Access to Care for the Uninsured and Underserved:

An Assessment of the 20-County Service Area
of The Health Foundation of Greater Cincinnati

by: The Health Foundation of Greater Cincinnati

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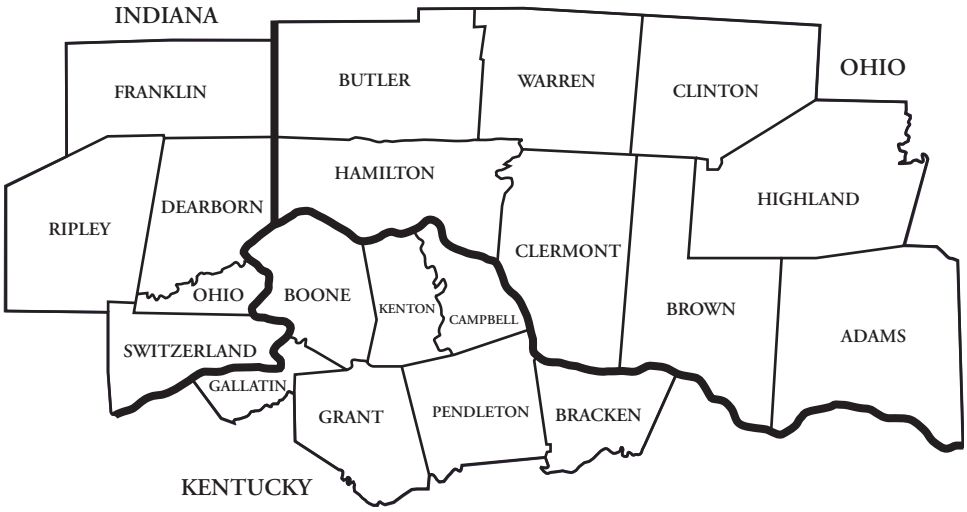
For More Information

In 1997, The Health Foundation of Greater Cincinnati began a multifaceted project to identify the health issues and assess the healthcare needs of the Cincinnati area, encompassing 20 counties in Indiana, Kentucky, and Ohio (see the figure below).



Through this process, the Health Foundation identified four focus areas in which to concentrate its grantmaking efforts:

- Strengthening Primary Care Providers to the Poor
- School-Based Child Health Interventions
- Substance Abuse
- Severe Mental Illness

This report comes out of the Strengthening Primary Care Providers to the Poor focus area. For more information about this area, please visit our web site at http://www.healthfoundation.org/focus/spcpp.

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Health Centers: The staffs and patients of:
- Cincinnati Health Network
- HealthPoint Family Care (formerly Northern Kentucky Family Health Centers)
- Southern Ohio Health Services Network

Executive Summary

In 2002, The Health Foundation of Greater Cincinnati contracted with the Center for Health Services Research and Policy at The George Washington University to conduct a study of the Health Foundation's service area, looking specifically at issues related to access to healthcare for uninsured and underserved residents. This report provides information on the health and socioeconomic status of the population and the status of safety net providers in the region and identifies gaps in care that currently exist or are likely to surface in the near future. It also highlights areas that may be particularly sensitive to economic, political, or socioeconomic change in the near term.

This Executive Summary provides a brief overview of the full report, *Access to Care for the Uninsured and Underserved.*

Key Characteristics of the Population

- Approximately 2.1 million individuals live in the 20 counties in the Health Foundation's service area. These include Dearborn, Franklin, Ohio, Ripley, and Switzerland in Indiana; Boone, Bracken, Campbell, Gallatin, Grant, Kenton, and Pendleton in Kentucky; and Adams, Brown, Butler, Clermont, Clinton, Hamilton, Highland, and Warren in Ohio. More than three-quarters (77.3%) of this population live in the eight Ohio counties; 17.6% live in the seven Kentucky counties, and 5.1% live in the five Indiana counties.
- In general, the 20 counties are less diverse than their respective states and the nation, with relatively fewer African American, Hispanic, and other residents who identify themselves as members of ethnic minorities. The exception is Hamilton County, Ohio, which has a higher-than-state-average population of African American residents.
- Statistics on the income levels of county residents show a significant amount of poverty across the 20 counties. Nearly 600,000 residents in the region have household incomes below 200% of the federal poverty level (FPL), with most of these concentrated in a few Ohio counties.
- Only about half of Kentucky's residents statewide have private health coverage, compared to approximately two-

thirds of Indiana and Ohio residents. While there is considerable variation across counties in the Health Foundation's service area in terms of health coverage, the seven Kentucky counties have much higher combined rates of no insurance and of coverage through Medicaid or State Children's Health Insurance Program (SCHIP) compared to other counties in the service area.
- Approximately 254,000 residents in the Health Foundation's service area are uninsured (National Association of Community Health Centers, 2000). Uninsured residents in the Health Foundation's Indiana counties have lower household incomes than their counterparts in the Kentucky and Ohio counties.

Access to Care: The Healthcare Safety Net

The Health Foundation's service area includes several health center networks that provide a substantial amount of primary care and preventive services to county residents. Residents of the 20 counties also seek care at local physicians' offices, public health departments, and hospital outpatient clinics. University Hospital and Cincinnati Children's Hospital Medical Center are major safety net providers and receive tax levy funds to provide care to the uninsured.

By many accounts, specialty care is in short supply in this region, although it is difficult to quantify the problem at the county level. Areas throughout the Health Foundation's 20-county region are substantially underserved. The lack of availability of primary care and specialty providers, the difficulty of traveling to and from medical and other health-related appointments, and the low income of the residents of this region result in communities that are in serious need of improved access to healthcare.

In Their Own Words: Results of Conversations with County Residents

Patients at several health center networks located within the Health Foundation's service area were asked about their access to services and perceptions about quality of care in the community, and specifically about access to primary care, specialty services, hospital and emergency room care, oral health services, mental health services, and prescription medications. There was also considerable discussion about coverage issues and the costs of obtaining health services.

All of the participants were extremely pleased with the care they receive at the health center networks in terms of the overall quality of care, the ease with which they can make appointments and access services, and the ability to obtain referrals for specialty services. Several participants stated that they were always treated with respect by health center staff, despite being uninsured or publicly insured. They mentioned the convenience of health center locations, the availability of transportation to and from appointments, the reasonable costs associated with visits, and access to sample medications.

Specialty services are not nearly as accessible. There was a general sense that the problem is both one of supply—there are not enough specialists to handle the patients in need of care—and financing—not being able to afford the specialists that are available. Specialty services mentioned include oral health care, mental health care, and prescription medications.

Findings from the Interviews with Local Providers, Advocates, Researchers, and Other Stakeholders

Local stakeholders, including providers and advocates, gave their perspective on the issues facing uninsured and underserved residents of the area as well as the challenges providers face in serving these populations. Some of the issues they discussed include:

- growing numbers of uninsured people, some of whom may be eligible for Medicaid but who are not enrolled;
- low Medicaid payment rates, which contribute to the difficulties people face in accessing services, especially specialty services;
- increasing numbers of Spanish-speaking residents without a concurrent increase in Spanish-speaking healthcare staff;
- a shortage of specialty providers who are available for new patients and willing to accept Medicaid rates and discounted fees; and
- a lack of access to affordable prescription medications, which causes many low-income people to not fill their prescriptions or to ration their dosages to make them last longer.

Improving Care for the Uninsured and Underserved

Given the access problems identified in the report, the critical reliance on local subsidies, and the stresses on the availability of public and private health insurance, the following areas seem worthwhile in terms of their value for improvements in access for Greater Cincinnati's uninsured and underserved populations.

- Expand the scope of services within community health centers and strengthen health center networks.
- Improve access opportunities, especially in very underserved areas.
- Improve culturally and linguistically appropriate care.
- Develop a better understanding of the effects of payment (both public and private) on availability of primary, specialty, mental health, and oral health care providers.
- Simplify Medicaid and SCHIP application processes.
- Identify the importance of Medicaid coverage for low-income working families.

Introduction

Many changes are occurring in the healthcare system in the Greater Cincinnati area and across the country. Safety net providers are feeling the stresses of caring for growing numbers of uninsured people. They are also caring for more underinsured people—people who have private insurance with unaffordable co-payments and annual deductibles that essentially make them uninsured for primary care, preventive services, and prescription medications. Hospital emergency rooms are also seeing increasing numbers of Medicaid enrollees and other insured individuals using their services instead of, or as a supplement to, primary care providers (Brewster, Rudell, and Lesser, 2001; Gordon, Billings, et al., 2001).

Changes in employer-sponsored health insurance plans may also put pressure on safety net providers. A recent review of trends in private sector coverage found sharp decreases in managed care plans; less variation among managed care plan types such as Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), and Point-of-Service (POS) plans; and decreases in plan choices for employees (Regenstein, Repasch, Borzi, Cyprien, and Rosenbaum, 2002). Most importantly for low-income workers, the review also showed steep increases in the cost of managed care premiums, a decline in the enrollment rate among workers during years in which slightly more employers offered health insurance to their employees, and increased cost sharing by employees through higher co-payments, premiums, and deductibles for primary care services and prescription medications (Kuttner, 1999; Marquis and Long, 1999; Gabel, et al, 2000; Marquis and Long, 2001; Maxwell, Temin, and Watts, 2001; Dalzell, 2001; Muirhead, 2001; Ginsburg, 2001).

For people who are uninsured or underinsured, identifying and accessing healthcare can be difficult. Ample evidence shows a clear and consistent relationship between a lack of health insurance and reduced access to health services and inferior health outcomes (Shi, 1992; Shi, Starfield, Kennely and Kavachu, 1999). In fact, insurance status and ability to pay for healthcare are the most important predictors of the quality of healthcare across various populations (Smedley, Stith, and

Nelson, 2002). The uninsured receive less preventive care, are diagnosed at more advanced stages of disease, and, once diagnosed, tend to receive lower amounts of certain types of care, including medications and surgical procedures (Hadley, 2002). Uninsured children are also at greater risk for poor health outcomes (Lave and Keane, 1998).

