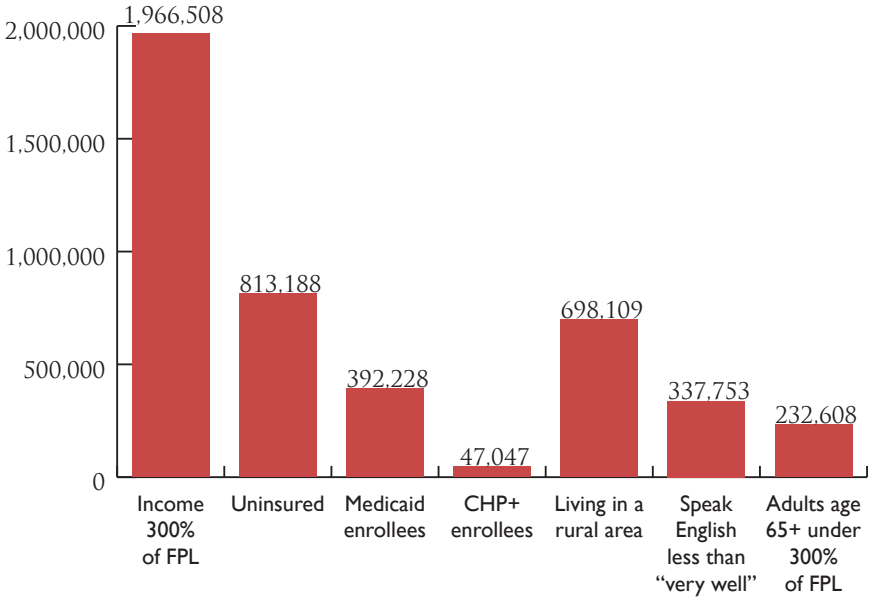
Center for the Study of the Safety Net
Colorado Health Institute

PRIMER

Colorado's Health Care Safety Net

Over the most recent seven-year period for which data are available, the proportion of Coloradans who report having no public or private health insurance coverage has hovered between 15 percent in 2000-01 and 17 percent in 2006-07. By 2006-07, this percentage corresponded to approximately 813,000 individuals or roughly one in six Coloradans. Additionally, another 439,000 low-income Coloradans were insured through two publicly financed programs, Medicaid and the Child Health Plan Plus (CHP+)—a 45 percent increase since FY 2000-01. Most of the percentage increase was within the Medicaid population.

Graph 1. Number of Coloradans by low-income status and other dimensions of vulnerability



Note: Categories are not mutually exclusive; individuals may be included in more than one group.

As the number of uninsured and underinsured Coloradans continues to climb, the cost of health care escalates and the caseloads of publicly funded health insurance programs increase, the health care "safety net" serves as the default source of care for this growing number of vulnerable Coloradans. In its efforts to develop a Safety Net Indicators and Monitoring System for Colorado, the Colorado Health Institute (CHI) defines "vulnerable" as individuals with incomes below 300 percent of the federal poverty level (FPL)—approximately $66,000 for a family of four in 2009—who lack access to primary health, dental and mental health care by virtue of their low-income status coupled with other vulnerability factors such as:

- Being uninsured
- Enrolled in a publicly financed health insurance program or high deductible health plan
- Geographic isolation
- No regular source of primary care
- Cultural, language and other social barriers.

Graph 1[1, 2] displays the relative size of subgroups of the population in Colorado that are considered vulnerable. It is important to note that many low-income people belong to more than one group, which is likely to increase their vulnerability.

The Institute of Medicine's (IOM) landmark 2000 study, *America's Health Care Safety Net: Intact but Endangered*, described the nation's safety net as a highly localized and fragile patchwork of health care providers that face increasing financial stress and capacity constraints in providing health care to vulnerable populations. The rising numbers of uninsured coupled with uncertain economic conditions at the community level led the IOM study group to recommend that:

> "…efforts [must] be directed to improving this nation's capacity and ability to monitor the changing structure, capacity and financial stability of the safety net to meet the health care needs of the uninsured and other vulnerable populations."[3]

Recognizing the importance of Colorado's safety net system and the challenges it faces, The Colorado Health Foundation provided a two-year grant to CHI in 2005 to establish a Safety Net Indicators and Monitoring System for Colorado. With this support, CHI has developed a data-driven reporting system that is identifying, describing and monitoring Colorado's health care safety net providers and vulnerable populations.

