healthcare Clinic (2004), and Trafalgar Family Health Center (also in Edinburgh – 2004). These FQHCs are the beneficiaries of a Bush Administration initiative begun in 2002 to significantly expand the number of FQHCs. The President’s initiative makes available approximately 20 percent more in funding, available through a competitive process, to serve an additional 6 million individuals across the country over a five-year period.<sup>8</sup>

In 2002, FQHCs’ patient mix included 27 percent Medicaid and 41 percent uninsured,<sup>9</sup> and in 1998, FQHCs served more than 120,000 uninsured individuals. (Appendix B)

FQHCs are a critical primary care access point for their targeted population. They are required to provide:

- Primary and preventive health care, outreach, and dental care;
- Essential ancillary services such as laboratory tests, X-ray, environmental health, and pharmacy services as well as related services such as health education, transportation, translation, and prenatal services;
- Links to welfare, Medicaid, mental health and substance abuse treatment, the Women, Infants and Children (WIC) Program, and related services; and
- Access to a full range of specialty care services.

FQHCs generally provide all primary care services on-site or through a network of clinic sites. Ancillary services are usually provided under an arrangement with the ancillary service

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<sup>8</sup> President’s Initiative to Expand Health Centers, Program Assistance Letter 2002-09, pages 1-2 (May 16, 2002).

<sup>9</sup> Based on data provided by the Indiana Primary Health Care Association reported in the *Assessment of Indiana Health Funding* report, February 2004, page 22.

provider. As a primary care setting, FQHCs are also an opportunistic site for the coordination of other care, such as mental health care. Given this opportunity, the ISDH Bureau of Primary Health Care is looking at ways to integrate mental health care into this setting. FQHC social workers provide outreach and linkage to other health services and facilitate Medicaid enrollment, and Indiana FQHCs are also now participating in a ISDH/Medicaid chronic care collaborative initiative which involves patient management of various chronic conditions including diabetes, asthma, mental health and cardiac care.

FQHCs are financed through a combination of federal grants, state and local grants, public and private insurance payments, patient fees, foundations and other donations. In 2002, the average Indiana FQHC payor mix was:

- Medicaid (31 percent);
- State grants including maternal child health services, WIC, and children with special health care needs (about 15 percent);
- Federal grant from the Bureau of Primary Health Care (about 23 percent);
- Medicare (about four percent), and
- County/local funds (about three percent).

Service gaps for an FQHC occur due to local shortages in one or more types of health care professionals limiting the FQHC's ability to provide ancillary services and/or referrals for specialty services. Linking patients to mental health services, for example, is challenging in areas where there is a shortage of mental health professionals.

While Indiana would likely benefit from the development of additional FQHCs, the resources needed and length of time it takes to become federally designated as an FQHC sometimes discourages some neighborhood clinics from applying. Also, the intensive process and requirements can be daunting. While IPHCA is able to provide technical assistance, the work of developing the applications must be managed by the clinic or it can hire consultants to assist in the process. Both ways, however, require significant resources.

### ***Rural Health Centers***

Rural Health Centers (RHCs) are facilities located in rural areas with shortages of primary health care providers that meet Medicare requirements for providing outpatient physician services. An



RHC may operate independently (e.g., as a physician office) or as a part of a larger organization, such as a hospital, a skilled nursing facility or a home health agency. There are 49 RHC sites in Indiana. (For a list of RHCs, see Appendix D.)

Unlike FQHCs, there are no specific mandates for RHCs, other than they must serve Medicare patients. They are not required to serve Medicaid patients or the uninsured or offer services on a sliding scale fee basis (as are FQHCs). Compared to FQHCs, RHCs receive a smaller proportion of revenue from Medicaid and a much higher proportion of Medicare, commercial insurance and self-pay revenue.<sup>10</sup> Despite these differences, from a public policy perspective, providers designated as RHCs are considered an important component of the safety net because they provide services in rural areas that otherwise might have no primary care provider, or where access to a primary care would be difficult if not impossible.

RHCs receive cost-based reimbursement under both the Medicare and Medicaid programs. In 2003, Indiana's Medicaid program paid a total of \$3.7 million to providers designated as RHCs. In addition, the ISDH, through local liaison offices, currently funds rural clinical preventive services from the Preventive Health & Health Services Block Grant. Challenges faced in rural health services discussed below are equally applicable to clinics that have an RHC designation. However, their existence does not assure that services are available to the uninsured.

### ***Local Health Departments***

The local health departments have primary responsibility for public health and safety including, but not limited to: residential sewage disposal; retail food inspections; vital records; public health nursing; housing, pest control and nuisance issues. They also provide health education and screening services especially for chronic diseases. All 92 counties have a local health department so they are a good access point for many uninsured individuals for some services. (Appendix E) However, most public health departments in the state are minimally funded and are struggling to provide services. They provide relatively few to no direct services and funded services for the most part are limited to screening services and some immunization services. In 2004, local health departments will receive pass-through funding for breast and cervical cancer screening, tuberculosis control and cessation services for pregnant women. They would also receive some funding from tobacco settlement.

### ***Community Health Centers***

Since 1995, the Indiana General Assembly has appropriated funds to help establish and sustain Community Health Centers (CHCs) that follow the federal FQHC model. With an initial funding level of \$2 million for the 1995-1996 biennium, 13 sites received start-up dollars. For the 1997-1998 biennium, this amount grew to \$10 million. The advent of Tobacco Master Settlement Fund appropriations has increased state funding for CHCs to \$30 million for the current biennium.

Community Health Centers (CHCs) are local, non-profit organizations that provide comprehensive primary and preventive health care services by establishing a medical home for uninsured and underinsured residents of underserved communities. There are 68 CHC sites statewide. (For a list of state funded CHCs, see Appendix D.) CHCs are staffed with interdisciplinary teams of health professionals and are linked with other providers for their patient's specialty and inpatient care needs. A condition of receiving State grant funding is that they have at least one full-time physician on site or a nurse practitioner with prescription authority on site at least 32 hours per week to provide consistency and continuity of care. They also provide community health education, outreach, and translation services. An underlying goal of health center programs is to help communities and their residents assume more responsibility for their health by providing an accessible primary care site and by providing public and private resources to communities to meet local health needs. CHCs must:

- Make an effort to extend services and promote appropriate utilization of preventive services and assure that no one will be refused services;
- Provide 24-hour access through on-call arrangement among CHC-employed providers or a broader group of providers through formal arrangements, and
- Provide linkages to specialists (including mental health and dental), and coordination and referral services with public health programs (HIV, immunization, EPSDT, WIC, family planning, etc.).

Continued funding of CHCs depends largely on future allocation of dollars by the Indiana General Assembly, including start-up capital funding, planning, implementation and expansion of services. A joint IPHCA/ISDH task force will also be looking at recommending the development of additional CHCs in underserved areas across the state as one of the options to improve access to primary care services. Finally, IPHCA continues to work with state-funded CHCs to prepare them to seek FQHC designation and compete for federal funds.

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<sup>10</sup> "Health Centers and Rural Clinics: Payments likely to be Constrained Under Medicaid's New System," U.S.



### ***School Clinics***

School-based clinics are an important part of the safety net for children, especially in providing certain routine primary care services, including assisting parents and children in managing chronic illness during the school day such as asthma, diabetes. In addition, schools bear primary responsibility under the Individuals with Disabilities in Education Act (IDEA) to evaluate, participate in service planning and coordination for children with disabilities, to ensure that the necessary support and services are provided to the child to enable the child to succeed in the educational environment.

Health care services provided in schools through school-based clinics are primarily funded through the Medicaid program when provided to children who are Medicaid eligible and when the services are covered by the Medicaid program. However, schools in Indiana have historically not billed the Medicaid program for a variety of reasons.

In Marion County, private funding from foundations as well as some state and federal grant opportunities help in funding school health services. Learning Well is a model program in Marion County schools established to develop a coordinated approach to school based health services and funding. Learning Well is a collaborative of health care providers in Marion County and Marion County school corporations incorporated as a non-profit entity in October of 2002. Its mission is to expand health care services in its member schools. Since its inception, Learning Well's funding has included:

- \$5.5 million grant from the Legacy Health Foundation;
- \$100,000 grant from the Indiana State Department of Health for childhood obesity;
- \$90,000 in federal grant funds to initiate an integrated health services delivery system, and
- Some funding from the Marion County Health and Hospital Corporation.

With these funds, Learning Well has been able to establish 32 school-based nurse practice clinics serving Marion County schools. However, this does not meet the need since in Marion County there are 310 schools, including 79 Indianapolis Public Schools, not all of which can readily access the 32 school-based clinics. If this model is successful, it could be replicated across the state depending on funding availability. Statewide there are around 1,954 schools, but the number of

clinics serving these schools is undetermined. However, if the landscape is similar to Marion County it can be assumed that there are not enough clinics serving kids in school across the state.

A potential source of funding not currently accessed in Indiana is Medicaid administration in schools to reimburse schools for the costs of administrative activities (e.g., outreach, assistance with Medicaid application, and referral, coordination and monitoring of Medicaid-covered medical services) which support the Medicaid program. These school expenses, if reimbursed, can be utilized to augment medical services provided to other low-income children. In Marion County, Learning Well has an arrangement with schools to participate in administrative claiming and funding from Medicaid will be utilized to fund expansion of school-based clinics in Marion County.

### ***Free Clinics***

Free clinics are generally provided by physician offices and health care centers where practitioners devote a set amount of time of their practice to providing care for uninsured individuals. These may also be organized through churches, homeless shelters and other local organizations and at health fairs to provide screenings, immunizations, health education and at times health care supplies for uninsured individuals. For individuals who do not have a primary care physician, free clinics can sometimes be a significant access point for some of their primary health needs.

While free clinics can often fill the gap in primary care services, they are limited in the number of patients they can take and how much service they can offer because of limited resources. A few counties from the Step Ahead Surveys specifically identified free clinics as a source of primary care. The Shelby Health Clinic, a free clinic for uninsured individuals, operates solely with volunteers and donated funds, and is open only 2-3 hours per week. Hamilton County also has a free clinic (Trinity Free Clinic) through Our Lady of Mt. Carmel Catholic Church in Carmel. "Volunteers in Medicine" provide services in Bartholomew County for the uninsured funded with private donations

### ***Efforts to Enhance Primary Care in Rural Areas***

The ISDH Office of Rural Health has in place specific strategies to develop and coordinate the activities of RHCs, support community-based systems of comprehensive primary health care, and train primary health care providers to serve in rural areas. These strategies include:



- Creating infrastructure support for RHCs by providing technical assistance to develop rural health clinics and training centers, and nurse-managed clinics;
- Researching innovative approaches to the delivery of health care throughout Indiana's rural areas;
- Establishing and maintaining a clearinghouse for collecting and disseminating information on rural health care issues, and
- Promoting activities that support the recruitment and retention of health care professionals to serve in rural areas.

