State of Missouri
Department of
Social Services
Division of Medical
Services

E V A L U A T I O N

O F T H E

M I S S O U R I

S E C T I O N 1 1 1 5

W A I V E R

Review Period: September 1, 2001 – August 31, 2002

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INTRODUCTION

This report constitutes the fourth evaluation of the Missouri Medicaid Section 1115 Healthcare Demonstration Waiver program (1115 Waiver) and covers the period from September 1, 2001 through August 31, 2002. The 1115 Waiver, known as Managed Care Plus (MC+), expanded Medicaid eligibility to uninsured children, adults leaving welfare for work, uninsured custodial parents, uninsured non-custodial parents, and uninsured women losing their Medicaid eligibility 60 days after the birth of their child.[1] Implemented on September 1, 1998[2] , the original goals of the 1115 Waiver were to:

- reduce the number of people in Missouri without health insurance coverage;
- increase the number of children, youth, and families in Missouri who have medical insurance coverage;
- improve the health of Missouri's medically uninsured population, and
- demonstrate that not providing NEMT and requiring cost sharing will not negatively impact access to medical coverage or an individual's health.

Previous evaluations completed by Behavioral Health Concepts, Inc. (BHC) demonstrate that the waiver expansion has been successful at meeting these goals. BHC found that the waiver expansion:

> *Increased Rates of Insured Missourians.* Missouri reached 92% of the targeted population in the first year of the waiver. Since then, rates of uninsured persons in Missouri have been lower than national rates for children and adults.
>
> *Improved Health of Missourians.* Beneficiaries consistently reported high rates of satisfaction with providers compared to national and commercial benchmarks.

[1] Uninsured non-custodial parents no longer covered and coverage for uninsured custodial parents and women losing their Medicaid eligibility post-partum has been reduced.

Cost sharing Had a Minimal Impact. After several years of review, no "demonstrable negative impact of cost sharing on health status or access" was found. Subsequently, this evaluation question has been eliminated from the annual evaluation.

Lack of Non-Emergency Transportation Had a Minimal Impact. No statistically significant differences were found between persons who missed medical appointments due to lack of transportation and those who did not report missing medical appointments due to transportation problems.

Improved Access to Services for Children and Youth with Serious Emotional Disturbance. Beneficiaries reported that they were able to obtain needed services, and parents reported improved child functioning in the home and school setting.

Had a Minimal Crowd-Out Effect. In the 2001 evaluation, BHC concluded that crowd-out is not a problem in the state of Missouri and that MC+ is not affecting the private insurance market.

SCOPE OF THE EVALUATION

This evaluation is being completed in accordance with the requirements of Missouri Senate Bill 632 and the Centers for Medicare & Medicaid Services (CMS). This report covers the evaluation period September 1, 2001 through August 31, 2002, and addresses the following questions:

- **RESEARCH QUESTION 1:** Has the MC+ expansion provided health insurance coverage to children and families who were previously uninsured?
- **RESEARCH QUESTION 2:** Has the MC+ expansion improved the health of Missouri children and families?

[2] Service delivery to children began September 1, 1998. Service delivery for adults began February 1, 1999.

- **RESEARCH QUESTION 3:** What is the impact of MC+ on providing a comprehensive array of community based wraparound services for Seriously Emotionally Disturbed Children (SED) and children affected by substance abuse?

- **RESEARCH QUESTION 4:** What is the effect of MC+ on the number of children covered by private insurers? Does the MC+ expansion to cover children with a gross family income above 185% FPL have any negative effect on these numbers?

This report also provides an initial look at the "Health Care for the Indigent of St. Louis" amendment (The "St. Louis Amendment") to the 1115 Waiver. The St. Louis Amendment authorizes the use of a limited portion of Disproportionate Share Hospital expenditures to be used for two purposes: (1) to transition Connect Care, a public-private hospital in St. Louis, from an inpatient facility to an outpatient facility; and (2) to enable the St. Louis region to transition its "safety net" system of care for the medically indigent to a viable, self-sustaining model. With the addition of the St. Louis Amendment to the 1115 Waiver, a new research question has been added to the evaluation. The new question is:

- **RESEARCH QUESTION 5:** Has the 1115 Waiver Amendment improved the health of the indigent of St. Louis City?

DATA SOURCES AND APPROACH

Our evaluation relies on the use of previously aggregated, readily available data supplied by the State of Missouri and obtained from other sources. A description of the major data sources and their uses is provided below.

Dataset/Report Name	Description
Current Population Survey/Annual Demographic Supplement – US Bureau of the Census	The Current Population Survey (CPS) is a monthly survey conducted by the Bureau of the Census for the Bureau of Labor Statistics. In March, a more comprehensive survey is conducted, which is referred to as the Annual Demographic Supplement (ADS). The CPS ADS provides national and statewide estimates of rates of insurance by type of coverage. Data from the CPS ADS was used to respond to Research Questions 1 and 4.
Consumer Assessment of Health Plans (CAHPS 2.0H) -	CAHPS® is a survey instrument designed to collect data on consumer's satisfaction with their health care

Dataset/Report Name	Description
Division of Medical Services, Department of Social Services	experiences and health plans. The tool is specifically designed to measure health care performance from the consumer's point of view. This report evaluates responses to the child survey for the Missouri Medicaid managed care population relative to National Medicaid, National Commercial and Missouri Medicaid consumer responses for the purpose of responding to Research Question 3. Note: Prior to 2001, the CAHPS® survey was administered by the state of Missouri, and the results were available separately for individuals in fee-for-service and managed care regions of the State as well as the 1915(b) Waiver and 1115 Waiver populations. Now, MC+ health plans retain a vendor to administer the CAHPS® survey in accordance with NCQA requirements, and results are only available in aggregate for all MC+ managed care enrollees. Data for the fee-for-service population is not collected. Therefore, this report discusses survey results for the MC+ managed care population in aggregate only. Although results for the 1115 Waiver population can not be isolated, the aggregate results can be viewed in light of the fact that previous evaluations found that 1115 Waiver beneficiaries "reported a significantly greater ease in obtaining health care when needed, as compared to 1915(b) beneficiaries". There was also evidence of the same pattern with regard to "rating of treatment with respect to courtesy and helpfulness by provider". As a result, the satisfaction ratings presented in this report (which combine responses of 1115 Waiver and 1915(b) Waiver enrollees) likely understate satisfaction ratings for the 1115 Waiver population alone.
Health Status Indicator Rates – Missouri Department of Health and Senior Services, Community Health Information Management and Epidemiology (CHIME)	The Missouri Department of Health and Senior Services, CHIME unit provided data on several health status indicators for children, including preventable hospitalizations, emergency department visits, asthma emergency department visits, and asthma hospitalizations. This data was used for the purpose of responding to Research Question 3. Note: The results presented in this report were developed using Medicaid eligibility data for the purpose of classifying utilization data for the "1115 population", "Other Medicaid", and "Non-Medicaid" populations. When using the payor source to classify data the results differ, particularly for the "Non-Medicaid population."

Dataset/Report Name	Description
	This discrepancy is still being investigated. Therefore, the findings discussed in this report should be viewed as preliminary and used with caution until such time as the reporting discrepancy can be resolved.
MC+ Mental Health Utilization and Penetration Rates, November 15, 2002 – MC+ Mental Health Subcommittee	The MC+ Mental Health Subcommittee has collected three years of mental health penetration and utilization data. This data was used for the purpose of responding to research question 4.
St. Louis ConnectCare Emergency Room Utilization, July 1, 2002 – December 31, 2002 **St. Louis ConnectCare Urgent Care Utilization December 1, 2002 – May 31, 2003.** **St. Louis ConnectCare Provider Visits, FY 2001, FY 2002 and FY 2003 - St. Louis ConnectCare**	St. Louis ConnectCare provided emergency room, urgent care and clinic utilization data to assist with the evaluation of Research Question 5.
"Building a Healthier Saint Louis" – The St. Louis Regional Health Commission, March 2003	This report documents the types and volume of care provided by St. Louis safety-net providers, health status, and health disparities in the region. This report was primarily used for the purpose of obtaining baseline data for response to Research Question 5.
Monthly Management Report – Department of Social Services	The monthly management report provides point-in-time enrollment by month. This report was used to examine enrollment activity by eligibility group and region for the purpose of responding to Research Question 1.

RESEARCH QUESTION 1: HAS THE MC+ EXPANSION PROVIDED HEALTH INSURANCE COVERAGE TO CHILDREN AND FAMILIES WHO WERE PREVIOUSLY UNINSURED?

To answer this question we analyzed changes in the rates of uninsured children and adults in Missouri over the past several years. This information is based on data from, the March 2002 Current Population Survey's Annual Demographic Survey (CPS ADS)[3]. The data presented in this section for 1999 and 2000 is taken from the most recently revised figures published by the Census Bureau. The Census Bureau revised figures for these years to reflect the results of a sample expansion of the survey to 28,000 households in 2001 and the Census 2000-based weights. As a result, the rates of uninsured children and adults in 1999 and 2000 presented below differ from the rates discussed in previous evaluations (See Tables 1, 2 and 3).

In total, 10.2% of the population in Missouri was uninsured in 2001. Although there was a statistically significant increase in the rate of uninsured, from 8.1% in 1999/2000 to 9.9% in 2000/2001 (Mills 2002), Missouri still has one of the lowest rates of uninsured in the country. Specifically, based on a three-year average from 1999 to 2001, Missouri has the fourth lowest rate of uninsured in the country, only after Rhode Island (7.2%), Iowa (8.0%), Wisconsin (8.5%), and Pennsylvania (8.7%) (Mills 2002). The increase in the overall rate of uninsured in Missouri is consistent with the national trend. At the national level, the rate of uninsured has increased from 14.2% in 2000 to 14.6% in 2001, reversing two years of falling uninsured rates in 1998 and 1999. This reversal has been attributed to the weak economy, rising unemployment, and rising cost of providing health benefits (Fronstin 2002).

UNINSURED CHILDREN

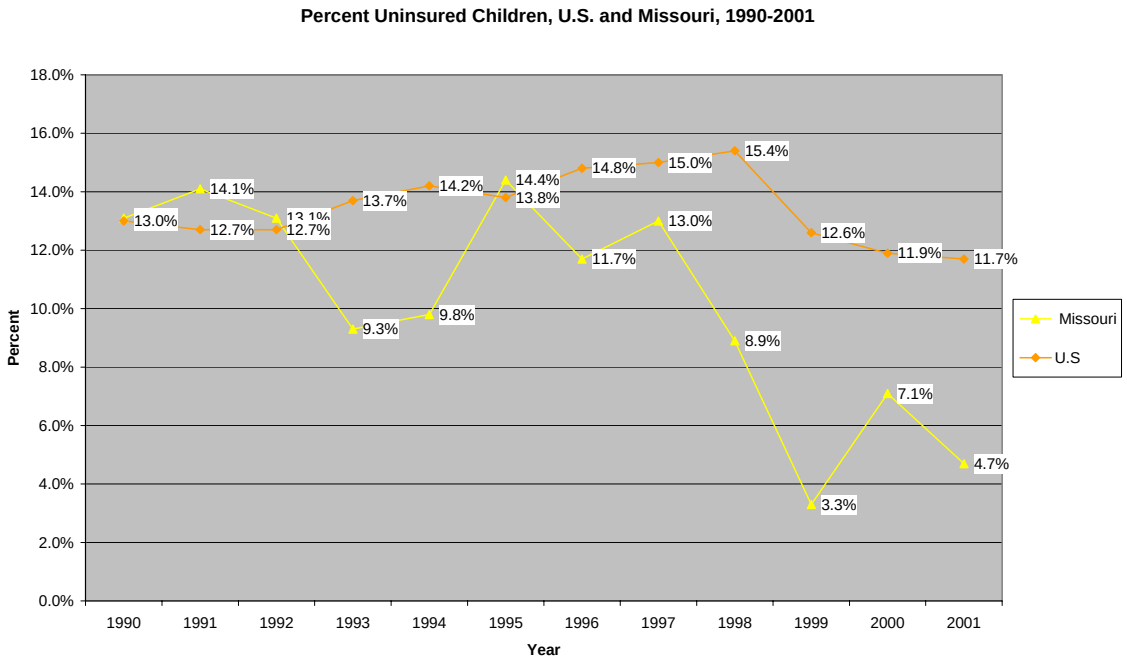
The State of Missouri originally estimated that 91,301 uninsured Missouri children would be eligible under the 1115 Waiver and expected 75% of these children to present for enrollment. In November 2000, after 26 months of operation, enrollment of children reached 69,967, surpassing the original enrollment target of 68,476. By the end of the evaluation period in

[3] Results from the 2003 survey will not be available until September 2003

question, August 2002, enrollment had reached 78,240 (DSS 2002). It is apparent that the growth in 1115 Waiver enrollment has reduced the number of uninsured children in the State of Missouri.

According to the U.S. Census Bureau, the rate of uninsured children under 18 years of age in Missouri was 8.9% in 1998. Over the course of the waiver, the rate decreased to 3.3% in 1999, increased to 7.1% in 2000, and has since decreased to 4.7% in 2001 (See Figure 1). As mentioned previously, two changes were made to the CPS ADS in 2001 -- the sample was expanded to improve SCHIP enrollee estimates, and weights based on the 2000 census were introduced. These changes likely account for some of the variation seen in the 2000 figures, which are from the 2001 CPS ADS.

FIGURE 1



Using a two-year rolling average, the rate of uninsured children in Missouri increased slightly from 5.2% in 1999/2000 to 5.9% in 2000/2001. However, the rate of uninsured children in Missouri continues to be well below the national average, as it has been for the past five years. In 2001, Missouri's rate of uninsured children was 7.0% lower than the national average of

11.7%. This year's rate of uninsured children represents the greatest variation between the national average and Missouri's rate in the past decade.

Overall the number of uninsured children in 2001 was 66,000, which is roughly half of the number of uninsured children the previous year. Missouri now ranks as the fourth lowest state in the number of uninsured children. Figure 2 illustrates the number of uninsured children in Missouri by year.

