State Efforts to Measure the Health Care Safety Net

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The U.S. health care system relies on safety net providers to meet the needs of its 37 million citizens who do not have access to health insurance and for others who may have some coverage but still face barriers to getting the health care they need. A patchwork of local providers and services has developed over time to fill the gaps in access and coverage experienced by communities. There is no central planning, no organized system of care but a loosely defined "system" of providers, programs, services, and funding that has emerged to meet the unique needs of individuals and families.

The providers and services that make up the safety net are critical components of the U.S. health care system and there is increasing interest in understanding how the safety net is organized and funded. This interest stems in part from the realization that universal access to health insurance coverage in the U.S. is not likely to occur in the near future. Advocates as well as policy analysts may be now turning to an alternative goal of assuring access to needed health care services. Do people in the U.S. have access to health care services when they need them? Part of that question has been answered by looking at the numbers of people with and without health insurance coverage. The other part of that question is whether needed care is available for the 37 million people without health insurance or with minimal coverage, the so-called underinsured, estimated to be between 10 and 25 percent of the US population.[1]

There is additional concern that funding for these safety net providers, programs and services may be eroding such that the number of safety net providers may no longer be sufficient to provide needed health care services to un- and underinsured.[2,3,4] Yet it is difficult to define and

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[1] Committee on the Changing Market, Managed Care, and the Future Viability of Safety Net Providers, *America's Health Care Safety Net: Intact but Endangered*, edited by Marion Ein Lewin and Stuart Altman (Washington, D.C.: National Academy Press, 2000).

[2] Gage, L.S. and M. Regenstein, *Bolstering the safety net.* Health Affairs, 1999. **18**(5): p. 254-257.

[3] Lurie, N., *Strengthening the US health care safety net [commentary].* JAMA, 2000. **284**(16).

[4] Norton, S.A. and D.J. Lipson, *Portraits of the Safety Net: The Market, Policy Environment, and Safety Net Response*. 1998, The Urban Institute: Washington D.C

quantify the health care safety net in a comprehensive way that allows policy makers to assess its capacity and monitor it over time. While the federal and state governments fund specific programs that fit the definition of safety net care,[5] there are many additional community-based programs that are locally funded and organized and do not lend themselves to the discrete categories required to quantify baselines and monitor change over time.

This paper represents an initial look at the capacity of states to collect data on specific elements of the safety net. It is not a comprehensive review or analysis but the start of an ongoing discussion of federal and state-level efforts to define and monitor the safety net in the U.S. We begin our analysis by focusing on five states and their data collection efforts around traditional safety net providers. The purpose of this report is to: (1) provide an initial review of state efforts to measure the health care safety net by focusing on the efforts of five states, (2) highlight the role states could play in any national data collection effort, and (3) provide recommendations to the federal government, from a state perspective, on the development of a data collection scheme to monitor the health care safety net.

State Efforts to Measure the Health Care Safety Net

We recognize that a comprehensive look at the safety net requires data from federal, state, and perhaps more importantly, local sources including community- and faith-based organizations, community clinics, and other volunteer efforts. This paper focuses exclusively on the role states could play in data collection. In addition, it is important to point out that states vary significantly in their capacity and interest in data collection in general. Any effort to design and implement a federal initiative that relies on state-level data must keep this state variability in mind.

While there may be more refined gradations, states fall into three broad categories of data and information systems: (1) Sophisticated data states where there is institutional interest,

[5] These include Federally Qualified Health Centers (FQHCs), Community Health Centers (CHCs), public hospital

funding and capacity for the collection and use of data at the state level. These states have built internal capacity to collect data, produce reports and use data in a policy-making capacity. (2) Less sophisticated but interested states where there is interest in data and information but limited state infrastructure or financial support. Many of these states rely on outside consultants to provide targeted studies and support when intermittent funding is available. (3) Limited capacity states that do not have the capacity, the funding, or the political interest in collecting data relating to their health care system. These states primarily rely on their Medicaid agency and its technical information and support system; they have almost no capacity for additional data collection and analysis.

The state interviews conducted for this study focused on a select group of states from among the more sophisticated data users. The intent of these interviews was to highlight the potential for state capacity in the area of data collection by examining the measurement efforts of leading states. Interviews were conducted with representatives from Florida, Massachusetts, Rhode Island, Washington, and Wisconsin[6] over a three-week period by staff at the State Health Access Data Assistance Center (SHADAC). State representatives were asked about the States' role in monitoring their health care safety net, data currently available and collected on an ongoing basis, and reports or relevant studies conducted by the states in the last five years. Specific questions were designed and organized to reflect the health care safety net typology developed at the May 16th, 2001 "Meeting to Explore the Development of a Typology to Characterize Community Health Care Safety Net Systems" sponsored by the Office of the Assistant Secretary for Planning and Evaluation (ASPE). A description of the typology is provided as Appendix A. Due to time and budget constraints, measures associated with the structure and demand features of the typology constituted the focus of the current investigation. The following is a summary of the sampled states' measurement efforts.

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subsidies, and uncompensated care pools.

[6] States were chosen to represent a breadth of criteria. Florida represented a state with an uncompensated care pool, Massachusetts represented a rate-setting state, Rhode Island has small business subsidies, Washington provided some geographic diversity, and Wisconsin was a state known to have an ongoing state-initiated population survey.

Florida. An overview of Florida's efforts to measure the selected aspects of its health care safety net is provided as Table 1. Florida collects data on a number of different facets of the health care safety net's structure and the demand for the services it offers. Examples of structure include service provision levels and the existence of waiting lists. Examples of demand include household surveys to measure rates of uninsurance, underinsurance, and perceived health status. In addition, Florida was the only state interviewed that collected information on the "systemness" of the safety net by trying to assess whether recipients of safety net services had a medical home and how well different agencies were linked to one another. Lastly, although not depicted in the table, Florida collects robust information regarding health care safety net funding. Examples include information on major funding sources for indigent care services (e.g., local, state, or federal government, foundations, private donations, and United Way), expected increases or decreases in funding, dollar value of donated services, and the total operating budgets for varied health care safety net programs.

Insert Table 1 about here

Most of Florida's measures are self-reports obtained from the Florida Health Insurance Study (FHIS). The FHIS is a multi-year, multi-project series of studies undertaken by the Florida Agency for Health Care Administration in response to a legislative request. The principal sources of the measures depicted in Table 1 are the FHIS Telephone Survey of Florida households and the Local Subsidy survey of community clinics, programs and other "safety net" resources that provide medical care services to poor and uninsured Floridians. The Local Subsidy survey was intended to quantify the amount of uncompensated care provided to people without insurance and to find out more about programs and organizations that provide medical services other than hospital care. The programs surveyed included: health departments, community health programs, volunteer programs, population-specific programs (such as homeless,

HIV/AIDS, women's health), hospital-based clinics, church-based clinics, and local-based programs funded by the government. Respondents provided information on services offered and who received those services, as well as information on funding sources for their program.

Massachusetts. Of the five states interviewed, Massachusetts had the highest level of data activity associated with its health care safety net. These activities, however, seem to be undertaken in a fragmented and uncoordinated manner as evidenced by the large amount of contacts made (over 20 different state departments and health associations were contacted) and demonstrated by the following interviewer summary:

- *"The **American College of Physician; American Society of Internal Medicine (ACP-ASIM)** says that the **Division of Medical Assistance** is the agency that oversees the safety net.*
- *The **Massachusetts Hospital Association** says that the **MA Division of Health Care Finance and Policy** examines information related to the safety net.*
- *The **Massachusetts Public Health Association** directed my attention to **Health Care for All**.*
- *The **Massachusetts Health Council, Inc.**, says that **Health Care for All** has information about the safety net.*
- ***Health Care for All** says that the free care pool is under the **MA Division of Health Care Finance and Policy** but that other programs are under the **Department of Public Health**.*
- *The **Massachusetts Health Data Consortium** says that the two organizations to contact for information about the safety net are the **MA Division of Health Care Finance and Policy** and **Health Care for All**.*
- *The **Massachusetts Division of Health Care Finance and Policy** referred me to their Webpage at www.state.ma.us/dhcfp to look at both (a) their "Uncompensated Care Pool PFY00 Annual Report" and at (b) the information on health care resources in MA collected by the Division. In addition they referred me to the webpage www.state.ma.us/healthcare which has the "Massachusetts Health Care Task Force Interim Report" and to www.state.ma.us/hrsa which is the webpage for the HRSA Massachusetts State Planning Grant."*

Organizational challenges notwithstanding, Massachusetts utilizes a variety of different measures and draws upon a breadth of data sources in its assessment of the health care safety net. Table 2 provides an overview of Massachusetts' measures of its health care safety net, how they

are defined, and from which data sources it has drawn its information.

Insert Table 2 about here

Massachusetts collects information on almost every facet of the structure and demand features of the ASPE draft safety net typology. In addition, it is one of the few states that capture robust information on school health centers and the availability of pharmaceutical services within the state as safety net resources. Not shown in the table is the great deal of budgetary information Massachusetts collects on its health care safety net including: 1) total expenses by overhead, ancillary, routine inpatient and routine outpatient departments; 2) departmental expense breakouts by salaries and wages, physician compensation, purchased services, supplies and expenses, and major movable equipment depreciation; and 3) gross and net service revenues by payer. Other statistics such as number of beds, patient days, admissions, discharges, occupancy and length of stay by routine inpatient and outpatient departments are also collected.[7]

Rhode Island. Table 3 provides an overview of Rhode Island's measurement efforts. Like Massachusetts, Rhode Island collects a wide variety measures on its health care safety net using combinations of administrative data, state surveys, and national data sources. They also tend to collect more information on the structure aspect of the safety net rather than on demand. Rhode Island, like Massachusetts, reports on the number of school-based health centers. Unlike Massachusetts, Rhode Island's efforts are quite centralized. The centrality provided by Rhode Island Department of Health made it much easier for interviewers to assess the status of Rhode Island's efforts and could likely serve as a model for other states.