Special projects and initiatives within these strategies include:

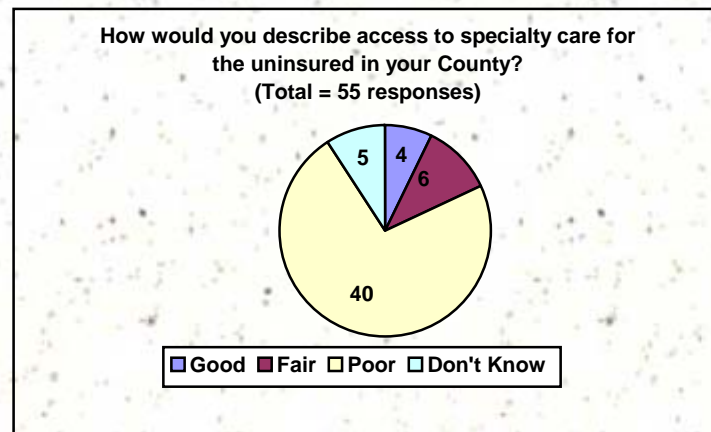
- Working with the Indiana University School of Medicine to develop a rural health curriculum track for medical students;
- Developing the Indiana Rural Health Association;
- Supporting existing rural health care training centers in Petersburg, Clay City and Worthington, and
- Planning RHC training grants for Randolph County, Greene County, and Crawford County. (The first of such training centers was in the Clay City satellite clinic of the Midwest Center for Rural Health affiliated with Union Hospital in Terre Haute.)

The strategies and initiatives listed above are an indication of the challenges that rural areas face in attracting and retaining medical providers. The inability to train and recruit sufficient numbers of medical professionals to serve in rural areas is a barrier to access.

### III. Specialty Care

As shown in Figure 4 below, respondents to the Step Ahead Survey indicated that access to specialty care across Indiana for the uninsured in their respective counties was generally poor.

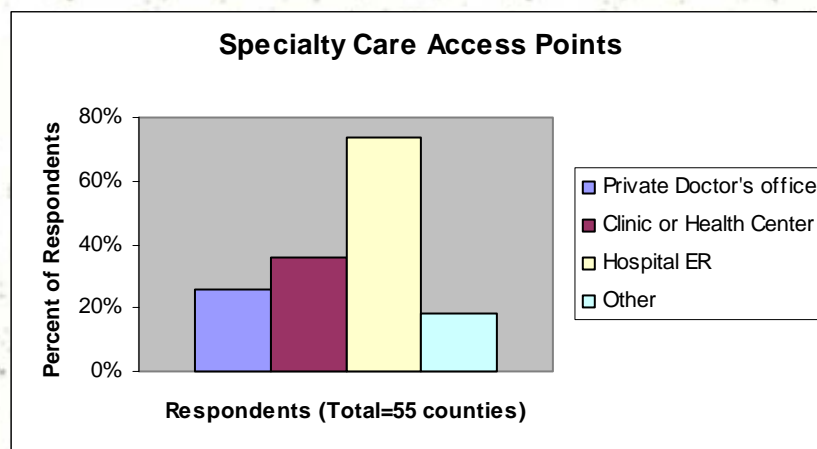
Figure 4



Forty (40) out of 55 responders stated that access was poor, and seven responded that access was fair. Only four counties (Marion, Grant, Tipton and Bartholomew) responded that access to specialty care was good. (Appendix F) While Marion County, through Wishard Health Services, provides specialty care services, those services also are difficult to access as they have long wait times.

According to the Step Ahead Survey, specialty care services are primarily accessed by uninsured individuals through hospital emergency rooms. Other access points include private health clinics and private doctors' offices where the uninsured are responsible for payment.

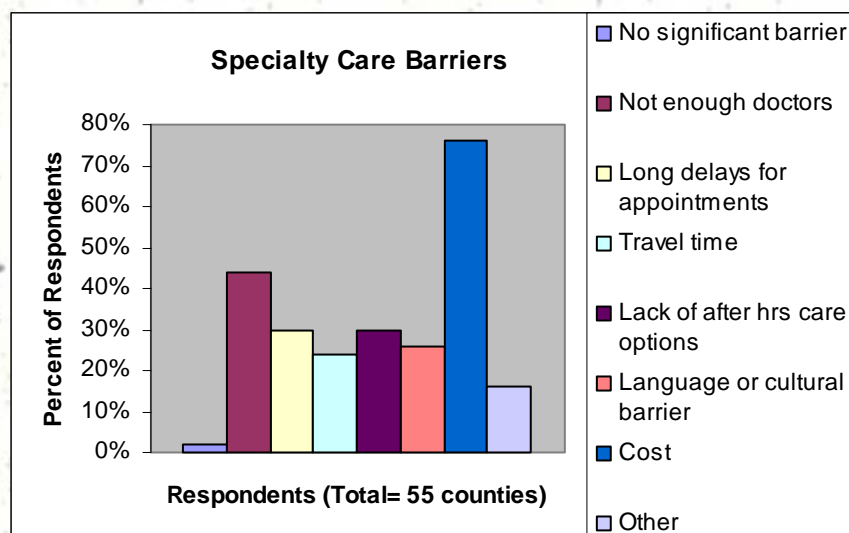
Figure 5





Cost of care, lack of specialty physicians and long delays in getting appointments were the most frequently cited barriers to specialty care which is true even in those counties reporting that access is good. More often, hospital emergency rooms only have enough time and resources to stabilize individuals and send them home. However, if the individual's emergency condition warrants immediate admission, then the individual would receive the specialty care necessary. While Wells County reported that access to specialty care overall is fair, no significant barriers to specialty care was reported and specialty care in the county is provided through a health clinic.

Figure 6



In general, there is no revenue source that is specifically dedicated to fund the provision of specialty care for the uninsured. To the extent that specialty care is provided for free or at reduced fees by a specialty care provider or in a hospital setting, it is likely done so by spreading the cost to other insured patients. In Marion County, the Health and Hospital Corporation (HHC) uses a portion of its hospital revenues (derived in part from local property taxes) to finance its contract with the Indiana University School of Medicine to provide specialty care to its indigent patients.

Also, FQHCs and other health clinics often assist their clients in obtaining specialty care referrals and sometimes are successful in developing relationships with specialists who are willing to see clinic patients on a sliding fee scale basis. One community, Fort Wayne, has developed a community response. The local United Way agency has established a Medical Referral Service that will pay for a single visit to a specialist for the Neighborhood Health Center (FQHC), Mathew 25 (a free clinic) and the hospital residency programs. After the single visit, it again becomes a case-by-case situation for the clinic to arrange additional care if it is required.<sup>11</sup>

## IV. Hospital Care

Many Indiana hospitals function as safety net providers by virtue of law, mission and/or tradition. In 2002, there were 132 acute care hospitals in Indiana (including 17 specialty and rehabilitation hospitals) that ranged in size from the 775 bed Clarian Methodist hospital in Indianapolis to the 15 bed Bloomington Hospital of Orange County in Paoli, Indiana.<sup>12</sup> While the urban counties usually have more than one acute care hospital (for example, there are nine full service hospitals in Marion County, and nine in Lake County), most rural counties have at most one hospital and 16 counties<sup>13</sup> in Indiana have no acute care hospitals at all. Appendix K contains the locations of the DSH and Critical Access Hospitals and Appendix M contain maps of the hospitals locations in Indiana.

According to statistics collected by the American Hospital Association, 112 non-specialty acute-care hospitals in Indiana reported charity care in 2002 totaling over \$293 million, total “bad debt”

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<sup>11</sup> E-mail from Alice Rae, IPHCA, February 6, 2004.

<sup>12</sup> According to the Indiana State Department of Health’s 2002 Statewide Hospital Service Report, the breakout of Indiana acute care hospitals by size was as follows:

- 13 hospitals had more than 300 beds;
- 27 hospitals had 150 to 299 beds;
- 46 hospitals had from 51 to 149 beds, and
- 45 hospitals had less than 50-bed capacities.

Accessed at [www.in.gov/isdh/regsvcs/acc/services/2002/02\\_summary.htm](http://www.in.gov/isdh/regsvcs/acc/services/2002/02_summary.htm).

<sup>13</sup> Benton, Brown, Carroll, Crawford, Fountain, Franklin, Martin, Newton, Ohio, Owen, Parke, Pike, Posey, Spencer, Switzerland and Union Counties. Source: Indiana Hospital and Health Association.



of over \$544 million and total patient revenues of over \$10 billion.<sup>14</sup> The vast majority of reported charity care – 79 percent – was reported by just twenty hospitals and hospital systems located predominantly in urban areas. These same 20 hospitals and hospital systems also accounted for 52 percent of the total reported bad debt.

Table 2

<b>Indiana Acute Care Hospital: 2002 Charity and Bad Debt Revenue Data</b>						
<b>Acute Care Hospitals</b>	<b>Total Net Patient Revenues</b>	<b>Percent of Total</b>	<b>Charity</b>	<b>Percent of Total</b>	<b>Bad Debt</b>	<b>Percent of Total</b>
Top 10*	\$3,946,976,373	39%	\$183,092,849	62%	\$186,019,556	34%
Top 20**	\$5,660,965,659	56%	\$231,516,401	79%	\$281,546,971	52%
All 112	\$10,120,923,510		\$293,397,510		\$544,161,888	

\*The ten hospitals or hospital systems with the highest reported spending for charity care.

\*\*The twenty hospitals or hospital systems with the highest reported spending for charity care.

Source: Indiana Hospital and Health Association, AHA Hospital Statistics, 2004 Edition (generally includes 2002 data).

### ***Urban Hospitals***

The largest providers of hospital charity care in Indiana tend to be large urban hospitals that have a larger capacity generally, have access to specialists and whose mission encompasses charity care. These hospitals have benefited financially in recent years from expanding Indiana Medicaid and Children's Health Insurance Program enrollments (for patients who would have otherwise been uninsured) and, in some cases, from increased supplemental Medicaid payments made possible through special financing arrangements utilizing “intergovernmental transfers” (IGTs). However, the ever-growing number of uninsured patients combined with the increasing workforce costs and other health care cost increases is placing greater financial strain on these hospitals. Wishard Memorial Hospital, for example, ended CY 2003 with a deficit of about \$30 million (equal to about 10 percent of its annual budget).<sup>15</sup> While Wishard was able this year to cover this shortfall from some one-time reserves, it is unlikely that it can sustain ongoing annual losses of this magnitude.

