MEDICAL INDIGENCY IN IDAHO

AN ANALYSIS OF COUNTY INDIGENCY AND STATE CATASTROPHIC HEALTH CARE SERVICES

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ABOUT THE CENTER FOR HEALTH POLICY

The Center for Health Policy (CHP) is the research unit of the College of Health Sciences at Boise State University. Its purpose is to assist in the development, implementation, and evaluation of health services programs, policies and practices.

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EXECUTIVE SUMMARY

Counties are statutorily bound to pay for necessary health care for medically indigent citizens (Idaho Code §31-3501). Residents with medical expenses who lack sufficient resources to pay can apply to the county for assistance in paying those bills. County Commissioners have discretionary authority over which cases are approved for payment. In 1982, the Catastrophic Health Care Cost Program was established as an insurance program for the counties to cover the cost of treatment for catastrophic illness claims in excess of $10,000. Legislation was enacted in 1991 shifting the catastrophic program from county to state funding in FY 1994.

The Idaho State Planning Grant on the Uninsured commissioned the Center for Health Policy at Boise State University to study medical indigency services administered by Idaho counties. Fiscal year 2001 program and case abstract data from the counties were analyzed to describe the county programs, and demographic and socioeconomic characteristics of recipients, as well as expenditure levels and types of medical services paid. Thirty-nine of Idaho's 44 counties (89%) participated in the county survey, the first phase of data collection. A majority of counties (67%) participated in the case abstract phase of the study resulting in a final sample of 534 cases.

Results of the county survey demonstrate variability among the counties in numbers and types of cases approved for payment. Per capita case rates ranged from 0.0 to 13.2 cases per 1,000 in population with a median among counties of 1.7 approved cases per 1,000 population. Counties with higher per capita case rates tended to have fewer applications for payment denied. The percent of approved cases that were emergent also varied, ranging from 12% to 100% among the counties. As the proportion of approved county cases that were emergency applications increased, so did the average expenditure per case.

The typical profile of a medically indigent case is a 41-year-old single adult with an income equal to 96% of the federal poverty line. A majority (58%) of sample cases represented a family size of one. Adults without minor children in the home (categorized as childless adults) comprised the large majority of cases accounting for 77% of cases.

Cases were about as likely to be employed as not. Recipients with family income below the poverty line accounted for 56% of cases. Another 28% of cases had income between 100-185% of poverty. Over 80% of cases had total countable assets of less than $1,000.

Most cases included an inpatient hospitalization and/or emergency room service. Over three-fourths of abstracted cases were emergent with application occurring after an episode of medical service.

Total expenditure per abstracted case, excluding eligible cases that were only for medication prescriptions, averaged $13,809. The average expenditure per case paid by county funds was $6,494 while the average expenditure paid from State Catastrophic Health Care Program funds was $7,314. When prescription-only cases were included, the average county expenditure per case was $3,705.

A hypothetical health insurance program targeted to employed, uninsured adults with incomes below 185% of the poverty line could potentially have impacted as many as 34% of recipients of county and/or State Catastrophic Health Care Program medical assistance in CFY 2001 (182 of 534 cases), if the program had reached them (their employer was eligible for the product and chose to participate) and if 100% enrolled. Such a program could potentially have averted 29% of the total county-state expenditure (the portion of total expenditure accounted for by those 182 recipients).

A program targeted to uninsured adults with incomes below 185% of the poverty line regardless of employment status could potentially have impacted 84% of recipients (449 of 534 cases). Such a program could have averted combined county-state expenditures amounting to 73% of total expenditures if all cases had enrolled.

Actual impacts would be affected by program design and consumer choices. Enrollment limits, eligibility criteria, ease of enrollment, and recipient cost sharing would affect actual enrollment in a publicly subsidized health insurance program.

The poor account for a majority of medical indigency cases. Adults with incomes less than one-half the poverty level accounted for 36% of cases in the study sample. Another 20% had incomes up to the poverty threshold. Medicaid in Idaho covers only certain categories of the poor. Non-disabled adults without minor-age children in the home are not covered. Parents with income above a threshold roughly equivalent to 31% of the poverty level are likewise not eligible.

Federal Medicaid policy allows the state several options for expanding coverage to low-income persons. Should Idaho choose to implement any of these options, federal matching funds would be made available to pay at least 70% of expenditures. Exploration of strategies to capitalize on that match to expand health coverage seems warranted.

MEDICAL INDIGENCY IN IDAHO

AN ANALYSIS OF COUNTY INDIGENCY AND STATE CATASTROPHIC HEALTH CARE SERVICES

INTRODUCTION

RESEARCH PURPOSE

A study of medical indigency services administered by Idaho counties was undertaken by the Center for Health Policy at Boise State University with funding from the Idaho State Planning Grant on the Uninsured. The purpose of the research was to better understand characteristics of the county-administered programs and recipients of medical indigency services to guide further policy decision-making to expand health insurance coverage of the uninsured in Idaho.