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[7] A report summarizing this information, the Massachusetts Acute Care Hospital Fiscal Year 403 Cost Report, is given annually to the Massachusetts Division of Health Care Finance and Policy.

Insert Table 3 about here

Rhode Island is the only state interviewed that collects information on other vulnerable populations within the state including persons with mental illness, developmental disabilities, and substance abuse problems. The Rhode Island Department of Mental Health, Retardation, and Hospitals spearheads data collection in this regard. Rhode Island is also the only state interviewed to draw upon its Behavioral Risk Factor Surveillance System (BRFSS) survey (described in a later section of this report) to measure levels of insurance coverage.

Washington. Like Massachusetts, Washington does not have a centralized agency charged with overseeing the health care safety net. Accountable entities include the State Department of Health, the Medical Assistance Administration of the Washington Department of Social and Health Services (the State's Medicaid Agency), the Office of Financial Management, and the Community Health Services Program. Although this diffusion of responsibility made it difficult to characterize the state's measurement efforts, Table 4 demonstrates that Washington does capture a depth of information on its safety net. Unlike the other states interviewed, Washington's measures focus more on the demand aspects rather than structure; the principal source of the former is the Washington Population Survey. Within the structure domain, Washington excels in its measurement of the services available to the uninsured. Washington has many programs to provide care for those in need of safety net health care services, as well as reasonable mechanisms for evaluating the status of those programs.

Insert Table 4 about here

Wisconsin. As shown in Table 5, Wisconsin collects a breadth of information on the availability of health care safety net provides relative to the other states we interviewed. As one of the only states conducting surveys of physicians, Wisconsin captures unique information

relating to safety net provider availability including the number of licensed physicians, type of practice, percent of providers providing *pro bono* care, payment plans or sliding fees for needy patients. Wisconsin also joins Massachusetts as being one of two states that measure the availability of pharmaceutical services as a safety net resource. The two states differ in the focus, however. Massachusetts reports on the performance of its Senior and Disabled Pharmacy Program while Wisconsin collects data on the AIDS/HIV Drug Reimbursement Program (ADRP).

Insert Table 5 about here

Like its counterparts in Florida and Massachusetts, Wisconsin collects information that could be used to measure the support facet of the ASPE draft safety net typology. Levels of uncompensated and charity care, as well as bad debt data are collected from all hospitals in the state. These data are compiled in an annual report from the Bureau of Health Information, Department of Health and Family Services. The report provides information on the total and projected charges of charity care and bad debt, the number of patients receiving charity care, uncompensated health care as a percentage of total gross patient revenue and as a percentage of total gross non-governmental patient revenue, and Hill-Burton obligations. Wisconsin uses the common definition of hospital-based charity care defined as the sum of charity care and bad debt. Charity care is defined as care for which a hospital does not charge because it has determined that the patient cannot afford to pay. Bad debt is defined as payment that the hospital is expecting to receive but is unable to collect.[8]

Summary of State Interviews

It must be stated at the outset that we were not likely able to accurately portray the

[8] A copy of the most recent uncompensated care report is not available without purchasing, however, a copy of the 1996 uncompensated care report is available at: http://www.dhfs.state.wi.us/healthcareinfo/excerpts/uncomp.htm. Also additional information is available at: http://www.dhfs.state.wi.us/healthcareinfo/pgstndrd.htm#t-uhciw.

depth of measurement effort within the states due to the short data collection period coupled with the difficulty contacting appropriately informed state representatives. The current investigation was not intended to be a comprehensive review or analysis but the start of an ongoing discussion of state efforts to monitor the health care safety net in the U.S. The summary below is provided to affect and inform future discussions in that regard. More in-depth investigations, especially in the support and environment facets of the ASPE draft safety net typology, are warranted.

The states we interviewed collect a lot of varied data on different elements of the safety net. All of the states collect structural information pertaining to the services available to the uninsured, underinsured, or others with limited access to care. All of the states have also made efforts to measure the level of insurance coverage and the health status of their respective populations, which are measures of health care safety net demand. A minority of the states has measured the number of school-based health centers in the state, the availability of pharmaceutical services as a safety net resource, and measures of the "systemness" of the health care safety net. None of the states have combined these data sources to allow a comprehensive look at their health care system and safety net infrastructure.

In each state there are many agencies and systems involved in collecting data. These agencies often do not share data, information, or a common mission. The data may be collected for one purpose; using it for another purpose (i.e., safety net monitoring) would require additional resources and infrastructure. One of the states we did not formally interview (Oregon) has a state-level effort underway to define and monitor its own safety net. The state of Oregon sees such monitoring as a state responsibility and has initiated efforts to assess capacity internally. Oregon's effort exemplifies a process that is state-specific and community-driven. The process requires the commitment and input from various levels of government, the community, as well as providers. Oregon's process started from the ground up and is designed

to generate support and commitment around assuring access to and delivery of needed health care. Key aspects of Oregon's approach are highlighted below.[9]

First, Oregon realized that some definition of the health care safety net needed to be agreed upon. That definition was provided by the Oregon Committee on Health Care Safety Net Support, a committee composed of providers, advocates, and government officials from throughout the state.[10] Next, Oregon formally integrated and strengthened the health care safety net. Using grant money from the HRSA Community Access Project, the Oregon Community Health Information Network (OCHIN), a statewide network of health care safety net programs, was formed. OCHIN's vision is to be a jointly owned and operated management services organization that provides practice management and information services as well as other support services to member safety net clinics. OCHIN also hopes to streamline safety net clinics' ability to collect and use data. OCHIN helps health care safety net providers organize information and coordinate with other care providers and services. Oregon's final step was to work with the state government to develop a state "home" for the health care safety net. When established, this home will complement the role of the OCHIN and further streamline the collection and use of available data on the health care safety net. The state home could also act as a single point of contact in the state for those wishing to obtain information on the status of Oregon's health care safety net.

Once the infrastructural obstacles are attended to (if not overcome), possible data sources need to be identified. One of the lessons learned from the interviews is that state data fall into five general categories: 1) administrative data, 2) regulatory data, 3) budgetary information, 4)

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[9] Based on a personal communication from Laura Brennan, Policy Development Manager, Universal Health Care Project, September 18, 2001.

[10] Florida also undertook a similar process by working with an advisory committee composed of representatives from state government, the University of Florida, the Florida Department of Elder Affairs, Florida Department of Health, Florida Hospital Association, county health department, local health councils, community health centers, rural health networks, health care taxing districts, community subsidized clinics, and healthcare policy/consulting groups to develop criteria for what types of programs should be construed as composing their health care safety net.

federally-initiated state surveys, and 5) state-initiated surveys. Each of these is profiled below.

Administrative Data. These data typically include enrollment and claims information relating to Medicaid, SCHIP, medically needy programs, disproportionate share payments, high-risk pools, and uncompensated care pools. An example of a systematic effort to pool national, regional, and state level administrative data is the Healthcare Cost and Utilization Project (HCUP) maintained by the Agency for Healthcare Research and Quality (AHRQ). HCUP is a Federal-State-industry partnership to build a standardized, multi-state health data system. HCUP databases are a family of longitudinal, administrative databases including state-specific hospital discharge databases, state-specific ambulatory surgery databases, and a national sample of discharges from community hospitals.

Another useful resource is the HRSA Area Resource File (ARF). The ARF contains more than 7,000 variables at the county level including information on health facilities (e.g., number of admissions, inpatient days, outpatient visits, beds by type, and number of personnel), health professions (including information on Health Profession Shortage Areas), revenues and expenditures, service utilization, and sociodemographic and environmental characteristics. Information is provided to the ARF by various sources including: the American Hospital Association, the American Medical Association, the American Dental Association, the American Osteopathic Association, the Bureau of the Census, the Centers for Medicare and Medicaid Services (CMS, formerly known as the Health Care Financing Administration), the Bureau of Labor Statistics, InterStudy and the Veteran's Administration.

A new resource to facilitate the use of public health care program administrative data is the Research Data Assistance Center (ResDAC). ResDAC is funded by CMS to assist researchers in gaining access to and understanding of Medicare and Medicaid administrative data that is available from CMS. The ResDAC contract was awarded to a university consortium chaired by the University of Minnesota School of Public Health and includes faculty and staff

from Boston University Medical Center, Dartmouth Medical School, and Morehouse School of Medicine.

Regulatory Data. These data are collected through state or federally mandated data collection schemes for the purposes of regulation of providers or services. This includes data on licensed providers, hospital and nursing home bed capacity, mandated state surveys, or provider cost reports.

Budgetary Information. In addition to national resources such as HCUP and HRSA-ARF, data on programs and the funding of specific state programs designed to support safety net providers can often be found in state budget documents. Again, the programs (definition as well as organization) are likely to be state-specific, but they may also include specific subsidies to public hospitals or public-run clinics, tobacco settlement dollars allocated to free clinics or children's health insurance programs, state-specific subsidies to uncompensated care pools or high-risk pools, and state-specific funding of public health initiatives, including free mammograms, immunization programs and other screening and prevention services. As referenced in earlier state summaries, some of these budget reports can be accessed via state web pages.