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<sup>14</sup> The Indiana State Department of Health also collects (but does not audit) hospital fiscal information including costs incurred for charity care. The ISDH 2001 Statewide Hospital Fiscal Report Summary reflects total statewide hospital charity care costs of \$393.2 million. “Charity care” is defined as “the unreimbursed costs of providing, funding, and otherwise financially supporting health care services that never were expected to result in cash inflows and based on the hospital’s adopted charity care policy to provide services free of charge to individual who meet the hospital’s financial criteria.” The totals for Fiscal Years 1999 and 2000 were \$188.2 million and \$245.9 million, respectively. Accessed at [www.in.gov/isdh/regsvcs/acc](http://www.in.gov/isdh/regsvcs/acc).

<sup>15</sup> D. Penner, “Wishard Chief: Shortfall for 2003 is Covered,” Indianapolis Star, January 21, 2004.

## ***Rural Hospitals***

Most hospitals in rural areas would likely be considered safety net providers due to the lack of other hospital resources in their respective communities. Rural hospitals, however, are more likely to be small and provide more limited services. For example, as of January 2004, 21 Indiana hospitals have been designated and certified by CMS as “critical access hospitals.”<sup>16</sup> A critical access hospital (CAH) is a limited service rural facility that must provide 24-hour emergency services, operate 25 or fewer inpatient beds and have an average length of stay of 96 hours or less. Being certified as a CAH means that the hospital is considered a sole source of inpatient care in a community and plays a critical safety net role. However, while a CAH might treat and stabilize an uninsured patient with an emergency condition in its emergency room, there may not be appropriate specialists on staff or in the community that could provide follow-up care or procedures. In some cases, the CAH may refer the patient to another hospital that does have the capacity to provide the specialty care on a charity care basis. In other cases, the patient simply will not receive the needed specialty care. Because small rural hospitals operate on slim margins due to their size, their capacity to absorb charity care cases is also limited.

Indiana also has two hospitals recently designated under Medicare as “sole community hospitals” (SCHs). These are hospitals that, because of factors such as isolated location, weather conditions, travel conditions, or absence of other hospitals, are the sole source of inpatient services reasonably available in a geographic area, or are located more than 35 road miles from another hospital.

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<sup>16</sup> The 21 CAH designated hospitals are **Blackford Community Hospital**, Hartford City, IN (Blackford County), **Bloomington Hospital of Orange County, Inc.**, Paoli, IN (Orange County), **Cameron Memorial Community Hospital, Inc.**, Angola, IN (Steuben County), **Community Hospital of Bremen, Inc.**, Bremen, IN (Marshall County), **Dukes Memorial Hospital**, Peru, IN (Miami County), **Gibson General Hospital, Inc.**, Princeton, IN (Gibson County), **Greene County General Hospital**, Linton, IN (Greene County), **Jay County Hospital**, Portland, IN (Jay County), **Pulaski Memorial Hospital**, Winamac, IN (Pulaski County), **Rush Memorial Hospital**, Rushville, IN (Rush County), **St. Vincent Clay Hospital**, Brazil, IN (Clay County), **St. Vincent Frankfort Hospital**, Frankfort, IN (Clinton County), **St. Vincent Jennings Hospital, Inc.**, North Vernon, IN (Jennings County), **St. Vincent Mercy Hospital, Inc.**, Elwood, IN (Madison County), **St. Vincent Randolph Hospital**, Winchester, IN (Randolph County), **St. Vincent Williamsport Hospital**, Williamsport, IN (Warren County), **Tipton County Memorial Hospital**, Tipton, IN, (Tipton County), **Wabash County Hospital**, Wabash, IN (Wabash County), **Washington County Memorial Hospital**, Salem, IN (Washington County), **White County Memorial Hospital**, Monticello, IN (White County), and **Woodlawn Hospital**, Rochester, IN (Fulton County).



### ***Financing of Hospital Charity Care***

In 2001, the most significant source of patient revenue for Indiana hospitals was commercial/private insurance (59.25 percent) followed by Medicare (33.2 percent), Medicaid (6.9 percent) and other government sources (0.4 percent).<sup>17</sup> Individual hospitals that play a larger role serving low-income populations, however, are likely to have a much larger share of their patient revenues derived from Medicaid and a smaller share derived from commercial insurance. For example, for 2001 Methodist Hospital in Gary reported that commercial insurance comprised only 31 percent of net patient revenue while Medicare accounted for 28 percent and Medicaid accounted for 27 percent.<sup>18</sup> The federal government has recognized the unique financial concerns of these hospital safety net providers by providing enhanced reimbursement mechanisms in both the Medicare and Medicaid programs for hospitals that serve a disproportionate number of low-income patients.

Medicare DSH. Medicare makes additional payments to acute care hospitals that serve a large number of low-income Medicare and Medicaid patients as part of its inpatient prospective payment system. All hospitals are eligible to receive Medicare disproportionate share hospital (DSH) payments when their DSH patient percentage or threshold amount exceeds 15 percent. This is a relatively low threshold that allows a large majority of Indiana hospitals to qualify. Historically, the Medicare DSH adjustment was less for rural hospitals than for urban hospitals with over 100 beds. However, starting for discharges after April 1, 2004, qualifying rural hospitals will receive the same Medicare DSH adjustment as for large urban hospitals, subject to a limit, as a result of the recently enacted Medicare Prescription Drug, Improvement and Modernization Act of 2003 (the “2003 Medicare Act”). A shortcoming, however, of the Medicare DSH formula is that it does not take into consideration care provided to uninsured patients that do not qualify for either Medicaid or Medicare. Thus, Medicare DSH funding is not necessarily targeted at core hospital safety-net providers, but is more broadly available.

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<sup>17</sup> ISDH 2001 Statewide Hospital Fiscal Report Summary accessed at [www.in.gov/isdh/regsvcs/acc/fiscal01/statewide01.htm](http://www.in.gov/isdh/regsvcs/acc/fiscal01/statewide01.htm).

<sup>18</sup> ISDH 2001 Statewide Hospital Fiscal Report Summary accessed at [www.in.gov/isdh/regsvcs/acc/fiscal01/005002.htm](http://www.in.gov/isdh/regsvcs/acc/fiscal01/005002.htm).

Graduate Medical Education. Both Medicare and Medicaid make additional funding available to hospitals that provide graduate medical education (i.e. residency programs). While many hospitals have smaller residency programs, it is usually academic medical centers and other safety net institutions that provide the bulk of the medical education in the United States. These additional payments and the use of residents generally have been seen as a method to finance indigent care by some. Medicare reductions in the indirect payment rate for graduate medical education in recent years and reductions in the number of hours a resident can work mean that this is no longer true, if it ever was. Residents are still a critical source of physician manpower in safety net institutions providing care to the uninsured. However, the costs associated with these programs cannot be spread to the uninsured or the commercially insured in most cases. This leaves a funding gap for the most vulnerable institutions. In Indiana, the largest teaching programs are at the Clarian hospitals and at Wishard Memorial Hospitals in Indianapolis. These hospitals also provide the most care to the uninsured. Resident manpower in treating patients in these institutions is critical; however, the funding from Medicare and Medicaid cover “their share” of the cost, but do not come close to covering the entire cost of the programs.

Medicaid DSH. Like Medicare, Medicaid also makes DSH payments to offset the costs of serving a large number of uninsured patients and Medicaid enrollees. The federal government and the state share in the funding of these payments. While states are subject federal limits and requirements, states also have a great deal of flexibility to determine their own priorities and methodologies. States can decide how much they spend on DSH (subject to a federally determined state DSH cap<sup>19</sup>) and, subject to federally determined individual hospital limits, how payments are divided among facilities, the conditions necessary to receive DSH payments and how much each hospital gets.

Indiana implemented a minimal Medicaid DSH program in 1987. In 1991, Indiana added a significant supplement through the use of a “leverage” program patterned after methods used in other states. Generally, in a leverage program, a provider will pay the state’s portion of the Medicaid payment. Then, when Medicaid makes a provider’s DSH payment, the federal portion of the payment is drawn down.

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<sup>19</sup> Indiana’s state DSH cap for Federal Fiscal Year 2002 is \$327 million. The State has paid out its full DSH allocation since 1998.



In Indiana, the Medicaid DSH payment methodology is complex and constantly changing. From a financial and policy perspective, it is also inextricably interrelated with certain other supplemental Medicaid payments made to hospitals using intergovernmental transfers to provide the non-federal financial share (including supplemental payments to certain defined safety-net hospitals and Medicaid “shortfall” payments). In general, to qualify as a DSH hospital, an acute care hospital must have a “Medicaid inpatient utilization rate” (MUIR) of at least one percent and meet one of the following conditions:

- (1) The hospital’s MUIR is at least one standard deviation above the mean Medicaid inpatient utilization rate for providers receiving Medicaid payments in Indiana, or
- (2) The hospital's low-income utilization rate (LIUR) exceeds twenty-five percent (25 percent).<sup>20</sup>

Once qualified, DSH distributions are based on hospital specific limits which themselves are based on a hospital’s unreimbursed Medicaid and indigent care costs.

Indiana Medicaid and the Indiana Hospital Association has always recognized that indigent care has fallen disproportionately on a few hospitals and structured their Disproportionate Share Medicaid Program and other Medicaid supplemental payment programs on those hospitals. This is in contrast to many other states, which operate broader based programs that generate much less money for the facilities with the uneven patient mixes. This has helped insure that key providers of care to the uninsured have been able to continue to offer relatively strong services to these communities. In particular, this has helped Wishard and Gary Methodist, the states’ only two acute care Low Income Utilization qualified hospitals in the state (LIUR status indicates they have the most extremely skewed payor mixes to the low income population).

More recently, the willingness on the part of some hospitals to support most of the resources flowing to a few hospitals has started to erode. As margins have decreased for all hospitals there has been more pressure to take from the hospitals with the highest low-income percentages and shift this money to a broader group of hospitals. This has the potential to require those facilities that have historically served a higher mix of low-income patients to reduce services to the poor or close.

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<sup>20</sup> The MUIR compares a hospital’s Medicaid inpatient days with its total inpatient days. The LIUR compares a hospital’s total Medicaid, state and local cash subsidies and charity care to the hospital’s total revenues and charges for patient services.