There are huge disparities in the healthcare received by insured individuals. Some of these disparities are related to type of insurance or the ability to pay out-of-pocket for co-payments or uncovered services. Many disparities, however, are a result of non-insurance- or non-income-related variables such as a patient's ethnicity, cultural background, country of origin, language spoken, or other variables (Fiscella, et al, 2000; Collins, Hughes, Doty, et al, 2002; Zuvekas, Weinick, and Cohen, 2000). Recently, the Institute of Medicine (Smedley et al., 2002) recommended a number of strategies to eliminate these disparities, including increasing awareness of disparate care, adhering to clinical guidelines, increasing the proportion of underrepresented U.S. ethnic minorities among health professionals, and removing barriers to care by offering transportation assistance, interpreter services, and cross-cultural training.

The Safety Net in Greater Cincinnati

The Health Foundation's service area contains clusters of high-quality primary care and specialty care available to many, but not all, residents in the counties. Some populations, especially in the Appalachian regions, face multiple threats to their health. Multigenerational poverty has resulted in poor health status, marginal economic progress, and significant difficulties in accessing care. At the same time, a substantial number of uninsured and underserved people in certain parts of the Greater Cincinnati region benefit from a highly concentrated healthcare market that is dedicated to providing care to these residents. Hamilton County alone has four tax levies that provide support for health services (including mental health care) for indigent residents. The City of Cincinnati also has a history of supporting indigent care; for example, it provides $1 million a year to local community health centers.

Residents also face huge problems accessing mental health services. In Greater Cincinnati and countless other communities

around the country, mental health services are seriously underfunded. Most state Medicaid programs provide mental health services for adults and a few cover substance use disorder treatment, although many will cover services for people with co-occurring mental health and substance use disorders. Indiana, Kentucky, and Ohio are experiencing a severe shortage of psychiatrists, especially for children. Some children are referred to Cincinnati hospitals for pediatric psychiatric services, but this creates transportation problems—an additional barrier to care. Even with adequate transportation and referrals, children often face unacceptably long waits to get the care they need.

Prescription medication access is also difficult. Medications are expensive and insured individuals are increasingly being expected to pay higher proportions of their costs out-of-pocket. This is particularly burdensome to low-income elderly people who may qualify for Medicaid only after spending hundreds of dollars each month on health-related expenses, which are most commonly for prescription medications.

Background of this Study

In 2002, The Health Foundation of Greater Cincinnati contracted with the Center for Health Services Research and Policy at The George Washington University to conduct a study of the Health Foundation's 20-county service area, looking specifically at issues related to access to healthcare for uninsured and underserved residents. This report provides information on the health and socioeconomic status of the population in the Health Foundation's service area, the status of safety net providers in the area, and the gaps in care that exist or are likely to surface in the near future. It also identifies the opportunities and challenges associated with providing primary, preventive, and other essential services to vulnerable residents within the Health Foundation's service area, highlighting areas that may be particularly sensitive to economic, political, or socioeconomic change.

This study draws upon several data sources to describe how safety net providers are meeting the needs of uninsured and underserved people. This report presents county-level data to create a deep understanding of the particular resource and access issues in this region. These data come from the 2000 Census,

Resources to Expand Access to Community Health (REACH),[1] the Health Resources and Services Administration, and state health departments.

Complementing these data are the results of focus groups with community residents who provided firsthand accounts of their own experiences accessing care for themselves and their families. Also included are interviews with the providers who make up the safety net to identify their perceptions of the pressures on the system and the areas that they believe are most vulnerable to political or economic externalities.

[1] *REACH data use Census data from a three-year period and estimate county percentages. The most recent REACH data are from 1997–1999.*

Characteristics of the 20-County Region

The Health Foundation of Greater Cincinnati serves 20 counties in three states (see Map 1). Approximately 2.1 million people live in these 20 counties, with 39% of these people living in Hamilton County, Ohio (see Table 1).

Map 1: The Health Foundation of Greater Cincinnati's 20-county service area

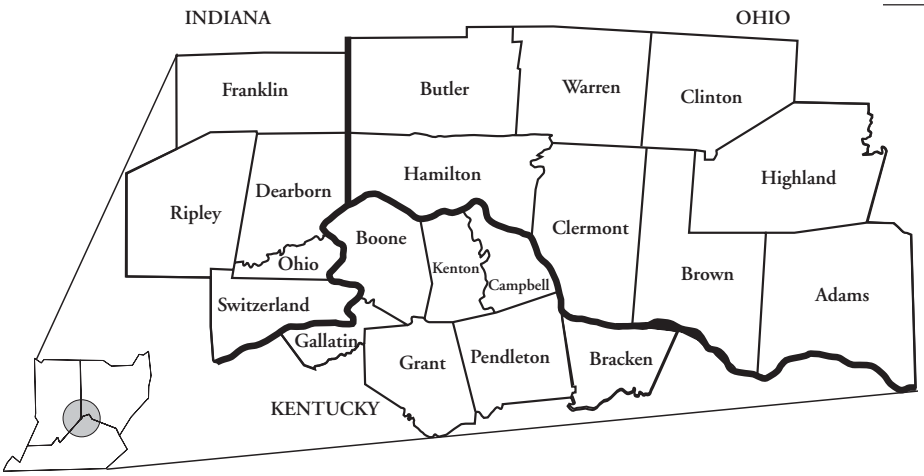


Table 1: Population of the Health Foundation's service area, by county

County	Population	
	No.	%
Ohio County (IN)	5,623	0.3%
Gallatin County (KY)	7,870	0.4%
Bracken County (KY)	8,279	0.4%
Switzerland County (IN)	9,065	0.4%
Pendleton County (KY)	14,390	0.7%
Franklin County (IN)	22,151	1.0%
Grant County (KY)	22,384	1.0%
Ripley County (IN)	26,523	1.2%
Adams County (OH)	27,330	1.3%
Clinton County (OH)	40,543	1.9%

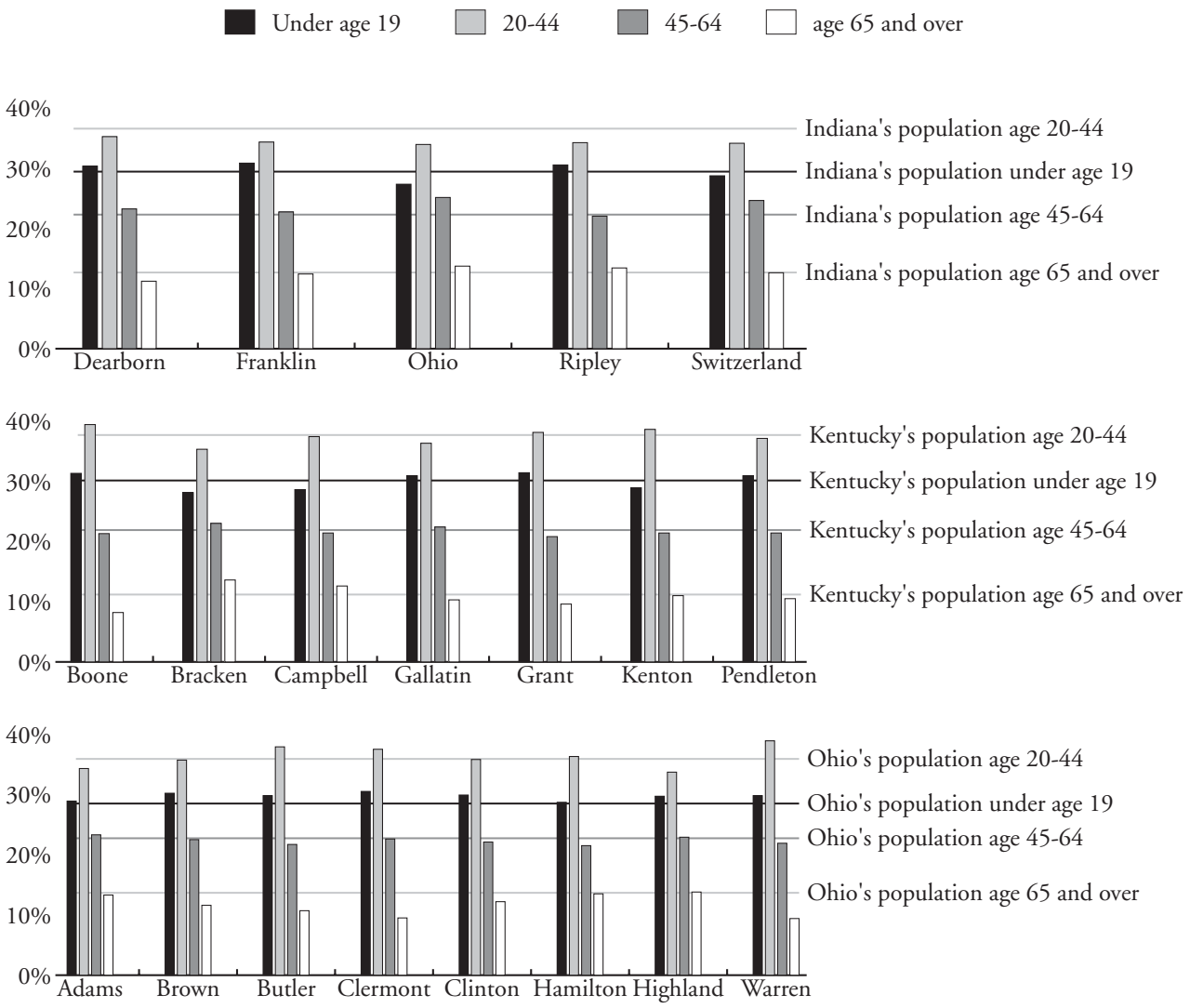
County	Population	
	No.	%
Highland County (OH)	40,875	1.9%
Brown County (OH)	42,285	2.0%
Dearborn County (IN)	46,109	2.1%
Boone County (KY)	85,991	4.0%
Campbell County (KY)	88,616	4.1%
Kenton County (KY)	151,464	7.0%
Warren County (OH)	158,383	7.4%
Clermont County (OH)	177,977	8.3%
Butler County (OH)	332,807	15.4%
Hamilton County (OH)	845,303	39.2%

Source: U.S. Census Bureau (2000).