Federally-initiated State Surveys. These are the efforts designed to collect state representative data at the national level. The Behavioral Risk Factor Surveillance System (BRFSS), the Current Population Survey, the Medical Expenditure Panel Survey-Insurance Component (MEPS-IC), and the State and Local Area Integrated Telephone Survey (SLAITS) are examples of federal surveys that may be used for purposes of measuring states' health care safety nets. Brief summaries of each of these sources are provided as Appendix B.

State-initiated Surveys. Many states have developed their own household surveys that would be useful in evaluating the health care safety net. States often prefer their own surveys because the item can be tailored to their unique programs and policy questions. Table 6 lists household survey initiatives that could be useful in measuring the health care safety net at

the state level. Many of these surveys are currently supported by the HRSA State Planning Grant program.

Insert Table 6 about here

State-initiated surveys also include surveys of other populations such as employers, the safety net survey conducted by Florida, a physician clinic survey fielded annually by the state of Wisconsin, and the uncompensated care clinic survey also fielded by the state of Wisconsin.

State-initiated surveys (household and employer) are a valuable source of data and information for state-specific policy purposes but do not lend themselves to cross-state comparisons. The State Health Access Data Assistance Center (SHADAC) is attempting to coordinate state survey initiatives to facilitate comparisons, but success depends on state-initiated efforts that will take time and resources to develop and implement.

Recommendations

States have been given increased responsibility in the provision and funding of care for the poor and uninsured. The SCHIP program is the most recent example of the expanded role states continue to play in the design and implementation of federally-initiated and funded health insurance programs. State and local systems of care have evolved over time and are unique based not only on the characteristics of their population, but also on the politics and culture of each state. Any national effort to collect data to compare these systems across states must include some capacity to summarize data for comparative purposes and to describe the breadth and depth of each unique state constellation of program and services. The following are specific recommendations:

(1) Build on existing national data collection efforts that allow for state-level comparisons and work toward better funding, sample techniques and distribution of information and analysis to

the states. SLAITS may be the best place to start.

(2) Use aggregate data and information that is currently available from various data sources to summarize capacity at national level. Then, use case studies and more in-depth analyses throughout the country to describe and monitor the safety net across communities and over time. This approach would require an ongoing focus on a select group of communities that might be representative of other parts of the country.

(3) Use the model of the National Survey of American Families (NSAF) conducted by the Urban Institute to do more focused surveys to obtain additional information on a select group of states regarding both medical and social indicators of need (and change in need) over time. Surveys such as the NSAF are extremely expensive but also extremely valuable. Any one state could not fund such a comprehensive survey and sustain it over time. Yet the information collected does provide for national estimates and cross-state comparisons.

(4) Involve state analysts and policy makers in discussion of any new data collection efforts that will require state capacity and state-level data collection. States are already pursuing their own data collection schemes. Federal analysts can learn from what states are doing and may be a catalyst or disseminator of data and information to other states.

(5) Be explicit and forthcoming about the goals of data collection and the role of the federal government in this pursuit. States may be less willing to participate if the goal is information only without a specific policy objective in mind.

Table 5. Wisconsin's Efforts to Measure the Structure of the Health Care Safety Net

Information/Data	Measures [a]	Definition	Data Source	Data Type
Structure				
The number and availability of providers (such as: primary care physicians, nurse practitioners, etc.) and their type of practice setting.	Number of Wisconsin licensed physicians Type of practice Percentage of providers providing *pro bono* care, payment plans or sliding fees for needy patients Number of federally funded agencies, certified rural health clinics, and physicians by region	Physicians/providers registered for licenses in the last year Example: Family practice, general practice, internal medicine Example: tribal, Community Health Center, Mental Health Center, etc.) The number of physicians divided into five regions: Northeastern, Northern, Southeaster, Southern, Western	Data obtained from the Wisconsin Department of Regulation and Licensing 2000 Physician Workforce Survey and the 1996 Physician Profile Survey [1]	Regulatory/ State Survey
The number of school health centers within the state.	DNF			

[a] DNF (Did Not Find) denotes a data element that may exist at the state but its presence or use could not be confirmed in the interview.

Table 5. Wisconsin's Efforts to Measure the Structure of the Health Care Safety Net

Information/Data	Measures [a]	Definition	Data Source	Data Type
Services available to the uninsured, underinsured, or others with limited access to care.	Free or Reduced Health Care clinics (members of Wisconsin Primary Health Care Organization)	Organization members include community health centers, migrant health centers, health care for the homeless programs, rural health clinics, Indian health centers	Wisconsin Primary Health Care Association (WPHCA)[2]	Administrative/ Regulatory/ Budgetary
	Utilization and expenditures of mental health services	The number of clients being served and the type of service	Human Services Reporting System (HSRS)[3]	
The availability of pharmaceutical services within the state as a safety net resource.	Number of enrollees in and their utilization of the AIDS/HIV Drug Reimbursement Program (ADRP). Cost information is also collected.	ADRP provides benefits and access to HIV drug therapies for Wisconsin residents who have been diagnosed with HIV, have no or insufficient third party payment, and have a family income that does not exceed 200% of the Federal Poverty Guidelines.	Monthly report to HRSA for Ryan White Grant funds	Administrative/ Regulatory/ Budgetary
Facility and provider hours of operation, wait times, telephone coverage, cycle times (i.e., how long it takes to get in and out of a clinic).	DNF			

[a] DNF (Did Not Find) denotes a data element that may exist at the state but its presence or use could not be confirmed in the interview.

Table 5. Wisconsin's Efforts to Measure the Structure of the Health Care Safety Net

Information/Data	Measures [a]	Definition	Data Source	Data Type
Measures of "systemness" such as the degree to which referrals can be made across aspects of the health care safety net.	DNF			
Information about the level of managed care penetration and competition in the state.	Managed care penetration	HMO (closed panel and point-of-service plan) enrollment by county	Consumer's Guide to Managed Health Plans in Wisconsin[4]	Administrative
Information on the efficiency and practice style of providers in the state (e.g., hospitalization rates).	Inpatient hospitalizations Surgical procedures in hospital outpatient and freestanding ambulatory surgery centers	Statewide utilization and charge information on all inpatient hospitalizations Summary of cases, average charges, age, pay source for each procedure.	Health Care Data Reports[5]	Administrative/ Regulatory/ Budgetary
Demand				
The level of insurance coverage. (Wisconsin also collects employment status and income rates)	Health Insurance Coverage Insured and Uninsured rates	Health Insurance Coverage over past year defined as: Percent of individuals covered by health insurance for complete 12 months preceding the telephone survey, percent with coverage during part of 12 months and were not covered part of the time, and percent with	Wisconsin Family Health Survey[6]	State Survey

[a] DNF (Did Not Find) denotes a data element that may exist at the state but its presence or use could not be confirmed in the interview.

Table 5. Wisconsin's Efforts to Measure the Structure of the Health Care Safety Net				
Information/Data	**Measures** [a]	**Definition**	**Data Source**	**Data Type**
		no insurance during past 12 months. Current estimates of Insured and Uninsured rates defined as the percent of individuals covered at the time of the telephone interview.		
The level of employer-sponsored insurance in the state.	DNF			
The number of children enrolled in the State Children's Health Insurance Program (SCHIP).	# of children enrolled in BadgerCare	All children enrolled in BadgerCare are covered by Title XXI (State Children's Health Insurance Program [SCHIP])	Wisconsin Department of Health and Family Services[7]	Administrative
Information on the health status and health needs of the state's population.	Satisfaction with health care services.	Survey asks respondents whether they are satisfied or dissatisfied with the health care available to them and their family.	Wisconsin Family Health Survey	State Survey
Other information on vulnerable populations within the state (e.g., mental illness, substance abuse).	DNF			
Information on unmet health care needs.	DNF			

[1] A brochure on Wisconsin's Physician Workforce Data, 2000, is available at http://www.dhfs.state.wi.us/provider/pdf/00physicianworkforce.pdf. This document also includes technical information on the 2000 Physician Workforce Survey, and the 1996 Physician Profile Survey. Wisconsin is currently working

[a] DNF (Did Not Find) denotes a data element that may exist at the state but its presence or use could not be confirmed in the interview.

on a Physician Data Collection Project which will consist of an administrative data collection system which can provide information on the health care utilization and expenditures in Wisconsin. This new system will provide information on who is getting care and who is not getting care, as well as information on patient's ability to pay and information on the efficiency of the health care system in Wisconsin. http://www.dhfs.state.wi.us/healthcareinfo/downloadable/design.pdf.

[2] The Wisconsin Primary Health Care Association (WPHCA) is a non-profit organization of community health centers, migrant health centers, rural health centers, Indian health centers, programs for the homeless, and other organizations with the goal of providing access to care to uninsured and underserved populations. Members of the association include health centers receiving federal funding as well as non-federally funded centers who support the mission and goals of WPHCA. Information on the association and a list of members is available at: http://www.wphca.org/.

[3] Personal communication with Dan Zimmerman, Bureau of Community Mental Health, Division of Supportive Living, Department of Health and Family Services. Mr. Zimmerman stated that counties receive funding titled "Community Aids" from the state for mental health services to the indigent. Counties are required by state statute to provide access to emergent and crisis care mental health services. Other mental health services available would be up to the discretion of the county. Counties report the number of clients served and the type of service received through the Human Service Reporting System (HSRS).