While the process of calculating DSH payments attributable to FY 2002 is not yet complete, it appears likely that 22 acute care hospitals (compared to nine in FY 2001) will qualify for DSH payments with Clarian Health Partners and the Health and Hospital Corporation of Marion County (that operates Wishard Memorial Hospital) receiving the vast majority (at least 70 percent) of the funding.<sup>21</sup> The other hospitals that are likely to qualify for FY 2002 are:

- Community Health Network's Anderson Hospital;
- Davies Community Hospital (Davies County);
- St. Elizabeth Ann Seton Hospital of Indianapolis;
- Fayette Memorial Hospital (Fayette County);
- Huntington Memorial Hospital (Huntington County);
- Kindred Hospital (a long-term care specialty hospital in Indianapolis);
- Lafayette Home Hospital (Tippecanoe County);
- Memorial Hospital of South Bend (St. Joseph County);
- Scott Memorial Hospital (Scott County);
- St. Catherine Hospital (East Chicago – Lake County);
- St. Vincent Frankfort Hospital (Clinton County);
- St. Anthony Memorial Health Centers (LaPorte County);
- Saint Joseph Regional Medical Center (St. Joseph County);
- St. Margaret Mercy Healthcare Centers – Hammond Hospital (Lake County);
- St. Vincent Children's Specialty Hospital (Marion County);
- St. Vincent Randolph Hospital (Randolph County);
- Sullivan County Community Hospital;
- Terre Haute Regional Hospital (Vigo County);
- Methodist Hospital – Gary Hospital (Lake County);

By definition, these 22 hospitals play a critical role in providing hospital care for the State's Medicaid population.

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<sup>21</sup> It should be noted that Health and Hospital Corporation of Marion County (Wishard), Indiana University, and the State of Indiana provide all the non-federal funding necessary to leverage the Federal Medicaid match. The size of Wishard's IGT has the effect of reducing the net DSH payment to Wishard to an amount equal to between 50 to 60 percent of Wishard's DSH cap. All other historical DSH providers receive 100 percent of their cap. New DSH providers receive a percentage of their cap starting at 33 percent and reaching 100 percent in the fifth consecutive year of qualifying.



Enhanced Medicare Payments for Certain Rural Hospitals. A hospital designated as a Critical Access Hospital (CAH) is able to receive more favorable reimbursement under Medicare – 101 percent of its reasonable costs of service for care rendered to Medicare beneficiaries – and therefore this designation has become an important financial support program for rural health systems in Indiana. Key informants on rural health in Indiana suggest that CAH certification has been the means of survival for a number of rural Indiana safety net hospitals. Indiana’s two hospitals recently designated as “sole community hospitals” (SCHs) also receive more favorable Medicare reimbursement based on their historical costs.

Hospital Care for the Indigent. Indiana’s Health Care for the Indigent (HCI) program is a program that pays for urgent and emergency hospital care for low-income individuals provided in an Indiana hospital. Indiana hospitals can receive a supplemental Medicaid “HCI add-on” payment for emergency care provided to eligible uninsured Indiana residents. The non-federal share of the Medicaid HCI add-on payments is provided by county property tax levies that are transferred to the state. Medicaid HCI add-on payments to hospitals are expected to total \$53.1 million in FY 2004.

Other Local Funding. According to the ISDH, approximately 28 percent of Indiana hospitals are county or municipally owned.<sup>22</sup> With the exception of Wishard Memorial Hospital in Marion County, other local funding for county or municipal hospitals is either not significant or non-existent. Wishard benefits from an annual county property tax levy for the Marion County Health and Hospital Corporation (HHC). In 2003, HHC’s property tax levy proceeds totaled \$88 million.<sup>23</sup> Approximately 40 to 50 percent of HHC’s annual level is used to finance Wishard Health Services (which encompasses Wishard Memorial Hospital, a nursing facility, seven community health centers and a community mental health center) and the remainder is used to operate the Marion County Department of Health.

Tax-Exempt Status. According to the ISDH, 52 percent of Indiana hospitals (not including county and municipal hospitals) are not-for-profit and therefore tax-exempt. Theoretically, their tax-exempt status better enables these hospitals to provide charity care in their communities. Indiana law also requires that these hospitals to annually file with the ISDH a Community Benefits Plan

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<sup>22</sup> ISDH 2002 Statewide Hospital Services Report Summary accessed at [http://www.in.gov/isdh/regsvcs/acc/services/2002/02\\_summary.htm](http://www.in.gov/isdh/regsvcs/acc/services/2002/02_summary.htm).

<sup>23</sup> *Assessment of Indiana Health Funding*, A Report to the Health Insurance for Indiana Families Committee by Health Evolutions, February 2004, p.27.

Report that includes a community-wise health needs assessment, goals and objectives for providing “community benefits that include charity care and government sponsored indigent health care” and disclosure of the amount and types of community benefits actually provided, including charity care.<sup>24</sup>

### ***Emergency Room Care to the Uninsured***

Most Indiana acute care hospitals are either not-for-profit (48 percent) or are publicly owned (32 percent) and therefore are likely to consider the provision of at least some charity care as part of their mission (although actual efforts vary). Much of this charity care likely originates in a hospital’s emergency room. In fact, respondents to the Step Ahead Survey identified hospital emergency rooms as the most significant source of primary and specialty care for persons without health insurance. Also, the results of the 2003 Household Survey conducted for the HIF Committee indicate that a higher proportion of the uninsured (who report having a regular source of care) are more likely to use an emergency room as their regular source of care, than people with either private or public coverage:

Table 3

**Distribution of Health Care Sources for Those with a Regular Source of Care:**

Source	Type of Insurance		
	Uninsured	Public	Private
Emergency Room	11.1%	5.9%	2.9%
Doctor’s Office	19.5%	15.1%	11.0%
Clinic	66.9%	76.9%	85.2%
Other	2.5%	2.1%	0.9%
	100.0%	100.0%	100.0%

The widespread phenomenon of the uninsured poor obtaining much of their care from hospital emergency rooms results in large part from a federal law that prevents them from being turned away from these care settings. The Emergency Medical Treatment and Active Labor Act (EMTALA) requires hospitals participating in Medicare that operate an emergency room to provide necessary screening and stabilization services to any patient who comes to an emergency room requesting examination or treatment – regardless of ability to pay – in order to determine

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<sup>24</sup> I.C. 16-21-9.



whether an emergency medical situation exists.<sup>25</sup> Thus, virtually all non-specialty, acute care hospitals provide at least some charity care in their emergency rooms (or they may characterize it as “bad debt”), although not all would be considered safety-net providers.

This care by its nature is episodic and does not provide for continuity of care. It also does not provide preventive services or chronic disease management. Uninsured patients are stabilized and treated for the acute issue at hand, but no other services are necessarily provided. For these reasons, emergency room care that may be high quality for emergencies is problematic as a source of primary care. Additionally, it costs more to treat a person in the emergency room than in a primary care setting which leads to more costs to both the patient and the health care system.

### ***Adequacy of the Hospital Safety-Net***

In recent years, Indiana hospitals – especially hospitals serving a disproportionate share of the low-income population – have benefited financially from expanding Medicaid enrollments. The expanded use of special financing arrangements within Medicaid to make supplemental payments to hospitals has also increased resources for a number of safety-net hospitals. Further, the recently enacted 2003 Medicare Act contained provisions that will increase Medicare funding for rural hospitals and also increase FY 2004 Medicaid state DSH allotments by 16 percent over the FY 2003 allotment level. These funding improvements in Medicaid and Medicare have helped and will help Indiana hospitals continue to survive in a difficult economic environment with growing numbers of uninsured.

However, the future hospital funding outlook is uncertain at best. The Indiana Medicaid program has already made hospital reimbursement cuts as part of the overall effort to constrain Medicaid spending growth as the state continues to suffer from weak state revenue growth and a large state budget deficit. The federal government is also looking with increasing disfavor upon the special Medicaid financing arrangements utilizing IGTs that have been so important to hospitals in recent years. In light of the now increasingly severe federal budget deficit, there are concerns that the federal government will attempt to limit and even reduce these financing programs. Increasing financial pressure on hospitals from these sources as well as an increasing number of uninsured is likely to reduce the capacity of the hospital safety net to provide hospital care for the uninsured in the future.

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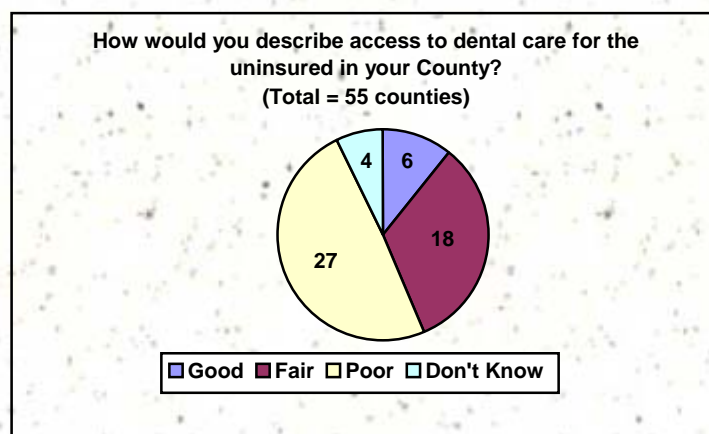
<sup>25</sup> Hospitals that are found to be in violation of EMTALA requirements may face civil monetary penalties

Even if no additional federal or state funding cuts occurred, however, it is extremely unlikely that the current level of charity care provided to the uninsured by Indiana hospitals could be defined as “adequate” to meet their hospital care needs. While there is no available data source that can quantify this gap, the gap almost certainly exists, especially as it relates to non-emergent specialty care provided in a hospital inpatient or outpatient setting. While an uninsured pregnant woman will almost certainly be able to be admitted to a hospital through its emergency room to have her baby delivered, a chronically ill uninsured adult who needs diabetic education and monitoring may find it difficult or impossible to access that care. Tragically, they may only be able to receive treatment when amputation is required. Further, the injured adult will get treatment for those immediate wounds, but is unlikely to get any rehabilitative services.

## V. Dental Services

Accessing dental care in Indiana is a critical challenge for many of the uninsured who are unable to pay cash for the entire cost of care up-front. Even those with health insurance often lack coverage for dental services and thus would face similar challenges as those with no insurance at all. As shown in Figure 7 below, respondents to the Step Ahead Survey indicated that access to dental care for the uninsured in their respective counties was generally fair to poor.

Figure 7



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and termination of their Medicare provider agreement.



Twenty-seven (27) out of 55 counties that responded stated that access was poor, and 18 responded that access was fair. Only six counties responded that access to dental care was good. In identifying where the uninsured access dental care, one respondent listed private doctors' offices, the Indiana University Dental School and "Jail" adding "individuals may commit a crime to have dental work done."