Age, Ethnicity, and Socioeconomic Factors

The age distribution across the 20 counties is very similar to the distribution across states with a few notable exceptions. The Indiana counties have more children but fewer adults ages 18-44 compared to Indiana's state averages. In addition, when compared to their respective states' averages, Boone County (Kentucky) and Clermont County (Ohio) have relatively low numbers of residents ages 65 and above, while Switzerland (Indiana), Bracken (Kentucky), and Highland (Ohio) Counties have high numbers of senior residents (see Figure 1) (for data tables for this and other figures, see Appendix A).

Figure 1: Population in service area, by age and county

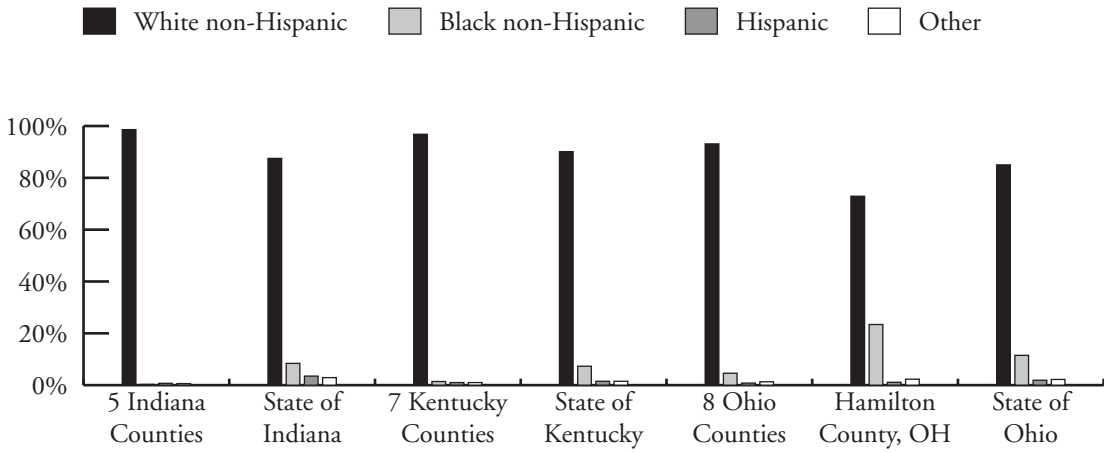


Source: U.S. Census Bureau (2000).

For data tables, please see Appendix A.

In general, the region is not very diverse, with fewer residents who identify themselves as members of ethnic minorities than each of the three states' averages. The Ohio counties as a group seem a little more diverse than the rest of the service area because of Hamilton County, which has a higher than state average population of African American residents (see Figure 2).

Figure 2: Population in service area, by ethnicity and state



Source: U.S. Census Bureau (2000).

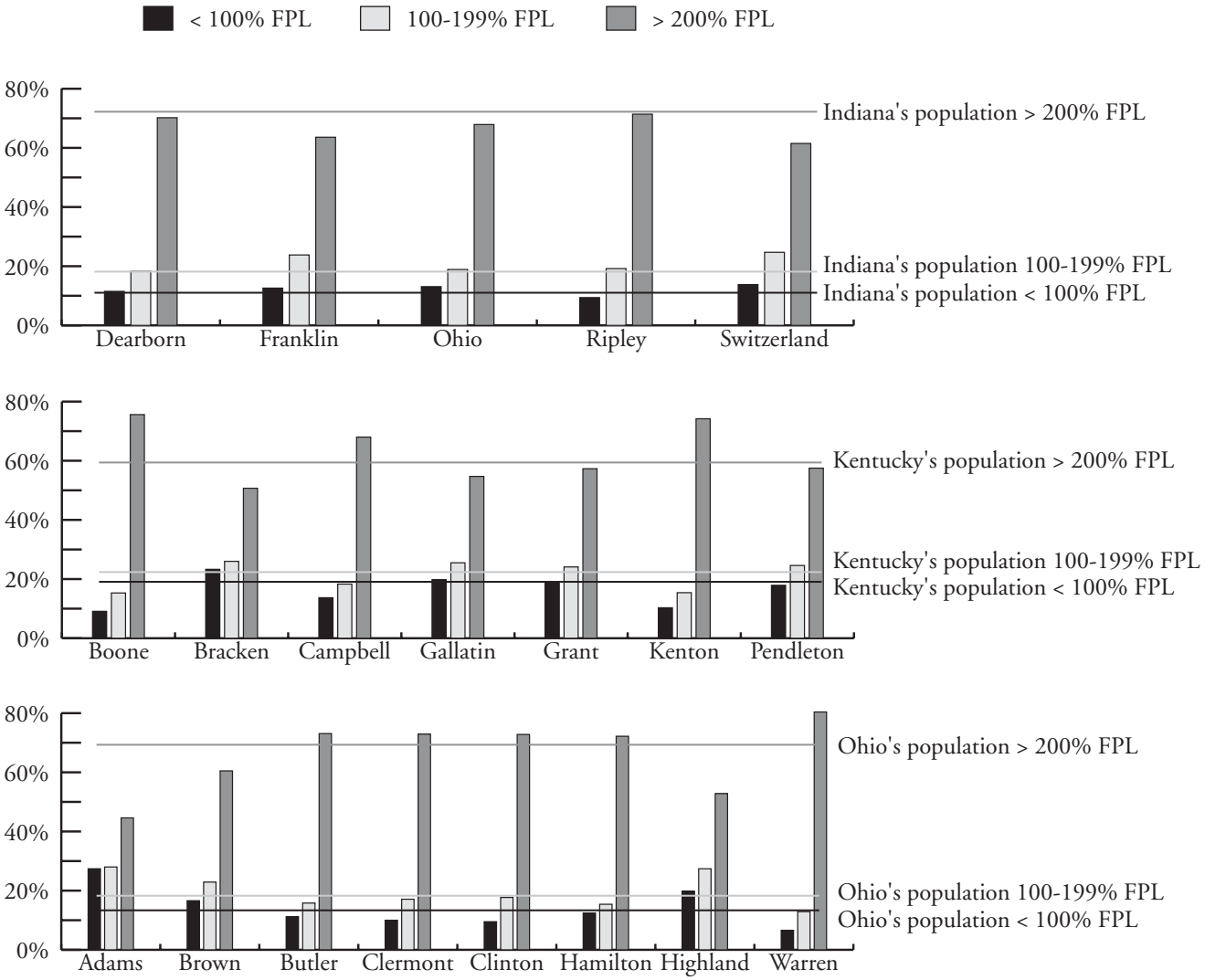
For data tables, please see Appendix A.

A significant number of people in the Health Foundation's 20-county region live in poverty. Nearly 600,000 residents in the service area have household incomes below 200% of the federal poverty level (FPL), with most of these concentrated in a few Ohio counties.

Many of the Health Foundation's counties have lower poverty rates than their respective states' averages. For example, four of seven Kentucky counties and five of eight Ohio counties have lower percentages of residents below 100% FPL than their states' averages. This is not the case with the Indiana counties, where

four of the five counties in the Health Foundation's service area have higher percentages of residents below 100% FPL than the state of Indiana's average (see Figure 3).

Figure 3: Population in service area, by median income and county



Source: National Association of Community Health Centers, 2000.

Note: Data are estimates derived from 1997-1999 Census data. In 1997, 100% FPL for a family of three was an income of $13,330; in 1998 it was $13,650; and in 1999 it was $13,880. For complete FPL guidelines for these years, please visit http://aspe.hhs.gov/poverty/poverty.shtml.

For data tables, please see Appendix A.

There is quite a bit of variation in the 20-county region in selected socioeconomic indicators such as home ownership and high school graduation rates. Interestingly, and despite the poverty seen in the Indiana counties in the Health Foundation's service area, all five Indiana counties have higher home ownership rates than Indiana's statewide average of 71.4% (U.S.

Census Bureau, n.d.). The Health Foundation's Kentucky and Ohio counties also have relatively high home ownership rates, with the exception of Hamilton County (Ohio), where the rate is 59.9%, much lower than Ohio's statewide average of 69.1%.

Many of the counties have relatively high proportions of people age 25 and above who have not completed a high school education. Interestingly, the Health Foundation's Indiana counties, which are among the poorest, do not have the highest rates of adults without a high school diploma. Instead, it is Bracken County, Kentucky, that does, with 29.4% of adults without a high school diploma.

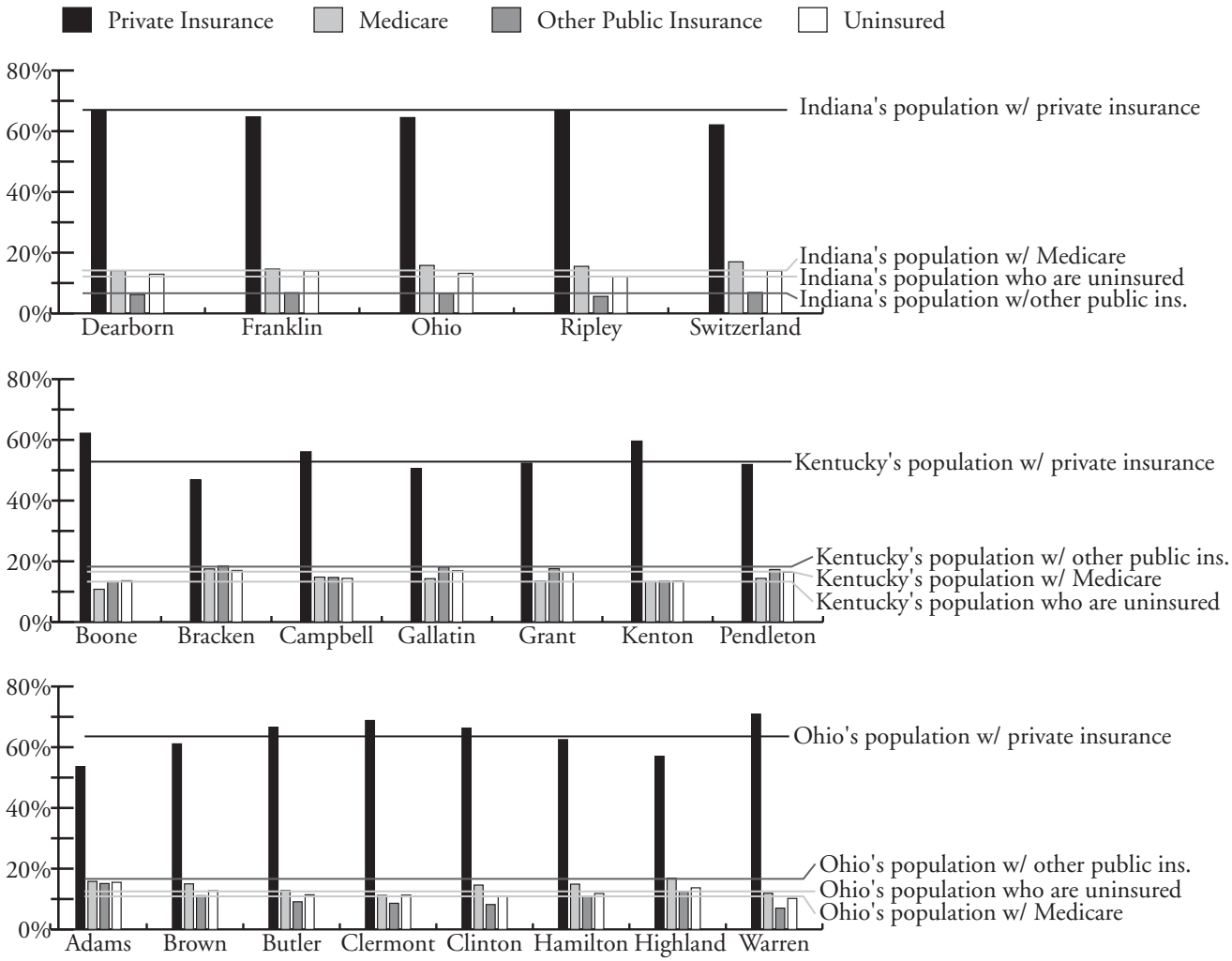
Sometimes, adults can not work or have to leave the workforce because of severe disability. The percentages of these adults in the Health Foundation service area are relatively low but are estimated from state-level data that may not fully identify individuals who have left the workforce because of disabling conditions. Local providers and others in the Greater Cincinnati area anecdotally report significant numbers of adults who left the workforce because of injuries, chronic conditions, or unspecified chronic pain, especially in the Indiana and Kentucky counties.