[4] Produced by the Wisconsin Office of the Commissioner of Insurance. http://badger.state.wi.us/agencies/oci/pub_list/pi-044.pdf.

[5] The Health Care Data Reports are published quarterly and annually. http://www.dhfs.state.wi.us/healthcareinfo/pgstndrd.htm.

Additional Notes: The Bureau of Health Information's facility data products include data from the Annual Survey of Hospitals, the Hospital Fiscal Survey Data, and the Hospital Uncompensated Health Care Plan Data. http://www.dhfs.state.wi.us/healthcareinfo/dbfacili.htm.

[6] The Wisconsin Family Health Survey is a statewide telephone survey of Wisconsin residents. A full report of the survey is available at http://www.dhfs.state.wi.us/stats/familyhealthsurvey.htm.

[7] http://www.dhfs.state.wi.us/badgercare/html/glance_2.htm.

[a] DNF (Did Not Find) denotes a data element that may exist at the state but its presence or use could not be confirmed in the interview.

Table 4. Washington's Efforts to Measure the Structure of the Health Care Safety Net

Information/Data	Measures [a]	Definition	Data Source	Data Type
Structure				
The number and availability of providers (such as: primary care physicians, nurse practitioners, etc.) and their type of practice setting.	Physician workforce in the state of Washington	Number of physicians licensed in Washington	State Department of Health[1]	Regulatory
The number of school health centers within the state.	DNF			
Services available to the uninsured, underinsured, or others with limited access to care.	Annual state funding allotments to specific programs: Community Health Services Grant Program Grantees provide mental health, dental, primary care services to the uninsured. Medically Indigent Program Hospital charity care	Community Health Services Grant Program provides state funding to Community health centers both federally funded and non-federally funded. Medically Indigent program provides limited medical coverage for uninsured persons who require hospital services due to an emergent condition The state defines charity care as necessary hospital health care rendered	Community Health Services Program collects data on all grantees of the program.[2] The Medical Assistance Administration (MAA) administers the Medically Indigent program. The only data collected is claims information submitted by the hospital to MAA.[3] Hospitals are required by the state to maintain a charity care policy on file with the Department of Health, Center for Health Statistics.[4]	Administrative/ Budgetary/ Regulatory

[a] DNF (Did Not Find) denotes a data element that may exist at the state but its presence or use could not be confirmed in the interview.

Table 4. Washington's Efforts to Measure the Structure of the Health Care Safety Net				
Information/Data	**Measures [a]**	**Definition**	**Data Source**	**Data Type**
		to indigent persons, to the extent that the persons are unable to pay for the care or pay the deductibles or co-insurance amounts required by a third-party payer.		
The availability of pharmaceutical services within the state as a safety net resource.	DNF			
Facility and provider hours of operation, wait times, telephone coverage, cycle times (i.e., how long it takes to get in and out of a clinic).	Staffing patterns and hours of operation for Community Health Service programs	FTE counts Hours of operation	Community Health Services Program report[5]	Administrative/ Regulatory
Measures of "systemness" such as the degree to which referrals can be made across aspects of the health care safety net.	DNF			
Information about the level of managed care penetration and competition in the state.	DNF			
Information on the efficiency and practice style of providers in the state (e.g., hospitalization rates).	DNF			

[a] DNF (Did Not Find) denotes a data element that may exist at the state but its presence or use could not be confirmed in the interview.

Table 4. Washington's Efforts to Measure the Structure of the Health Care Safety Net

Information/Data	Measures [a]	Definition	Data Source	Data Type
Demand				
The level of insurance coverage.	Health insurance coverage rates	Defined as whether or not a person has health care coverage at the time of the survey	Washington Population Survey, Office of Financial Management[6]	State Survey
	Population income levels	Percent of residents living below Federal Poverty Guidelines (FPG)		
	Population rates of unemployment	Percent of temporary and part-time workers in Washington. Percent of temporary and part-time workers with access to health insurance benefits		
The level of employer-sponsored insurance in the state.	Number of residents with employer-sponsored health insurance	Does the survey respondent have an employer sponsored health plan? Is a health care plan available through respondent's job?	Washington Population Survey, Office of Financial Management	State Survey
The number of children enrolled in the State Children's Health Insurance Program (SCHIP).	SCHIP enrollment	Enrolled in SCHIP at any time in past year	Washington State Department of Social	Administrative/ Regulatory

[a] DNF (Did Not Find) denotes a data element that may exist at the state but its presence or use could not be confirmed in the interview.

Table 4. Washington's Efforts to Measure the Structure of the Health Care Safety Net				
Information/Data	**Measures [a]**	**Definition**	**Data Source**	**Data Type**
			and Health Services, Annual Report, 2001.[7]	
Information on the health status and health needs of the state's population.	Population measures of health status	Survey participants are asked to rank their health as "Excellent," "Very Good," "Good," "Fair," or "Poor."	Washington Population Survey	
Other information on vulnerable populations within the state (e.g., mental illness, substance abuse).	DNF			
Information on unmet health care needs.	DNF			

[1] The Washington State Department of Health surveyed all licensed health care providers when they applied for license renewal. Funding for this data collection was eliminated in 1998. The Department of Health, Office of Rural Health and the Center for Health Workforce Studies at the University of Washington, are currently working on a project to develop a statewide health workforce data system focusing on primary medical, dental, mental, and public health services. http://www.bhpr.hrsa.gov/healthworkforce/partnership/washington.htm.

[2] The Community Health Services Program is a state funded program with the mission of providing preventive and illness care services to the low-income uninsured and underserved residents of the state of Washington. Program information is available at http://www.wa.gov/hca/chs/index.htm, including a list of program grantees.

[3] https://wws2.wa.gov/dshs/maa/Eligibility/MedicalOverviewMI.htm

[4] A copy of the 1998 Charity Care in Washington report is available at http://www.doh.wa.gov/EHSPHL/hospdatamenu.htm#Charity%20Care%20in%20Washington%20Hospitals

[5] Personal communication with Bob Blacksmith, Director, Community Health Services Program. According to Mr. Blacksmith, little is done with the data collected on staffing patterns and hours of operation among the health clinic grantees. This information may be used on site visits and discussed when speaking about staffing patterns and access issues.

[a] DNF (Did Not Find) denotes a data element that may exist at the state but its presence or use could not be confirmed in the interview.

[6] A full report of the Washington Population Survey is available at http://www.ofm.wa.gov/sps/index.htm.

[7] https://wws2.wa.gov/dshs/maa/CHIP/Index.html

[a] DNF (Did Not Find) denotes a data element that may exist at the state but its presence or use could not be confirmed in the interview.

Table 3. Rhode Island's Efforts to Measure the Health Care Safety Net

Information/Data	Measures [a]	Definition	Data Source	Data Type
Structure				
The number and availability of providers (such as: primary care physicians, nurse practitioners, etc.) and their type of practice setting.	Availability of safety net services	Health Care Professionals who are licensed in RI (representing 74 health professions and 470 license types).	RI Department of Health in conjunction with the RI Department of Administration	Administrative/ Regulatory
The number of school health centers within the state.	Number of School-based Health Centers	School-based centers that are licensed as a health facility are open during school hours and provide after-hours coverage through an operating agency. Students without health coverage, or limited coverage, get care free of charge.	The data comes from the School Based Health Centers in Rhode Island report, created by the Rhode Island Department of Health, Division of Family Health. The report contains information on each of the 7 school based health centers.	Administrative/ Budgetary/ Regulatory
Services available to the uninsured, underinsured, or others with limited access to care.	Amount of hospital-based charity care	The Hospital Conversions Act (23-17.14-3) states that one of the purposes of the HCA is to "assure that standards for	1999 Hospital Community Benefits Report. Annual reports sent by all licensed hospitals to the RI Department of	Administrative/ Budgetary/ Regulatory

[a] DNF (Did Not Find) denotes a data element that may exist at the state but its presence or use could not be confirmed in the interview.

Table 3. Rhode Island's Efforts to Measure the Health Care Safety Net				
Information/Data	**Measures [a]**	**Definition**	**Data Source**	**Data Type**
		community benefits continue to be met." This includes developing "programs, procedures, and protocols that meet the needs of the medically indigent", as well providing "charity care" and "Medicaid shortfalls".	Health.	
The availability of pharmaceutical services within the state as a safety net resource.	DNF			

[a] DNF (Did Not Find) denotes a data element that may exist at the state but its presence or use could not be confirmed in the interview.

Table 3. Rhode Island's Efforts to Measure the Health Care Safety Net

Information/Data	Measures [a]	Definition	Data Source	Data Type
Facility and provider hours of operation, wait times, telephone coverage, cycle times (i.e., how long it takes to get in and out of a clinic).	Health Plan Enrollment Information Financial Information Effectiveness of Care Information Health Plan Stability Information Access to Availability of Care Information Use of Services Information Member Satisfaction Information Utilization Review Information		Data was collected by the RI Department of Health from Health Plans in RI.[1] Information is summarized in 1999 RI Health Plan Performance Report [2]	Administrative/ Budgetary/ Regulatory/ State Survey
	Quality of Hospital Care	Hospitals that are licensed and accredited in RI	Data from Joint Commission on Accreditation of Healthcare Organizations	Administrative/ Regulatory
Measures of "systemness" such as the degree to which	DNF			

[a] DNF (Did Not Find) denotes a data element that may exist at the state but its presence or use could not be confirmed in the interview.