The purpose of the monitoring system is to inform local communities and state policymakers about the changing dynamics of Colorado's safety net. Specific objectives include describing and monitoring the characteristics of current and potential safety net users and the financial viability of safety net providers. Through the identification of a robust set of indicators, access to care and health status measures of vulnerable Coloradans will be monitored over time.

The monitoring system includes physical, mental and dental health care providers that deliver basic primary care services. CHI staff has identified an initial set of population-based indicators that focus on Coloradans who are below 300 percent of FPL and are uninsured, as well as individuals enrolled in the Medicaid and Child Health Plan Plus (CHP+) programs. As the monitoring system evolves and more data become available, the indicators will expand to include other vulnerable population groups such as low-income Medicare beneficiaries and people facing social, cultural and geographic barriers to care.

This primer provides CHI's working definition of safety net providers and a snapshot of current and potential users. In addition, it discusses the importance of the safety net, how it is financed and the range of services safety net providers offer.

Safety net providers

The health care safety net has often been described as a patchwork of providers that provide medical, dental and mental health care to low-income, uninsured and underinsured individuals and those enrolled in publicly funded health insurance programs. Making generalizations about safety net providers is difficult because the safety net is highly localized and varies from community to community. Some communities may have a public hospital, community health center and public health agency, while others have no core safety net providers and few health care resources available for low-income individuals and families.

Despite the different forms they take, the IOM study defines core safety net providers as those that share two distinguishing characteristics:

- Either by legal mandate or explicitly adopted mission, they offer care to patients regardless of their ability to pay for those services; and
- A substantial share of their patient mix is uninsured, are Medicaid enrollees or people who have other vulnerability risk factors.[4]

Although a large number of private physicians, dentists and mental health workers provide essential primary care services to low-income patients, many of them do not meet these two criteria.

CHI has chosen to adopt the IOM definition of core safety net provider which includes the following:

- **Community and public hospital emergency departments (EDs)** provide emergency medical care to patients regardless of their ability to pay or insurance status as required by the Emergency Medical Treatment and Active Labor Act (EMTALA).[5] A large number of EDs also provide episodic basic primary care services to medically indigent individuals who lack access to alternative sites of care.
- **Community health centers (CHCs),** also known as federally qualified health centers, provide primary care to low-income populations of all ages. CHCs are located in areas with a medically underserved designation and provide preventive physical, dental, behavioral health and substance abuse services to populations the federal government defines as medically underserved. If a CHC does not provide the full range of basic health services in its community, it will arrange for required services through other local providers.
- **Local public health departments and public nursing services** provide a limited array of primary care services. While these services vary by community, they include comprehensive health assessments and screenings for Medicaid children,[6] immunizations, family planning services, oral health services, cancer screenings and testing for sexually transmitted diseases (STDs) and human immunodeficiency virus (HIV).
- **Other community-based clinics** include faith-based clinics, those staffed by volunteer clinicians and family practice residency clinics that offer free, low-

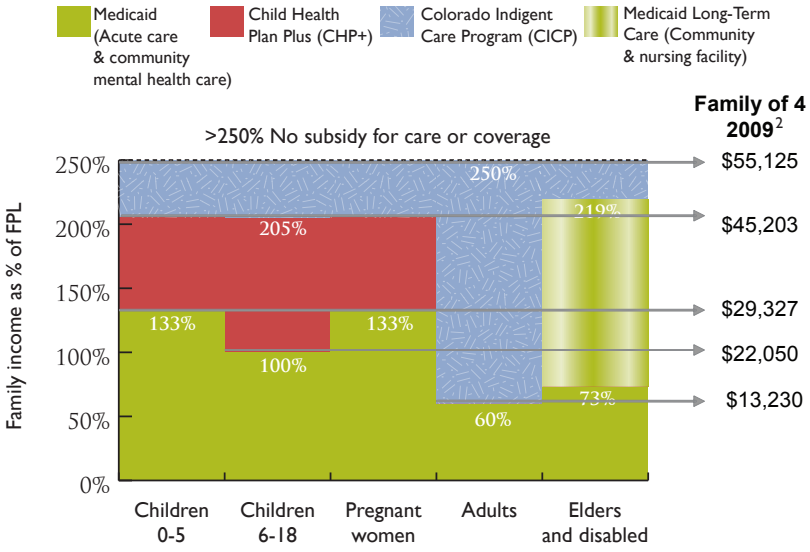
cost or sliding-fee primary care services to low-income and uninsured families and individuals.