THE COUNTY INDIGENCY/STATE CATASTROPHIC HEALTH CARE PROGRAM

Idaho counties have had the responsibility for the provision and payment of health care for their citizens dating back to Idaho Territorial Law. Over time those responsibilities have evolved into two primary mechanisms: county hospitals for the provision of care, and the county medical indigency/catastrophic fund for the payment of medical care for county residents without any other means of paying medical bills (Idaho Code §31-3501). The county pays medical bills under $10,000 in a one-year period. Bills in excess of $10,000 are referred to and paid by the state Catastrophic Health Care Cost Program. The law, rules, and operating procedures apply to both payment sources.

The County Indigency Program is incident based, meaning that only persons requiring medical treatment for a specific health condition, illness or injury are provided assistance on a per-claim basis. Essentially, county residents with medical expenses but without any private or public means of payment can apply to the county for financial assistance. There is a uniform application and standard review process in place for use by all 44 counties. The application must be submitted within 31 days of the first day of emergency medical service, but for non-emergent medical services must be submitted 10 days prior to receipt of care. Healthcare facilities must notify the county within a day of identifying a patient as potentially medically indigent and needing county support. There are set timeframes for review and decision-making, with allowances for findings of eligibility for other public or private sources of payment. Once a person applies, the county attaches an automatic lien on all real and personal property of the applicant and sets a reimbursement schedule based upon what is reasonable for the applicant's circumstances. The Clerk or designee is required to investigate and review each application submitted. The Board of County Commissioners has the

authority to approve the application and determine the level of reimbursement, if the applicant is found eligible.

Not all medical services are reimbursed. Idaho code mandates counties and the State Catastrophic Health Care Cost Program pay for "necessary medical services." Counties have discretion to determine which medical services they will pay for in addition to those deemed medically necessary; however, those services are not eligible for payment by the State Catastrophic Health Care Cost Program. Services not reimbursed by the State Catastrophic Health Care Fund include: bone marrow and organ transplants, elective and cosmetic procedures, normal pregnancies, and services provided by state, federal, or local health programs.

Medical indigency service is available to individuals who meet the medical indigency criteria and who have lived for a consecutive period of 30 days or more within Idaho. Temporary visitors are excluded. The Idaho code sets the rules to determine which county is responsible for payment if a person has lived in differing counties or is living in certain facilities within a county. The county indigency program and state catastrophic fund reimburse for medical costs only when all other sources have been exhausted. Because of this reimbursement, the amount of uncompensated care provided by hospitals and physicians is reduced.

Funding for the two programs comes from the state general fund, the Millennium Fund (tobacco company master settlement funds), and local property taxes. In state fiscal year 2001, state expenditure by the Catastrophic Health Care Cost Program was almost $12 million (Division of Financial Management, 2002). It climbed to $14.1 million in FY 2002 and is estimated to be $14.7 million in FY 2003 (Division of Financial Management, 2003). Most of the funding for the Catastrophic Program comes from the state general fund. Recently, funding has been received from the Millennium Fund to reduce the county deductible for the State Catastrophic Health Care Cost Program from $10,000 to $5,000 for tobacco-related health care costs.

Counties fund their expenses from local property taxes at about $15-17 million per year. Individuals who receive assistance also pay back into the fund. In state fiscal year 2001, the Catastrophic Fund received $1.15 million in reimbursement (Catastrophic Health Care Cost Program, 2001). The amount received by counties is unknown. Moneys reimbursed by individuals are placed back in the fund for future use.

Many counties struggle with medical indigency costs as the cost of healthcare is rising faster than county revenue. Counties are limited to no more than 3% growth in their annual property tax budgets and greater increases in medical costs come at the expense of other services.

It is hypothesized that a significant portion of medical indigency expenditure could qualify for Medicaid matching through a Medically Needy or waiver program. This would increase the funds available through federal matching, but could also change the program. Alternatively, implementation of health insurance expansions that qualify for federal Medicaid matching may have the potential to reduce the burden of medical indigency on counties and the State Catastrophic Health Care Cost Program. This research is undertaken to provide information to inform such policy deliberations.

RESEARCH QUESTIONS

The purpose of the research was to quantify aspects of the county indigency programs and to answer the following questions about recipients of medical indigency services:

1) What are the demographic and socioeconomic characteristics of recipients of medical services paid by the counties and the State Catastrophic Health Care Program?

2) What are the most prevalent diagnostic categories and service procedures for which claims are paid?

3) What are the levels of expenditure among various recipient population segments?