Health Insurance Coverage of Residents in the 20-County Service Area

Because the state of Kentucky as a whole has high rates of poverty, it is not surprising to see that fewer Kentucky residents are covered by private insurance. Only about 50% of Kentucky residents have private health insurance coverage, compared to approximately 67% in both Indiana and Ohio. While there is considerable variation across the Health Foundation's service area in terms of insurance coverage, the seven Kentucky counties have more uninsured residents than other counties in the region. The most variation is seen across the eight Ohio counties, whose insurance rates reflect the very different economic levels in the area. Adams County, which is among the poorest, has the lowest percentage of residents with private coverage (53.6%) while

Warren County, with the highest median income in the eight-county region, has the highest (70.9%) (see Figure 4).

Figure 4: Population in service area, by type of insurance and county

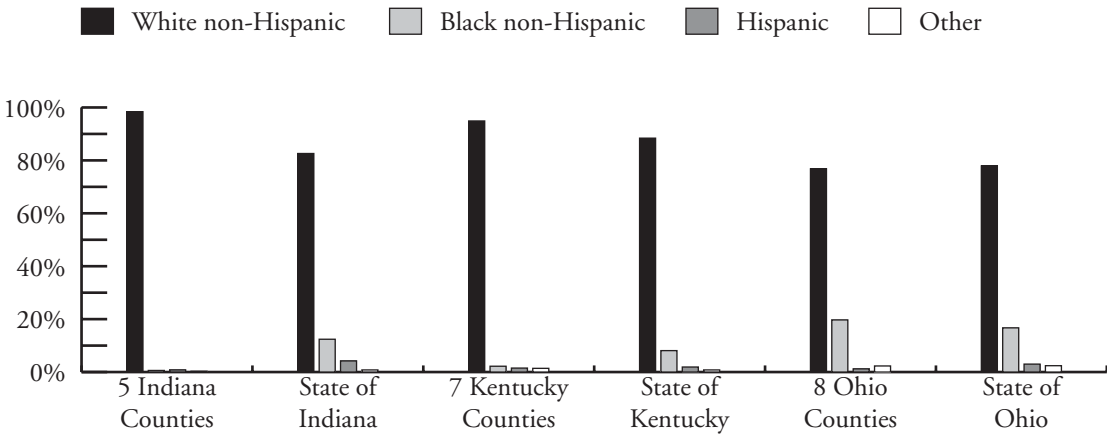


Source: National Association of Community Health Centers, 2000.
Note: Data are estimates derived from 1997-1999 Census data.

For data tables, please see Appendix A.

People who are uninsured in the Health Foundation's Indiana and Kentucky counties are much more likely to be white, non-Hispanic. In the Health Foundation's Ohio counties, however, the uninsured population includes proportionally more members of ethnic minority groups (see Figure 5).

Figure 5: Uninsured population in service area, by ethnicity and state



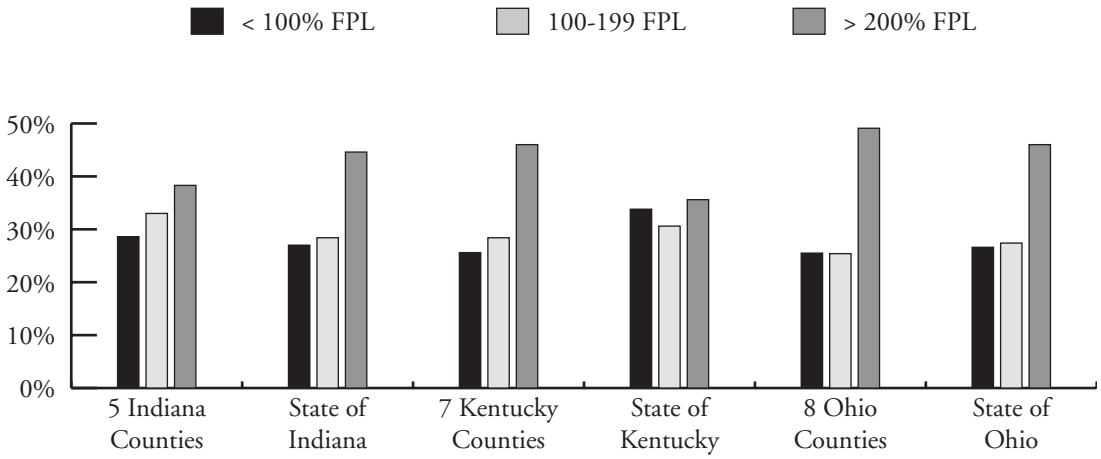
Source: National Association of Community Health Centers, 2000.
Note: Data are estimates derived from 1997-1999 Census data.

For data tables, please see Appendix A.

Uninsured residents in the Health Foundation's Indiana counties have lower household incomes than their counterparts in Kentucky and Ohio. Only 38.3% of uninsured people in the Health Foundation's Indiana counties have incomes over 100% FPL, compared to 46.0% of Kentucky residents and 49.1% of Ohio residents in the Health Foundation's service area. Uninsured Indiana residents in the Health Foundation's service area are also more likely to have lower incomes than uninsured residents in all of Indiana: 38.3% of the uninsured in the service area's Indiana counties have incomes above 100% FPL compared to 44.6% in the state of Indiana as a whole. On the contrary, uninsured Kentucky residents in the service area are more likely to have higher incomes than their statewide counterparts — 46.0% of the uninsured in the service area's Kentucky counties have incomes over 100% FPL versus 35.6% in the state of

Kentucky as a whole. Half of the uninsured in the Health Foundation's Ohio counties have household incomes at 200% FPL or above (see Figure 6).

Figure 6: Uninsured population in service area, by income and state



Source: National Association of Community Health Centers, 2000.
Note: Data are estimates derived from 1997-1999 Census data.

For data tables, please see Appendix A.

Health Status

The Health Resources and Service Administration (HRSA) collects county-level information on selected health conditions. Although not comprehensive, this information allows comparisons among communities across the nation and state and national averages. Each of the Health Foundation's 20 counties compares favorably to similar counties across the nation and to the national average on some health indicators. For example, 13 counties compare favorably on one or more birth-related measures, such as birth weight, infant mortality, premature birth, births to teen mothers, and births to unmarried mothers. However, the counties also compare unfavorably on other

indicators, including lung cancer, with 17 counties comparing unfavorably (see Table 2).

Table 2: Health indicators compared to peer group and national average, by county

● Compares favorably to peer group and national average[2]

○ Compares unfavorably to peer group and national average

		Birth weight	Breast cancer	Colon cancer	Congestive heart disease	Coronary heart disease	Homicide	Infant mortality	Lung cancer	Motor vehicle injuries	Post-neonatal infant mortality	Premature births	Stroke	Suicide	Teen mothers[3]	Unintentional injury	Very low birth weight
Indiana	Dearborn	●	●		●				○	○				○	●		
	Franklin	●	●	●				●		○			●				○
	Ohio				○				○				○				
	Ripley		●	●	●			●	○	○	○	●	○	○			●
	Switzerland			●	○				○				○			○	
Kentucky	Boone	●	●	○		○		●	○	●			○	●		●	
	Bracken	○		○	○			○	○				●				
	Campbell	●	○		○		●		○	●	○		○				
	Gallatin			○	●				○				●				
	Grant			●	○			●	○			●	○		●		
	Kenton	●	○	○	●		●	●	○	●			●	○	●		
	Pendleton	○		○	○				○	○		●	●	○	●	○	
Ohio	Adams	●	●	○				●	○	○			●	○	●		
	Brown	●	○	○	●			●	○	○			○	○		●	
	Butler		●					○	○				●	●			
	Clermont		○	●				○	○				●	●		●	
	Clinton				●			●					○	●		●	
	Hamilton	○	○	○			●	○	○	●		○		●		●	
	Highland	●	●	○	○			●	●	○			●	●		●	
	Warren	●	●	●					○	●		●	○	●	●		

Source: Health Resources and Services Administration, 1997

[2] Peer group contains counties from across the nation with similar population size, age of structure, population density, and frontier status. This table only shows indicators for which the county rates are significantly lower (compares favorably) or higher (compares unfavorably) than their peer groups and the national average. Empty boxes indicate that there was no significant difference between a county and its peer group and the national average.