FIGURE 2

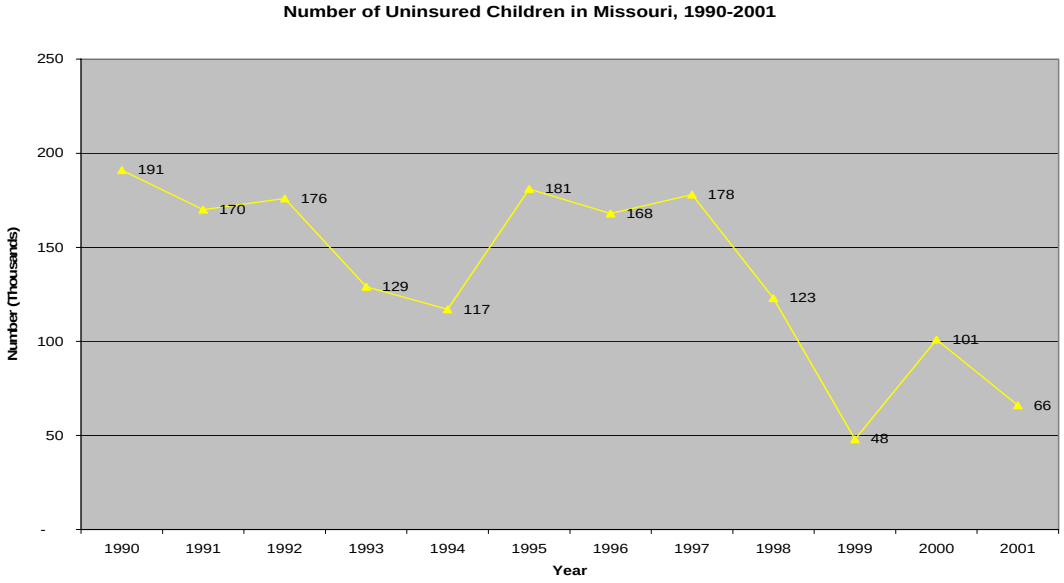
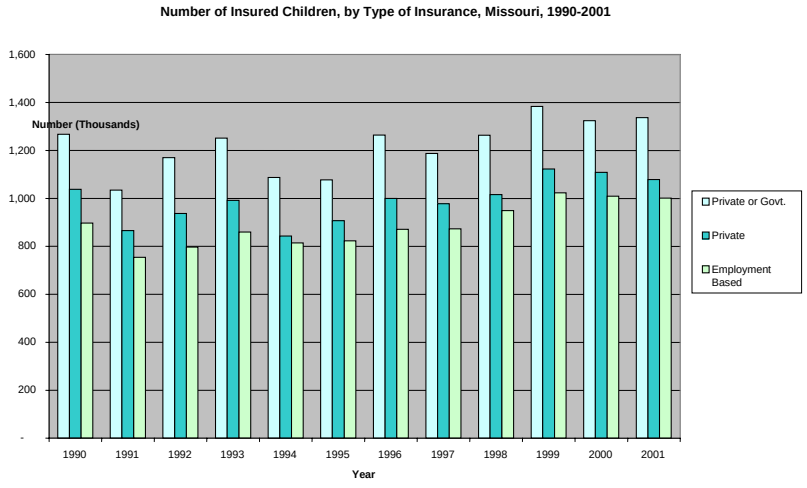


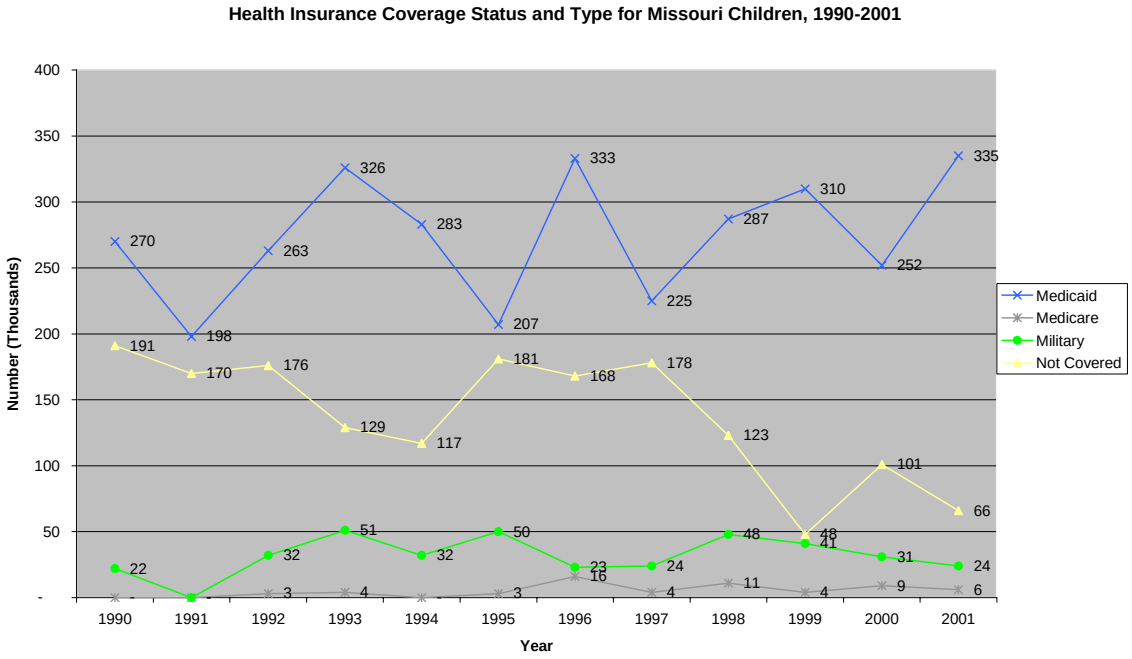
FIGURE 3



Types of Coverage

The number of children in Missouri with health insurance increased from 1.324 million in 2000 to 1.337 million in 2001, according to the CPS ADS. This increase appears to be attributable to an increase in the number of children covered by Medicaid (this includes the 1115 Waiver population) from 252,000 in 2000 to 335,000 in 2001 (See Figure 4). The increase in Medicaid coverage occurred as the rate of children with employment-based coverage decreased only slightly (0.7%), demonstrating that the 1115 Waiver is expanding health coverage to children who were previously uninsured. Increases in the number and rate of children covered by Medicaid are also occurring at the national level, but the decrease in the rate of children with employment-based coverage from 2000 to 2001 are larger (2.1%) than Missouri.

FIGURE 4



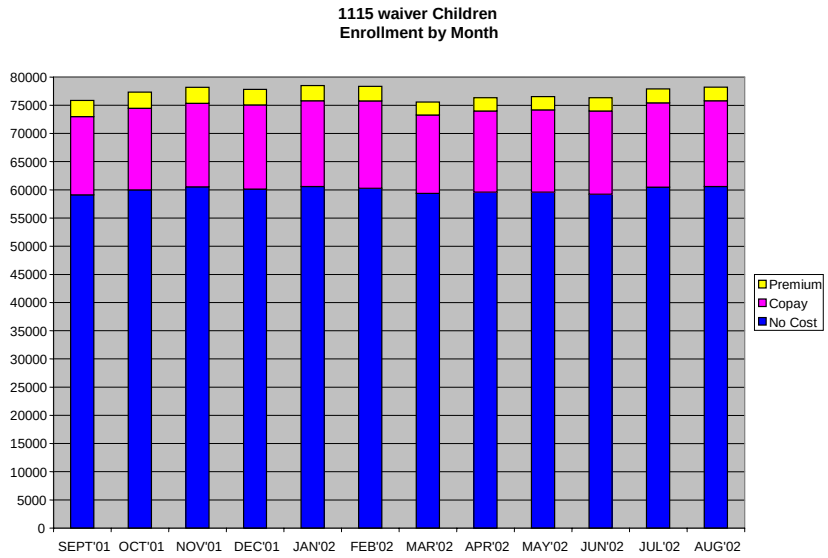
1115 Waiver Enrollment

As mentioned previously, enrollment of 1115 Waiver children reached 78,240 by the end of the evaluation period. Although this represents a 4.0% increase in enrollment over August of the prior year, enrollment at the end of the evaluation period was down slightly from the peak of 78,509 which occurred in January 2002. Enrollment increases were limited to children with

no cost sharing (children below 185% of the Federal Poverty Level (FPL)) and children with co-payments (children at and between 186% to 225% of the FPL) (See Figure 5). Enrollment of children with premium responsibilities (children above 225% and below 300% of the FPL) decreased 23.9%, from 3,183 enrollees in August 2001 to 2,422 enrollees in August 2002. Enrollment of children in all three categories reached their lowest point in March 2002, which is when the annual notice of changes in financial requirements is made (See Table 4).

Enrollment figures by major geographic region in the state (Northwest, Northeast, Southeast, Southwest, Kansas City, St. Louis City and St. Louis County) reveal that the largest increase in enrollment of 1115 Waiver children occurred in St. Louis County followed by St. Louis City. In St. Louis County, enrollment increased 12.8% over the prior year, by 924 children. In St. Louis City, enrollment increased 9.1% over the prior year, by 447 children.

FIGURE 5



UNINSURED ADULTS

The rate of non-elderly uninsured adults in Missouri increased from 9.6% in 1999, to 12.1% in 2000, and again in 2001 to 14.4% (See Table 2), but continues to remain lower than the national rate (18.46%). At the national level, the increase in the uninsured has been attributed to the more recent weakened economy, rising unemployment, and increasing cost of providing

health benefits which have contributed to the erosion in employment-based health benefits (Fronstin 2002). As demonstrated by an increase in the unemployment rate from 3.5% in 2000 to 4.7% in 2001, Missouri's economy has been particularly hard hit by the weakened economy. This has resulted in the departure of several major manufacturers from the state, and is clearly reversing the gains in reducing the number of uninsured adults seen in earlier years.

FIGURE 6

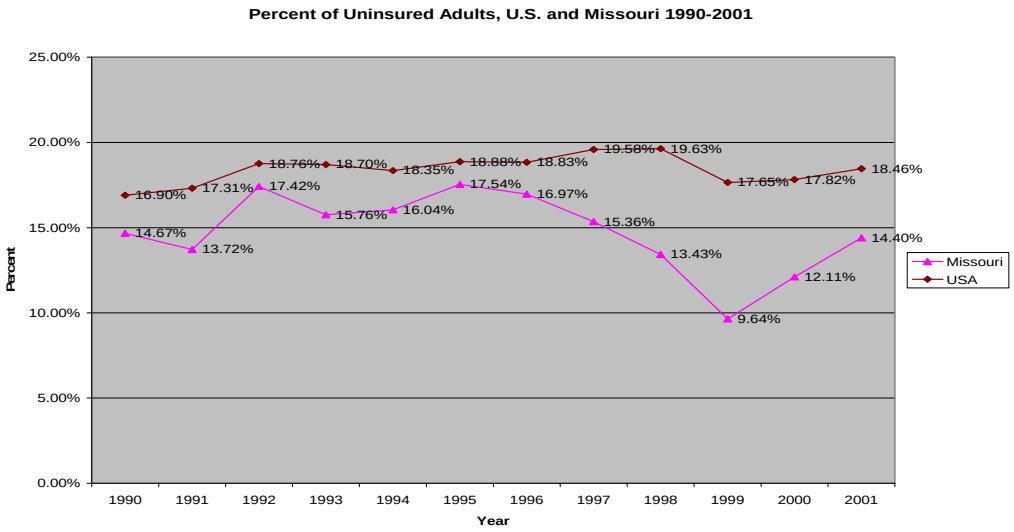
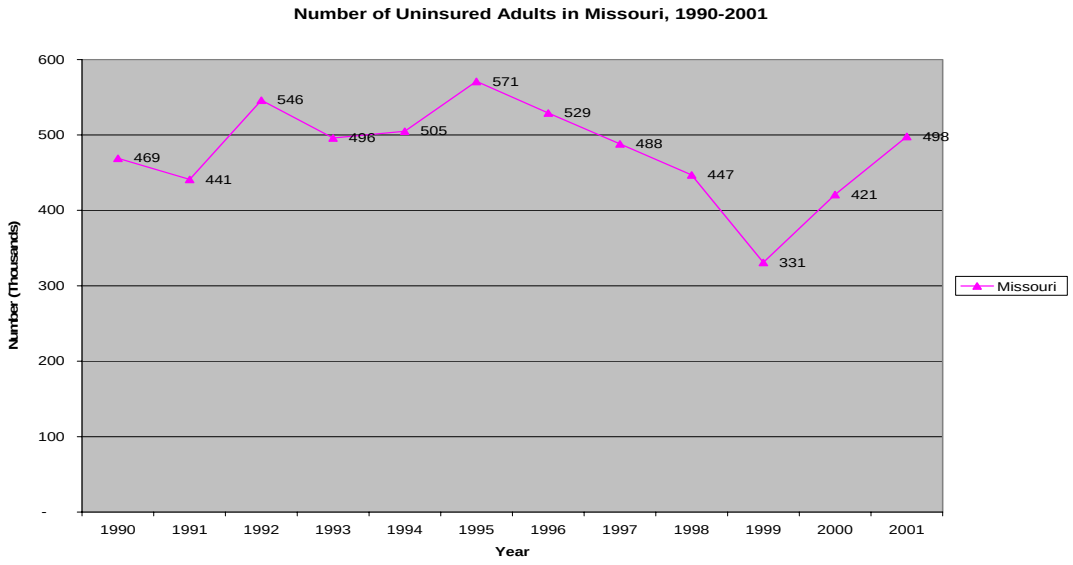


Figure 7 illustrates the number of uninsured adults in Missouri.

FIGURE 7

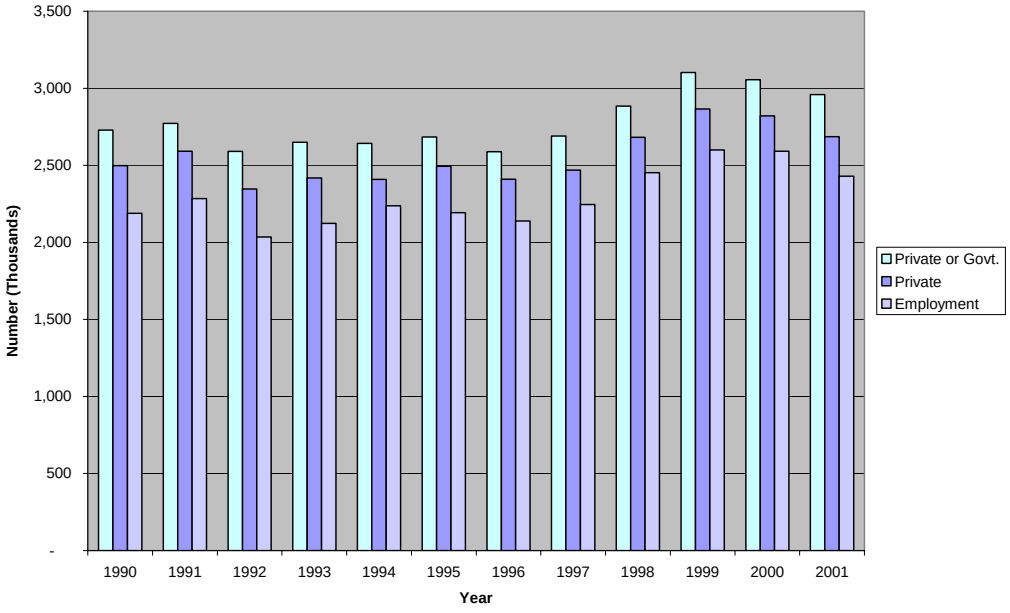


Types of Coverage

Figures 8 and 9 show the number of non-elderly adults by type of health insurance coverage. Between 1998 and 1999, the number covered by all types of insurance (private, government and employment-based) increased. This trend reversed beginning in 1999, driven by decreases in the number of adults with private and employment-based coverage. Although the number of adults with Medicaid coverage increased from 230,000 in 2000 to 252,000 in 2001, this increase has not been sufficient enough to offset losses of private and employment-based coverage.