In Indiana, uninsured individuals and families can seek free or reduced cost dental care through FQHCs and FQHC "look-alikes," at the Indiana University Dental School and through various formal and informal "donated dental services" arrangements. Options vary; however, in different areas of the state, and even where free or reduced price dental services are available, long waiting times are often an issue. Appendix G of this report contains a list, by county, of dental services clinics for low-income clients that was assembled by the ISDH in January 2003 in a document entitled "*Dental Services Clinics for Low Income Clients*." This document is also used by the Indiana Dental Association for referral purposes.

### ***Federally Qualified Health Centers***

Individuals and families can obtain primary dental care on a sliding fee scale basis through one of the 15 FQHCs or FQHC look-alikes in Indiana. These health centers are federally required to provide preventive dental services, pediatric dental screening and emergency dental services (but not restorative care). If dental care is not available on-site at the health center, the FQHC must make arrangement with local providers to provide access to the required services. Access to these services must be made available to all health center users regardless of ability to pay and health centers must be able to justify why services and/or populations are excluded if the scope of services is limited and/or less than comprehensive. Health centers charge a sliding fee for dental services with no charge for patients below the federal poverty level and no discount for those above 200 percent of the FPL.

### ***County Health Departments***

Only two county health departments - Marion County and Elkhart County - offer dental services. In Elkhart County, dental services are limited to children age seven and younger. In Marion County, services are available to children and pregnant women and to adults enrolled in the Wishard Advantage program with a \$10 charge per visit. Marion County also operates the "Smile Mobile" which provides free dental services to children. The Bartholomew County Health

Department will refer a limited number of children to area dentists with funds for payment of services.

### ***Other Clinics***

There are a limited number of other dental clinics in the state that provide a range of free or reduced price dental services to low-income Hoosiers. About a dozen such clinics are listed in the ISDH publication, *"Dental Services Clinics for Low Income Clients."* The range of services offered and the age range of patients seen vary by clinic. Some of these clinics also accept Medicaid and other forms of insurance while others accept no insurance of any kind.

### ***Dental School***

The Indiana University Dental School offers services at somewhat reduced fees, although the school's willingness to work with patients on payment arrangements make this a potential option for those who would be able to pay over time but have difficulty paying 100 percent of the cost up front. Many dentists in private practice are reluctant or unable to allow patients to pay over time. Discounted fees may also be available at the Pediatric Dental Clinic at Riley Hospital for Children. Cleanings, x-rays, sealants and fluoride treatments at reduced rates are also available at several university-related dental hygiene clinics including IUPUI at Fort Wayne, Indiana University Northwest, Indiana University, South Bend and the University of Southern Indiana. Step Ahead survey respondents from two southern counties also identified the University of Louisville Dental School as source of dental care for the uninsured.

### ***Donated Dental Services***

One vehicle for finding free dental care is the Donated Dental Services Program (DDS) of the Indiana Foundation of Dentistry for the Handicapped. DDS provides free dental care for a serious dental problem<sup>26</sup> to people who cannot afford needed treatment. The person must have a limited income that is linked to a disability (mental or physical), frail health associated with advanced age, or an involved medical problem. The health problem must be permanent. The DDS refers eligible applicants to dentists throughout the state who have volunteered to provide comprehensive dental care at no charge to persons in the DDS program. Applicants are placed on a waiting list for the area of the state in which they live, and some areas of the state have longer

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<sup>26</sup> General check-ups and cleanings are not covered.



waiting lists than others – it could take as long as six months for an applicant to reach the top of the waiting list. In FY 2003, the DDS program treated a total of 212 patients. The total value of the donated dental services was \$461,769 for dentists and \$46,192 for laboratories. This program is “narrow” (i.e., serves a relatively small number of patients), but “deep” (provides comprehensive dental care).

There likely exists other informal local arrangements whereby dental services are donated to low-income and insured Hoosiers. It is impossible to know, however, how widespread these efforts are and the lack of readily available information about such efforts would make it difficult for a prospective patient to access these programs and providers.

### ***Major Issues, Challenges in Accessing Dental Care in Indiana for the Uninsured***

While the discussion above illustrates that there are some free and reduced cost dental services options within the State of Indiana for those without dental insurance, access to dental care remains a significant issue. There are large areas of the state where few options exist and where they do exist, the overall capacity is limited leading to long waiting times for appointments. For those uninsured persons that are willing and able to pay in cash if there is an ability to enter into a payment plan, the requirement by many dental providers for payment in full up front can be a significant barrier to dental care as well.

Lack of adequate numbers of dentists, generally, is also a problem in some parts of the state. As of March 2003, there were 14 counties or portions of counties that had been designated as a Dental Health Professional Shortage Area (HPSA) by the Health Resources and Services Administration of the federal Department of Health and Human Services. (See Appendix H.) A HPSA designation brings with it the ability to qualify for other federal programs including the National Health Service Corps Scholarships and Loan Repayment Programs. It is up to the ISDH, working with a local community, to submit a HPSA designation request – it does not happen automatically. Thus, it is possible that other areas of the state might qualify for a Dental HPSA designation if an application were submitted. Overall, in 1998 Indiana had 40.8 dentists per 100,000 population – below the national average of 48.4 dentists per 100,000 population.<sup>27</sup>

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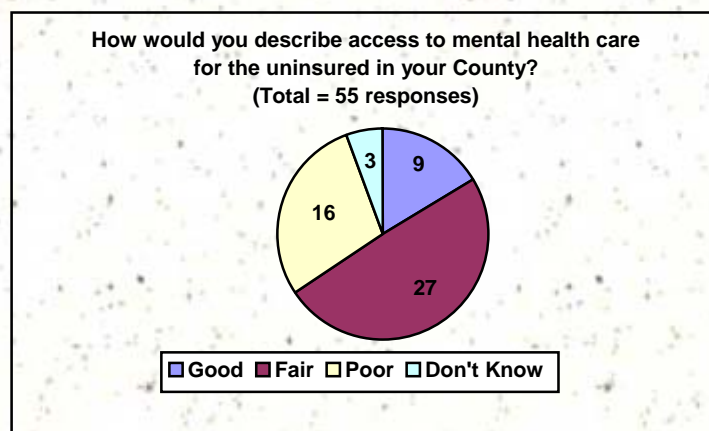
<sup>27</sup> HRSA *State Health Workforce Profiles*, Bureau of Health Professions, National Center for Health Workforce Information & Analysis, Health Resources and Services Administration, US Department of Health and Human Services, December 2000, accessed at <ftp://ftp.hrsa.gov/bhpr/workforceprofiles/IN.pdf>.

Finally, after a number of years of declining participation by dentists in Indiana's Medicaid program, access to dental services in Medicaid began to improve after reimbursement rates were increased and other policy changes were made in 1998 to respond to the complaints of dental providers. Since 1998, however, dental reimbursement rates (considered somewhat generous in 1998) have remained static, and in 2003, Indiana Medicaid imposed a \$600 annual cap on dental services for adults (with certain exceptions) as part of its overall cost containment efforts. Indiana Medicaid continues to monitor the impact of these changes on dental access in the Medicaid program.

## VI. Mental Health Services

The significant majority of outpatient mental health services in Indiana are provided through a statewide system of 31 community mental health centers (CMHCs), (Appendix I) with exclusive geographic areas. Overall access to mental health services was fair based on the Step Ahead Survey.

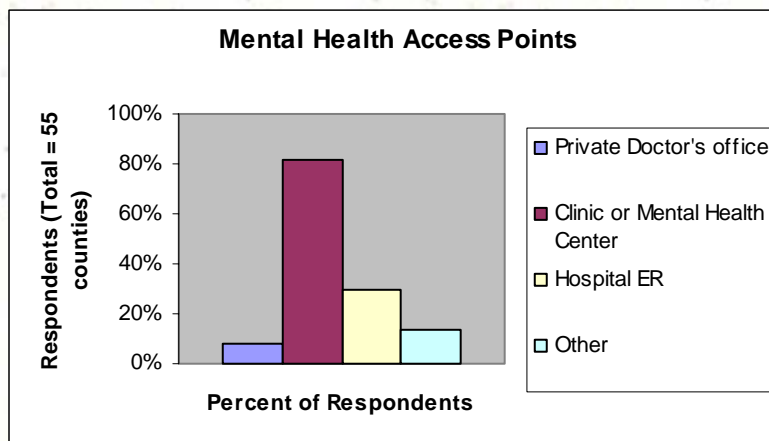
Figure 7



Respondents to the Step Ahead Survey reported that the uninsured in their respective counties accessed mental health services primarily at CMHCs followed by private physician offices.



Figure 8



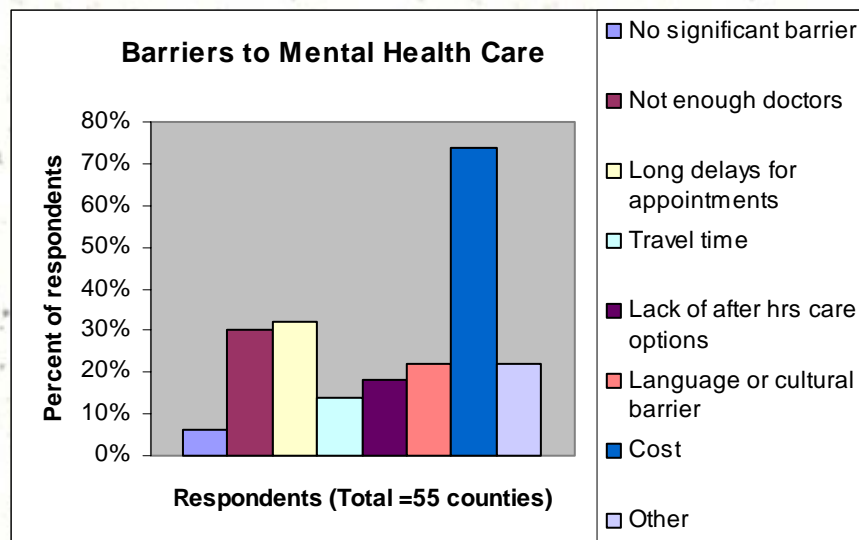
The mission and mandate of CMHCs is to provide comprehensive mental health services to individuals regardless of their ability to pay.<sup>28</sup> They are essentially the “primary care provider” for individuals with serious mental illness and addictions.<sup>29</sup> On average, about one-half of all CMHC patients are Medicaid recipients. Their patient mix also varies between adults and children depending on the availability of service for the population.