[3] Mothers under 18 years of age.

Access to Care: The Healthcare Safety Net

The Greater Cincinnati safety net is made up of community health centers, primary care physicians, hospitals, and other health agencies that receive state and federal dollars to treat uninsured and Medicaid-enrolled residents. Community health centers provide a substantial amount of primary and preventive care to people in the region but only provide care to about 11% of the uninsured residents in the Health Foundation's service area.

Detailed here are data from three community health center networks in Greater Cincinnati to provide a snapshot of the community health center's role in the safety net.

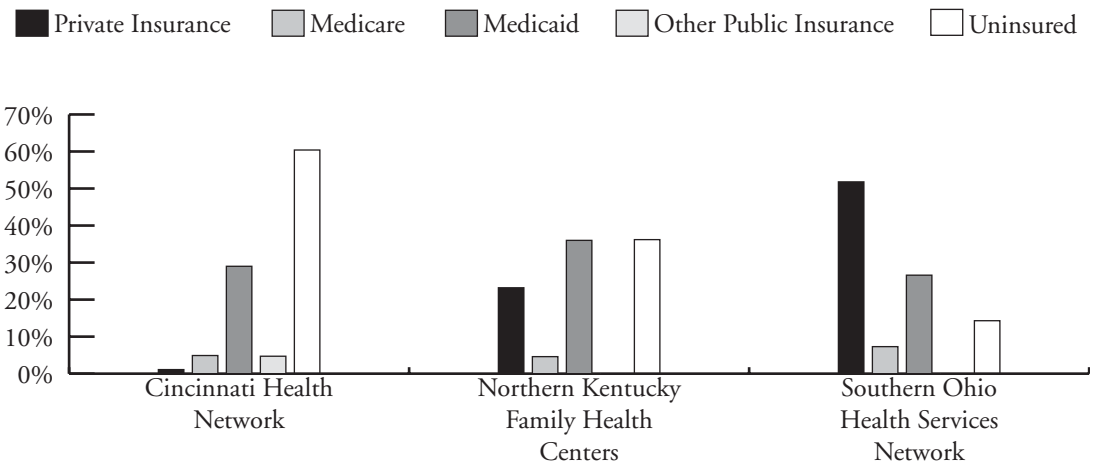
These three networks—Southern Ohio Health Services Network, the Cincinnati Health Network,[4] and Northern Kentucky Family Health Centers (now known as HealthPoint Family Care)—currently report annual financial, utilization, and outcome data to the Uniform Data System (UDS), a national database of more than 700 community health center networks across the country. In 2000, these three networks provided care to more than 97,000 people. According to UDS data, each user visited a site in these networks an average of 4.3 times a year, indicating that the community health centers in these networks are serving as medical homes for their patients.

The users of these three networks have varying levels of insurance coverage, including private, public, and no insurance. For example, while more than 50% of people who receive their care from Southern Ohio Health Services Network have some form of private health insurance, only 1.1% of people receiving care from the Cincinnati Health Network are privately insured. Just over 60% of Cincinnati Health Network's patients have no health insurance, compared to about 33% of people using

[4] *At the time these three networks were surveyed for user information, the Cincinnati Health Network included, among other organizations, Neighborhood Health Care, Inc.; West End Health Center; Winton Hills Medical and Health Center; Crossroad Health Center; and Elm St. Clinic. In December 2002, the Network reorganized and the organizations listed here are now independent.*

Northern Kentucky Family Health Centers and about 25% of people using the Southern Ohio Health Services Network (see Figure 7).

Figure 7: Insurance status of users of three community health center networks



For data tables, please see Appendix A.

In addition to community health centers, low-income and uninsured people seek care at local physicians' offices, public health departments, and hospital outpatient clinics. Cincinnati Children's Hospital Medical Center and University Hospital receive tax levy funds to pay for services for the uninsured. These two hospitals provide primary, specialty, inpatient, and emergency care to all in need, regardless of insurance status or ability to pay. University and Children's Hospitals also serve as major referral points for specialty care for uninsured and underserved adults and children across the area.

The safety net in the Greater Cincinnati region is further complicated by the presence of many Health Professional Shortage Areas (HPSAs)[5] and Medically Underserved Areas (MUAs).[6] To qualify to be an HPSA or MUA, a region or group must apply to the Department of Health and Human Services' Health Resources and Services Administration (HRSA). The HRSA then determines if the applying region, population group, or facility has enough primary, oral health, or mental health care providers for the number of residents, regardless of insurance status or ability to pay. Given the scarcity of providers in the Greater Cincinnati area, it is not at all surprising that there are large percentages of county residents who are underserved or

[5] *Health professional shortage area (HPSA) means any of the following which the Secretary of Health and Human Services determines has a shortage of health professionals: (1) An urban or rural area that forms a rational area for the delivery of health services); (2) a population group; or (3) a public or a private nonprofit medical facility.*

[5] *An area is deemed a medically underserved area (MUA) if it meets certain criteria as needing additional primary healthcare services.*

unserved by the healthcare system. In the Health Foundation's service area, 14 of the 20 counties are HPSAs and 16 have applied for and were deemed wholly or partially MUAs (see Table 3).

Table 3: Health shortage and medically underserved areas, by county

● Whole county has HPSA or MUA status ◒ Part of the county has HPSA or MUA status ○ The county does not have HPSA or MUA status

		Health Professional Shortage Area (HPSA) status	Medically Underserved Area (MUA) status	% of population deemed ***underserved***[7]	% of population deemed ***unserved***[8]
Indiana	Dearborn	○	○	—	—
	Franklin	●	●	100%	81.7%
	Ohio	●	●	100%	67.3%
	Ripley	◒	◒	—	36.0%
	Switzerland	●	●	100%	64.8%
Kentucky	Boone	○	○	—	—
	Bracken	●	●	100%	65.8%
	Campbell	◒	◒	—	6.7%
	Gallatin	●	○	100%	77.6%
	Grant	○	○	—	—
	Kenton	○	◒	—	1.8%
	Pendleton	●	●	100%	73.6%
Ohio	Adams	●	●	100%	69.2%
	Brown	●	●	100%	68.5%
	Butler	◒	◒	19.0%	7.3%
	Clermont	◒	◒	63.9%	36.2%
	Clinton	○	◒	1.6%	1.0%
	Hamilton	◒	◒	15.2%	5.6%
	Highland	◒	◒	42.4%	20.3%
	Warren	○	◒	2.5%	1.6%

Source: U.S. Census Bureau, 2000; Health Resources and Services Administration, 1997

[7] If an entire county is deemed to be an MUA, 100% of that county is deemed to be underserved. If part of the county is deemed to be an MUA, a percentage of the population is classified as underserved.

[8] Each physician in the county is presumed to be able to see 1,500 patients. If the total population of that area exceeds the number of physicians multiplied by 1,500, the additional residents are considered unserved.

If there are few providers in a region, there are most likely even fewer who will be in the safety net. In many cases, the availability of a provider in a given area does not mean that residents of that area have access to that provider. Only a fraction of providers in a given county are willing to see uninsured and underserved patients. The shortage is also true for dentists, whose numbers are extremely limited outside of the City of Cincinnati and who may be unwilling to accept Medicaid fees or reduced payments from uninsured or underinsured patients. Some community health centers offer basic oral health services but may not offer services beyond prevention and emergency extractions that patients might need.

Clearly, there is substantial underservice throughout the Health Foundation's 20-county service area that creates significant access problems. While there are exceptions, the lack of availability of primary care and specialty providers and the difficulty of traveling to and from medical and other health-related appointments, coupled with pockets of deeply entrenched poverty, portray a series of communities that are in serious need of improved access to healthcare.

In Their Own Words: Results of Conversations with County Residents

To get a better picture of healthcare access for uninsured and underserved people, the Center for Health Services Research and Policy study team conducted a series of focus groups with people who receive their care from three community health center networks in The Health Foundation of Greater Cincinnati's 20-county service area. Focus group participation was voluntary. Community health center staff recruited participants. A total of 23 people (16 women and 7 men) participated in the focus groups.[9] Their ages ranged from 22 to 79 and about half were uninsured. All but two of the participants were white. Most of the participants and their children had been patients of the community health centers for many years.

[9] *Of these, two women were interviewed individually at a health center.*

Telephone interviews were held with additional users of Greater Cincinnati health centers and social service organizations. Participants for the phone interviews were recruited by health center personnel.

Given the methodology used to select focus group and telephone interview participants, the responses may be biased and are not representative of the general population in Greater Cincinnati.

Findings

The discussion during the focus groups and telephone interviews centered around access to services and perceptions about quality of care in the community. Participants were specifically asked about access to primary care, specialty services, hospital and emergency room care, oral health services, mental health services, and prescription medications. There was also considerable discussion about coverage issues and the costs of obtaining health services.

Primary Care

All participants were extremely pleased with the care they receive at the community health centers in terms of the overall quality of care, the ease with which they can make appointments and access services, and the ability to obtain referrals for specialty

services. Several participants stated that they were always treated with respect by health center staff, despite being uninsured or publicly insured. They mentioned the convenience of health center locations, the availability of transportation to and from appointments, the reasonable costs associated with visits, and access to sample medications. According to one participant who has been a patient at more than one health center, *"They don't rush me in and out like I am a number or anything. They treat me well and take the time."* Others noted that community health center staff helped facilitate enrollment in Medicaid, State Children's Health Insurance Program (SCHIP), or other public programs, making filling out forms "really easy."

Most participants indicated that the community health center's sliding-scale fees help reduce the need to delay or forgo necessary primary care. However, some participants still had to delay care. For example, one woman with two young children said that, because healthcare is so expensive, she "almost never" seeks primary care for herself; instead, she "waits out" the illness, sometimes obtaining samples of antibiotics through a relative who works in a physician's office.

Specialty Care

Specialty services are not nearly as accessible. Participants noted that while it was relatively easy to obtain a referral to a specialist, it was sometimes quite difficult to actually get an appointment. There was a general sense that the problem is both one of supply—there are not enough specialists to handle the patients in need of care—and financing—not being able to afford the specialists that are available. Several people mentioned long waiting times associated with accessing specialty care in the Greater Cincinnati area, attributing these waits to a shortage of providers rather than insurance coverage. Most participants felt quite favorably about the quality of specialty care.