FIGURE 8

Number of Insured Adults, by Type of Insurance, Missouri 1990-2001

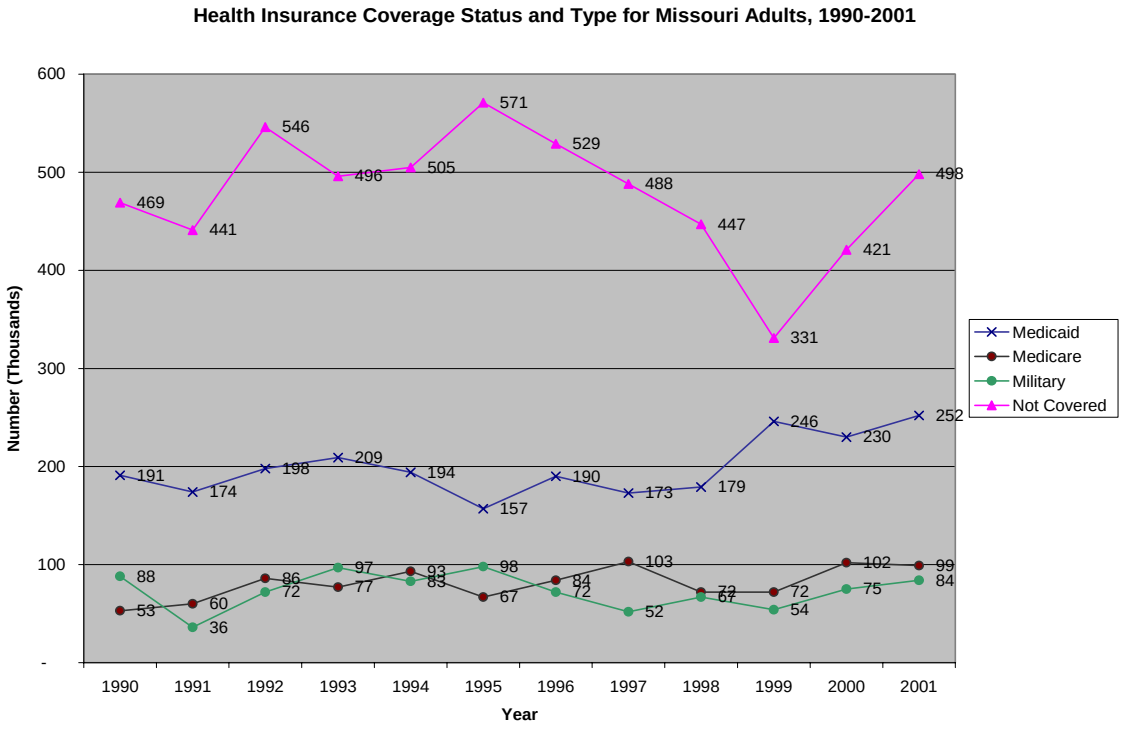


Private or Govt: Includes those with private (whether purchased directly from an insurance company or employment based) and government insurance. Government insurance includes Medicaid, Medicare, CHIP, Military health insurance, VA healthcare, Tricare or CHAMPUS, CHAMPVA and Indian Health Insurance.

Private: Anyone covered by a plan purchased directly from an insurance company and anyone with employment based health insurance.

Employment Based: Anyone insured through his/her (or a relative's) employer or union

FIGURE 9



Summary and Conclusion

The MC+ expansion has clearly provided health insurance to children who were previously uninsured. At the end of the evaluation period, the waiver had reached its four-year anniversary, and the enrollment results for children during this period were consistent with expected outcomes for state children's health insurance plans. After initial rapid enrollment increases in the early years of the waiver, enrollment has stabilized at high levels. Looking forward, it appears the challenge for the State will be maintaining enrollment of children who have a premium responsibility. The decline in enrollment of these children at the time of premium increases demonstrates that the families of these children are particularly sensitive to premium requirements.

After an initial drop in 1999, the rate of uninsured adults in Missouri has been increasing. The increase corresponds with increases in the unemployment rate, and is most likely attributable to the weakened economy and loss of employer-based coverage. But, it should also be noted that the state eliminated eligibility for certain uninsured non-custodial parents and reduced

eligibility for custodial parents and uninsured women losing their Medicaid eligibility post-partum during this period. Despite this, the rate of uninsured adults in Missouri remains below the national average. Further reductions in eligibility for adults when access to employer coverage is decreasing, will challenge the ability of the state to realize decreases in the rate of uninsured adults as a result of the waiver program.

RESEARCH QUESTION 2: HAS THE MC+ EXPANSION IMPROVED THE HEALTH OF MISSOURI'S CHILDREN AND FAMILIES?

To evaluate the impact of the 1115 Waiver on improving the health of Missouri's children and families, we examined three types of data: health status indicators, preventive health service utilization, and enrollee satisfaction.

HEALTH STATUS

Data was obtained from the Missouri Department of Health and Senior Services for several indicators previously used to assess health status: rates of preventable hospitalizations[4], emergency room visits, emergency room visits for asthma, and hospitalizations for asthma. These indicators were reviewed for calendar years 1999 through 2001, in order to assess the impact of the waiver expansion over the course of the waiver and provide continuity with earlier evaluations. Comparisons were also made between children enrolled in the 1115 Waiver, Non-Medicaid Children and all Other Medicaid children since pre-waiver baseline information on 1115 Waiver beneficiaries is not available.

The results presented in this section are based on reports that were generated by using Medicaid eligibility data for the purpose of aggregating results. Subsequent data quality checks show that the results differ when the payer is use to aggregate results, particularly for the Non-Medicaid population. As a result, these findings must be considered preliminary until the discrepancies can be resolved.

As seen in the previous two evaluations for which this data was captured, 1115 Waiver children have lower utilization rates across all indices than Other Medicaid beneficiaries, but higher rates than Non-Medicaid beneficiaries (or others who did not receive either type of

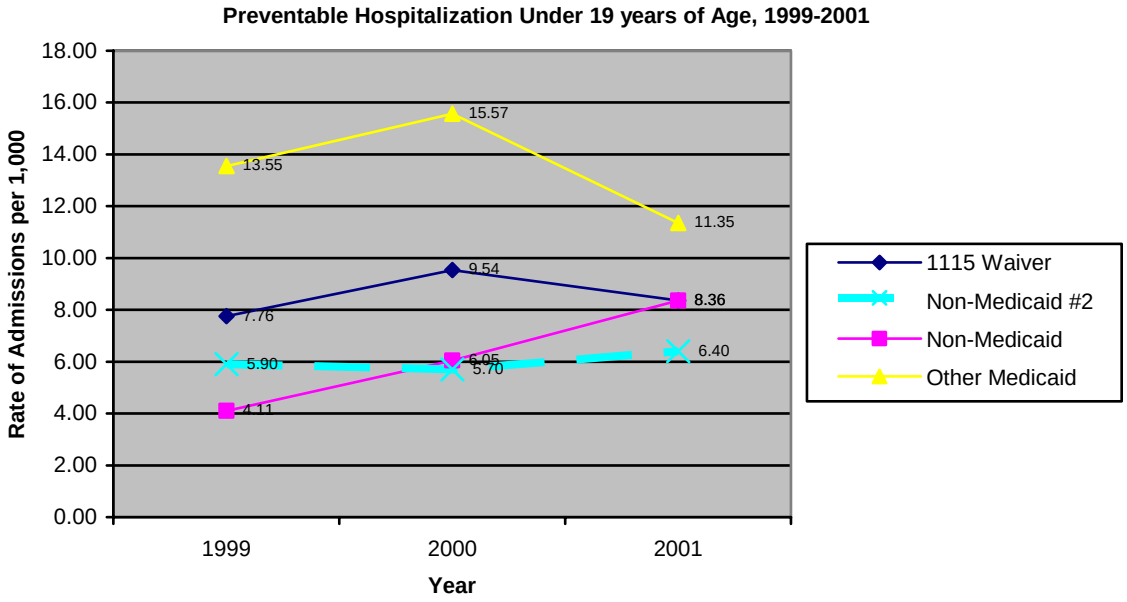
[4] Preventable hospitalizations include hospitalization for the following diagnoses: Angina; Asthma; Bacterial Pneumonia; Cellulites; Chronic Obstructive Pulmonary Disease; Congenital Syphilis; Dehydration; Dental Conditions; Diabetes; Epilepsy; Failure to Thrive; Gastroenteritis; Hypertension; Hypoglycemia; Kidney or Urinary Infection; Pelvic Inflammatory Disease; Severe Ear, Nose, or Throat infection; Tuberculosis

coverage). The Non-Medicaid group includes individuals with commercial insurance and without any insurance. A discussion of each indicator is provided below.

Preventable Hospitalizations

Although defined differently by the American Academy of Pediatrics (AAP), the rate of hospitalizations for ambulatory sensitive conditions (asthma, diabetes, epilepsy, dehydration, gastroenteritis, pneumonia, urinary tract infection/kidney infection) is a recommended indicator for evaluating state children's health insurance plan outcomes. High rates of preventable hospitalizations can indicate a lack of primary care. As shown in Figure 10, the Other Medicaid population had the highest rates of preventable hospitalizations, while the Non-Medicaid group had the lowest rates. For the third consecutive year, the rate of preventable hospitalizations for 1115 Waiver beneficiaries fell between the other two groups at 8.31 per 1,000. Preliminary results show that the rate of preventable hospitalizations for the Non-Medicaid population has increased from 4.11 in 1999 up to 8.36 in 2001, the same rate as the 1115 population. However, reports generated by payor show a more modest increase (see "new Non-Medicaid" # 2 in Figure 10).

FIGURE 10

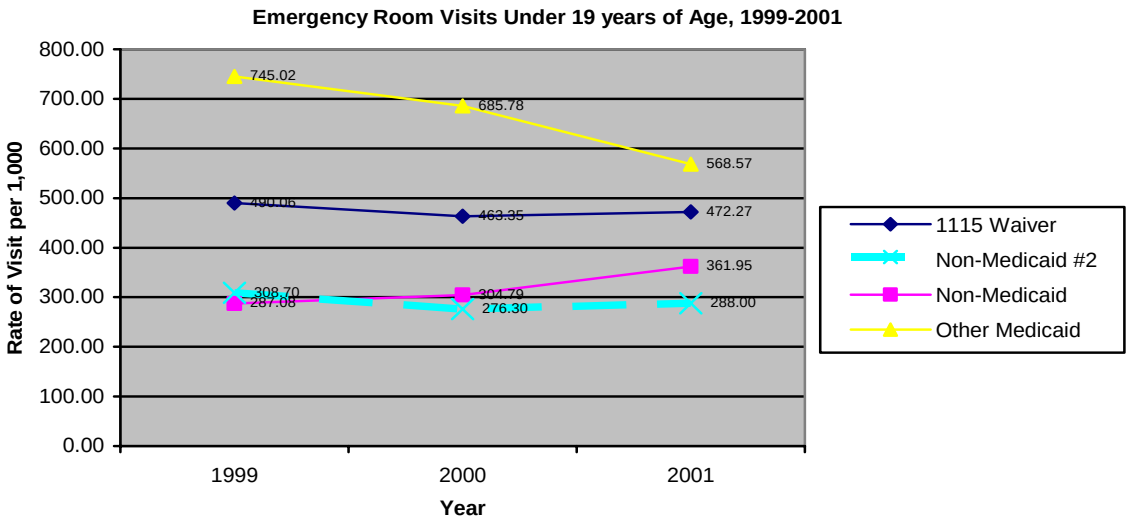


Using either results, the rate of preventable hospitalizations for the Non-Medicaid population is increasing, and the rates for the 1115 Waiver and Other Medicaid populations are decreasing, minimizing the disparity seen among the three populations in previous evaluations. In 2001, the 1115 Waiver population continues to experience a lower rate of preventable hospitalizations per 1,000 than the Other Medicaid population (8.31 and 11.35 respectively). However, the rate of preventable hospitalizations for the Other Medicaid population decreased more dramatically than it did for the 1115 Waiver population (27.1% to 12.9%, respectively).

Emergency Room Visits

The trends for emergency room utilization are similar to the trends for preventable hospitalizations (See Figure 11). The emergency room utilization rate continued to increase in 2001 over and above the increase in 2000, from 304.79 per 1,000 to 361.95 per 1,000. The rate for the Other Medicaid population decreased 17.1%, from 685.78 per 1,000 in 2000 to 568.57 per 1,000 in 2001. The rate for the 1115 Waiver population continues to fall between these two populations, increasing slightly from 463.35 per 1,000 in 2000 to 472.27 per 1,000 in 2001. As seen with the preventable hospitalization rates, the rate of emergency room visits across the three populations is converging, although not as dramatically when reports are generated by payor.