For counties responding to the Step Ahead Survey, cost was cited as the primary barrier to access for mental health services. This, along with lack of mental health professionals and long delays in appointments, means only those in need of emergency or urgent care receive services. Noble, Tipton and Wells counties, however, reported no significant barriers to mental health care.

<sup>28</sup>Services include 24-hour crisis intervention, case management, treatment planning, counseling services, day treatment, training in activities of daily living, medication management and monitoring, outreach and education, residential services as well as linkage to other non-mental health services.

<sup>29</sup> Many centers also have programs to assist patients become employed or retain employment with services like employment follow-along that assist individuals with mental illness manage the stresses of working. CMHCs also serve as the gatekeepers of admissions into state psychiatric hospitals including the provision of all necessary screening and follow-up assistance to state institutions to return individuals back into the community.

Figure 9



Although it is the mission and mandate of CMHCs to serve all individuals, limited funding, with some CMHCs only having 30 days' worth of cash on hand, often means many uninsured individuals may be turned away or must wait significant periods of time to receive services. To supplement their funding, all CMHCs offer a sliding fee scale to their patients.

The ability of CMHCs to continue to be the safety net for the uninsured population who need mental health services is at a breaking point due to lack of funding. Currently, 80 percent of total state appropriations for mental health and addiction services and a significant portion of county property tax funding that CMHCs use to pay for services is used to support the non-federal share of the Medicaid Rehabilitation Option program for Medicaid eligible recipients. The remainder is used primarily to support Medicaid administrative claiming for outreach, enrollment, transportation, translation and other activities that CMHCs perform in support of the Medicaid program administration. Seventy percent (70%) of all funding coming into the CMHC is Medicaid MRO funding. The CMHCs also receive Medicaid funding for other mental health (non-MRO) services such as individual and group therapies. This has created a crisis for the uninsured. While individuals on Medicaid have available the full range of mental health services, uninsured individuals are only receiving emergency or urgent care and limited, non-intensive programming (such as group therapy instead of individual therapy). Furthermore, in most cases, uninsured individuals have a wait period to receive non-emergency or non-urgent care. The wait period varies across the state. In fact, the Indiana Council of Community Mental Health Centers



are advising CMHCs to be prepared to start limiting services to only emergency and urgent care for uninsured individuals.

Where there is a shortage of health professionals, there will also be a gap in services, regardless of insurance status. For example, while a high percentage of children served by CMHCs are Medicaid-eligible, there are very few child psychiatrists available statewide leading to limited access even for those children covered by Medicaid. Add to this the real or perceived abuse of psychiatric medication in children, the need is for more professional education in child psychiatry with an emphasis on evidence-based practices for children.

Lack of funding for residential services still remains a critical service gap for most CMHCs, even for the Medicaid population. Many have entered into arrangements with providers of room and board assistance to provide mental health services to those recipients. Another gap in services is the lack of programs specifically for individuals who have mental illness and mental retardation. These individuals often end up shuffled between two systems; one for their mental retardation and another for their mental illness with very little and usually ineffective coordination because no single entity is able to take ownership of the individual's care and funding is usually in the silos of two systems. For young children in schools with dual-diagnosis, there is a third system of care which they must navigate which includes special education. Developing a statewide coordinated approach to care with funding silos and multiple state entities is a major challenge for CMHCs.

Services are accessed in a variety of ways, either individually, or through the judicial system. Individuals who are arrested and under the influence of drug or alcohol are oftentimes brought to the CMHCs by the Sheriffs for care. Unless services needed are emergency or urgent care services, these individuals do not receive the care that they need. The result is that county jails and correctional facilities have more mentally ill individuals than state operated mental health facilities. The juvenile system is also another point of access for children with untreated mental illnesses. These children end up as wards of the State and often required to be treated by CMHCs.

While the statewide mental health system is strained and unable to support care for the indigent, when it comes to the security of the mental health safety net, the areas most at risk are those CMHCs in counties that are economically depressed, and/or where there is a shortage of mental health professionals.

## VII. Medicaid and the Indiana Safety Net

Medicaid is the single largest financier of health care services for low-income populations in the United States providing coverage for more than 50 million Americans (compared to the 40 million covered by Medicare) including:

- Twenty-five million children (more than one in four in the United States);
- Thirteen million adults, primarily low-income working parents;
- Five million seniors, and
- Eight million persons with disabilities.<sup>30</sup>

In Indiana as of June 2003, the Medicaid program served over 760,000 people including:

- 478,533 children;
- 115,731 low-income adults and pregnant women;
- 65,146 aged, and
- 103,524 persons with disabilities.<sup>31</sup>

Appendix J contains Medicaid enrollment by region, as well as other health and demographic indicators. In addition to providing health care services to the uninsured, safety-net providers are usually also key providers of health care for the Medicaid population. Thus, Medicaid plays a vital financing role for Indiana's safety-net providers by covering over 760,000 Hoosiers who might otherwise be uninsured. Also, due to the reliance of most safety-net providers on Medicaid, these providers are particularly sensitive to, and impacted by, changes in Medicaid policies, eligibility standards, reimbursement and/or other coverage or benefit changes.

### ***FQHCs, RHCs and DSH Hospitals Receive More Favorable Medicaid Reimbursement***

Both federal law and state law recognize the unique needs of certain core safety-net providers and ensure them more favorable Medicaid reimbursement than would otherwise be the case. Federal law grants FQHCs and RHCs protected status within all state Medicaid programs by making coverage of FQHC and RHC services mandatory and also by requiring that all Medicaid programs reimburse FQHCs and RHCs on a reasonable cost basis. To the extent states (including

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<sup>30</sup> "The Medicaid Program at a Glance," Kaiser Commission on Medicaid and the Uninsured, January 2004, accessed at [www.kff.org/kcmu](http://www.kff.org/kcmu).



Indiana) contract with managed care organizations (MCOs) to provide care to Medicaid enrollees, federal law also requires the state Medicaid program to pay the difference, if any, between what an FQHC or RHC receives from an MCO and what it would have received on a reasonable cost basis.

Federal law also allows state Medicaid programs to make supplemental payments to certain acute care hospitals that provide a “disproportionate share” of the care for the Medicaid and uninsured (“DSH hospitals”). While states are subject to federal limits and requirements, states also have a great deal of flexibility to determine their own priorities and methodologies. In Indiana, the Medicaid DSH payment methodology is complex and constantly changing. For State Fiscal Year 2002, 22 acute care hospitals will likely qualify for approximately \$120 million in net Medicaid DSH payments (after netting off the non-federal share funded through intergovernmental transfers). Also, as a result of the recently enacted Medicare Prescription Drug, Improvement and Modernization Act, Indiana’s state Medicaid DSH allocation in FFY 2004 will increase by 16 percent. The state has indicated that the increase will be used to assist Wishard Memorial Hospital in Indianapolis.

### ***Recent Indiana Medicaid Cost Containment Measures***

Over the past two years, Indiana Medicaid has implemented a number of cost containment measures in an attempt to slow the rate of spending growth in the Indiana Medicaid program. As safety-net providers are also often significant providers of health care for Medicaid enrollees, Medicaid cost containment measures also impact their overall financial health, and therefore, their capacity to provide charity care to the uninsured. For the most part, Indiana’s actions in this area have attempted to avoid major adverse impacts on core-safety-net providers. In particular, some of the more significant cost containment measures have focused on nursing homes and pharmacy utilization that are less likely to significantly impact safety-net providers. However, some of the cost-containment measures that more directly impact safety-net providers include:

- Hospital reimbursement reductions of five percent in FY 2003 and a delay of the January 2003 inpatient inflationary adjustment;
- With certain exceptions, imposition of a \$600 annual cap on dental services for adults, and

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<sup>31</sup> 2004-2005 Medicaid Forecast Update, Office of Medicaid Policy and Planning, Indiana Family and Social Services Administration, January 12, 2004.

- The elimination of 12-month continuous eligibility for children.

On the positive side, Indiana Medicaid is also implementing a Chronic Disease Management program that was also designed to strengthen the existing public health infrastructure. Among other things, the program relies on a nurse care manager network that the state has contracted with the Indiana Minority Health Coalition and the Indiana Primary Health Care Association to provide. In addition to improving the quality of care and hopefully the health outcomes of Medicaid enrollees with chronic diseases, the Indiana Medicaid program has ensured that resources necessary to implement this program will also help strengthen Indiana's traditional safety-net providers.

Finally, another of Indiana's cost containment measures was the imposition of mandatory risk-based (capitated) managed care (RBMC) for most non-aged/non-disabled adults and children in certain urban counties (including Marion, Allen, Elkhart, St. Joseph, and Lake in 2002 and LaPorte, Porter, Madison, Grant, Howard, Johnson and Morgan planned for 2004). It is unclear whether this policy change will have a significant impact, positive or negative, on safety-net providers. As was discussed above, FQHCs and RHCs are ensured, under federal law, that Medicaid reimbursement will be based on reasonable costs regardless of whether or not the Medicaid patient is enrolled in an MCO.

## VIII. Spotlight: Innovations in Care to the Uninsured

In the absence of federal or state initiatives to reduce the number of uninsured, many local communities throughout the nation have worked to develop unique systems to provide care for the uninsured. This section examines some unique Indiana programs: the Marion County Health Advantage program, three projects federally funded through the Healthy Communities Access Program, and the implementation of organized volunteer physician programs throughout the State. The communities and providers involved in these efforts have utilized non-traditional methods to expand, organize and develop more comprehensive systems of care for the uninsured. These examples are true innovations, and solid testament to Indiana's commitment to, and concern for, the uninsured.



### ***Marion County Health Advantage***

In Indiana, Marion County is unique in the magnitude of its public resources devoted to providing health care for the uninsured through the Health and Hospital Corporation of Marion County (HHC). In 2003, HHC received property tax levy proceeds totaling \$88 million<sup>32</sup> that were used to finance Wishard Health Services (which encompasses Wishard Memorial Hospital, a nursing facility, seven community health centers and the Midtown Community Mental Health Center) and the Marion County Department of Health. Marion County is also unique among Indiana counties in the magnitude of the problem of the uninsured: approximately 40 percent of the uninsured in Indiana reside in the Indianapolis Metropolitan Statistical Area according to the 2003 FSSA Household Telephone Survey commissioned by the HIIF Committee.