Some participants stated that their health center facilitates the appointment process, often linking patients with specialists who will reduce their fees for health center patients. In general, however, finding a specialty provider who would accept lower payments or Medicaid was sometimes quite a challenge. Participants typically waited months to get an appointment with a specialist who often was located far from the their homes. Some participants also felt they were treated disrespectfully by certain specialists. In one person's own words, *"They treat you like low class if you have [Medicaid]."*

Oral Health Care

The participants were mixed in their opinions regarding access to oral health care, in part because some oral health services are provided by some community health centers and are therefore much easier to obtain. Several participants described difficulties in finding dentists who would accept Medicaid or who would offer discounted fees, especially in Southern Ohio. One woman whose children were covered by Medicaid noted that she was referred to a dentist for specialty care, only to find out that this provider accepted new patients only two times during the year; once accepted, new patients had to wait up to five months for an appointment.

Mental Health Care

Several participants discussed difficulties in accessing adequate and appropriate mental health services, citing long waiting times and the inability to find providers. Like with other specialty areas, participants were able to obtain referrals for mental health services but found that actually accessing the care was much more difficult. For example, when the daughter of one participant was diagnosed with a rare chronic physical condition, the participant got a referral for a psychologist to help with the psychosocial aspects of managing that condition. Her daughter had to wait six months to actually see the psychologist. Several participants talked about having very good experiences accessing mental health services through certain mental health providers that charge lower fees to uninsured and low-income patients.

Prescription Medications

Across all of the focus group discussions, participants voiced concerns about the inability to access prescription medications. These sentiments were particularly strong among the uninsured in the group. Many depended heavily on samples from their physicians; in the absence of free medications, the majority of participants stated that they went without necessary medications from time to time. Several participants also obtained free or low-cost medications from St. Vincent DePaul, and others were enrolled in MedShare, a program that assists low-income and uninsured people with getting prescription medications. Without these programs, many participants would not be able to fill their prescriptions. One participant acknowledged the risks associated with "skipping" his medication for hypertension, but stated that it is sometimes necessary when he cannot afford to fill his prescription.

Likewise, a female participant who had been uninsured stated that her son sometimes skipped his medication for attention deficit/hyperactivity disorder (ADHD) because the prescription was too expensive to fill on a regular basis. In these cases, her son's condition would worsen and she would have to bring him to the community health center, where the physician would sometimes provide samples at no charge. Now that she and her family are insured, she hopes *"…to never have to put her children through anything like that again."*

Two of the participants qualified for Medicaid "spend-down," in which eligibility for Medicaid is tied to monthly health-related expenses. One of the participants, for example, must pay $427 in health-related expenses during a given month before she can qualify for Medicaid. At the time of the focus group, she was taking many different prescription medications that cost her less than $427 per month to fill. Since she can not afford to fill her prescriptions each month, she "spaces the medications out" to meet the spend-down requirements during some months but not others. The woman stated: *"I don't see how I can go on for more than a few months like this… What I've been doing is trying to stretch my medications out and meet my spend-down one month and not the next. I know it's not good, and I've been getting thunder from my doctors. But you let your body do that for a while and then, you know, your body tells you it won't do it anymore."*

Emergency/Hospital Care

The groups had very mixed views about the quality of care received at various hospitals in the region. For example, all participants of one focus group felt that the hospitals in the area treated people fairly, regardless of insurance status. Some participants in other groups said that they tried to avoid certain hospitals because they did not consider the quality of care to be as high as other area hospitals. According to one woman, who was pregnant at the time of the focus group, *"I've been told to watch when I go to have my baby that they don't try to stick me in a low-class room or nasty room just because I'm on [Medicaid]. They just think you're poor trash because you're on [Medicaid], and that's not the case with everybody."*

Other Concerns

Many of the participants expressed frustration about personal difficulties in obtaining and retaining Medicaid coverage. Two of the participants were pregnant at the time of the focus groups

and therefore qualified for Medicaid during that pregnancy. Each knew that she would lose Medicaid coverage after her pregnancy and was concerned about future access to specialty care, prescription medications, and other services. Some participants also discussed the logistical challenges in accessing supplies or services, especially transportation to and from the limited number of providers and specialists willing to take Medicaid patients or see patients on a reduced-fee basis.

There were several participants who stressed the difficulties elderly people have in accessing health services. According to one woman, senior citizens are "struggling big time" to access healthcare in the Greater Cincinnati area. Another woman stated, *"There's kind of a gap between the ages of 62 and 65. If you retire early, you're doomed, but I'm unable to work."* Still another woman stated that she was unprepared for the differences in coverage after her retirement.

Summary

The focus group and telephone interview participants describe a system of care in Greater Cincinnati that has significant gaps in access to services. While there appears to be extremely high satisfaction with the primary care services received through the community health centers, other services such as oral health, mental health, and specialty care are in short supply to uninsured, underserved, and Medicaid-covered residents. Many participants depend heavily on free or low-cost prescription medications, often forgoing medications if they are available only at full price. Care at local hospitals and emergency rooms is described as uneven at best, with clear preferences for certain hospitals in the area. According to the participants, community health centers serve an additional role as liaison between primary care and specialty care and also assist with enrolling in public insurance programs such as Medicaid and SCHIP.

Findings from Interviews with Local Providers, Advocates, Researchers, and Other Stakeholders

The Center for Health Services Research and Policy study team also independently interviewed a group of 12 providers, advocates, researchers, and other stakeholders in the Greater Cincinnati area to develop an understanding of the challenges providers face in serving uninsured and underserved populations. Interviewees included community health center and hospital administrators and clinical leadership, public health department representatives, advocates, mental and oral health providers, school-based health staff, researchers, and others who deliver healthcare and other services to vulnerable populations in the area.

Information in this section is taken from these interviews and is not a generalized picture of the healthcare system in Greater Cincinnati. The information is anecdotal but comes from people who are knowledgeable about the system. Data to support the reports by interviewees were not collected and are not presented here. In addition, interviewees were asked about problems in the system to identify gaps, not about the system in general, and positive things about the Greater Cincinnati healthcare system are not included here.

Coverage Issues

Anecdotally, several interviewees identified two growing groups of uninsured people: uninsured people who may be eligible for public insurance and uninsured people who are not (see Appendix B for more information on eligibility for select public insurance programs in the three states).

Providers are seeing more poor families who are uninsured and may be eligible for Medicaid or SCHIP but who are not enrolled, especially in Kentucky and Ohio. This may be partially because after a first-wave of aggressive outreach and marketing to enroll families in SCHIP, efforts quickly tapered off. There are also what one provider called the "pure uninsured:" people who are not eligible for public insurance but who can not afford

employer-based coverage (if it is available to them) or who can not afford to self-insure. The majority of these "pure uninsured" are self-employed or work for small companies. These two groups of uninsured people will place enormous pressure on safety net providers providing free or discounted services.

Providers interviewed also cited difficulties caused by a shortage of specialty care providers. According to some reports, the Greater Cincinnati healthcare market has been reducing provider payments for several years now, causing specialists and other providers to leave this region for more lucrative areas. Some individuals felt that the market has settled down and that, with some exceptions, the region has the capacity to handle much of the demand, although virtually everyone interviewed acknowledged that certain communities were extremely underserved. Others felt that the market was losing too many physicians and that more work was necessary to improve payment for physicians, both across the board and in certain speciality areas.

Many interviewees commented about low Medicaid payment rates. Community health centers that are Federally Qualified Health Centers (FQHCs) receive higher payments than other Medicaid providers, but are not available in sufficient numbers or locations to meet the demand. According to interviewees, low Medicaid payment rates for outpatient specialty care mean fewer providers will accept Medicaid patients, contributing to the difficulties in obtaining specialty services. In addition, dentists who do not work within the safety net perceive Medicaid payments for oral health services to be extremely low and identify these low rates as a barrier to accepting Medicaid patients.

Respondents were also mixed in their views about the ease of enrollment in Medicaid and SCHIP, with some saying that they have been very pleased with the changes in application procedures. Other respondents pointed out that many entry points into the safety net (especially hospitals) do not take full advantage of enrollment opportunities and do not present uniform applications for assistance. Finally, respondents felt that many people in Greater Cincinnati are not well informed of the free or reduced-fee services available.

The Healthcare Safety Net

From interviews and visits to several primary care sites, it appears that access to primary care is determined largely by geography. People who live close to a community health center are able to take advantage of well-staffed, high-quality care; those who do not must scramble to find appropriate services for themselves and their families regardless of insurance coverage.

Reportedly, like other markets across the country, Greater Cincinnati providers are seeing growing numbers of underinsured individuals who are essentially without coverage for most primary care and preventive services. Even community health centers with fairly high numbers of insured patients see few whose insurance covers most of the costs of care. This creates added pressures on providers who are called upon to provide free or reduced-fee services to growing numbers of patients.

The growing Spanish-speaking population in Greater Cincinnati is also affecting the safety net. Community health centers are responding by recruiting Spanish-speaking staff and using interpreters. Not surprisingly, centers with front-office staff members who are fluent in Spanish are seeing the greatest growth, as word-of-mouth spreads about the availability of bilingual services. Still, Spanish-speaking providers are quite scarce and limited English-speaking capacity is an impediment to appropriate access to care regardless of the person's native language.

In part because of gaps in coverage and shortages of primary care providers, school-based health centers have been introduced to the healthcare safety net in Greater Cincinnati. School-based health centers provide children and their families access to health and social services, especially in areas with little or no public transportation. During interviews, school-based health center staff reported decreases in chronic absences from school, greater compliance with immunization schedules, and increased enrollment in SCHIP programs. According to the providers interviewed, some school-based health centers are providing more mental health services than originally intended. Students frequently come to the center for a physical ailment, which, upon further investigation, is associated with a psychological issue.

The centers have shown to be helpful to families, especially transient families, who have not developed relationships with community health centers or other primary care providers. This is particularly important to poor families who, whether insured or not, do not have the means to pay for private physicians' visits (assuming they were accessible) and are "too proud" to seek help through more conventional social service settings. Although some centers bill Medicaid and other insurance companies, school-based health centers are designed to provide care for all regardless of their ability to pay.