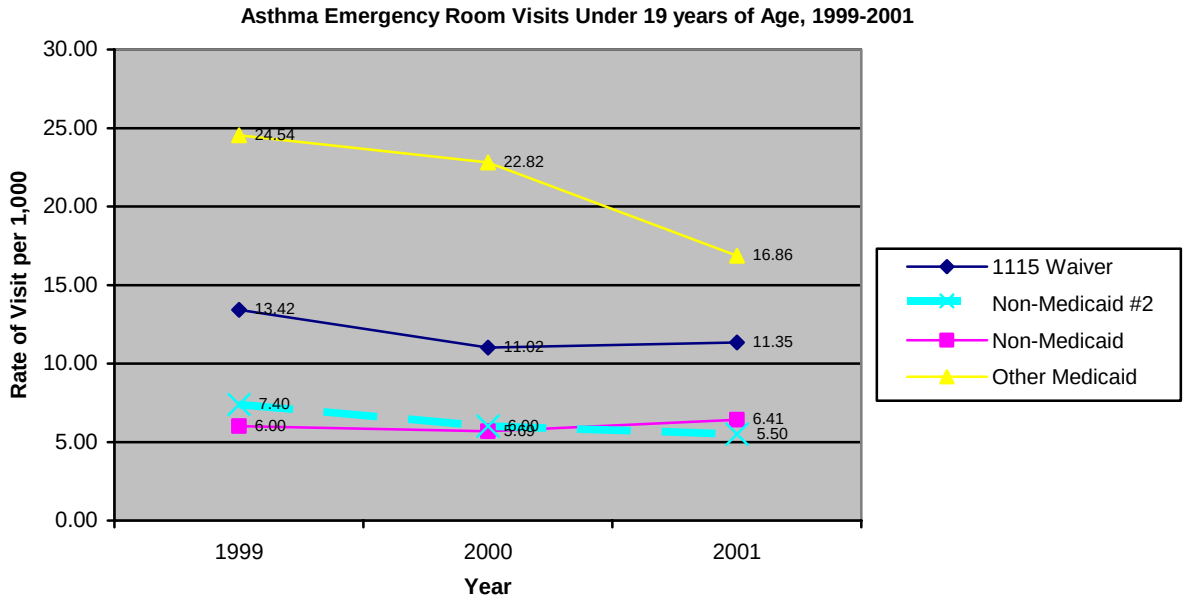
FIGURE 11



Asthma - Emergency Room Visits and Hospitalizations

The rates of emergency room visits for asthma are shown in Figure 12, and the rates of hospitalization for asthma are shown in Figure 13. In terms of emergency room visits for asthma, the Other Medicaid population experienced the greatest decrease in rates, which dropped from 22.8 per 1,000 in 2000 to 16.9 per 1,000 in 2001. Rates for the 1115 Waiver population increased slightly from 11.0 per 1,000 in 2000 to 11.4 per 1,000 in 2001. The changes in asthma emergency room rates are consistent with the changes seen in the rates of preventable hospitalizations and emergency room visits: Rates for the Other Medicaid population decreased the most, and rates for the 1115 Waiver population remained between the Other Medicaid and Non-Medicaid populations.

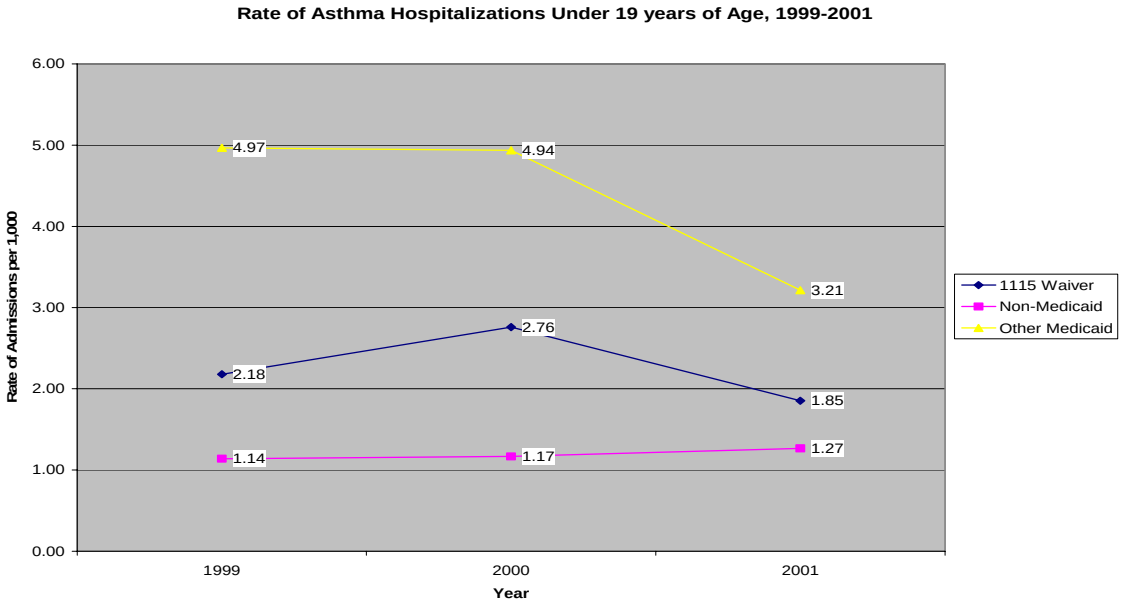
FIGURE 12



This same pattern occurred with the second asthma indicator for children. The greatest decrease in the hospitalization rate for asthma was in the Other Medicaid Population. This population's rate decreased from 4.94 per 1,000 in 2000 to 3.21 per 1,000 in 2001, an overall decrease of 34.9%. The greatest increase occurred in the rates for the Non-Medicaid population, which rose from 1.17 per 1,000 in 2000 to 1.27 per 1,000 in 2001. The 1115

Waiver population's hospitalization rate decreased most dramatically by 32.89% from 2.76 per 1,000 in 2000 to 1.85 per 1,000 in 2001.

FIGURE 13



Summary and Conclusion

Overall, health status indicator rates for the Other Medicaid population decreased most dramatically, but the 1115 Waiver population continues to experience lower rates than the Other Medicaid population across all indicators. While the overall rate of emergency room visits, and the rate of emergency room visits for asthma are remaining relatively constant, decreases in preventable hospitalizations and hospitalizations related to asthma indicate the health status of the 1115 Waiver population is improving. Based on the changes in these health status indicators, a few preliminary conclusions can be drawn. However, the data upon which these conclusions are based requires further analysis to explain the variation in results before these conclusions can be finalized.

- The 1115 Waiver population has a better health status than the Other Medicaid population, as determined by all four measures reviewed.
- The 1115 Waiver population has a lower health status than the Non-Medicaid population.

- The gap between the health status of the 1115 Waiver population relative to these other two populations is decreasing.

Regional Variation

Rates for each population were also compared across MC+ managed care state regions and fee-for-service state regions. The 1115 Waiver population receives services through either the fee-for-service delivery system or the managed care delivery system, depending on the location of the individual's residence. Some regional variations should be noted. Across all three populations (Non-Medicaid, Other Medicaid and 1115 Waiver), the fee-for-service regions generally had the highest rates of preventable hospitalizations and emergency department visits, but these regions also had the lowest rates of emergency room visits and hospitalizations for asthma. The Eastern Region had the highest rates of emergency room visits for asthma and hospitalizations for asthma across all three populations (see Table 5).

CONSUMER SATISFACTION

Another approach that is often used to evaluate health care programs is the evaluation of consumer rating of their health care experience through the use of CAHPS®, a survey instrument designed to collect data on consumer satisfaction with health care experiences and health plans. The tool is specifically designed to measure health care performance from the consumer's point of view. To further examine whether MC+ is improving the health of the 1115 Waiver population, we evaluated responses of the Missouri MC+ Managed Care Population to the CAHPS® child survey.

Prior to 2001, the CAHPS® survey was administered by the state of Missouri, and the results were available separately for individuals in fee-for-service and managed care regions of the State as well as the 1915(b) Waiver and 1115 Waiver populations. Now, MC+ health plans retain a vendor to administer the CAHPS® survey in accordance with NCQA requirements, and results are only available in aggregate for all MC+ managed care enrollees. However, previous evaluations that used CAHPS® survey responses to examine access to care, utilization of services, and satisfaction with health care found that 1115 Waiver beneficiaries "reported a significantly greater ease in obtaining health care when needed, as compared to 1915(b) beneficiaries". There was also evidence that this

applied to the same pattern with regard to rating of treatment with respect to courtesy and helpfulness by provider. As a result, the satisfaction ratings presented below, which combine responses of 1115 Waiver and 1915(b) Waiver enrollees, likely understate satisfaction ratings for the 1115 Waiver population alone.

For the purpose of this evaluation we examined responses to three of the five composite questions in CAHPS® and three overall rating questions. The three composite questions are:

- Courteousness and helpfulness of the office staff;
- Ability to get care quickly; and
- Ability to get needed care.

The questions that make up the composites can be found at the end of this section. The three rating questions we selected are:

- Rating of the managed care organization;
- Rating of overall healthcare; and
- Rating of the member's personal doctor.

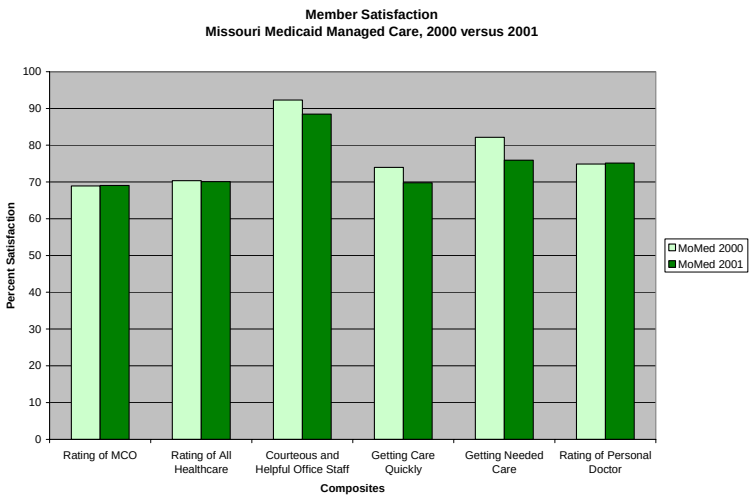
For each question, MC+ managed care enrollee (MoMed) responses to the 2001 and 2000 survey are compared to the following benchmarks:

- Missouri's HMO members (MoHMO);
- National HMOs members (Nat'l HMO); and
- All member in all plans, nationally (Nat'l Ave).

Overview of Findings

As reflected by high MCO ratings relative to other populations and increased personal doctor ratings from 2000 to 2001, MC+ member satisfaction remains high despite the fact that ratings of "getting needed care" and "getting

FIGURE 14



care quickly" fell between 2000 and 2001. The lower rating for "getting care quickly" is not limited to the MC+ population. Missouri HMO member ratings for "getting care quickly" as well as their rating of their MCO, also fell during this period, while National HMO member ratings in these categories went up. The phenomenon of high health plan and provider ratings combined with less positive experiences in "getting needed care" and "getting care quickly" is also reported at the national level for Medicaid enrollees (NCBD 2002).

Overall Rating of Health Plan

Using 0 to 10 where 10 is the worst possible and 10 is the best possible, how would you rate your health plan?

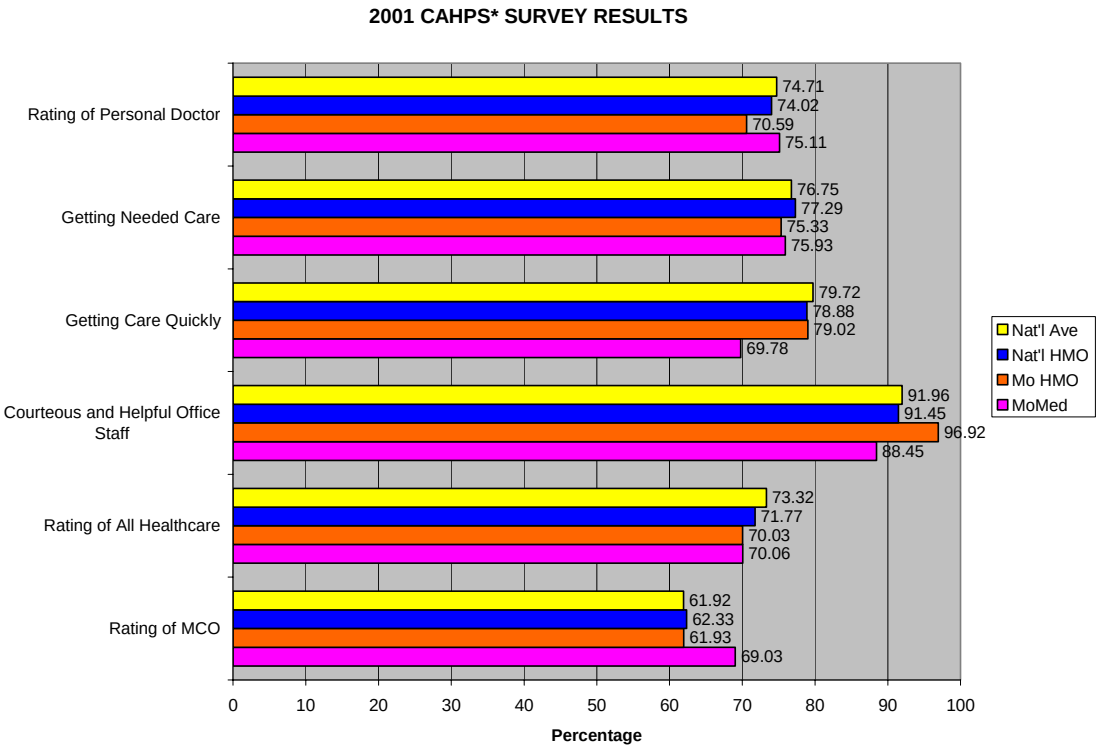
For the third consecutive year, the MC+ managed care population rates their health plan higher than all other populations did. The percentages shown in Figure 14 represent the percentage of respondents who rated their health plan an 8, 9, or 10.

Overall Rating of Health Care

Using 0 to 10 where 10 is the worst possible and 10 is the best possible, how would you rate all your health care?

Overall Rating of Health Care is the most general question. It provides a more global view of the member perceptions of generally available healthcare. This question can serve as a backdrop or as a source of comparison to member answers to more specific questions. MC+ member ratings in 2001 remained relatively constant with 70.1% of the population rating their health plan an 8, 9 or 10. Missouri HMO ratings also remained relatively stable. National HMO ratings increased from 69.9% in 2000 to 71.8% in 2001. The percentages shown in Figure 14 represent the percentage of respondents who rated their health care an 8, 9, or 10.

FIGURE 15



Courteousness and helpfulness of the office staff

This composite combines responses from two questions on how often office staff were courteous and helpful. Figure 14 shows the percentage of respondents who answered "always" (instead of "never", "sometimes", or "usually"). The MC+ population rating fell from 92.3% in 2000 to 88.5% in 2001, while the Missouri HMO population rating moved in the opposite direction, improving from 90.5% to 96.9%.

Getting Care Quickly

"Getting Care Quickly" is a composite of responses from four questions related to how often the individual received various types of care in a timely manner. The MC+ managed care population rated their experience in "getting care quickly" less favorably than other populations did and less favorably in 2001 than they had 2000. Figure 15 shows the percentage of individuals who responded "Always" or "Usually".