- **Federally designated rural health clinics** (RHCs) are located in non-urbanized geographic areas with documented shortages of health care providers and/or medically underserved populations. While the types and range of services differ from clinic to clinic, all RHCs provide basic primary care services.
- **School-based health centers** (SBHCs) provide primary health care services in schools with high concentrations of low-income children. All Colorado SBHCs offer immunizations, well-child checks, sports physicals, chronic care management for conditions such as asthma and diabetes and acute medical care. Depending on the center, services may also include mental and dental care, substance abuse treatment and violence prevention services.
- **Community mental health centers** provide outpatient, emergency, day treatment and partial hospitalization mental health services to low-income individuals residing in a designated geographic service area.
- **Community-based low-income dental clinics** provide dental services to low-income individuals without dental insurance or to individuals enrolled in public coverage programs that experience difficulty finding a dental provider.

Safety net users

Potential users of safety net services include people who lack access to basic health care services because of their low-income status; lack of or inadequate health insurance coverage; cultural, language or geographic barriers; or special health care needs.[7, 8] Research has demonstrated that many uninsured individuals forego needed care, even for acute conditions, until a disease or condition significantly worsens. Not surprisingly, uninsured and otherwise vulnerable individuals have poorer health status than otherwise similar individuals with insurance coverage. According to the IOM, uninsured individuals' lower utilization of health care services leads to higher morbidity and mortality compared to insured populations.[9]

Graph 2: Income eligibility guidelines for Medicaid, Child Health Plan Plus and the Colorado Indigent Care Program



A large number of low-income Coloradans qualify for publicly financed health care coverage jointly financed by Colorado and the federal government. Coloradans can qualify for public coverage in a variety of ways, but individual or family income is always a requisite factor coupled with available assets, age, disability status and whether a low-income parent has a dependent child. Graph 2 illustrates the family income thresholds for state-sponsored health care coverage and subsidized financing (Colorado Indigent Care Program).[10]

State-sponsored financing programs

Medicaid

Medicaid is a state/federal partnership that provides health care coverage to nearly 400,000 low-income children and parents, pregnant women, elders and individuals with disabilities. Eligible individuals have coverage for a range of services including certain preventive services, primary and acute care and long-term care services in a nursing home or in the community. While most Medicaid enrollees are eligible to receive mental health services, only children are entitled to non-emergency dental services. Because some areas in Colorado have an inadequate supply of medical and dental health care providers who are willing to accept Medicaid enrollees into their practices, many people rely on safety net providers to receive the health and dental care they need.

Child Health Plan Plus Program (CHP+)

CHP+ is also a state/federal partnership providing health care coverage to low-income children up to age 18 and pregnant women with incomes at or below 205 percent of the FPL. Covering a range of benefits similar to the private standard health insurance plan available to small employer groups in Colorado, CHP+ provided health care coverage to nearly 58,000 children in FY 2007-08. Enrollees receive inpatient and outpatient hospital care, physician services, prescription drugs and a limited dental and mental health care benefit. CHP+ benefits are delivered primarily through managed health care organizations where enrollees can choose their primary care provider from a variety of providers including community health clinics and private physicians.

Colorado Indigent Care Program (CICP)

CICP partially reimburses certain high-volume hospitals and clinics for the uncompensated care rendered to patients who are uninsured and underinsured, have limited assets and incomes at or below 250 percent of the FPL.[11] CICP is not an insurance program but rather a reimbursement mechanism for providers. Covered services include but are not limited to emergency medical care, inpatient and outpatient care and prescription drugs. Around 173,000 Coloradans received services that were reimbursed by CICP in FY 2006-07.

Colorado's uninsured population

According to a 2008 analysis of the uninsured, CHI estimated that in 2005-07 approximately 17 percent of Coloradans were uninsured. The uninsurance rate among Colorado's children (ages 0-18 years) was 14 percent compared to 20 percent for adults (ages 19-64).