Access to Specialists, Mental Health Services, and Oral Health Care

A pressing concern for the region is the shortage of specialty providers who are willing to accept Medicaid rates and discounted fees. The situation is far less problematic in the City of Cincinnati where community health centers have strong relationships with specialty practices. Most providers interviewed reported that specialty care is available in Greater Cincinnati, especially if patients are willing to wait months for an appointment. With the right "connections," the providers felt that referrals were relatively easy to obtain and high-quality care at affordable rates involved simply getting in the queue for service.

However, the providers interviewed also recognized that there are communities within the Health Foundation's service area that have long-standing and critical access problems for uninsured, Medicaid-covered, and otherwise vulnerable residents. People who live in rural areas must travel long distances to see a provider; those who do not have a reliable means of transportation are left with few options when trying to access care. Consequently, there are reports that emergency departments across the counties (and even in the Cincinnati area) are experiencing overcrowding and are filled with people whose conditions could have been better managed with routine primary care.

The situation is especially acute for mental health and oral health care, a finding that was also echoed in the patient focus groups and telephone interviews. Virtually all providers interviewed talked about the shortage of mental and oral health care

providers and the extent to which residents forgo or delay necessary services. Providers identified barriers that are difficult to overcome for many underserved residents. For example, Medicaid payment for oral health services is considered by many (but not all) providers to be inadequate to accept Medicaid patients. Very few dentists in the area take patients covered by Medicaid, so finding a provider becomes a difficult task. Many community health centers offer oral health services, but they have trouble staffing the services due to shortages of dentists and hygienists.

The providers interviewed admitted that care at mental health centers can be quite comprehensive, providing the most up-to-date treatments and therapeutic protocols—there just isn't enough to go around. Reportedly, privately insured individuals in managed care plans have such inadequate mental health benefits that these people must turn to the public system for care, placing additional strains on an already overburdened system. According to one provider, *"If you are extremely poor and severely ill and disabled, then you have good access to the mental health system. If you are wealthy and can pay your own way, you also have access. Everyone in the middle has a problem getting care."*

This lack of available mental health services places a huge burden on safety net providers to provide the care. Anecdotal reports from providers in Greater Cincinnati and across the country tell of primary care providers (PCPs) being expected to provide significantly more mental health care, and essentially crossing into territory that has traditionally belonged to psychiatrists, psychologists, and psychiatric social workers. While PCPs do screen for mental illnesses and provide some mental health treatment, they are often not connected to new developments in mental health care, including emerging best practices that have shown to be more effective than older treatment options.

Providers interviewed cited oral health care as another extremely underfunded service, although the private sector continues to provide better coverage for oral health care than mental health care, at least for routine preventive care. Oral health care provided through community health centers and outpatient hospital departments is frequently the only real opportunity for low-income and Medicaid-covered individuals to receive services. Not infrequently however, chairs at community health centers sit vacant because there are no oral health care providers to see patients.

The providers interviewed felt that payment rates were a principal reason for difficulties providing care for Medicaid-covered individuals. However, some safety-net providers asserted that it also appears difficult to find dentists interested in developing a Medicaid practice, even with enhanced payments. As an alternative, some communities across the country are beginning to provide some preventive oral health care through PCPs and other general medical care practitioners. While this could relieve some of the significant unmet need for oral health care, it would require additional training and would ultimately add responsibilities to safety net providers. If the services were available, however, the community health center and hospital staff interviewed felt that there would be no trouble filling appointments for these services, thereby generating some of the revenue necessary to staff services. This could be a promising alternative to address at least some of the oral health care needs in Greater Cincinnati.

Improving Care for the Uninsured and Underserved

Given existing access issues, reliance on local tax levies, and the stresses on the availability of public and private health insurance, the following ideas seem worthwhile strategies. Many of these areas reflect an overall movement to reduce dependence on local tax levies, a current strength for Greater Cincinnati. The suggested strategies complement the community's investment in and dedication to the tax levies for services for indigent populations.

Expand the scope of services at community health centers and strengthen health center networks

There has been considerable growth nationally in community health center capacity and services over the past several years to meet the needs of a growing uninsured and underinsured population. Some centers in the Greater Cincinnati area have grown as well, adding new services and implementing quality improvements such as updating management information systems. This growth, however, does not cover all of the communities that are suffering from poor access and underservice. Efforts to work with health centers to expand their geographic coverage as well as services to provide oral health care, mental health care, and chronic disease management would have extremely positive benefits for the residents of the communities.

Improve access opportunities, especially in very underserved areas

Community health center expansions are particularly difficult due to a lack of providers in underserved areas. Bringing new providers into the area and addressing transportation barriers to existing providers could help more people access healthcare. Health centers and other providers should also explore opportunities in telemedicine to link rural residents with primary and specialty care providers and other health services.

Improve culturally and linguistically appropriate care

Greater Cincinnati has traditionally had a very small population with limited English language proficiency. Recently, however, there has been rapid growth in the number of Spanish-speaking people who live within the Health Foundation's service area. Non-English speaking people are among the most likely to be uninsured. In addition, language and cultural differences are a significant barrier to accessing healthcare. While the absolute numbers are still relatively low, non-English speaking people are concentrated in a few neighborhoods, creating the need for culturally and linguistically appropriate care in these areas. Many resources are available to help providers deliver care in a culturally appropriate manner to minority and non-English speaking populations.

Develop a better understanding of the effects of payment (both public and private) on availability of primary, specialty, mental health, and oral health care providers

Payment rates seem to affect whether providers will practice in a certain area or will accept various types of insurance, including private and public insurance. Therefore, community stakeholders—policymakers, local medical associations, health departments, community health centers, chambers of commerce, and others—could collaborate to study the impact of public and private insurance payment rates on local providers, including primary care providers and specialists. The data from such a study, combined with the experiences of providers who serve Medicaid-eligible and underserved patients, could provide support for an effort to improve the numbers of local primary, specialty, mental health, and oral health care providers to the poor.

Simplify Medicaid and SCHIP application processes

Efforts to enroll people in Medicaid and SCHIP have produced positive results, but these efforts are usually episodic. Because income fluctuations affect Medicaid eligibility on a monthly basis, these episodic outreach efforts do not reach the majority of eligible individuals. More regular, consistent efforts by community health centers, hospitals, school-based health centers, faith-based organizations, and other community-based

organizations to enroll people in SCHIP and Medicaid can result in better coverage and thus better access (Nolan, et al., 2002). However, state Medicaid budget cuts may significantly reduce the number of people eligible for Medicaid and the services covered by Medicaid, negating outreach efforts that take place prior to any cuts.

Identify the importance of Medicaid coverage for low-income working families

Medicaid can be important for many low-income working families and for families moving from public assistance to employment. Even when employed, however, many working people do not have access to employer-sponsored health insurance plans or can not afford the plans that are offered. Current eligibility criteria force some families off of Medicaid before they can afford employer-based coverage, creating the dilemma of having to choose to pay for healthcare or to pay for necessities such as housing and food. When faced with these decisions, people generally choose to meet their immediate needs of food and shelter, even in the presence of chronic health problems. Therefore, Medicaid is extremely important to the economic stability and health of the most vulnerable working families.

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Appendix A: Data Tables

Table 4: Population in service area, by age and county (from Figure 1)

	<19	20-44	45-64	>65
Dearborn	30.3%	35.2%	23.2%	11.2%
Franklin	30.8%	34.3%	22.7%	12.4%
Ohio	27.3%	33.9%	25.1%	13.7%
Ripley	30.5%	34.2%	22.0%	13.4%
Switzerland	28.7%	34.1%	24.6%	12.6%
State of Indiana	29.1%	36.5%	22.1%	12.4%
Boone	31.3%	39.4%	21.3%	8.2%
Bracken	28.1%	35.3%	23.0%	13.6%
Campbell	28.6%	37.4%	21.4%	12.6%
Gallatin	30.9%	36.3%	22.4%	10.3%
Grant	31.4%	38.1%	20.8%	9.6%
Kenton	28.9%	38.6%	21.4%	11.0%
Pendleton	30.9%	37.1%	21.4%	10.5%
State of Kentucky	27.6%	37.0%	23.1%	12.5%
Adams	28.9%	34.3%	23.3%	13.3%
Brown	30.2%	35.7%	22.5%	11.6%
Butler	29.8%	37.9%	21.7%	10.7%
Clermont	30.5%	37.5%	22.6%	9.5%
Clinton	29.9%	35.8%	22.1%	12.2%
Hamilton	28.7%	36.3%	21.5%	13.5%
Highland	29.7%	33.7%	22.9%	13.8%
Warren	29.8%	38.9%	21.9%	9.4%
State of Ohio	28.3%	35.7%	22.7%	13.4%

Table 5: Population in service area, by ethnicity and state (from Figure 2)

	White non-Hispanic	Black non-Hispanic	Hispanic	Other
5 Indiana counties in service area	98.6%	0.3%	0.7%	0.6%
State of Indiana	87.5%	8.4%	3.5%	2.9%
7 Kentucky counties in service area	96.8%	1.4%	1.0%	1.0%
State of Kentucky	90.1%	7.3%	1.5%	1.5%
8 Ohio counties in service area	93.1%	4.6%	0.8%	1.3%
Hamilton County	72.9%	23.4%	1.1%	2.3%
State of Ohio	85.0%	11.5%	1.9%	2.2%

Table 6: Population in service area, by median income and county (from Figure 3)

	<100% FPL	100-199% FPL	>200 % FPL
Dearborn	11.5%	18.3%	70.2%
Franklin	12.6%	23.8%	63.6%
Ohio	13.1%	18.9%	67.9%
Ripley	9.4%	19.2%	71.4%
Switzerland	13.8%	24.7%	61.5%
State of Indiana	10.6%	18.0%	71.4%
Boone	9.1%	15.3%	75.6%
Bracken	23.3%	26.0%	50.7%
Campbell	13.7%	18.3%	68.0%
Gallatin	19.8%	25.5%	54.7%
Grant	18.6%	24.1%	57.3%
Kenton	10.3%	15.4%	74.2%
Pendleton	17.9%	24.6%	57.5%
State of Kentucky	18.3%	22.0%	59.7%
Adams	27.4%	28.0%	44.6%
Brown	16.6%	22.9%	60.5%
Butler	11.2%	15.8%	73.1%
Clermont	10.0%	17.1%	72.9%
Clinton	9.5%	17.7%	72.8%
Hamilton	12.4%	15.4%	72.2%
Highland	19.8%	27.4%	52.8%
Warren	6.6%	12.9%	80.4%
State of Ohio	12.5%	17.9%	69.6%