Getting Needed Care

The questions that make up the "Getting Needed Care" composite combine responses from four questions regarding how much of a problem, if any, the individual had with certain aspects of care. Recall that previous evaluations found that 1115 Waiver beneficiaries reported a significantly greater ease in "getting needed care" compared to 1915(b) beneficiaries. The MC+ results presented here are a composite of both populations. In total, the MC+ population rating fell from 82.2% in 2000 to 75.9% in 2001. Even with this decline in ratings, the MC+ population rating is still slightly higher than the Missouri HMO population's rating, but for the first time in three years it is lower than the National HMO rating. Figure 15 illustrates the percentage of respondents who indicated there was "not a problem".

Overall Rating of Personal Doctor

Using 0 to 10 where 10 is the worst possible and 10 is the best possible, how would you rate your personal doctor or nurse?

MC+ members rated their personal doctor or nurse more favorably than any other population. For the third consecutive year in a row, MC+ members rated their personal doctor or nurse more favorably than they did in the preceding year. MC+ members also rate their personal doctor higher than their health plan. This same dynamic is also reported at the national level for commercial, Medicaid and Medicare respondents (NCBD 2002). Figure 54 portrays the percentage of respondents who rated their personal doctor an 8, 9, or 10.

Member Complaints

To further understand the reason for the decline in the MC+ population ratings of their ability to get needed care and to get care quickly, we examined member complaints for the 1115 Waiver population during the evaluation period. In total, the number of complaints was extremely low. The volume of complaints dropped by more than 50% between the third calendar quarter of 2001 and the third quarter of 2002. Additionally, the decrease in ratings should be viewed in light of the fact that the rate of preventable hospitalizations and emergency room visits actually decreased in 2001.

CAHPS® COMPOSITE QUESTIONS

CONSUMER REPORTS AND ITEMS	RESPONSE GROUPINGS FOR PRESENTATION
Getting Needed Care	
• With the choices you (child's) health plan gave you, how much of a problem, if any was it to get a personal doctor or nurse you are happy with?	**A big problem** **A small problem** **Not a problem**
• In the last….months, how much of a problem, if any, was it to get a referral to a specialist that you (your child) needed to see?	**A big problem** **A small problem** **Not a problem**
• In the last….months, how much of a problem, if any, was it to get care (for you child) you or a doctor believed necessary?	**A big problem** **A small problem** **Not a problem**
• In the last….months, how much of a problem, if any, were delays in (your child's) health care while you waited for approval from your (child's) plan?	**A big problem** **A small problem** **Not a problem**
Getting Care Quickly	
• In the last…months, when you called during regular office hours, how often did you get the help or advice you needed (for your child)?	**Never Sometimes** **Usually Always**
• In the last…months, how often did you (your child) get an appointment for regular routine health care as soon as you wanted?	**Never Sometimes** **Usually Always**
• In the last…months, when you (your child) needed care right away for an illness or injury, how often did you (your child) get care as soon as you wanted?	**Never Sometimes** **Usually Always**
• In the last…months, how often did you (your child) wait in the doctor's office or clinic more than 15 minutes past your appointment time to see the person you (your child) went to see?	**Never Sometimes** **Usually Always**
Courteous and Helpful Office Staff	
• In the last….months, how often did office staff at a (your child's) doctor's office or clinic treat you (and your child) with courtesy and respect?	**Never Sometimes** **Usually Always**
• In the last….months, how often were office staff at a (your child's) doctor's office or clinic as helpful as you thought they should be?	**Never Sometimes** **Usually Always**
Rating of Personal Doctors	
• Use any number on a scale from 0 to 10 where 0 is the worst personal doctor or nurse possible, and a 10 is the best personal doctor or nurse possible. How would you rate your (child's) personal doctor or nurse now?	**0-6** **7-8** **9-10**
Rating of Health Care	
• Use any number on a scale from 0 to 10 where 0 is the worst health care possible and 10 is the best health care possible. How would you rate all your (child's) health care?	**0-6** **7-8** **9-10**
Rating of Health Plan	
• Use any number on a scale from 0 to 10 where 0 is the worst health plan possible and 10 is the best health plan possible. How would you rate your (child's) health plan now?	**0-6** **7-8** **9-10**

<u>RESEARCH QUESTION 3:</u> WHAT IS THE IMPACT OF MC+ ON PROVIDING A COMPREHENSIVE ARRAY OF COMMUNITY BASED WRAPAROUND SERVICES FOR SERIOUSLY EMOTIONALLY DISTURBED CHILDREN (SED) AND CHILDREN AFFECTED BY SUBSTANCE ABUSE?

Previous evaluations have examined the types of "wraparound" services provided to seriously emotionally disturbed (SED) children through the Missouri Department of Health. This data revealed that SED children who were enrolled in MC+ through the 1115 Waiver had a median age of 14 years and the majority were of Caucasian, non-Hispanic race/ethnicity. The most frequent diagnosis was ADHD (hyperactivity). Other diagnosis included major depression, acute stress or adjustment disorders, and oppositional defiant disorders or conduct disorders in order of frequency (BHC 2002). The ability of the evaluator to draw conclusions about the level of community-based wrap around services was limited by a number of factors. Ultimately, a telephone survey was administered to obtain additional insight. The survey findings suggested that "from the caregivers' perspective, children's behavioral health needs are being met, and their emotional, behavioral, and functional status has improved since being enrolled in MC+ under the 1115 Waiver," although whether children received "wraparound" services and the source of those services could not be determined (BHC 2002).

As in previous years, our ability to determine the impact of the 1115 Waiver on providing a comprehensive array of community-based wraparound services for SED children and children affected by substance abuse is limited. However, a review of MC+ quality improvement activities and three years of data collected by the MC+ subcommittee provides insight into the types of improvements in mental health service delivery that are continuing to be made.

Quality Improvement Activities

As reported by the state's External Quality Review Organization, several initiatives have been undertaken to improve coordination of services and authorization of mental health services, including but not limited to:

- Training Division of Family Services case workers on how to access health and behavioral health services from MCOs to ensure that Children's Treatment services funds are used as the payor of last resort for children in state custody.

- Developing protocols for wraparound services for managed care members.
- Educating administrative agents with regard to the services of the Department of Mental Health, Department of Health and Senior Services and MC+ health plans.
- Educating community mental health center staff to encourage appropriate use of mental health services offered by MC+ health plans.
- Analyzing the duplication, fragmentation and alternative mechanisms for providing EPSDT services to maximize efficiency and access to mental health services.
- Analyzing mental health services that are paid, authorized and denied by MC+ health plans. This analysis will then be compared with fee for service financial analysis.

MC+ Mental Health Penetration and Utilization Rates

A review of the data collected by the MC+ Mental Health Subcommittee, shows that access to mental health services and mental health utilization is increasing.

- Access to Mental Health Services. As measure by the penetration rate, access to mental health services for children is increasing. The percentage of children using mental health services increased for children ages birth through 12 and children ages 13 through 17 in 2000 and 2001.

- Mental Health Utilization. Use of inpatient mental health services and substance abuse services, as measured by inpatient days per 1,000 and inpatient admissions per 1,000, increased during calendar year 2000, but dropped during 2001. Use of outpatient services increased steadily in 2000 and 2001.

- Follow-Up Care for Mental Health Hospitalization. The percentage of health plan members receiving follow-up mental health services after discharge from an inpatient mental health facility increased in 2000 and 2001. On average 29.7% of plan members had follow-up mental health services within 7 days of discharge and 53.3% of plan members had follow-up mental health services within 30 days of discharge. These results include all plan members; they are not specific to children.

MEASURE	1999	2000	2001
Penetration Rate Birth – 12 Years	4.0%	4.2%	4.4%
Penetration Rate 13-17 Years	7.1%	8.0%	8.4%
Inpatient Days per 1,000	31.5	40.4	37.8
Inpatient Admissions per 1,000	6.3	11.3	8.3
Inpatient Substance Abuse days per 1,000	2.7	5.1	3.3
Inpatient Substance Abuse admissions per 1,000	1.2	1.5	1.1
Outpatient Visits/1,000	222.1	249.4	290.7
Alternative Services/1,000	14.4	27.4	12.4
Ambulatory Follow-up Visit with 30 days	35.8%	47.1%	53.3%
Ambulatory Follow-up Visit with 7 days	17.8%	27.6%	29.7%
Note: indicators do not include mental health services/medications provided by PCPs			

SOURCE: November 15, 2002 MC+ Managed Care *Mental Health Utilization and Penetration Rate*: Calendar Years 1999, 2000 & 2001

The 16 State Pilot Indicator Study

Review of penetration rates and readmission rates published as part of the work of the 16 state indicator pilot, a part of the Mental Health Statistics Improvement Program also show that improvements in mental health service delivery are being made in the state. This group has been working to develop standards for mental health data for the last 20 years. As a part of this initiative sixteen states, including the state of Missouri, collect and submit penetration/utilization, readmission and survey data using uniform reporting guidelines.

- Community-Based Program Utilization. Community-based program utilization rates are based on unduplicated counts of all individuals served by community mental health programs that are operated or funded by the state mental health authority. The figures include all individuals served by these programs, regardless of insurance coverage or legal status. The community-based program rate per 1000,000 children in Missouri increased from 677 in Fiscal Year 1999 to 729 in Fiscal Year 2000.

- Readmission rates. Readmission rate to state hospitals capture the number of admissions to any state psychiatric inpatient care that occurred within 30/180 days of a discharge. At 7.01%, the rate of Seriously Mentally Ill (SMI) Children in Missouri readmitted within 30 days in 2000 was less than the 16 state average of 7.53%. At 4.01%, the readmission rate for non-seriously mentally ill children in 2000 was lower than the 16 states average of 5.99%.

  As expected the rate of readmissions after 180 days of discharge is higher for both SMI Children and non-SMI children. 12.22% of SMI Children and 9.73% of non-SMI children were readmitted. The rates for both populations were lower than the 16 state average (12.54% and 12/15% respectively).

<u>RESEARCH QUESTION 4:</u> WHAT IS THE EFFECT OF MC+ ON THE NUMBER OF CHILDREN COVERED BY PRIVATE INSURERS? DOES THE MC+ EXPANSION TO COVER CHILDREN WITH A GROSS FAMILY INCOME ABOVE 185% FPL HAVE ANY NEGATIVE EFFECT ON THESE NUMBERS?

The issue of crowd-out is central to this research question. In the past, CMS officials have been particularly concerned that the expansion of Medicaid and SCHIP eligibility to families with higher incomes, particularly incomes above 200 percent of the Federal Poverty Level, would result in the substitution of public insurance for private insurance, a phenomenon known as crowd-out (Mathematica 2003). Although BHC concluded that crowd-out was not occurring in the State of Missouri in the most recent 1115 evaluation, they also noted, "given state budget concerns, crowd-out should continue to be monitored through sources such as CPS and other nationally conducted studies." (BHC 2002).

The State of Missouri has implemented several safeguards against crowd-out, including a six-month waiting period and cost-sharing requirements. According to an interim evaluation report prepared by Mathematica, et. al, for Congress, a waiting period is the most common strategy used to deter crowd-out. At six months, Missouri has adopted the longest waiting period of the six states evaluated by Mathematica. The six states in the study account for over half of the SCHIP enrollment in the country. The application process for Missouri also has a number of other deterrents built in. Although Missouri has taken several steps to simplify the application process by reducing the size of its application and accepting applications by mail, it has also built more steps into the verification process than many states to ensure that only applications from eligible people are accepted. For example, Missouri is the only one of six states examined by Mathematica that requires an assets test or age verification. Missouri also requires applicants with income between 226% and 300% of the Federal Poverty Level to obtain two price quotes from private insurers as proof that affordable insurance alternatives do not exist.

Despite these deterrents, a review of the issue of crowd-out is warranted. In order to determine if crowd-out was an issue during the period September 1, 2001, through August 31,

2002, we have examined changes in the number of uninsured children relative to the number of children with private insurance. These changes are examined in the context of other economic indicators that may affect the data used to identify evidence of crowd out.

The rate of uninsured children in Missouri decreased to 4.7% in 2001, the lowest level since the implementation of the 1115 Waiver. This year's rate is significantly below the national average of 11.7% and represents the greatest variation in the past decade between the national average and Missouri's rate. Between 2000 and 2001, there was a 2.1% decrease in the number of children with access to employment-based coverage at the national level. The decrease in the number of children with employer-based coverage in Missouri was only 0.69%.

Summary and Conclusion

The number of children insured by private or employment-based insurance has remained relatively constant, even as uninsured rates have been decreasing. This refutes the crowd-out argument since there do not appear to be children leaving private insurance for public insurance; rather they are leaving the "uninsured". These findings are consistent with discussions with the Director of the Department of Insurance, Scott Lakin, who indicated that he has still not seen any evidence of crowd-out in the state.

RESEARCH QUESTION 5: HAS THE 1115 WAIVER AMENDMENT IMPROVED THE HEALTH OF THE INDIGENT OF ST. LOUIS CITY?

The St. Louis Waiver Amendment authorizes the use of a limited portion of Disproportionate Share Hospital (DSH) expenditures for the purpose of transitioning St. Louis ConnectCare (ConnectCare), a public-private hospital in St. Louis, from an inpatient facility to an outpatient facility and enabling the St. Louis region to transition its "safety net" system of care for the medically indigent to a viable, self-sustaining model. Essentially, it allows DSH money to be used to provide outpatient care. In doing so, the goal is to develop a system of care that will improve the health of the indigent of St. Louis City. This report provides an initial look at the status of the amendment.

BACKGROUND

ConnectCare was established in 1997. Until June of 1997, the Delmar facility that is the primary site of ConnectCare's operations was known and operated as Regional Hospital. Regional was a 350-bed hospital serving primarily low-income Medicaid, Medicare, and uninsured individuals living in St. Louis City and County. As the State began to aggressively move its Medicaid population into managed care plans, and St. Louis City and St. Louis County contracts expired without renewal, Regional found it increasingly difficult to compete in the market and, by June 1997, began to phase down its operations.

As Regional phased down, a new board was established to develop the ConnectCare concept and guide the transition to a new entity. In addition, a consortium of local hospitals was formed to assist in the development and nurturance of the ConnectCare concept. With the formation of ConnectCare the number of hospital beds was reduced to 24.