Table 3. Rhode Island's Efforts to Measure the Health Care Safety Net				
Information/Data	**Measures [a]**	**Definition**	**Data Source**	**Data Type**
referrals can be made across aspects of the health care safety net.				
Information about the level of managed care penetration and competition in the state.	Managed Care Enrollment	Quarterly enrollment in state licensed HMOs	The Council used the InterStudy report, *The Inter Study Competitive Edge: HMO Industry Report* 7.2 (1997). It also used the RI Department of Business Regulation, Health Plan Annual and Quarterly Reports (1994 – 1998).[3]	Administrative/ Regulatory
Information on the efficiency and practice style of providers in the state (e.g., hospitalization rates).	Hospitalization rates		The data used in this report were collected by means of the Rhode Island Uniform Hospital Discharge Data System (UHDDS).[4]	Administrative
	Health Plan Performance Statistics	Discharges per 1,000 Population by Age, Diagnosis, Procedure groups. C-section rates	Data is collected by the Rhode Island Department of Health, Office of Health Plan Statistics.[5] HEDIS is also used.[6]	Administrative

[a] DNF (Did Not Find) denotes a data element that may exist at the state but its presence or use could not be confirmed in the interview.

Table 3. Rhode Island's Efforts to Measure the Health Care Safety Net

Information/Data	Measures [a]	Definition	Data Source	Data Type
Demand				
The level of insurance coverage.	Health insurance coverage	The number of uninsured The number of low income residents Unemployment rates	Rhode Island measures the uninsured using the Behavioral Risk Factor Surveillance System (BRFSS) – conducted by a professional survey firm, and is overseen by the Office of Health Statistics, RI Department of Health.[7]	State Survey
The level of employer-sponsored insurance in the state.	DNF			
The number of children enrolled in the State Children's Health Insurance Program (SCHIP).	Number and percent of children enrolled in Rite Care.	Children up to age 19 in families with income of up to 250% FPL and to low income-income parents with incomes up to 185% FPL.	Data sources: U.S. Bureau of the Census, CPS, 1995 – 1999 average. RIte Care enrollment data, RI Department of Human Services Food stamp enrollment data [8]	Federal Survey/ Administrative
Information on the health status and health needs of the state's population.	Health status and access to care for people with and without health	Sociodemographic characteristics Access to Health Care	BRFSS aggregated database for 1996, 1997 and 1998.[9]	State Survey

[a] DNF (Did Not Find) denotes a data element that may exist at the state but its presence or use could not be confirmed in the interview.

Table 3. Rhode Island's Efforts to Measure the Health Care Safety Net				
Information/Data	**Measures** [a]	**Definition**	**Data Source**	**Data Type**
	insurance coverage.	and Preventive Health Services Tobacco Use Health Status and Disability		
Other information on vulnerable populations within the state (e.g., mental illness, substance abuse).	Service population Facility capacity Yearly budget Total employees	Measures collected on persons with mental health disorders, mental illness, developmental disabilities, and substance abuse disorders[10]	Data is gathered and collected by the RI Department of Mental Health, Retardation and Hospitals	Administrative/ Regulatory/ Budgetary
Information on unmet health care needs.	DNF			

[1] The RI Health Care Accessibility and Quality Assurance Act (RIGL 23-17.13), passed in 1996, stipulates that, among other things, Health Plans submit performance data to the RI Department of Health. The Act defines a Health Plan as one "operated by a health care entity, that provides for the delivery of care services to persons enrolled in such plans though: arrangements with selected providers to furnish health care services; and/or financial incentives for persons enrolled in the plan to use the participating providers and procedures provided for by the plan. The functional definition of a Health Plan is along product lines (e.g., the entity ABC Insurance Company may operate 4 Health Plans consisting of 2 Commercial Plans, 1 Medicare Plan and 1 Medicaid Plan)."

[2] The report examines both HMOs and PPOs. It does not include data on Harvard Pilgrim Health Care of NE that ceased RI operations in December, 1999. In addition, smaller Health Plans with fewer than 10,000 RI members were excluded from the analysis.

[3] The Advisory Council concluded that approximately 27% of the RI population was enrolled in managed care as of July 1997. The *HIS Health Group* estimates that the HMO penetration is currently 49.5% See <http://www.medicaldata.com/MCMap/mcpm.asp?PID=MAP-RI&S=Rhode%20Island>

[a] DNF (Did Not Find) denotes a data element that may exist at the state but its presence or use could not be confirmed in the interview.

[4] See <http://www.healthri.org/hpb9707.htm>

[5] See <http://www.healthri.org/planstats/bench98.htm>

[6] More specifically, "[A]ll Health Plans in Rhode Island are required to report statistical information to the Department of Health. The statistical information coves the following areas of Health Plan operations: revenue and expenses, plan enrollment, complaints received, requests for prior authorization, appeals and "HEDIS" (Health Plan Employer Data and Information Set) indicators. HEDIS indicators are intended to measure: effectiveness of care, access/availability of care, health plan stability, and use of services." <http://www.healthri.org/planstats/statistics.htm>

[7] See <http://www.healthri.org/hdb9701.htm>

[8] RIte Care includes federal money from SCHIP and the state. In 1998 RIte Care also incorporated help from the Robert Wood Johnson Foundation's *Covering Kids: A National Health Access Initiative for Low-Income, Uninsured Children*. See the link to Rhode Island at <www.aecf.org/kidscount/kc2001/>. RIte Care is a Medicaid managed health care program, that provides care through contracts with three participating health plans: Blue CHIP, United Healthcare of New England, and Neighborhood Health Care Plan of Rhode Island.

[9] The data was compiled and published in the report Does Health Insurance Make a Difference? Differences in Health Status and Access to Care for Rhode Islanders Ages 18 – 64 by Insurance Status (October, 2000) The report was prepared for the Division of Health Quality, Financing and Purchasing, RI Department of Human Services, in partial fulfillment of the scope of work under the contract "Medicaid Research and Evaluation Project".

[10] The Department specifically states that one population that they serve is "[H]ospital patients with chronic, long-term debilitating diseases and medical conditions who generally are uninsured or underinsured." <http://www.mhrh.state.ri.us/About_Our_Dept.htm>

[a] DNF (Did Not Find) denotes a data element that may exist at the state but its presence or use could not be confirmed in the interview.

Table 2. Massachusetts' Efforts to Measure the Health Care Safety Net

Information/Data	Measures [a]	Definition	Data Source	Data Type
Structure				
The number and availability of providers (such as: primary care physicians, nurse practitioners, etc.) and their type of practice setting.	Availability of safety net services	The amount and type of free, discounted and self-paid care provided to patients in the physicians' offices.	A survey, created by the MA Division of Health Care Finance and Policy together with the MA Medical Society, sent to 8000 primary care and specialist physicians, with an over-sampling of the former.	State Survey
The number of school health centers within the state.	School-Based Health Centers	These are "comprehensive primary care programs located within or on the campus of elementary, middle and high schools and linked to other community-based services, that provide developmentally and culturally appropriate health care to students who otherwise might not have access to primary care."[1]	The Office of Statistics and Evaluation in the MA Department of Public Health "monitors data quality and analyzes and reports on the data."[2]	Administrative/ Budgetary

[a] DNF (Did Not Find) denotes a data element that may exist at the state but its presence or use could not be confirmed in the interview.

Table 2. Massachusetts' Efforts to Measure the Health Care Safety Net				
Information/Data	**Measures** [a]	**Definition**	**Data Source**	**Data Type**
	Enhanced School Health Program[3]	In October 1997, the Department funded 19 school districts under the Enhanced model and 8 school districts with experience in developing the Enhanced model to provide consultation to approximately 64 (8 each) additional school districts desiring to start similar school health service programs across Massachusetts. Monthly reports focus on health services activities, medication management, medical procedures, case management, and tobacco prevention. Status reports twice a year regarding program infrastructure, MIS development, quality evaluation, and health screenings and surveys.	Monthly activity reports are submitted to the MA Department of Public Health.	Administrative/ Regulatory

[a] DNF (Did Not Find) denotes a data element that may exist at the state but its presence or use could not be confirmed in the interview.

Table 2. Massachusetts' Efforts to Measure the Health Care Safety Net				
Information/Data	**Measures** [a]	**Definition**	**Data Source**	**Data Type**
Services available to the uninsured, underinsured, or others with limited access to care.	Freestanding Community Health Centers	"Community health centers (CHCs) are not-for-profit, community-based organizations that provide comprehensive primary and preventive health care and social services to medically underserved individuals and families regardless of their ability to pay."[4] CHCs are freestanding when they are not financially affiliated /managed with a hospital.[5]	Audited financial and cost reports of 33 out of 35 freestanding CHCs in MA. The data is submitted to the MA Division of Health Care Finance and Policy on an annual basis.	Administrative/ Regulatory

[a] DNF (Did Not Find) denotes a data element that may exist at the state but its presence or use could not be confirmed in the interview.