In 1997, HHC developed the Health Advantage program (formerly known as the “Wishard Advantage” program), to reorganize the delivery of care by Wishard Health Services to low-income and uninsured Marion County residents with incomes at or below 200 percent of the federal poverty level. Health Advantage was designed to simulate a commercial managed care program by enrolling patients in the program for one year, encouraging them to select a Wishard primary care physician who would manage their care, and providing them with membership cards, and handbooks. HHC paid physicians on a per-member per month basis, which encouraged the doctors to develop a relationship with the patients. Patients that enrolled in the program received care for free or at a significantly reduced cost. The purpose of the program was to encourage the uninsured to proactively seek health care to prevent disease, divert patients from the emergency room and encourage more appropriate utilization of care. Health Advantage has received several awards and been the focus of national attention.

In the seven years since the inception of Health Advantage, several key developments have had a significant impact on the program. To increase enrollment (a priority of HHC), HHC invested in a state-of-the art electronic application system that facilitated enrollment not only into Health Advantage but also into Medicaid and other health programs as well (see below). Enrollment in the program has been a huge success moving from 12,000 in 1997 to almost 40,000 as of December 2003, with the most significant period of growth occurring after 2002. This remarkable enrollment growth, however, is also a testament to the growing number of uninsured in the

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<sup>32</sup> *Assessment of Indiana Health Funding*, A Report to the Health Insurance for Indiana Families Committee by Health Evolutions, February 2004, p.27.

county. In 1999, HHC also made a historic gesture by expanding the Wishard-only network to include all the key safety net providers in the county. Marion County has a number of safety net providers, including nurse-managed clinics and FQHCs that provide primary health care, that are independent of HHC and Wishard Health Services. The network expansion initiative was an effort to develop a more coordinated system of care for the county and was also the foundation of HHC's application for a federal Healthy Communities Access Program grant. HHC also began paying a nominal capitation to non-Wishard providers for primary care. All of this was done in an effort to promote access, with the long-term goal of improving the health of the community.

Increasing enrollment, while enormously beneficial to the uninsured, was not without a price to HHC and Wishard Health Services. Beginning in 2000, Wishard Health Services began to face a significant and well-publicized financial crisis. HHC had to make critical decisions including the potential rationing of health care services. While the basic Health Advantage program was kept intact, key components of the program were eliminated, including the cards, handbooks, and the utilization management program. Patients are allowed to select clinics, but not individual physicians. The payment methodology to the physicians also changed from capitation to fee-for-service. New cost-sharing policies were also implemented in 2003, and patients were asked to make copayments for all services, including \$10 for primary care, \$20 for specialty care, \$5 for prescription drugs, and \$50 for emergency care. Other fees applied to inpatient services. This was a landmark change for an institution that had never implemented cost sharing so widely. Since it has been less than a year since many of these changes were implemented, no comprehensive study has measured the impact on the patients and their quality of care.

Despite the financial challenges, the history and experience of the Health Advantage program offer significant lessons for policymakers. Rapidly growing enrollment highlights the growing number of uninsured and the vast need for health care services in Marion County and in Indiana. It also depicts the conundrum that faces safety net providers – while trying to improve quality through improving access, proactively providing preventative care, and continuity of care, they must also be careful with how far the door swings open. Providers are in an impossible situation of having to balance high quality care with the increasing numbers of uninsured that require basic health care services. This reveals the basic issue: demand surpasses capacity and available resources. By investing in primary care and seeking innovative approaches to changing utilization behaviors, Health Advantage raised the bar in terms of the approach to how health care to the uninsured can be provided. This innovative approach helps improve overall care, but can only go so far in resolving the issue of resources.



### ***Indiana Community Access Programs***

The Institute of Medicine Report, "Safety Net Intact but Endangered," called for the federal government to provide funding on the local level to help communities to coordinate "safety net" services for the uninsured. Congress responded with the development of the Community Access Program, or CAP in 1999. Renamed the Healthy Communities Access Program (HCAP), by the Bush Administration, the program provides three-year competitive grants to promote the development of local systems of care. Funding over the three-year period for most grantees is over \$2 million. The grant funds are not for planning, but to help build self-sustaining infrastructure over the long-term and thereby help local communities serve more uninsured and improve quality of care for the uninsured population. Indiana is home to three HCAP grants, one in Marion County, one in St. Joseph County, and one encompassing a four-county rural area (Clinton County, Northern Madison County, Howard County, and Randolph County). Early results indicate these programs have been a significant force in forging partnerships and collaboration on the local level. The grants have brought together systems that are normally competitors to focus on improving care to the uninsured. They have helped improve access to existing services and have created new services by improving the current systems and promoting efficiencies. However, the long-term impact has not yet been evaluated, and there is little information on whether these programs will help communities deal with growing numbers of uninsured, as the program does not provide resources to the safety net to allow them to serve more individuals.

Marion County. Marion County, through a partnership of HHC and the other safety net clinics in the county, received the first Indiana HCAP grant in 2000. The dollars were used to support the expansion the Health Advantage program beyond the HHC system and consisted of four major project areas.

- The Marion County CAP worked toward developing a web-based eligibility and enrollment system, **IndeApp**. This system allows financial counselors to screen patients for a variety of health assistance programs, including Medicaid, to determine potential eligibility. IndeApp also assists in completing the necessary paperwork for the programs. In the case of the Health Advantage Program, IndeApp allows for electronic enrollment into the program with a completely paperless process.

- The HCAP grant was used to implement a pharmacy assistance program in all of the safety net clinics across Marion County. Aided by a purchased software system, staff can complete the necessary paperwork to obtain the free prescription drugs available through most drug manufacturers.
- The Marion County partners worked to develop a common indigency policy, which attempted to identify uniform cost-sharing and copayment policies for all of the providers. This was an attempt to develop consistency across the system and help promote personal responsibility.
- HHC is also working to develop a disease and case management system for the high-utilizers of health services in the Health Advantage program.

RUAH. The Rural Underserved Access to Health (RUAH) CAP project funded through both HCAP, and Ascension Health is located in Clinton County, Northern Madison County, Howard County, and Randolph County and began in 2001. The collaborators in this effort include St. Vincent Health (SVH), Butler School of Pharmacy, Indiana Health Centers (IHC), ADVANTAGE Health Plan, Inc., and HHC. Their collective interest is in the development of community systems of care that can serve as models to be adapted to meet the needs of other rural areas throughout the state. While this project addresses the needs of the uninsured and underinsured in general, it places special emphasis on reaching the Hispanic population, including migrant farm workers as well as the growing number of Hispanics who have permanently established residence in the area. Specifically, RUAH:

- Established field-based health access workers to assess the needs of over 7,300 vulnerable individuals in the four-county service area and connect them to needed health, human and social services while removing barriers that impede access to these services. Over 1,500 people have been placed within a primary medical home and over 500 have been enrolled in Medicaid;
- Facilitates coordination of services through establishment of a management information system (MIS) to enable client tracking among safety net providers;
- Trained over 35 medical interpreters to improve the delivery of culturally and linguistically appropriate care to non-English speaking individuals;
- Developed diversity councils in each of the partner hospitals in each county served;
- Improved access to free or reduced-cost prescription drugs for the uninsured and the underinsured. Since November 2002, over \$2 million in free or reduced-cost prescription drugs have been accessed by the uninsured, and
- Created a long-term strategy to sustain the goals of providing access to care to the target populations.



St. Joseph County. The St. Joseph County HCAP was funded in 2003, with a goal of maximizing access to health care services and eliminating disparities of health outcomes through a “high touch, high tech” integrated program. The St. Joseph HCAP has three components: case management for clients with asthma, diabetes, or hypertension, a volunteer physician network, and the expansion of a community health information network. Collaborators in the project include the Healthy Communities Initiative of St. Joseph County, Indiana Health Centers, Inc., Memorial Health and Hospital System, Inc., Saint Joseph Regional Medical Center, Inc., the United Way of St. Joseph County, the Council of Clinics, and the St. Joseph County Medical Society. The project will:

- Provide a comprehensive care management system through a network of local service providers coordinated by case management staff called Family Health Navigators (FHN’s). With this focus on increased case management, the Family Health Navigator Program expects to reduce hospitalizations and emergency room visits for its target population by 10 percent;
- Improve access to volunteer physician services (primary care and specialty) by developing a systematic and equitable referral process for the uninsured, and
- Continue to further develop and expand the community health information network, a clinical management information system that allows for secure access to patient medical records from multiple sites. The goal is to have clinical data and patient encounters accessible in a timely fashion, thus eliminating the potential for fragmented health care and reducing duplication in health care services including office visits, laboratory tests, x-rays, and pharmaceuticals.

### ***Donated Health Care Services: Health Indiana and Project Health***

With the burden on the safety net increasing dramatically, private providers have been concerned with the lack of services available for the uninsured. Nationwide, local medical societies have organized volunteer programs, where physicians agree to provide services to a set number of indigent patients. In 1994, an estimated 82 percent of primary care visits by the uninsured in the United States occurred in physician offices, compared to ten percent in community health centers, and eight percent in hospital outpatient departments.<sup>33</sup> While this number is significant, a study by the Center for Health System Change indicated that the proportion of volunteers providing charity care had decreased,<sup>34</sup> most likely due to declining

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<sup>33</sup> Christopher B. Forrest and Ellen-Marie Whelan, "Primary Care Safety Net Delivery Sites in the United States: A Comparison of Community Health Centers, Hospital Outpatient Departments, and Physician Offices, *Journal of the American Medical Association*, 284 no 16 (October 25, 2000) pg 2077-83.

<sup>34</sup> Peter Cunningham, "Mounting Pressures, Physicians Serving Medicaid Patients and the Uninsured, 1997-2001," Tracking Report Number 6, Center for Health System Change, December 2002

provider reimbursements, that limit their ability to cross-subsidize uninsured patients. National studies also show that most physicians do provide at least some charity care, amounting to approximately 14 percent of their total patient care hours.<sup>35</sup> This indicates that the majority of charity care provided by physicians is provided by a minority of providers. Typically, the volunteer efforts of a physician encourage other providers to donate services and the result is a well-organized system of donated health care services, including free pharmaceuticals. Patients are screened for eligibility and staff work to assure patients attend their scheduled appointments, and to organize care for any gaps in services that arise. When coordinated with the safety net, these programs help fill the gaps in services for the uninsured, and are an excellent example of local partnerships. These programs undoubtedly provide a significant service to the community, but still do not resolve the crisis in care to the uninsured, as providers can only provide a limited amount of free services and remain financially solvent.