In October 1997, ConnectCare began operating as a private, non-profit corporation with a permanent board that included representation and support from the four major hospital systems operating in St. Louis that had been part of the consortium. The State funded a

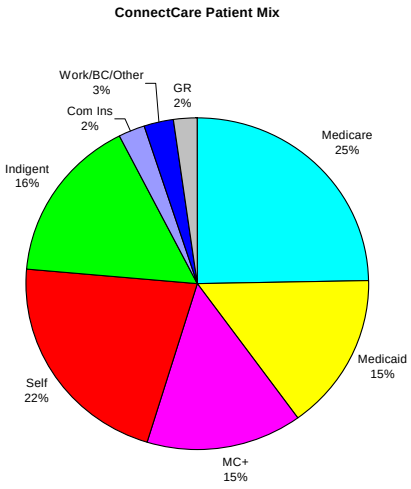
large portion of ConnectCare's operation through reimbursement for Medicaid enrollees using the clinics and through the DSH program to help offset the uncompensated care burden carried by ConnectCare in its hospital operation. In January 2000, DMS commissioned a report to determine what potential funding sources might be available to assist ConnectCare in its on going operations and to address an anticipated funding shortfall that was driven by a reduction in the amount of DSH payments the organization was eligible for under the Medicaid DSH program.

Subsequently, the Indigent Task Force of Civic Progress was formed to address the funding crisis facing ConnectCare. The Task Force retained The Lewin Group to assist with the development of solutions to address the funding crisis and safety-net delivery system. Ultimately, the Task Force recommended the establishment of a Regional Health Authority, and in September 2001, the St. Louis Regional Health Commission (the "RHC") was formed. The RHC now plays a key role under the 1115 Waiver, including the development of a strategic plan for the delivery of services to the medically indigent by the end of 2003.

THE ROLE OF SAINT LOUIS CONNECTCARE

Previous reports completed by staff of Engquist, Pelrine & Powell, Inc. (who are now at Alicia Smith & Associates, LLC) and The Lewin Group have recognized that the preservation of DSH funding is critical to maintaining access to safety-net services in St. Louis City through ConnectCare. The vital role that ConnectCare plays in serving the St. Louis region is demonstrated by its patient profile, the majority of whom are uninsured or Medicaid beneficiaries (See Figure 16).

FIGURE 16



SOURCE: ConnectCare, "Patient Demographics – Age/Sex Analysis by PCP" as of December 28, 1999.

The vast majority of uninsured ConnectCare patients are between the ages of 19 and 65 (94% in December 1999).[5] This demographic profile is relevant, as a large segment of this population is not likely to be eligible for Medicaid, which primarily covers children and adults with dependent children. Specifically, The Lewin Group found that less than 24% of an estimated 50,193[6] uninsured in St. Louis City were eligible for Medicaid or SCHIP, highlighting the difficulty of solving funding problems for ConnectCare and other safety-net providers serving the uninsured in the region. Approximately half of the estimated number of uninsured in St. Louis are adults without children. And yet, without this Waiver Amendment, ConnectCare would not be eligible for DSH payments to help offset the cost of uncompensated care.

THE ST. LOUIS AMENDMENT

The St. Louis Amendment timeline provides for an initial 18-month planning process to be followed by a 12 month implementation period. As a result, it is premature to evaluate whether the St. Louis Amendment has improved the health of the indigent of St. Louis. But, in order to gauge the impact of the system redesign in future years and to assist with planning activities, the RHC published a report entitled "Building a Healthier St. Louis"

[5] ConnectCare - "PATIENT DEMOGRAPHICS - AGE/SEX ANALYSIS BY PCP", 12/28/99.

in April 2003. The report in and of itself is a major accomplishment and reflects the spirit of cooperation that the RHC has fostered among community providers and local governmental units. In completing this report, the RHC has addressed one of the major problems identified by the Indigent Task Force and The Lewin Group – a lack of a central source of information for data in the region. Other accomplishments to date reported by the RHC include meeting each of the milestones set forth in the project timeline submitted to the CMS for approval. These include the following:

WAIVER MILESTONE	STATUS
ConnectCare catalogs usage and costs between hospital, clinic, specialty care, pharmacy, dialysis, urgent care and other.	***Completed.*** Report submitted to state Division of Medical Services (DMS), and shared with RHC.
RHC forms Planning Work Groups to review regional health care issues.	***Completed.*** Three Planning Work Groups Formed in August 2003: Access to Care/Care Coordination; Community Health, and Measurement. Groups have been meeting bi-monthly. See attachment for rosters and Workgroup milestones.
RHC begins compiling and analyzing area data for use in planning, making recommendations, and marshaling resources.	***Completed.*** Primary data for over 50 key indicators collected from City, County and State health departments, Medicaid and managed care plans, and area hospitals. Over 150 detailed surveys of all area safety net providers sent, received, and analyzed.
ConnectCare completes a system redesign plan. This planning includes the phase-out and closing of hospital beds and the surrendering of their hospital license.	***Completed.*** ConnectCare closed inpatient unit and emergency room on December 15, 2002, and opens an urgent care center available 7 days/week, 9:00 AM to 9:00 PM.
DSH funding flows from DFA to ConnectCare.	***Completed.***
St. Louis Regional Health Commission completes and approves situational analysis document.	***Completed March 2003*** Public Release April 10, 2003
ConnectCare begins implementation of system redesign plan.	***Completed.***
St. Louis Regional Health Commission begins work on its conceptual framework document.	***Began March 2003***

[6] This figure was estimated by The Lewin Group, Inc. using a proprietary simulation model.

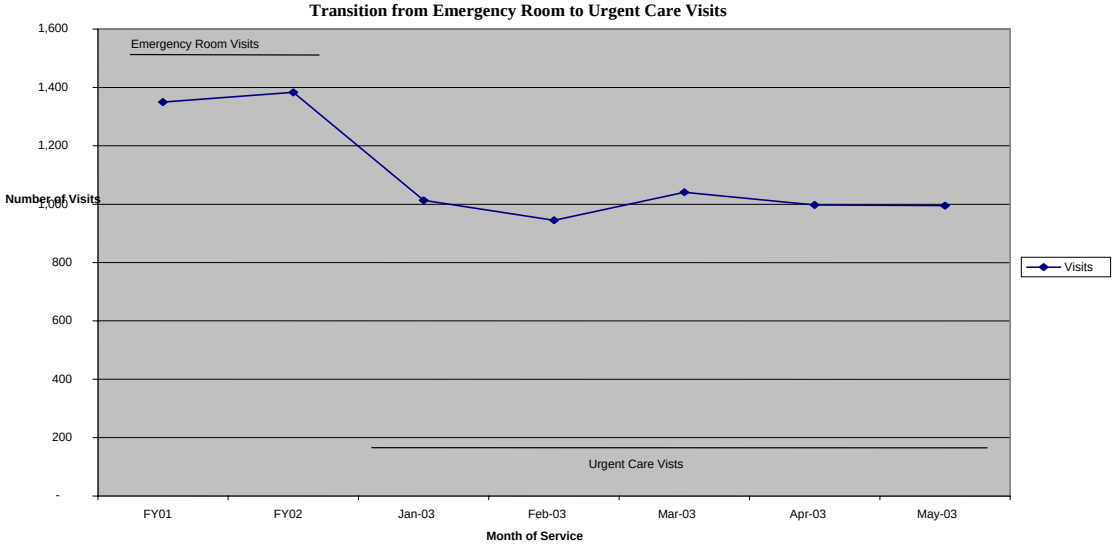
The remaining part of this discussion provides a description of health care utilization at ConnectCare during the transition from an inpatient facility to an outpatient and the health status of the population at the time the waiver amendment was implemented.

THE TRANSITION

One of the initial challenges for the region is to maintain access to services while the RHC is completing its planning process. ConnectCare plays a key role in making this happen. In addition to continuing to operate its four clinics, ConnectCare has successfully transitioned from an inpatient facility to an outpatient facility. ConnectCare closed its emergency room and hospital in December 2002, in accordance with the requirements of the waiver, and subsequently opened an urgent care center with extended hours of operation. In doing so, they are addressing one of the barriers to care in the St. Louis Region identified by the RHC – limited access to after-hours care.

Before closing the emergency room at ConnectCare, there were approximately 1,383 visits per month during the period July 1, 2001 through June 30, 2002. Since the first full month of operation of the urgent care center, there have been an average of 998 visits per month (See Table 6). Although the Urgent Care Center's utilization is not equal to that of the emergency room before it closed, this may be attributable to a number of factors including shorter hours of operation and the appropriate redirection of care to clinics or emergency rooms. While the emergency room was open 24 hours a day, seven days a week, the Urgent Care Center's hours of operation are from 12:00 p.m. to 7:00 p.m. It should also be noted that the urgent care center is currently not serving children. The capacity to serve children will be added in the next few months and utilization will undoubtedly increase as a result. Figure 17 shows the average number of emergency room visits and urgent care visits by month.

Figure 17
Transition from Emergency Room to Urgent Care Visits



In fact, after adjustments for under-reporting of visits with missing evaluation and management codes, the number of provider visits at ConnectCare clinics since the implementation of the waiver amendment are up slightly from 2002. The figures shown for 2003 include urgent care visits.

CLINIC	2003* July 1, 2002 – June 26, 2003	2002 July 1, 2001 – June 30, 2002	2001 July 1, 200 – June 30, 2001
Courtney		21,636	21,090
Hill		8,855	7,624
Phillips		18,568	18,974
Starkloff		25,834	29,424
Delmar		24,078	23,288
TOTAL	96,312 +Est. Unreported 4,000 **100,312**	**98,971**	**100,400**

*Results by clinic are available for 2003. Timing of data extract precluded our ability to incorporate results by clinic in this report.
**An estimated 4,000 visits missing evaluation and management codes were not captured in July 1, 2002 – June 26, 2003 figures.

The RHC reports that area hospital emergency departments provide a substantial amount of non-emergent care that could be delivered more cost effectively in a primary care setting to safety net patients – an average of 219 patients per day, half of whom arrive for

care after 4.pm. In total, the RHC reports, 79,910 uninsured and Medicaid patients were seen for non-emergent problems in hospital emergency departments, which accounts for 16% of all ambulatory encounters. Accordingly, the potential impact of the new urgent care center at ConnectCare may go beyond simply re-directing ConnectCare patients and also reduce the volume of emergency room visits at other facilities in the region. Future evaluations should examine whether patients currently accessing the emergency room for non-emergent conditions have been successfully redirected to more cost-effective settings including area clinics, including the urgent care center, for services.

Health Status

The report "Building a Healthier Saint Louis" goes a long way towards establishing baseline information to be used in future evaluations for assessing the impact of the waiver amendment on the region as a whole. As stated by the authors, one of the three main reasons for writing the report was "to provide a 'snapshot' of where we stand regarding health outcomes, health disparities, and the integrity of the health care safety net as it currently is organized and financed". This snapshot reveals that there are wide disparities in health status, particularly with respect to areas of St. Louis City and Northern St. Louis County and persons with lower incomes and less education. The greatest disparities are seen in birth-related indicators, including lack of early prenatal care and low infant birth weight.

Percentage of Birth Mothers with no 1st Trimester Prenatal Care

City:	18.3%
County:	8.0%
State:	12.2%
US:	6.3%

RHC, 1999 – 2001 Avg.
Page 79

Low Birth Weight <2,500 grams

City:	11.6%
County:	8.2%
State:	7.7%
US:	7.6%

1999 – 2001 Avg.
RHC, Page 83

The RHC also found that African-Americans in the region have a poorer health status than Whites for most outcomes examined, with the greatest disparities occurring in teen births, low birth weight, lack of first trimester prenatal care, homicide, tuberculosis, prostate cancer mortality and diabetes mortality.

HEALTH DISPARITIES

INDICATOR	BLACK	WHITE
Age Adjusted Diabetes Mortality Rate per 100,000 *1999 – 2001 avg.* *RHC, P. 101*	City: 53.4 County: 37.7 State: 49.6 US: 49.2	City: 31.1 County: 21.9 State: 23.9 US: 23.3
Prostate Cancer Mortality Rates per 100,000 *1999 – 2001 avg.* *RHC, P. 109*	City: 17.7 County: 18.5 State: 20.5 US: 23.4	City: 10.5 County: 8.8 State: 9.6 US: 10.7
Low Birth Weight <2,500 grams *1999-2001 avg.* *RHC, P.83*	City: 14.3% County: 12.9% State: 13.2% US: 13.0%	City: 7.5% County: 6.4% State: 6.7% US: 6.6%
Very Low Birth Weight <1,500 grams *1999-2001 avg.* *RHC, P.87*	City: 3.5% County: 3.0% State: 3.1% US: 3.1%	City: 1.4% County: 1.0% State: 1.2% US: 1.1%
Teen Pregnancy 10 to 17 *1999-2001* *Birth Cert. Records.* *RHC, P. 63*	City: 10.5% County: 7.2% State: 8.9% US: 7.8%	City: 2.7% County: 1.4% State: 3.4% US: 3.5%
TB PER 100,000 *1999-2001avg.* *RHC, P. 121*	City: 17.2 County: 7.3 State: 12.4 US: 15.2	City: 5.2 County: 1.1 State: 1.7 US: 1.9

There are a number of issues that contribute to poor health outcomes including barriers to accessing health care services, provider shortages and a lack of care coordination within health care systems. Although the RHC concludes that there is sufficient primary care capacity in the St. Louis Region, enough for up to 915,840 primary care visits per year, only 437,022 visits occurred relative to the projected need of 552,600[7]. In this case, barriers to care are more likely to be of the types identified by RHC as system barriers (e.g., hours of operation, financial barriers (e.g., lack of insurance) and cultural barriers (e.g., cultural and linguistic barriers). Other studies have demonstrated that uninsured adults and children are less likely to receive preventive care and more likely to be hospitalized for preventable conditions. But in the case of the specialty care, the RHC finds that the demand for subspecialty care "is significantly greater than existing safety-net capacity" even though they estimate a shortage of 246,400 subspecialty visits, indicating a shortage of providers – at least a shortage of providers who are willing to see

[7] The authors recognize that the number of primary care visits are likely underestimated due to the fact that data does not include visits to community primary care providers.

safety-net patients. Likewise, there is a shortage of dentists and limited availability of psychiatric and substance abuse services.

Summary and Conclusions

The transition of ConnectCare from an inpatient facility to an outpatient facility was a key step in ensuring the success of the St. Louis Waiver Amendment and provides a foundation for addressing many of the barriers of care that are impacting the health status of certain populations in the region. However, this is only the first-step in a series of initiatives that need to be accomplished in order to transition the safety net system of care for the medically indigent to a viable, self-sustaining model. As the year in which the RHC will develop the strategic plan that will guide the transition of the system of care, calendar year 2003, will be the turning point of the Amendment. The ability of the RHC to maintain collaboration among providers and local governmental units as they move from a process phase of the waiver timeline into the implementation and outcomes phases will be integral to their success and their ability to get to specific solutions for improving access, enhancing coordination of care, and achieving cost effectiveness to be included in the RHC's strategic plan.