Table 2. Massachusetts' Efforts to Measure the Health Care Safety Net

Information/Data	Measures [a]	Definition	Data Source	Data Type
	The Children's Medical Security Plan	The Children's Medical Security Plan is a health insurance program that provides limited coverage[6] for primary and preventive health care for children under age 19. All children <19 are eligible provided that they are not eligible for MassHealth (except for MassHealth Limited) and do not have other health insurance coverage with primary and preventive medical benefits.	Enrollment, utilization and fiscal data provided by the MA Department of Public Health and its current program administrator, Unicare.	Administrative/ Budgetary
The availability of pharmaceutical services within the state as a safety net resource.	The Senior (and Disabled) Pharmacy Program	Through the Pharmacy Program, eligible individuals may receive up to $1,250 per year to pay for prescription drugs. The Pharmacy Program Plus provided unlimited prescription benefit to eligible seniors and younger people who experienced high	Enrollment and utilization data came from the Massachusetts Division of Medical Assistance; Enrollment, demographic, and geographic data came from the Massachusetts Executive Office of	Administrative/ Budgetary

[a] DNF (Did Not Find) denotes a data element that may exist at the state but its presence or use could not be confirmed in the interview.

Table 2. Massachusetts' Efforts to Measure the Health Care Safety Net

Information/Data	Measures [a]	Definition	Data Source	Data Type
		prescription expenses relative to their incomes. The Prescription Advantage Plan offers coverage (on a sliding scale based on annual income) to all seniors and people with disabilities whose annual income is < 188% of FPL.[7]	Elder Affairs. Data was also gathered from "key informants".	
Facility and provider hours of operation, wait times, telephone coverage, cycle times (i.e., how long it takes to get in and out of a clinic).	DNF			
Measures of "systemness" such as the degree to which referrals can be made across aspects of the health care safety net.	DNF			
Information about the level of managed care penetration and competition in the state.	HMO Penetration in MA		*Reforming the Health Care System: State Profiles (1990 – 1999)*, American Association of Retired Persons.[8]	The AARP report utilizes administrative, budgetary, regulatory, and survey information.

[a] DNF (Did Not Find) denotes a data element that may exist at the state but its presence or use could not be confirmed in the interview.

Table 2. Massachusetts' Efforts to Measure the Health Care Safety Net

Information/Data	Measures [a]	Definition	Data Source	Data Type
	Managed Care Penetration Rate of the Medicare Population		*Reforming the Health Care System: State Profiles (1990 – 1999)*, American Association of Retired Persons; *Health, United States, 1999*, U.S. Department of Health and Human Services	
Information on the efficiency and practice style of providers in the state (e.g., hospitalization rates).	Number of Uninsured Acute Hospital Discharges and Percent of all MA Discharges	Uninsured includes self-pay and free care payer categories	Hospital discharge data from the MA Division of Health Care Finance and Policy	Administrative/ Regulatory
Demand				
The level of insurance coverage.	Health insurance coverage in the nongroup market.		A survey, developed by the MA Division of Health Care Finance and Policy, is being mailed by Blue Cross and Blue Shield of MA and Harvard Pilgrim Health Care to 5000 members of their nongroup health insurance products.[9]	State Survey

[a] DNF (Did Not Find) denotes a data element that may exist at the state but its presence or use could not be confirmed in the interview.

Table 2. Massachusetts' Efforts to Measure the Health Care Safety Net

Information/Data	Measures [a]	Definition	Data Source	Data Type
	Two Household reports/surveys of the uninsured and underinsured in MA as required by Section 25 of Chapter 203 of the Acts of 1996.[10]	The number of uninsured	Both surveys were conducted for MA by the University of Massachusetts Center for Survey Research using a RDD methodology. The survey questionnaires were available in English and Spanish. Responses were weighted in order to reflect current population estimates. For the 2000 survey, information was collected on 2,632 households comprised of 7,069 individuals between February and August 2000.[11]	State Survey
The level of employer-sponsored insurance in the state.	Employer-sponsored	Insurance offered	Employer survey	State Survey

[a] DNF (Did Not Find) denotes a data element that may exist at the state but its presence or use could not be confirmed in the interview.

Table 2. Massachusetts' Efforts to Measure the Health Care Safety Net

Information/Data	Measures [a]	Definition	Data Source	Data Type
	coverage Take-up rates Coverage levels		conducted by the MA Division of Health Care Finance and Policy. [12]	
The number of children enrolled in the State Children's Health Insurance Program (SCHIP).	SCHIP Enrollment		Data includes enrollment statistics, expenditure and budget data, management reports, CPS data, Division of Medical Assistance monthly enrollment data for MassHealth, Division of Medical Assistance Budget Office's Forecast Summary Report, acute hospital utilization data collected by the MA Division of Health Care Finance and Policy. Performance is also measured using HEDIS data.	Administrative/ Budgetary/ Regulatory
Information on the health status and health needs of the state's population.	"Massachusetts Health Status Indicators by Race and Ethnicity"[13]: Population Data	Data was most often parsed according to membership in: "White, non-Hispanic", "Black, non-Hispanic",	Data sources included: U.S. Bureau of Census, 1990 Census of Population.	Federal survey/ State survey

[a] DNF (Did Not Find) denotes a data element that may exist at the state but its presence or use could not be confirmed in the interview.

Table 2. Massachusetts' Efforts to Measure the Health Care Safety Net				
Information/Data	**Measures** [a]	**Definition**	**Data Source**	**Data Type**
	Maternal and Infant Health Indicators General Mortality Patterns Cause-Specific Mortality Indicators Health Status and Risk Behavior Indicators Health Care Access Indicators	"Hispanic" or "Asian".	MA Institute of Social and Economic Research. Bureau of Health Statistics, Research and Evaluation, MA Department of Public Health. BRFSS, Chronic Disease Surveillance Program Bureau of Health Statistics, Research and Evaluation, MA Department of Public Health	
Other information on vulnerable populations within the state (e.g., mental illness, substance abuse).	DNF			
Information on unmet health care needs.	DNF			

[1] <http://www.state.ma.us/dph/sbhc.htm> The centers are funded through the Tobacco Control Program.

[2] A copy of the "Enhanced School Health Services Program Data Report" for 1999-2000 is available at http://www.state.ma.us/dph/ose/rpt9900.pdf

[a] DNF (Did Not Find) denotes a data element that may exist at the state but its presence or use could not be confirmed in the interview.

[3] The 1998 – 1999 School Year Report Overview of the Enhanced School Health Service Program says that "[T]he Department of Public Health recognizes the need for quality health services and provides consultation to all of the Commonwealth's school districts. Since 1993, with resources from the Health Protection Fund, the Department of Public Health has extended to a limited number of school systems the opportunity to expand on the basic school health services model by establishing the Enhanced School Health Service Program (ESHS)." <http://www.state.ma.us/dph/overeshs.htm>

[4] http://www.massleague.org/what_are_chcs.htm

[5] In order for a Community Health Center to be recognized as "freestanding" by the Commonwealth of MA, it must provide the following services on-site or by referral: adolescent health, adult medicine, family planning, family practice, geriatric, gynecology, HIV/AIDS, health education, laboratory, mental health, nutrition, obstetrics, pediatrics, radiology, social services. (Source: MA Division of Health Care Finance and Policy <http://www.state.ma.us/dhcfp/pages/dhcfp_hc/chc02.htm>.

[6] The Children's Medical Security Plan benefit package (June 200o) includes: routine well-child check-ups, immunizations, doctor office visits, specialty consultations, 13 mental health and substance abuse visits, with an additional 7 visits if clinically necessary, up to $1000 for emergency care, limited outpatient surgery, lab tests, x-rays and other diagnostic tests, durable medical equipment up to $200 a year per child (increasing to $500 for equipment related to asthma, diabetes and seizure disorders), prescription medicine up to $200 per child per year, and primary and preventive dental benefits. (In An Evaluation of Health Care Programs for Low Income Uninsured and Underinsured Massachusetts Residents (June, 2000), chapter 1, p. 2)

[7] For a more complete description of each program see An Evaluation of Health Care Programs for Low Income Uninsured and Underinsured Massachusetts Residents (June, 2000), chapter 4, pp. 4 – 5.

[8] In Massachusetts Health Care Trends: 1990 – 1999. The AARP report, *Reforming the Health Care System: State Profiles (1999)* is available at <http://research.aarp.org/health/d17094_states99.html>

[9] Blue Cross and Blue Shield of MA and Harvard Pilgrim Health Care jointly account for "approximately 90% of the nongroup market in Massachusetts." <http://www.state.ma.us/hrsa/pages/hrsa_01.htm>

[10] The first report was completed in October 1998, and the second report (Health Insurance Status of Massachusetts Residents, second edition) was completed in December 2000. As noted in the second report, "[T]he Survey of Health Insurance Status of Massachusetts Residents is the only state specific survey designed expressly to provide reliable estimates of the number of uninsured residents in Massachusetts."

[11] See <http://www.state.ma.us/hrsa/pages/hrsa_01.htm>.

[12] This survey was conducted in "an effort to gain an understanding of how the rising cost of health insurance affects the purchasing behavior of employers, employees and their families." <http://www.state.ma.us/hrsa/pages/hrsa_01.htm>.

[a] DNF (Did Not Find) denotes a data element that may exist at the state but its presence or use could not be confirmed in the interview.

[13] The study was conducted by the Massachusetts Department of Public Health, Bureau of Health Statistics, Research and Evaluation, Division of Research and Epidemiology (Fall, 1996).

[a] DNF (Did Not Find) denotes a data element that may exist at the state but its presence or use could not be confirmed in the interview.