Health Indiana. *Health Indiana* was created when Representative Brian Hasler of Evansville, aware of similar programs in Kentucky, South Carolina and Maryland, initiated legislation in 2002 to create Health Indiana and calling on the Secretary of the Family Social Services Administration to cooperate and assist Health Indiana. While still in development, Health Indiana will be organized to coordinate the volunteer efforts of physicians and other providers to help provide health care to low-income Hoosiers. Health Indiana's goal is to work across the State community-by-community and region-by-region to identify volunteer medical providers to participate in Health Indiana. Medical providers that agree to participate will provide unlimited free care to a set number of indigent patients that they determine. Once they have met their allotment, patients are no longer referred to them. Physicians take comfort that Health Indiana will screen the patients for eligibility. The centerpiece of the Health Indiana program is the availability of free drugs. Representative Hasler has been successful in working with some of the pharmaceutical industry's top manufacturers, which represent over 80 percent of the Medicaid formulary. The manufacturers have agreed to provide free drugs to Health Indiana patients. Health Indiana is also working with pharmacies to have the donated drugs dispensed at local pharmacies throughout Indiana. Health Indiana will target uninsured Hoosiers that fall at or below 150 percent of the FPL. Representative Hasler has also obtained donations from the manufacturers to fund the operational costs of the program. Plans are underway to develop an annual fundraiser for the program. Health Indiana, while critical to providing services to the

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<sup>35</sup> Kane "Physician Provision," 7



uninsured, is intended to work in coordination with Indiana safety net providers to fill in service gaps. While the availability of the drugs is a major development that will assist scores of Hoosiers, the success of the program will rely on the goodwill of providers to provide free care to the uninsured.

The Hudson Institute, currently based in Marion County, has also initiated efforts in Marion County in partnership with the Medical Society to develop similar volunteer programs modeled on the “Project Access” program in Buncombe County North Carolina. The American Project Access Network, also affiliated with the Buncombe County model, is developing similar programs in South Bend (St. Joseph County), Kokomo (Howard County), Andersen and Elwood (Madison County), Jay County, Blackford County, Randolph County, Switzerland County, Franklin County, Ohio County, Dearborn County, and Ripley County. In Angola, private physicians have also organized to provide free care to low-income residents through a voucher program. Efforts are underway to coordinate Health Indiana with local efforts.

The obligation to provide charity care to the poor has historically been a part of physicians' professional ethos.<sup>36</sup> However, increasing costs of medical care, and physician concerns about the unstable health care market have limited such efforts. There is increasing debate about the role of volunteerism, as some believe that the uninsured are a fundamental societal responsibility that is too complex and fragmented for volunteer-based solutions, and others believing that these efforts should serve as the cornerstone to addressing the uninsured. There is concern that undue reliance on volunteer programs may detract from efforts to provide solutions to addressing the uninsured through public program expansion or funding for safety net institutions.

## IX. Recommendations

The recommendations outlined below offer suggestions aimed at maintaining and strengthening Indiana's health care safety net with a particular focus on maximizing existing resources and the promotion of efforts that would lead to increased federal funding through new FQHC designations. The first six recommendations focus on strategies to maximize the benefit of the current state resources appropriated to the ISDH to help fund CHCs. Also included is a

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<sup>36</sup> NHPF Paper

recommendation intended to maximize the benefit of Medicaid DSH payments to safety net hospitals. The recommendations also encourage support for Indiana's Medicaid program and efforts to expand eligibility, and the final recommendation is targeted at improving the availability of safety net-related data for policymaking purposes.

1. **The Medicaid program should be preserved and fully supported.** The Medicaid program is important not only to the Hoosiers on the program, but it is also critical to overall Indiana economy, and to vitality of business. The Medicaid program helps to reduce the number of uninsured which lowers health care costs for all employers. Additionally, the Medicaid program helps build the infrastructure of the safety net institutions that serve the uninsured, in turn the existence of the safety net helps protects other providers by reducing their uncompensated care, which can be passed on to insured patients. The program also serves to leverage significant federal dollars, and cuts to the Medicaid only reduces Indiana's share of federal tax dollars.
2. **Target available state CHC funding to health centers that meet state goals and expectations and promote additional FQHCs designations through CHC state funding requirements.** Further the efforts of ISDH, to create a higher level of accountability and access. Implement incentive payments for CHCs that are able to meet ISDH established goals and tie base payments to the number of uninsured cared on an annual basis. By linking funding with goals addressing quality of care, disease management and access provided, the primary care infrastructure would create rewards for meeting the needs of the state and its most vulnerable citizens. A strategic plan outlining clear standards and timelines for gaining FQHC status should be developed for individual CHCs. CHCs should demonstrate steps taken to meet FQHC status within a period of time as well as identify barriers and potential solutions
3. **Consider redirecting a portion of available state CHC funds, and or DSH, and HCI to support community-based initiatives.** The State, or ISDH, could consider giving funding to community access initiatives or organizations rather than specific health center organizations. In a time of scarce resources and private providers willing to donate services, coordination and collaboration is critical to supporting the existing safety net and expanding the services that are available. By funding communities, ISDH could encourage local planning and development around building systems for indigent care.



Alternatively, funded CHCs could be required to demonstrate partnership with other entities and providers.

4. **Set aside a portion of the available state CHC funding, or explore the availability of Medicaid administrative claiming to provide technical assistance to CHCs.** According to IPHCA, Indiana ranks 48<sup>th</sup> in the nation in terms of relative levels of federal funding for FQHCs. With the new federal initiative to expand federal FQHC funding over the next five years, Indiana has an opportunity to improve access in some areas of the state. These federal funds are important in solidifying a strong primary care safety net. ISDH should also provide additional technical assistance to other communities to encourage the development of FQHCs, which can help leverage federal resources to the community level. In so much as expanding FQHCs could address the provider shortages, and the availability of providers for the Medicaid program, the use of Medicaid administrative dollars should be explored.
5. **As an alternative to suggestion number three above, redirect current CHC State funding for a Medicaid program expansion.** State funding currently flowing to FQHCs and CHCs could be transferred to Medicaid to fund a new program. This could be a limited primary care only Medicaid program for low-income Hoosiers not currently covered under Medicaid. By matching this state money with federal Medicaid funds, the available funding could be increased significantly (for example \$15 million of state funding would become a program of over \$39 million).
6. **Continue to preserve (and ideally expand) existing Medicaid eligibility criteria.** With the exception of the elimination of twelve-month continuous coverage for children, recent Medicaid cost containment efforts have thus far not included cuts in eligibility which would be much more harmful to safety net hospitals, FQHCs and RHCs than rate cuts, for example, due to Medicaid DSH funding and cost-based reimbursement requirements for FQHCs and RHCs. Conversely, expansion of coverage through Medicaid or private insurance for low-income populations would strengthen the hospital safety net and other safety net providers. Coverage is more important to this group of providers than reimbursement rates in large measure. Increasing the number of people covered provides opportunities for other revenue streams that can assist with low reimbursement rates. Reimbursement rates have ceilings, which limit the amount of cross

subsidization that can be done for the uninsured. Additionally, providing health care also helps improve the health status of Hoosiers, which reduces health care costs for the State as a whole

7. **Continue to target Medicaid DSH funding.** Continuation of targeting finite resources (such as DSH) to the hospitals serving the most disproportionate payer mixes is critical to the health of the hospital safety net. The restrictive and progressive policy of the State of Indiana to concentrate limited financial resources on those institutions with the highest Medicaid and low-income inpatient utilization rate scores has allowed services to continue to be provided to low-income individuals in key locations (i.e., Gary, Indianapolis, and East Chicago).
8. **Improve Indiana's ability to monitor and assess the safety net's capacity, structure and financial stability.** The data available to adequately assess and continue monitoring the safety net is limited in Indiana, and has been in many other states. The federal Agency for Health Care Research and Quality has issued guidelines for states and communities to monitor their safety nets. In Indiana, the ISDH could assume responsibility for this role in monitoring the Indiana safety net and making the data available.

## X. Conclusion

While a safety net exists in Indiana, defining what that safety net is, especially in rural areas, is a difficult task. Even more difficult is assessing its overall strength and capacity in light of limited data sources, the reliance in some areas case on "donated" care arrangements and the inherent difficulty of quantifying the amount of needed medical care that the uninsured *did not* receive because it was simply unaffordable or otherwise unavailable.

Within individual counties and communities across Indiana, the strength of the health care safety net is highly dependent upon the structure of the local health care marketplace (including the contributions, if any, made from local public funds) and local economic factors such as the rate of uninsurance and unemployment. Due to its large population, Marion County also has the largest number of uninsured as well as the largest number of medically underserved residents, and therefore has the greatest demands for safety net services. Lake County is also significant. In addition to having the second highest number of underserved residents, 17.7 percent of all



uninsured Hoosiers reside in the Gary Metropolitan Statistical Area (according to the FSSA 2003 Household Survey). The financial stress of Marion County's main safety net system – Wishard Health Services – has been widely reported and its ability to maintain current service levels into the future is currently unclear. Lake County lacks the significant local funding for indigent health care available in Marion County and therefore is arguably at greater ongoing risk as the health and stability of the safety services in Lake County are largely dependent upon the decision of private sector health care providers who can choose to reduce the level of indigent care that they provide or stop providing care entirely.

While the emergence of FQHCs and other types of health clinics over the past two decades have helped to improve the availability of primary care in many parts of the State, in some communities, hospital emergency rooms remain the default primary care safety net provider by virtue of their mandate to provide emergency stabilization services. Also access to specialty care, dental care and mental health care for the uninsured throughout the state is very difficult or impossible. In particular, there are no federal or state funding streams specifically devoted to providing specialty care for the uninsured. Also, available state mental health funding has been largely used to serve Medicaid patients and thereby leverage federal Medicaid funds leaving community mental health centers no financial incentive to preserve a significant portion of that state funding for non-Medicaid eligible uninsured patients.

Despite the immense needs and challenges, examples of innovative local initiatives to support and enhance the provision of safety net services do exist and efforts to develop new initiatives continue to emerge. Unless and until a larger national effort to significantly reduce the number of uninsured comes to fruition, it will be important for the State of Indiana to continue to find ways to support safety net providers as they strive to respond to the compelling health care needs of the uninsured.

## **Appendices**

- Appendix A: [Step Ahead Survey Results: Access to Primary Care](#)
- Appendix B: [Indiana Primary Health Association Care Strategic Planning Access](#)
- Appendix C: [Safety Net Primary Care Providers \(Maps\)](#)
- Appendix D: [Inventory of FOHCs, State Funded CHCs and RHCs by Region](#)
- Appendix E: [County and City Health Departments](#)
- Appendix G: [Dental Services Clinics for Low-Income Clients](#)
- Appendix H: [Dental Health Professional Shortage Areas](#)
- Appendix I: [Community Mental Health Centers](#)