Table 1

Under 18 years	All Types of Coverage						Government-Based						Uninsured			
	Private or Govt.		Private		Employment - Based		Medicaid		Medicare		Military		Not Covered		% Uninsured	
Year	MO	USA	MO	USA	MO	USA	MO	USA	MO	USA	MO	USA	MO	USA	MO	USA
1990	1,267	56,786	1,038	46,436	897	39,981	270	12,094	-	88	22	2,408	191	8,504	13%	13.0%
1991	1,035	57,794	866	46,114	755	39,683	198	13,514	-	52	-	2,425	170	8,379	14%	12.7%
1992	1,170	60,005	937	47,183	797	40,382	263	15,109	3	97	32	2,378	176	8,716	13%	12.7%
1993	1,251	60,192	992	47,017	860	39,745	326	16,693	4	48	51	2,307	129	9,574	9%	13.7%
1994	1,087	60,505	843	46,266	814	42,966	283	16,132	-	228	32	2,708	117	10,003	10%	14.2%
1995	1,077	61,353	907	47,021	823	43,822	207	16,524	3	348	50	2,336	181	9,795	14%	13.8%
1996	1,264	60,670	1,000	47,219	871	44,054	333	15,502	16	484	23	2,291	168	10,554	12%	14.8%
1997	1,187	60,939	978	47,968	873	44,869	225	14,683	4	395	24	2,163	178	10,743	13%	15.0%
1998	1,263	60,949	1,016	48,627	949	45,593	287	14,274	11	325	48	2,240	123	11,073	9%	15.4%
1999	1,353	62,302	1,104	49,822	1,007	46,594	299	14,479	4	355	41	2,080	78	10,023	5%	13.9%
1999[1]	1,383	63,180	1,123	50,606	1,023	47,127	310	14,572	4	359	41	2,083	48	9,145	3%	12.6%
2000[2]	1,338	64,148	1,081	51,193	972	48,082	285	14,739	16	517	23	2,133	124	8,405	9%	11.6%
2000[3]	1,324	63,697	1,109	50,499	1,009	47,431	252	15,090	9	518	31	2,563	101	8,617	7%	11.9%
2001	1,337	64,118	1,079	49,647	1,002	46,439	335	16,502	6	423	24	2,381	66	8,509	5%	11.7%
% Change from 1998 - 1999	7.13%	2.22%	8.66%	2.46%	6.11%	2.20%	4.18%	1.44%	-63.64%	9.23%	-14.58%	-7.14%	-36.59%	-9.48%	-39%	-9.74%
% Change from 1998 - 1999[1]	9.50%	3.66%	10.53%	4.07%	7.80%	3.36%	8.01%	2.09%	-63.64%	10.46%	-14.58%	-7.01%	-60.98%	-17.41%	-63%	-18.18%
% Change from 1999 - 2000[2]	-1.11%	2.96%	-2.08%	2.75%	-3.48%	3.19%	-4.68%	1.80%	300.00%	45.63%	-43.90%	2.55%	58.97%	-16.14%	57%	-16.55%
% Change from 1999[1] - 2000[3]	-4.27%	0.82%	-1.25%	-0.21%	-1.37%	0.65%	-18.71%	3.55%	125.00%	44.29%	-24.39%	23.04%	110.42%	-5.77%	115%	-5.56%
% Change from 2000 - 2001	-0.07%	-0.05%	-0.19%	-3.02%	3.09%	-3.42%	17.54%	11.96%	-62.50%	-18.18%	4.35%	11.63%	-46.77%	1.24%	-45%	0.86%
% change from 2000[3] - 2001	0.98%	0.66%	-2.71%	-1.69%	-0.69%	-2.09%	32.94%	9.36%	-33.33%	-18.34%	-22.58%	-7.10%	-34.65%	-1.25%	-34%	-1.68%
% Change from 1998 - 2001	5.86%	5.20%	6.20%	2.10%	5.58%	1.86%	16.72%	15.61%	-45.45%	30.15%	-50.00%	6.29%	-46.34%	-23.16%	-47%	-24.03%

U.S. Census Bureau, Historical Health Insurance Tables, Table HI-3. Health Insurance Coverage Status and Type of Coverage--Children Under 18 by Age: 1987 to 2001
http://www.census.gov/hhes/hlthins/historic/hihistt3.html

1/ Estimates reflect the results of follow-up verification questions.

2/ Based on a November 2001 weighting correction.

3/ Implementation of Census 2000 based population controls. Sample expanded by 28,000 households.

Table 2

Adults between the ages of 18 & 65 Years Old	All Types of Coverage						Government-Based						Uninsured			
	Private or Govt.		Private		Employment - Based		Medicaid		Medicare		Military		Not Covered		% Uninsured	
Year	MO	USA	MO	USA	MO	USA	MO	USA	MO	USA	MO	USA	MO	USA	MO	USA
1990	2,729	127,565	2,498	115,133	2,188	100,232	191	9,585	53	3,377	88	6,363	469	25,939	14.67%	16.90%
1991	2,773	127,908	2,592	114,546	2,284	100,280	174	10,475	60	3,477	36	6,217	441	26,777	13.72%	17.31%
1992	2,590	128,102	2,347	113,639	2,035	98,470	198	11,438	86	3,843	72	5,969	546	29,576	17.42%	18.76%
1993	2,650	129,432	2,418	115,009	2,123	98,626	209	12,347	77	3,659	97	6,045	496	29,775	15.76%	18.70%
1994	2,643	130,904	2,408	116,793	2,238	105,598	194	12,638	93	3,496	83	6,907	505	29,425	16.04%	18.35%
1995	2,684	131,021	2,494	117,106	2,193	106,494	157	12,533	67	3,786	98	5,888	571	30,486	17.54%	18.88%
1996	2,588	132,866	2,409	118,952	2,138	108,219	190	12,733	84	4,126	72	5,423	529	30,825	16.97%	18.83%
1997	2,690	132,958	2,469	119,877	2,246	109,259	173	11,372	103	4,325	52	5,240	488	32,372	15.36%	19.58%
1998	2,884	134,477	2,681	122,063	2,452	111,833	179	10,619	72	4,476	67	5,321	447	32,850	13.43%	19.63%
1999	3,046	137,032	2,817	124,723	2,563	114,260	243	10,494	67	4,480	54	5,217	389	32,108	11.32%	18.98%
1999[1]	3,103	139,281	2,866	126,716	2,600	115,682	246	10,732	72	4,493	54	5,248	331	29,859	9.64%	17.65%
2000[2]	2,981	140,976	2,786	128,765	2,540	118,044	186	10,582	75	4,777	34	4,806	462	30,033	13.41%	17.56%
2000[3]	3,055	142,642	2,821	129,860	2,592	119,138	230	11,105	102	4,933	75	5,126	421	30,935	12.11%	17.82%
2001	2,960	143,259	2,686	129,461	2,429	118,467	252	11,828	99	5,162	84	5,015	498	32,426	14.40%	18.46%
% Change from 1998 - 1999	5.62%	1.90%	5.07%	2.18%	4.53%	2.17%	35.75%	-1.18%	-6.94%	0.09%	-19.40%	-1.95%	-12.98%	-2.26%	-15.66%	-3.31%
% Change from 1998 - 1999[1]	7.59%	3.57%	6.90%	3.81%	6.04%	3.44%	37.43%	1.06%	0.00%	0.38%	-19.40%	-1.37%	-25.95%	-9.11%	-28.24%	-10.08%
% Change from 1999 - 2000[2]	-2.13%	2.88%	-1.10%	3.24%	-0.90%	3.31%	-23.46%	0.84%	11.94%	6.63%	-37.04%	-7.88%	18.77%	-6.46%	18.46%	-7.48%
% Change from 1999[1] - 2000[3]	-1.55%	2.41%	-1.57%	2.48%	-0.31%	2.99%	-6.50%	3.48%	41.67%	9.79%	38.89%	-2.32%	27.19%	3.60%	25.65%	0.92%
% Change from 2000[2] - 2001	-0.70%	1.62%	-3.59%	0.54%	-4.37%	0.36%	35.48%	11.77%	32.00%	8.06%	147.06%	4.35%	7.79%	7.97%	7.36%	5.09%
% Change from 2000[2] - 2001	-3.11%	0.43%	-4.79%	-0.31%	-6.29%	-0.56%	9.57%	6.51%	-2.94%	4.64%	12.00%	-2.17%	18.29%	4.82%	18.94%	3.60%
% Change from 1998 - 2001	2.64%	6.53%	0.19%	6.06%	-0.94%	5.93%	40.78%	11.39%	37.50%	15.33%	25.37%	-5.75%	11.41%	-1.29%	7.25%	-5.99%

U.S. Census Bureau, Health Insurance Historical Tables, Table HI-6. Health Insurance Coverage Status and Type of Coverage by State--People Under 65: 1987 to 2001
http://www.census.gov/hhes/hlthins/historic/hihistt6.html
U.S. Census Bureau, Historical Health Insurance Tables, Table HI-3. Health Insurance Coverage Status and Type of Coverage--Children Under 18 by Age: 1987 to 2001
http://www.census.gov/hhes/hlthins/historic/hihistt3.html

1/ Estimates reflect the results of follow-up verification questions.

2/ Based on a November 2001 weighting correction.

3/ Implementation of Census 2000 based population controls. Sample expanded by 28,000 households.

Table 3

Non-Elderly - All People Under the Age of 65 Years Old	All Types of Coverage						Government-Based						Uninsured			
	Private or Govt.		Private		Employment - Based		Medicaid		Medicare		Military		Not Covered		% Uninsured	
Year	MO	USA	MO	USA	MO	USA	MO	USA	MO	USA	MO	USA	MO	USA	MO	USA
1990	3,996	184,351	3,536	161,569	3,085	140,213	461	21,679	53	3,465	110	8,771	660	34,443	14.2%	15.7%
1991	3,808	185,702	3,458	160,660	3,039	139,963	372	23,989	60	3,529	36	8,642	611	35,156	13.8%	15.9%
1992	3,760	188,107	3,284	160,822	2,832	138,852	461	26,547	89	3,940	104	8,347	722	38,292	16.1%	16.9%
1993	3,901	189,624	3,410	162,026	2,983	138,371	535	29,040	81	3,707	148	8,352	625	39,349	13.8%	17.2%
1994	3,730	191,409	3,251	163,059	3,052	148,564	477	28,770	93	3,724	115	9,615	622	39,428	14.3%	17.1%
1995	3,761	192,374	3,401	164,127	3,016	150,316	364	29,057	70	4,134	148	8,224	752	40,281	16.7%	17.3%
1996	3,852	193,536	3,409	166,171	3,009	152,273	523	28,235	100	4,610	95	7,714	697	41,379	15.3%	17.6%
1997	3,877	193,897	3,447	167,845	3,119	154,128	398	26,055	107	4,720	76	7,403	666	43,115	14.7%	18.2%
1998	4,147	195,426	3,697	170,690	3,401	157,426	466	24,893	83	4,801	115	7,561	570	43,923	12.1%	18.4%
1999	4,399	199,334	3,921	174,545	3,570	160,854	542	24,973	71	4,835	95	7,297	467	42,131	9.6%	17.4%
1999[1]	4,486	202,461	3,989	177,322	3,623	162,809	556	25,304	76	4,852	95	7,331	379	39,004	7.8%	16.2%
2000[2]	4,319	205,124	3,867	179,958	3,512	166,126	471	25,321	91	5,294	57	6,939	586	38,438	12.0%	15.8%
2000[3]	4,379	206,339	3,930	180,359	3,601	166,569	482	26,195	111	5,451	106	7,689	522	39,552	10.7%	16.1%
2001	4,297	207,377	3,765	179,108	3,431	164,906	587	28,330	105	5,585	108	7,396	564	40,935	11.6%	16.5%
% Change from 1998 - 1999	6.08%	2.00%	6.06%	2.26%	4.97%	2.18%	16.31%	0.32%	-14.46%	0.71%	-17.39%	-3.49%	-18.07%	-4.08%	-20.6%	-4.9%
% Change from 1998 - 1999[1]	8.17%	3.60%	7.90%	3.89%	6.53%	3.42%	19.31%	1.65%	-8.43%	1.06%	-17.39%	-3.04%	-33.51%	-11.20%	-35.47%	-11.72%
% Change from 1999 - 2000[2]	-1.82%	2.90%	-1.38%	3.10%	-1.62%	3.28%	-13.10%	1.39%	28.17%	9.49%	-40.00%	-4.91%	25.48%	-8.77%	25.0%	-9.6%
% Change from 1999[1] - 2000[3]	-2.39%	1.92%	-1.48%	1.71%	-0.61%	2.31%	-13.31%	3.52%	46.05%	12.35%	11.58%	4.88%	37.73%	1.40%	37.18%	-0.62%
% Change from 2000[2] - 2001	-0.51%	1.10%	-2.64%	-0.47%	-2.31%	-0.73%	24.63%	11.88%	15.38%	5.50%	89.47%	6.59%	-3.75%	6.50%	-3.3%	4.5%
% Change from 2000[3] - 2001	-1.87%	0.50%	-4.20%	-0.69%	-4.72%	-1.00%	21.78%	8.15%	-5.41%	2.46%	1.89%	-3.81%	8.05%	3.50%	8.44%	2.39%
% Change from 1998 - 2001	3.62%	6.12%	1.84%	4.93%	0.88%	4.75%	25.97%	13.81%	26.51%	16.33%	-6.09%	-2.18%	-1.05%	-6.80%	-4.0%	-10.2%

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1/ Estimates reflect the results of follow-up verification questions.

2/ Based on a November 2001 weighting correction.

3/ Implementation of Census 2000 based population controls. Sample expanded by 28,000 households.