Table 1. Florida's Efforts to Measure the Health Care Safety Net

Information/Data	Measures [a]	Definition	Data Source	Data Type
Structure				
The number and availability of providers (such as: primary care physicians, nurse practitioners, etc.) and their type of practice setting.	DNF			
The number of school health centers within the state.	DNF			
Services available to the uninsured, underinsured, or others with limited access to care.	Availability of safety net services	Types of services provided to uninsured by population type (men, women, children, elderly, general public) The number of uninsured/indigent patient visits seen last fiscal year	Section 1 of the Florida Health Insurance Study (FHIS) Local Subsidy Segment[1]	State Survey
The availability of pharmaceutical services within the state as a safety net resource.	DNF			
Facility and provider hours of operation, wait times, telephone coverage, cycle times (i.e., how long it takes to get in and out of a clinic).	Waiting lists	Existence of waiting lists by type of service Length of wait by type of service	Section 1 of the FHIS Local Subsidy Segment	State Survey
Measures of "systemness" such as the degree to which referrals can be made across aspects of the health care safety net.	Medical home Links with other agencies	Does the organization consider itself a medical home for uninsured patients? What other agencies	Section 1 of the FHIS Local Subsidy Segment	State Survey

[a] DNF (Did Not Find) denotes a data element that may exist at the state but its presence or use could not be confirmed in the interview.

Table 1. Florida's Efforts to Measure the Health Care Safety Net				
Information/Data	**Measures** [a]	**Definition**	**Data Source**	**Data Type**
		does the organization have links with for other medical services?		
Information about the level of managed care penetration and competition in the state.	DNF			
Information on the efficiency and practice style of providers in the state (e.g., hospitalization rates).	DNF			
Demand				
The level of insurance coverage.	Uninsurance rates	Lack of private or public health insurance coverage (with verification)	FHIS Telephone Survey[2]	State Survey
The level of employer-sponsored insurance in the state.	Availability of employment-based health insurance for uninsured, employed Floridians	Percentage of uninsured, employed Floridians aged 18-64 who have employers who do not offer health insurance Percent of the uninsured who have employers who offer health insurance, but are not eligible for coverage Percent of the uninsured who have employers that offer health insurance and	FHIS Telephone Survey	State Survey

[a] DNF (Did Not Find) denotes a data element that may exist at the state but its presence or use could not be confirmed in the interview.

Table 1. Florida's Efforts to Measure the Health Care Safety Net				
Information/Data	**Measures** [a]	**Definition**	**Data Source**	**Data Type**
		are eligible, but the employee premium is too high		
The number of children enrolled in the State Children's Health Insurance Program (SCHIP).	SCHIP Enrollment		SCHIP/Medicaid Enrollment Files	Administrative
Information on the health status and health needs of the state's population.	Perceived health status	Would you say NAME's health, in general, is excellent, very good, good, fair or poor?	FHIS Telephone Survey	State Survey
Information on unmet health care needs.	DNF			

[1] The full report on the Local Subsidy Segment of the FHIS is available at http://www.fdhc.state.fl.us/Publications/Technical_Reports/vol2.shtml.

[2] The full report on the FHIS Telephone Survey is available at http://www.fdhc.state.fl.us/Publications/Technical_Reports/vol1.shtml.

[a] DNF (Did Not Find) denotes a data element that may exist at the state but its presence or use could not be confirmed in the interview.

Table 6: State Survey Descriptions					
SURVEY	YEARS	SAMPLE	MODE	RESPONSE RATE	FUNDING SOURCE AND COST
Florida Health Insurance Study	1999 1997	17 geographical districts, stratified to exchange, oversampling for blacks, Hispanics, and low-income families N=14,100 households and 37,210 individuals	Telephone	49% for 1999	State Legislature and federal Medicaid funds $600,000
Iowa Health Insurance Survey	2000	RDD and list sample in exchanges for low-income areas; screened for households where at least one was uninsured N=1,500 households	Telephone	Not applicable	HRSA State Planning Grant Not available
Health Insurance Status of Massachusetts Residents	2000 1998	RDD stratified for 5 regions, separate oversample of 5 specific urban areas N=2,632 households and 7,069 individuals	Telephone	62% for 2000	HRSA State Planning Grant, Massachusetts Division of Healthcare Finance and Policy $450,000-$500,000

NOTE: This table was produced by the State Health Access Data Assistance Center (SHADAC) at the University of Minnesota.

Appendix A. OASPE Safety Net Typology

Meeting to Explore the Development of a Typology to Characterize Community Health Care Safety Net Systems

Washington, D.C.
May 16, 2001

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1. Meeting Purpose

- To identify a range of alternative organizing principles for identifying types of safety nets.
- To identify a set of priorities to consider in future work.
- To develop a short list of immediate next steps that OASPE can use in pursuing safety net mapping.

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2. Participants

The meeting was attended by: Raymond Baxter, John Billings, Lynn Blewett, Lynn Fagnani, Douglas Geurdat, Embry Howell, Mike Millman, Jessica Townsend, and Robin Weinick. OASPE staff included George Greenberg, Eileen Salinsky and Caroline Taplin. The meeting was facilitated by Larry Bartlett.

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3. Possible Dimensions to be Used to Develop a Safety Net Typology

Participants suggested a preliminary list of dimensions around which a safety net typology could be structures. They identified these dimensions within four domains: (1) structure of the community's health care delivery system; (2) demand on the safety net system; (3) support; and (4) environmental characteristics (both health and non-health related).

1. Structure

- Number and availability of providers (primary care physicians, nurse practitioners) and type of practice setting
- Level of presence of Federally qualified health centers (FQHCs), 330 clinics, migrant health centers, WIC programs, school health clinics, other HRSA-supported State and local health programs.

- Breadth of services available (mental, substance abuse, dental)

- Availability of pharmaceutical services

- Ownership: Is the safety net public, private, or investor-owned? What percentage of each?

- Concentration:
  - Of safety net activities among different types of providers.
  - Of the burden of safety net activities on individual facilities.

- Hours of operation, wait times, phone coverage, cycle times (how long it takes to get in and out) – all may affect safety net performance and levels of access.

- ED alternatives (eg, is there a primary care clinic next door?)

- Capacity (What is it? Is it expanding? Shrinking? Why?):
  - Absolute
  - Relative to demand
  - Unused capacity

- Measures of "systemness":
  - Degree of "open door" policy.
  - Willingness/ability to accept diversion (when a key safety net component shuts down (eg, hospital's ED), how well can the rest of the safety net accommodate that change?)
  - Degree to which referrals can be made across aspects of the safety net.
  - Vertical and horizontal integration.
  - Availability of information systems (IT infrastructure) to track low-income populations and their outcomes)

- Cost of caring for this population

- Assessment of what is the community's return on its investment in the safety net

- Market characteristics:
  - Level of managed care penetration (Medicaid and overall), level of competition
  - Herfindal index

- Efficiency and practice style (eg, hospitalization rates)

- Financial health of the safety net

- Demand

- Insurance coverage:
  - Number of uninsured
  - Number low income
  - Number unemployed

- Employer-sponsored insurance:
  - Offering
  - Uptake
  - Coverage

- SCHIP

- Immigrant populations

- Health status/needs of population:
  - Age
  - Incidence of chronic illness

- Health care preferences

- Demographics

- Vulnerable populations (mental illness, substance abuse)

- Income distribution

- Outreach activities
  - Need – demand

- Risk behaviors

- Unmet need:
  - Measured by lack of utilization?
  - Utilization can be a cause or a result – it is challenging to determine what it is a measure of. Lack of utilization measured unmet need, but increased utilization doesn't always mean better care.
  - No decision was made on utilization as a potential measure, but it was noted that utilization can be used as a measure for other dimensions discussed today.

- Summative measures of care-seeking behavior

3. Support

- State and local direct support:
  - State policies
  - Local funding ability
- Hospital uncompensated care pool
- Grants from DISH/FQHC/330/other HRS programs; other grant support
  - Other support: VA, HIS
- State policies on Medicaid cost and reimbursement (who, what is covered, reimbursement levels, Medicaid managed care)
- Philanthropy – local foundations
- Tobacco funds – levels and use
- SCHIP
- Medicare reimbursement policies
- State insurance initiatives
- Capital-related cashflows
- Rural-related policies
- State policies affecting access and provider responsibilities (community providers have different intake practices due to financing – institutional policies/attitudes)
- Cross-subsidy
- Level of cost-shifting (ability to move funds around)
- Measure of the funds entering the safety net system from various sources (State, local governments, insurance, Medicaid, etc) and mechanisms
- Environment

- State health professions practice acts:

- Measures of political environment (State and local):
    - Political priorities
    - Tax-related policies
    - County/local government responsibility

- Social supports system (effectiveness):
    - Welfare system
    - Education
    - Housing

- Public health system infrastructure

- Transportation infrastructure/availability

- Level of racial and economic segregation in community

- Industry characteristics (eg, unionization)
    - Coverage
    - Income

- Role of faith-based organizations

- Population changes

- Geographic distribution of:
    - Providers who serve the safety net population
    - Population served by the safety net
    - Jurisdictions served by the safety net – vis-à-vis political boundaries

- Measure of the social isolation in a community:
    - Immigrant families (cultural isolation also).
    - Urban, rural frontier communities.

4. Additional Issues Discussed

In addition to the discussion of specific dimensions, participants also offered their thoughts about the utility of a typology, as well as suggested next steps for OASPE:

1. Utility and feasibility of a safety net typology

- Given the amount of variability among safety nets in different communities, most participants felt that a typology would be useful for characterizing safety net systems and drawing national attention to the issues. They also thought that the development of a useful typology was a feasible undertaking.