Table 7: Population in service area, by type of insurance and county (from Figure 4)

	Private Insurance	Medicare	Other Public Insurance	Uninsured
Dearborn	66.8%	14.1%	6.2%	12.9%
Franklin	64.7%	14.6%	6.8%	14.0%
Ohio	64.5%	15.8%	6.5%	13.2%
Ripley	66.7%	15.5%	5.6%	12.2%
Switzerland	62.1%	17.0%	6.9%	14.0%
State of Indiana	66.2%	14.4%	6.1%	13.2%
Boone	62.2%	10.8%	13.3%	13.6%
Bracken	46.9%	17.5%	18.5%	17.0%
Campbell	56.1%	14.8%	14.7%	14.4%
Gallatin	50.6%	14.3%	18.1%	16.9%
Grant	52.3%	13.5%	17.6%	16.5%
Kenton	59.6%	13.3%	13.5%	13.6%
Pendleton	51.9%	14.4%	17.3%	16.4%
State of Kentucky	51.9%	14.8%	17.0%	16.3%
Adams	53.6%	15.8%	15.1%	15.5%
Brown	61.1%	15.0%	11.1%	12.7%
Butler	66.6%	12.8%	9.1%	11.4%
Clermont	68.8%	11.2%	8.6%	11.3%
Clinton	66.3%	14.6%	8.2%	10.9%
Hamilton	62.5%	14.9%	10.9%	11.8%
Highland	57.0%	16.9%	12.4%	13.7%
Warren	70.9%	11.9%	7.0%	10.2%
State of Ohio	63.2%	14.9%	10.1%	11.8%

Table 8: Uninsured population in service area, by ethnicity and state (from Figure 5)

	White non-Hispanic	Black non-Hispanic	Hispanic	Other
5 Indiana counties in service area	98.4%	0.6%	0.8%	0.3%
State of Indiana	82.6%	12.4%	4.2%	0.8%
7 Kentucky counties in service area	94.9%	2.2%	1.5%	1.4%
State of Kentucky	88.4%	8.1%	1.9%	0.8%
8 Ohio counties in service area	76.8%	19.7%	1.2%	2.3%
State of Ohio	77.9%	16.7%	3.0%	2.4%

Table 9: Uninsured population in service area, by income and state (from Figure 6)

	<100% FPL	100-199% FPL	>200 % FPL
5 Indiana counties in service area	28.6%	33.0%	38.3%
State of Indiana	27.0%	28.4%	44.6%
7 Kentucky counties in service area	25.6%	25.6%	28.4%
State of Kentucky	33.8%	46.0%	33.8%
8 Ohio counties in service area	25.5%	25.4%	49.1%
State of Ohio	26.6%	27.4%	46.0%

Table 10: Insurance status of users of three community health center networks (from Figure 7)

	Private Coverage	Medicare	Medicaid	Other Public Insurance	Uninsured
Southern Ohio Health Services	51.8%	7.3%	26.6%	--	14.3%
Cincinnati Health Network	1.1%	4.9%	29.0%	4.71%	60.4%
Northern Kentucky Family Health Centers	23.2%	4.6%	36.0%	--	36.2%

Appendix B: Medicaid and SCHIP Programs in Indiana, Kentucky, and Ohio

The Medicaid and State Children's Health Insurance Programs (SCHIP) in Indiana, Kentucky, and Ohio provide critical access to primary care, preventive services, and other important benefits for many low-income and vulnerable residents in the Health Foundation's service area. At the end of 2002 and the beginning of 2003, all states are experiencing their worst fiscal crises of the last century, and Medicaid programs are at risk for sudden, substantial changes.

The general eligibility criteria as of March 2003 are as follows.

Medicaid

- Hoosier Healthwise is **Indiana**'s Medicaid program, which covers children up to 200% FPL, pregnant women up to 150% FPL, and families with incomes up to 200% FPL (Indiana Family and Social Services Administration, n.d.). Indiana does not operate a spend-down program. Medicaid enrollment in Indiana grew significantly (30.2%) between 1996 and 2000, while the national enrollment rate grew 5.9% in that same time period (Maloy and Kenney, 2002).

- The **Kentucky** Medicaid program operates KenPAC,[10] a primary care case management program for all Kentuckians who qualify for Medicaid based on income, income-related medical assistance, or eligibility for adult Supplemental Security Income (SSI). Kentucky covers children up to 200% FPL and pregnant women up to 185% FPL (KY Cabinet for Health Services, Department for Medicaid Services, n.d.). It offers a Medicaid spend-down option for individuals and families (parents) after $217 in monthly health-related expenses. Kentucky's Medicaid program has seen growth that is more consistent with national averages; between 1996 and 2000, enrollment grew 8.2% (Maloy and Kenney, 2002).

[10]KenPAC is a loosely managed primary care case management program that provides monthly management fees to primary care physicians to compensate them for gatekeeping functions and creation of a medical home for the enrollee.

- **Ohio** operates a Medicaid program that covers children (up to age 19) in families with incomes up to 200% FPL, pregnant women up to 150% FPL, parents up to 100% FPL, and disabled individuals up to 64% FPL (Ohio Department of Job and Family Services, n.d.). It also operates a limited spend-down program for individuals with high health-related expenses. Of the three states in the Health Foundation's service area, Ohio's Medicaid program saw the greatest growth (51.1%) between 1996 and 2000.

SCHIP

- **Indiana** operates a two-part SCHIP program: CHIP Package A, which began the CHIP program as Phase I in July 1998 and expanded Medicaid coverage to children below age 19 with family incomes no greater than 150% FPL. CHIP Package C, which corresponds to Phase II of the program, began on January 1, 2000, and provides coverage to children in families with incomes between 150–200% FPL. Phase II is also referred to as the "premium share program."

- KCHIP, **Kentucky**'s program, also has a mixed model that combines a Medicaid expansion with a separate insurance program for children in families with relatively higher incomes. Phase I began in July 1998 by extending Medicaid coverage to children ages 14–18 in families with incomes up to 100% FPL. Phase II, which began exactly one year later, extended Medicaid coverage to previously uninsured children ages 1–18 living in families with incomes up to 150% FPL. Phase III, which began in November 1999, covers children in families with incomes between 151–200% FPL. Phase III does not cover non-emergency transportation and Early Periodic Screening Diagnosis and Treatment (EPSDT) special services. Children enrolled in KCHIP are enrolled in KenPAC, the state's Medicaid primary care case management program.

- **Ohio**'s SCHIP program, Healthy Start, is a Medicaid expansion that currently covers previously uninsured children with family incomes up to 200% FPL. Services for children who were brought into the program beginning in January 1998 as part of the Medicaid Healthy Start expansion are reimbursed at an enhanced rate. Family income for these children can not exceed

150% FPL. A second wave of children, who were enrolled beginning the following year and who have family incomes between 150–200% FPL, receive the same benefits but do not qualify for the enhanced SCHIP reimbursement rates.

Modifications in the State's Requirements

In addition to income eligibility criteria, states can ease income and asset requirements in an effort to make Medicaid more accessible to working individuals who are making the transition between cash assistance and earned income. As part of welfare reform, Congress replaced the automatic link between public cash assistance and Medicaid with a new eligibility category (Section 1931). As part of the new requirements, states could use less restrictive income and resource methodologies when determining eligibility for Medicaid. States could also relax at least seven key criteria for determining eligibility by:

- adopting more generous income disregards to essentially raise the income standards for family coverage,
- eliminating the gross income test,
- disregarding fully the first three months of earned income,
- disregarding a higher percentage of earnings for longer periods,
- extending transitional Medicaid by extending the availability and duration of earned income disregards,
- treating lump sum payments as income or an asset that is disregarded, and
- eliminating the asset test (Maloy, Kenney, 2002).

States could also relax other eligibility provisions that have proven to be significant impediments to Medicaid coverage. Two such provisions are the so-called 100-hour rule for two-parent families (which prevented the principal wage earner from working more than 100 hours per month; 42 states have eliminated this rule, including Indiana, Kentucky for current recipients only, and Ohio) and including part of the value of an applicant's or recipient's first car. Finally, some states have also lengthened the time available for transitional Medicaid to smooth the transition from welfare to work for low-income families.

- **Indiana** has eliminated the gross income test, but has not eliminated the requirement for an asset limit, which the state has set at $1,000. It eliminated the 100-hour rule for

two-parent families, but did not choose to completely disregard a client's first car (currently, up to $5,000 in equity value can be disregarded). It does not offer more than 12 months of transitional Medicaid. The program disregards $90 of an applicant's earnings. Indiana has developed a joint Temporary Assistance for Needy Families (TANF), food stamp, and Medicaid application and has eliminated the need for a face-to-face interview (although a telephone interview is still required). It does not allow self-declaration of income for applications or redeterminations and it does not offer lump sum payment diversion.

- **Kentucky** also disregards $90 of an applicant's earnings. It has not eliminated the gross income test or the asset test; the monthly income threshold for a three-person family is $1,000 and the asset threshold is $2,000. Kentucky eliminated the 100-hour rule for current recipients but not for new applicants. It does not disregard more than $1,500 (the original criterion) for a client's car, and does not offer more than 12 months of transitional Medicaid. It does disregard diversion lump sum payments. Kentucky has developed one application for both Medicaid and KCHIP, has eliminated the need for a face-to-face enrollment interview, and allows for self-declaration of income for redeterminations.

- **Ohio** disregards $250 of an applicant's monthly income, plus an additional 50% of the remainder, or all income up to 100% FPL. It has eliminated the asset test but continues to apply a gross income test which, for a family of three, is $1,813. Ohio eliminated the 100-hour rule and disregards lump sum payments. Because it no longer has an asset test, it disregards entirely a client's car. It has not extended transitional Medicaid beyond 12 months. Ohio uses one application for Medicaid and SCHIP and has eliminated the requirement for a face-to-face interview. It does not allow self-declaration of income.