Table 4

1115 Waiver Enrollment for Children

	Sept. 2001	Oct. 2001	Nov. 2001	Dec. 2001	Jan. 2002	Feb. 2002	Mar. 2002	Apr. 2002	May. 2002	Jun. 2002	Jul. 2002	Aug. 2002	Aug. 2001	Aug. 2000
AREA 1-Northwest														
No Cost	8,565	8,645	8,681	8,654	8,763	8,674	8,506	8,489	8,444	8,383	8,548	8,528	8,420	7,147
Copay	2,231	2,306	2,399	2,435	2,473	2,503	2,250	2,305	2,331	2,324	2,362	2,405	2,167	1,822
Premium	529	519	503	487	494	470	420	428	440	440	432	422	582	555
TOTAL	**11,325**	**11,470**	**11,583**	**11,576**	**11,730**	**11,647**	**11,176**	**11,222**	**11,215**	**11,147**	**11,342**	**11,355**	**11,169**	**9,524**
AREA 2-Northeast														
No Cost	8,865	9,049	9,198	9,208	9,284	9,192	9,077	9,117	9,163	9,086	9,234	9,175	8,827	7,662
Copay	2,254	2,319	2,359	2,407	2,438	2,506	2,229	2,286	2,346	2,388	2,422	2,452	2,190	1,799
Premium	390	400	402	381	382	380	358	391	370	366	405	409	450	438
TOTAL	**11,509**	**11,768**	**11,959**	**11,996**	**12,104**	**12,078**	**11,664**	**11,794**	**11,879**	**11,840**	**12,061**	**12,036**	**11,467**	**9,899**
AREA 3-Southeast														
No Cost	8,863	8,998	9,035	8,911	8,968	8,807	8,762	8,680	8,531	8,320	8,482	8,378	8,800	8,071
Copay	2,263	2,362	2,432	2,397	2,422	2,497	2,223	2,332	2,338	2,350	2,385	2,386	2,192	1,691
Premium	405	422	431	409	393	380	333	348	369	369	383	400	452	492
TOTAL	**11,531**	**11,782**	**11,898**	**11,717**	**11,783**	**11,684**	**11,318**	**11,360**	**11,238**	**11,039**	**11,250**	**11,164**	**11,444**	**10,254**
AREA 4-Southwest														
No Cost	15,847	16,077	16,190	15,936	16,006	15,956	15,698	15,766	15,704	15,629	16,083	16,091	15,692	13,964
Copay	3,527	3,739	3,773	3,827	3,899	4,027	3,672	3,799	3,863	3,949	4,011	4,096	3,410	3,010
Premium	715	724	732	720	712	677	555	588	591	593	615	608	794	817
TOTAL	**20,089**	**20,540**	**20,695**	**20,483**	**20,617**	**20,660**	**19,925**	**20,153**	**20,158**	**20,171**	**20,709**	**20,795**	**19,896**	**17,791**
AREA 5-Kansas City														
No Cost	7,061	7,137	7,237	7,202	7,253	7,208	7,080	7,203	7,289	7,227	7,341	7,372	7,019	6,014
Copay	1,605	1,640	1,725	1,730	1,763	1,747	1,578	1,663	1,676	1,697	1,716	1,722	1,603	1,363
Premium	423	395	391	374	373	360	319	293	297	287	282	259	458	399
TOTAL	**9,089**	**9,172**	**9,353**	**9,306**	**9,389**	**9,315**	**8,977**	**9,159**	**9,262**	**9,211**	**9,339**	**9,353**	**9,080**	**7,776**
AREA 6-St. Louis City														
No Cost	4,031	4,072	4,080	4,100	4,154	4,185	4,072	4,091	4,117	4,221	4,234	4,444	3,990	3,328
Copay	770	817	831	822	835	851	769	764	779	771	776	793	768	659
Premium	152	153	149	137	135	120	110	116	119	125	138	128	160	143
TOTAL	**4,953**	**5,042**	**5,060**	**5,059**	**5,124**	**5,156**	**4,951**	**4,971**	**5,015**	**5,117**	**5,148**	**5,365**	**4,918**	**4,130**
AREA 7-St. Louis Cnty														
No Cost	5,878	6,016	6,097	6,104	6,189	6,229	6,179	6,257	6,326	6,377	6,548	6,610	5,758	4,531
Copay	1,227	1,285	1,312	1,334	1,350	1,376	1,193	1,239	1,251	1,266	1,304	1,365	1,202	833
Premium	255	252	248	236	223	216	194	183	183	190	196	196	287	206
TOTAL	**7,360**	**7,553**	**7,657**	**7,674**	**7,762**	**7,821**	**7,566**	**7,679**	**7,760**	**7,833**	**8,048**	**8,171**	**7,247**	**5,570**
STATE WIDE														
No Cost	59,110	59,994	60,518	60,115	60,617	60,251	59,374	59,603	59,574	59,243	60,470	60,598	58,506	50,717
Copay	13,877	14,468	14,831	14,952	15,180	15,507	13,914	14,388	14,584	14,745	14,976	15,219	13,532	11,177
Premium	2,869	2,865	2,856	2,744	2,712	2,603	2,289	2,347	2,369	2,370	2,451	2,422	3,183	3,050
TOTAL	**75,856**	**77,327**	**78,205**	**77,811**	**78,509**	**78,361**	**75,577**	**76,338**	**76,527**	**76,358**	**77,897**	**78,239**	**75,221**	**64,944**

Table 5

Calendar Years 1999-2001 CHIP Indicator Rates Compared with Medicaid and Non-Medicaid Regional Rates

			Medicaid MC+ Region									
			Number					*Rate*				
			Eastern	*Central*	*Western*	*Other*	*State*	*Eastern*	*Central*	*Western*	*Other*	*State*
Asthma hospitalizations <19	1999	CHIP	37	6	24	27	94	4.58	1.30	2.90	1.22	2.18
		Any Medicaid	998	106	297	453	1,854	7.77	3.20	4.07	2.78	4.66
		Non-Medicaid	572	96	223	250	1,141	1.49	0.95	1.03	0.84	1.14
		"other Medicaid"	961	100	273	426	1,760	7.98	3.51	4.22	3.03	4.97
	2000	CHIP	58	14	36	54	162	4.74	2.28	3.26	1.84	2.76
		Any Medicaid	1,003	121	358	450	1,981	7.32	3.31	4.55	2.57	4.64
		Non-Medicaid	497	89	245	262	1,136	1.31	0.93	1.16	0.91	1.17
		"other Medicaid"	945	107	322	396	1,819	7.57	3.52	4.76	2.72	4.94
	2001	CHIP	45	12	26	48	131	2.52	1.62	1.90	1.51	1.85
		Any Medicaid	711	92	248	387	1,438	4.34	2.20	2.77	2.12	3.01
		Non-Medicaid	515	87	245	347	1,194	1.43	0.96	1.20	1.21	1.27
		"other Medicaid"	666	80	222	339	1,307	4.57	2.32	2.92	2.25	3.21
Asthma emergency room visits <19	1999	CHIP	203	43	126	207	579	25.11	9.34	15.21	9.34	13.42
		Any Medicaid	4,833	471	2,013	1,957	9,274	37.63	14.23	27.58	12.01	23.33
		Non-Medicaid	3,125	356	1,359	1,175	6,015	8.12	3.52	6.26	3.93	6.00
		"other Medicaid"	4,630	428	1,887	1,750	8,695	38.47	15.02	29.17	12.43	24.54
	2000	CHIP	222	38	167	220	647	18.13	6.19	15.12	7.51	11.02
		Any Medicaid	4,689	468	2,045	1,855	9,057	34.22	12.80	26.00	10.60	21.20
		Non-Medicaid	2,837	300	1,299	1,099	5,535	7.49	3.13	6.16	3.83	5.69
		"other Medicaid"	4,467	430	1,878	1,635	8,410	35.80	14.13	27.77	11.22	22.82
	2001	CHIP	315	38	185	247	803	17.66	5.14	13.54	7.76	11.35
		Any Medicaid	3,936	377	1,830	1,518	7,661	24.05	9.00	20.42	8.33	16.05
		Non-Medicaid	3,166	327	1,422	1,128	6,043	8.77	3.60	6.95	3.94	6.41
		"other Medicaid"	3,621	339	1,645	1,271	6,858	24.83	9.82	21.66	8.45	16.86
Emergency Visits <19	1999	CHIP	3,761	2,030	3,513	11,839	21,143	465.18	440.73	424.07	534.03	490.06
		Any Medicaid	84,572	23,078	48,814	128,639	285,103	658.45	697.16	668.88	789.58	717.34
		Non-Medicaid	102,215	24,207	59,699	101,537	287,658	265.49	239.67	275.11	339.59	287.08
		"other Medicaid"	80,811	21,048	45,301	116,800	263,960	671.43	738.60	700.22	829.83	745.02
	2000	CHIP	4,501	2,416	4,289	15,998	27,204	367.61	393.42	388.36	546.34	463.35
		Any Medicaid	81,661	24,220	48,196	125,851	279,928	595.97	662.26	612.67	719.26	655.22
		Non-Medicaid	102,625	25,341	66,433	102,165	296,564	270.78	263.97	314.85	355.98	304.79
		"other Medicaid"	77,160	21,804	43,907	109,853	252,724	618.38	716.51	649.31	754.02	685.78
	2001	CHIP	7,852	3,398	5,779	16,380	33,409	440.26	459.44	422.84	514.38	472.27
		Any Medicaid	86,989	24,524	45,150	107,989	264,652	531.47	585.14	503.87	592.50	554.30
		Non-Medicaid	128,507	29,956	78,702	104,050	341,215	355.98	329.91	384.66	363.42	361.95
		"other Medicaid"	79,137	21,126	39,371	91,609	231,243	542.63	612.08	518.45	609.03	568.57
Preventable hospitalizations <19	1999	CHIP	73	22	61	179	335	9.03	4.78	7.36	8.07	7.76
		Any Medicaid	1,851	368	783	2,133	5,135	14.41	11.12	10.73	13.09	12.92
Rates are per		Non-Medicaid	1,664	354	788	1,311	4,117	4.32	3.50	3.63	4.38	4.11
1,000 population.		"other Medicaid"	1,778	346	722	1,954	4,800	14.77	12.14	11.16	13.88	13.55
For non-CHIP	2000	CHIP	110	59	94	297	560	8.98	9.61	8.51	10.14	9.54
		Any Medicaid	2,048	489	949	2,813	6,299	14.95	13.37	12.06	16.08	14.74
		Non-Medicaid	2,095	532	1,141	2,122	5,890	5.53	5.54	5.41	7.39	6.05
		"other Medicaid"	1,938	430	855	2,516	5,739	15.53	14.13	12.64	17.27	15.57
	2001	CHIP	156	55	74	303	588	8.75	7.44	5.41	9.52	8.31
		Any Medicaid	1,773	404	731	2,297	5,205	10.83	9.64	8.16	12.60	10.90
Source: Missouri Dept. of Health		Non-Medicaid	2,954	709	1,361	2,854	7,878	8.18	7.81	6.65	9.97	8.36
and Senior Services 10-9-02		"other Medicaid"	1,617	349	657	1,994	4,617	11.09	10.11	8.65	13.26	11.35

Table 6

St. Louis ConnectCare
Urgent Care Center Utilization
December 16, 2002 – May 31, 2003

PAYOR	DECEMBER 2002 PATIENTS	JANUARY 2003 PATIENTS	FEBRUARY 2003 PATIENTS	MARCH 2003 PATIENTS	APRIL 2003 PATIENTS	MAY 2003 PATIENTS
AETNA	0	1	1	1	1	2
ATTY	2	4	4	0	0	0
BCBS	7	9	5	8	8	8
MC+CHIP	1	2	4	5	1	1
COMMERCIAL	7	19	11	11	9	14
DOH	10	21	28	14	14	8
HOMELESS	18	26	19	20	25	29
INDIGENT	116	188	186	187	161	178
LOCAL	2	5	3	2	2	4
MC+	50	90	103	107	108	118
MEDICAID	63	131	120	149	122	116
MEDICARE	14	37	31	62	76	97
OTHER*	5	7	2	11	3	5
CITY POLICE	0	0	1	0	0	0
CITY PRISONER	0	0	0	1	0	0
REFSTE	0	0	0	1	2	3
SELFPAY	221	473	426	461	463	412
WORKMENS COMP	0	0	1	1	2	0
TOTAL	516	1013	945	1041	997	995

*Includes Occupational Health, Victims of Crime and Other Misc. Payors

Total Medicaid (Includes MC+ CHIP, MC+ and Mediciad)	22%	22%	24%	25%	23%	24%
Self-pay & Indigent	65%	65%	65%	62%	63%	59%
Total Safety-Net	87%	87%	89%	87%	86%	83%

Table 7.a

Saint Louis ConnectCare
Fiscal Year 2001 Provider Visits

	Courtney	Hill	Phillips	Starkloff	Delmar	2001 Total	2000 Total
Adult Medicine	7,719	4,472	8,598	13,080	2,452	38,319	
Women's Health	3,430		3,948	5,875		14,576	18,228
Pediatrics	3,828	5,162	3,047	4,548		14,576	16,228
Dental	4,338		3,664			8,002	7,157
Dermatology			1,021	896			1,917
Opthalmology	591		598	768		2,257	2,689
Podiatry	1,184		1,464	893	1,093	4,334	3,648
Cardiology					1,553	1,553	1,158
Endocrinology					78	78	198
ENT		5,162			1,896	1,896	1,973
Gastroenterology					2,232	2,232	1,781
General Surgery					2,326	2,326	2,362
Infectious Disease					1,543	1,543	1,888
Neurology					2,664	2,664	2,435
Oncology					1,720	1,720	1,396
Orthopedics					1,372	1,372	1,725
Plastic (1)							293
Hypertension					118	118	
Renal					1,471	1,471	1,263
Rheumatology					720	720	720
Urology					1,134	1,134	1,473
Total Provider Visits	**21,090**	**7,624**	**18,974**	**29,424**	**23,288**	**100,400**	**101,554**
Emregency Department						**10200**	**18494**
Inpatient Admissions						**379**	**373**
Inpatient ALOS						**2.3**	**3.1**

Table 7.b

Saint Louis ConnectCare
Fiscal Year 2002 Provider Visits

	Courtney	Hill	Phillips	Starkloff	Delmar	2001 Total	2000 Total
Adult Medicine	7,027	4,568	8,138	9,295	2,843	31,871	36,319
Women's Health	3,887	1,092	3,577	5,692	2,079	16,327	14,498
Pediatrics	3,984	2,897	3,104	4,861		14,826	14,576
Dental	5,038			3,721		8,759	8,002
Dermatology			1,305	562		2,167	1,917
Opthalmology	769		1,028	693		2,490	2,257
Podiatry	851		1,416	710	861	4,038	4,334
Family Practice		298				298	
Cardiology					1,398	1,398	1,553
Endocrinology					106	106	78
ENT					1,872	1,872	1,899
Gastroenterology					2,351	2,351	2,232
General Surgery					2,043	2,043	2,326
Infectious Disease					1,577	1,577	1,543
Neurology					2,721	2,721	2,684
Oncology					1,542	1,542	1,720
Orthopedics					1,419	1,419	1,372
Hypertension					231	231	118
Renal					1,649	1,649	1,471
Rheumatology					291	291	720
Urology					985	985	1,134
Total Provider Visits	**21,636**	**8,855**	**18,568**	**25,834**	**24,078**	**98,971**	**100,727**
Emregency Department						**16,600**	**16,600**
Inpatient Admissions						**169**	**379**
Inpatient ALOS						**2.7**	**2.3**

APPENDIX A
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