- With respect to the uses of a typology, it was suggested that a typology could be helpful in:
    - Developing a performance scale based on outcomes and costs.
    - Providing some assessment of risk.
    - Identifying best opportunities to invest.
    - Developing an "autopsy" capacity.
    - Better understanding the safety net structure.

- Participants also noted that in order to priorities the dimensions identified at this meeting for possible use in developing a typology, there first needs to be a better definition of the critical policy questions that needs to be answered about safety net variability. They suggested that OASPE first formulate a list of such questions prior to asking for participants' priorities. One participant went further to suggest that OASPE select the key safety net-related policy questions from the last five years and examine whether the sort of typology being proposed would have been a useful tool for answering those questions.

- One participant suggested that, rather than an exhaustive and complex typology, policymakers might benefit more from aggregating up some of the suggested dimensions into coherent groups which could then be illustrated with case studies.

- It was noted that ultimately, the typology's utility will depend on whether or not OASPE plans to invest major resources into a data collection effort.

2. Suggested next step: Syntheses of available information

- There was a clear consensus among the group that OASPE needs to first synthesize all the information that is currently sitting in several community case studies (such as those of John Billings and Mike Millman). After the existing data is processed, some participants suggested developing a preliminary typology based on that available data.

- One point made throughout the discussion is that some dimensions are able to be measured relatively easily, and those are the dimensions OASPE should first pursue, possibly linking them to financial and outcomes measures, and then selecting (using a case study approach) the key indicators for which data is not available.

Appendix B. Description of National Survey Data

The following summary presents background information on select national sources available for states to monitor the health care safety net.

Behavioral Risk Factor Surveillance System (BRFSS)

The BRFSS was established based on the perception that national data collected on health status and risk behaviors was not available to states who had the primary role of targeting resources to address behavioral risks and that state and local agency participation was essential to achieve national health goals.[1] States conduct the rolling monthly telephone surveys based on a common sampling methodology and list of core questions to allow comparisons across states. An advantage of the BRFSS for state analysts is that the states conduct the surveys themselves, have control over questions included in the state-specific modules, and have access to the person-level survey data for ongoing state analysis. Some states have also pursued additional sample and developed a stratification that allows them to estimate prevalence for regions within their respective states. In this regard, the BRFSS is perhaps one model for future federal-state household survey initiatives.

Yet, there are several downsides to the BRFSS and these have led to its under-use. For state health coverage policy, the central drawback is the surveys public health focus on working-aged adults. Although some states have added a child component, the focus of BRFSS has not been on children. Given that the federal focus has been on children through the SCHIP program, BRFSS has not been used to monitor or evaluate national or state health access initiatives. Although the time lag is better than other national surveys, it still takes one year to collect the data and one year to create estimates. Concerns have also been raised about the potential for under-sampling low-income households by use of a telephone survey. This concern has lead to recent criticism of the BRFSS for its lack of data on special populations, including populations of color, and sufficient data on city- or

[1] CDC. 1999. "About the BRFSS." , vol. 2000: Centers for Disease Control and Prevention.

NOTE: This summary was produced by the State Health Access Data Assistance Center (SHADAC) at the University of Minnesota.

county-specific data needed for state health policy initiatives.[2] A more common complaint is the concern about lack of quality control in data collection methods. It is difficult to oversee 50 state data collection processes and assess the impact that these varied methods has on population estimates.

Current Population Survey (CPS)

The March Supplement of the Current Population Survey (CPS) is the most commonly used data source for estimating rates of uninsurance. Although the primary intent of the CPS is to provide government statistics on labor force participation, in addition to the income and employment items, each year the March Supplement includes questions concerning health insurance coverage toward the end of the survey. While the CPS was intended to provide *national* estimates and trends over time, policy analysts began using the CPS to derive *state* estimates of insurance participation. Noted limitations to the usefulness of the CPS for state-level estimates are that the state sample size is relatively small and the sampling frame does not include all counties within the state. However, the Census Bureau has made a number of accommodations over the years to improve the ability of states to obtain uninsurance estimates.[3,4] These adaptations include increased sample size in a number of states in the mid 1990s (still the Census recommends that states use a three-year average rather than the rate in any given year and produces this rolling average in its state tables); creating an algorithm that adjusts for the sampling design within states; and the inclusion of state-specific program names in the survey (e.g., Medicaid is

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[2] Figgs, L.W., Bloom, Y., Dugbatey, K., Stanwyck, C.A., Nelson, D.E., Brownson, R.C. 2000. "Uses of Behavioral Risk Factor Surveillance System Data, 1993-1997." *American Journal of Public Health* 90:774-776.

[3] Liska, D.W, N.J. Brennan, and B.K Bruen. 1998. *State-Level Databook on Health Care Access and Financing, Third Edition*. Washington, D.C.: The Urban Institute.

[4] Swartz, K. 1997. "Changes in the 1995 Current Population Survey and Estimates of Health Insurance Coverage." *Inquiry* 34:70-9.

NOTE: This summary was produced by the State Health Access Data Assistance Center (SHADAC) at the University of Minnesota.

referred to as Medi-Cal in California, Medical Assistance in Minnesota), as well as the addition of a catch-all question asking about participation in some state-run programs (e.g., TennCare, MinnesotaCare, etc).

Recently new monies were appropriated to the Census Bureau (P.L.106-113) to improve the precision of CPS state-level estimates of insurance coverage, so that states can respond to the federal mandate that they report the effectiveness of their State Child Health Insurance Program (SCHIP) on an annual basis. Beginning in 2000, the Census expanded the sample size as well as the number of sampling units within each state.[5] Although these changes will improve the precision of the state-level estimates, it should be noted that not all counties in a state are sampled and the resulting size may still be too small to provide detailed information about sub-populations of interest to many state policy analysts (e.g., rates of uninsurance by age, race/ethnicity, and geographic region). Despite this drawback, the CPS provides routine, consistent and timely estimates of the uninsured by state providing the only source of comparative information on the uninsured for broad categories of a state's population. Furthermore, the Census Bureau has made and continues to make adaptations to the CPS that have the potential to increase its usefulness to state policy makers, especially those states without the will or resources to collect their own data.

Medical Expenditure Panel Survey-Insurance Component (MEPS-IC)

The MEPS-IC is a well-designed and tested survey of private and public sector establishments. The MEPS-IC survey collects information on how many employers offer health insurance, how much is spent on employer-sponsored health insurance, how many people are enrolled in employer-sponsored health insurance, characteristics of health plans offered, and characteristics of the participating employers.

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[5] Davern, M., Blewett, L. 2001. "Impact of Changes to the Current Population Survey (CPS) on State Health Insurance Coverage Estimation." State Health Access Data Assistance Center (SHADAC), Minneapolis.

NOTE: This summary was produced by the State Health Access Data Assistance Center (SHADAC) at the University of Minnesota.

The possibilities for state policy research are largely untapped by states that are aware of MEPS because access to micro-data analysis is too costly and cumbersome for state policy needs. Researchers who would like to conduct their own analyses of the MEPS-HC data must: (1) submit a proposal for review by the Office of the Chief Economist at the Census, the Agency for Healthcare Research and Quality (AHRQ); (2) receive security clearance to access Census data; and (3) physically go to a Census Research Data Center (RDC).[6] There are six RDCs across the country: Washington DC, Boston, Pittsburgh, Los Angeles, Berkeley and a newly established center at Duke University in North Carolina. The proposal review process takes approximately two months and is conducted concurrently by Census and AHRQ.

Once a proposal has been accepted, the researcher must "buy time" on an RDC computer to run analyses or pay a programmer consultant to run programs. Anyone who enters an RDC must obtain "Special Sworn Status" (SSS) which includes a background check, security clearance, and analysts must sign and make a sworn statement about preserving the confidentiality of the data.[6] Individuals who violate this agreement are subject to the same criminal penalties as Census Bureau employees who violate the confidentiality of the data.

State and Local Area Integrated Telephone Survey (SLAITS)

SLAITS allows researchers to collect data using customized questionnaires and the National Immunization Survey sampling frame of nearly one million households.[7] The funding for SLAITS does not come from ongoing core NCHS federal funds but rather through outside government and non-profit sponsors. Sponsors may implement existing SLAITS survey modules or fund the development of new SLAITS modules at any time.[8] There are presently four existing SLAITS survey modules including: Health (Iowa and

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[6] Census. 1999. "The Research Data Center (RDC) Program." , vol. 1999: U.S. Bureau of the Census.

[7] NCHS. 2001. "State and Local Area Integrated Telephone Survey (SLAITS)." , vol. 2001: National Center for Health Statistics.

[8] NCHS. 2001. "Frequently Asked Questions, Potential Sponsors of Future SLAITS Modules." , vol. 2001: National Center for Health Statistics.

NOTE: This summary was produced by the State Health Access Data Assistance Center (SHADAC) at the University of Minnesota.

Washington State, 1997), Child Well-Being and Welfare (Texas and Minnesota, 1998-99), National Survey of Early Childhood Health (National sample, 2000), and Children with Special Health Care Needs (National and state samples, 2000-01).

SLAITS went through three years of pilot testing and has gone through significant design work and statistical modifications. For example, to correct for under-reporting of public programs typically seen in household surveys, NCHS developed a study in two states using people they knew who had recently left Medicaid to produce a statistically sound correction for this under reporting. The major drawback of SLAITS is that its timing and funding are variable. Nonetheless, SLAITS has the flexibility to accommodate state-specific needs and has tremendous potential as a mechanism for state-level comparisons.

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