A CHI analysis of 2005-07 U.S. Census data revealed certain risk factors associated with being uninsured:[12]

- **Age**—Approximately 78 percent of the uninsured population were working-age adults ages 18-64 years; just over 20 percent were children under 18 years. Young adults 18-34 years represented 42 percent of the uninsured, the largest uninsured age group.
- **Income**—In the period between 2005 and 2007, the uninsurance rate was nearly 43 percent among Coloradans with family incomes under 100 percent of the FPL ($20,650 for a family of four in 2007). At the other end of the income continuum, the uninsurance rate was 6 percent for Coloradans with incomes above 400 percent of the FPL ($82,600 for a family of four in 2007).
- **Employer size**—Nearly 30 percent of working-age Coloradans who worked in firms with fewer than 10 employees were uninsured, compared to 12 percent of employees who worked in firms with 500 or more employees.
- **Race and ethnicity**—Hispanics and Latinos in Colorado are at the greatest risk for being uninsured. More than one-third of Hispanics (36%) were uninsured compared to 20 percent of non-Hispanic blacks and 11 percent of non-Hispanic whites.

Safety net financing

Safety net providers rely on a variety of public and private funds and patient fees to provide services to low-income Coloradans. While providers' funding sources vary based on their patient mix and availability of local public support, some of the major funding streams include:

- Disproportionate share hospital (commonly referred to as "DSH") payments are federal funds available to help states partially compensate hospitals that provide a disproportionate share of medical care to uninsured indigent patients and Medicaid enrollees. Additionally, Upper Payment Limit funds[13] are allocated to some hospitals that provide Medicaid inpatient services. These federal funds, which totaled $148 million in FY 2006-07 in Colorado, were used to partially compensate hospitals for care provided to CICP patients.
- Under Section 330 of the Public Health Service Act, the federal government provides grants to community health centers, migrant health centers and the Health Care for the Homeless and Public Housing Primary Care Programs.[14] In 2007, grantees in Colorado received nearly $50 million in 330 grants.[15]
- Colorado receives a number of block grants from the federal government, portions of which are passed through to various safety net providers for direct care or enabling services for non-medical services. These federal grants include the Maternal and Child Health Services Block Grant, Ryan White CARE Act[16] funds and the Preventive Health and Health Services block grant.
- Federal and state funding is provided for services rendered under the Medicaid and CHP+ programs.

- In FY 2007-08, Medicaid medical services premiums paid to providers amounted to more than $2.2 billion. The state and federal government shared these costs equally.

- CHP+ medical and dental premiums totaled more than $113 million in FY 2007-08. The state funded approximately one-third of the costs, while the federal government funded the remaining two-thirds.

- Colorado's philanthropic community provides support to safety net providers through grants and contracts. Foundation funding is often directed at addressing the specific health care needs of a local community and/or special population group.
- Local public funding is available to fill gaps in services. The duration, type and level of local public financial support vary by community.
- Most safety net providers employ a sliding-fee schedule based on a patient's income, which offsets a portion of the costs associated with the care provided.

In November 2004, Colorado voters approved an amendment to the state Constitution to increase the excise tax on tobacco products. Some of the uses of these tax revenues include:

- Increasing Medicaid eligibility for low-income parents up to 60 percent of FPL;
- Expanding CHP+ eligibility for children and pregnant women up to 200 percent of FPL;
- Removing the asset test for Medicaid eligibility that in the past had prevented many low-income individuals from qualifying for Medicaid even if they had minimal assets;
- Providing Medicaid eligibility for some legal immigrants;
- Reinstating Medicaid presumptive eligibility for low-income, pregnant women;[17] and
- Annually providing nearly $30 million in grants to subsidize safety net providers who serve low-income uninsured, underinsured and Medicaid patients through the Primary Care Fund.

Additional information

For additional resources and more information regarding Colorado's safety net, see:

Colorado Health Institute Center for the Study of the Safety Net:
http://www.ColoradoHealthInstitute.org/SafetyNet

ClinicNet:
http://www.ClinicNet.org

Colorado Hospital Association:
http://www.cha.com

Colorado Behavioral Healthcare Council:
http://cbhc.org/

Colorado Coalition for the Medically Underserved:
http://www.ccmu.org

Colorado Consumer Health Initiative:
http://www.cohealthinitiative.org/

Colorado Community Health Network:
http://www.cchn.org

Colorado Association for School-based Health Care:
http://www.casbhc.org

Colorado Rural Health Center:
http://www.coruralhealth.org

Colorado Department of Health Care Policy and Financing:

- Medicaid: http://www.colorado.gov/cs/Satellite?c=Page&cid=1197969485591&pagename=HCPF%2FHCPFLayout
- CHP+: http://www.colorado.gov/cs/Satellite?c=Page&cid=1197969485551&pagename=HCPF%2FHCPFLayout CICP: http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1208251983444
- Old Age Pension Program: http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1218102966137

Colorado Department of Public Health and Environment:
http://www.cdphe.state.co.us

Endnotes

[1] Sources: Income and uninsured estimates are based on CHI analyses of the U.S. Census Bureau's Current Population Survey, CY 2001-07. Medicaid and CHP+ data come from FY 2006-07 average monthly caseload figures from the Colorado Department of Health Care Policy and Financing. Rural population is based on CHI's analysis of 2008 Colorado Demography Office population estimates utilizing the Colorado Rural Health Center's urban and rural designations. Language proficiency estimates are based on data from the U.S. Census Bureau's 2007 American Community Survey and include the population age 5 years and older who report speaking English "less than very well."

[2] The population with family incomes under 300% of the federal poverty level (FPL) estimate is based on a three-year average of CY 2005-07 CPS data calculated by CHI. Graph 1 in the May 2007 version of this Primer included an estimate that in CY 2003-05, 1,965,000 people had family incomes under 300% of the federal poverty level (FPL). Since that time, CHI has employed what it believes is a more precise method for calculating the ratio of income to poverty within households with multiple families. Using comparable methods, the May 2007 estimate would have been 1,930,167.

[3] Institute of Medicine. (2000). *America's Health Care Safety Net: Intact but Endangered*. Washington, DC: National Academies Press. p.10.

[4] Institute of Medicine. (2000). pp. 3-4.

[5] As a condition of receiving Medicare funds, hospitals must provide a medical screening examination to all individuals who enter the emergency room seeking treatment. If the hospital determines that the individual is suffering from an emergency medical condition, the hospital must provide treatment until the patient is stable or transfer the patient to another hospital.

[6] Screening and assessments are provided through the Early and Periodic Screening, Diagnosis and Treatment requirements outlined by federal Medicaid regulations.

[7] Special-needs populations include individuals with disabilities or chronic illnesses or who are homeless.

[8] Institute of Medicine. (2000). p.21.

[9] Institute of Medicine. (2003). *Hidden Costs, Value Lost: Uninsurance in America*. p. 39.

[10] Some additional Medicaid eligibility categories are not included in Graph 2.

[11] The previous income threshold was 185% of FPL. In 2006, SB 044 increased eligibility to 250% of FPL with funding from Referendum C passed by Colorado voters in November 2005.

[12] For more information on Colorado's uninsured populations, see the following issue briefs published by the Colorado Health Institute: *Profile of the Uninsured in Colorado, An Update for 2005* at: http://www.coloradohealthinstitute.org/documents/PolicyBriefs/Uninsured.pdf; *Profile of the Uninsured in Colorado, 2004* at: http://www.coloradohealthinstitute.org/Documents/bulletin_uninsured05.pdf; *Colorado Children's Health Insurance Status* at: http://www.coloradohealthinstitute.org/documents/PolicyBriefs/KidsInsurance.pdf; and *How Many Coloradans Are Uninsured? A guide to the estimates* at http://www.coloradohealthinstitute.org/Documents/sn/UninsuredTechBrief09.pdf.

[13] Upper Payment Limit funds are generated when the state increases its Medicaid payments to the federally allowable maximum amount without an increase in General Fund appropriations.

[14] Rural Assistance Center (2008). "FQHC frequently asked questions." Retrieved January 12, 2009, from http://www.raconline.org/info_guides/clinics/fqhcfaq.php#whatisphs330.

[15] Health Resources and Services Administration, Bureau of Primary Health Care, Colorado Uniform Data System Rollup Report. (2007). Available at ftp://ftp.hrsa.gov/bphc/pdf/uds/2007/07Rollup_StateCO_08Jul2008.pdf.

[16] These funds are targeted for people with HIV/AIDS.

[17] Presumptive eligibility occurs when a pregnant woman applies for Medicaid and is deemed eligible for services immediately, prior to the processing of her Medicaid application. She is presumed eligible to avoid delays in receiving prenatal care and other health care services.

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