RESEARCH METHODS

The study period was the fiscal year for Idaho counties of October 1, 2000 through September 30, 2001. The research methodologies included a two-pronged approach:

1) A written survey was distributed to County Clerks for completion by a representative of the medical indigency program in each of Idaho's 44 counties to gather information on numbers of applicants and recipients of medical services, total expenditures, and the availability of electronic data that could be used in the research (Appendix A). Data were entered into an Excel spreadsheet for analysis and are presented in Appendix C.

2) Case abstract data on a random sample of recipients were analyzed. Information was abstracted by county personnel from the case records and recorded on a standard case abstract form for mailing to the Center for Health Policy (Appendix B). No case-identifying information was recorded

on the case abstract form. Abstracted case data were entered into an Access database, and then imported into SPSS statistical software for analysis.

County survey results were used to establish a case sample size for each county to abstract. Counties with 30 or fewer cases were instructed to abstract data on all recipients; those with more were given a specific number and asked to select every second, third, fourth, etc., case to arrive at a random sample of the specified size. Counties were instructed to omit cases that were denied, applications for payment of additional claims subsequent to a previously approved application, and cases that were for only prescription drugs. The reasoning behind exclusion of prescription-drug-only cases was that counties varied extensively in their policies concerning approval of payment for claims that were solely for prescription drugs with a small number of counties typically approving such cases. This finding was discovered from the County Survey results.

COUNTY SURVEY RESULTS

SURVEY RESPONSE RATE

- 39 of 44 counties participated in the county survey resulting in an 89% participation rate. Counties not participating in the survey were Bear Lake, Bonneville, Owyhee, Power, and Shoshone.

SURVEY FINDINGS

- A total of 5,665 applications during FY 2001 (Oct. 2000 - September 2001) were received by the 39 counties participating in the survey.
- Of those applications for payment, 43% (2,418) were denied.
- Among the counties, the proportion of applications denied ranged from 0% to 100% with a median denial rate of 46%.

- The rate of approved cases per 1,000 in county population ranged from 0.0 to 13.2 cases per 1,000. The median rate per 1,000 population among counties was 1.7 cases. Counties with high case rates included Jerome (4.1), Kootenai (13.2), Lemhi (11.4), Lincoln (4.2), and Twin Falls (3.7).

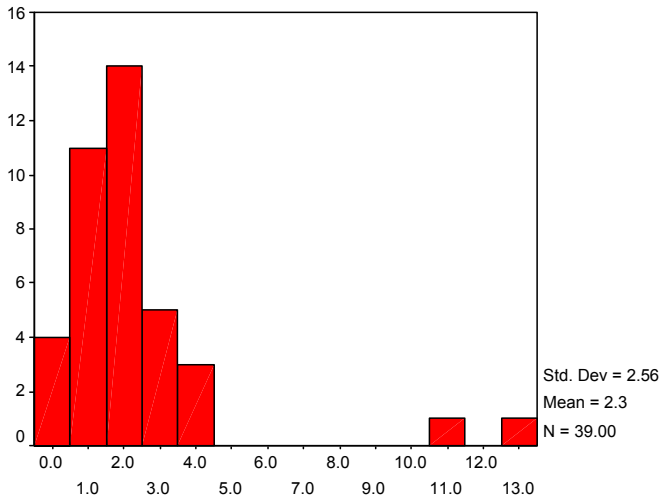

Figure 1: Number of counties by rate of cases per capita (per 1,000 population)

- There is an inverse relationship between case rate and proportion of applications denied. In other words, as the county's case rate rose, the percent of applications denied decreased (Spearman's rho correlation statistic=-0.418, p=0.008, n=39; the relationship was even stronger when 8 counties with extreme values were excluded: Spearman's rho correlation statistic=-0.585, p<0.001, n=31).

- The large majority of cases were emergent. The break down of types of cases as reported in the survey is as follows[1]:

	Number	Percent
Emergency cases	1,097	71%
Non-emergent cases	302	19%
Additional requests	88	6%
180-day delayed	65	4%

- The total reported county medical expenditure for FY 2001 was just over 12.0 million ($12,028,535). The mean county expenditure per eligible case was $3,705 when prescription-only cases were included.

[1] Percent based on 1,552 cases. Three large counties accounting for 2,004 recipient cases did not report cases by type.

- By county, average expenditure per eligible case ranged from $1,181 in Kootenai County (based on 1,430 cases) to a high of $18,823 in Gem County (based on 23 cases). The median expenditure per case among counties was $5,298.

- As the county's proportion of emergency cases increased, the average expenditure per case also increased (Spearman rho correlation statistic = 0.477, p = 0.004, n = 34).

- The most frequent kind of medical service reported as "typically not approved" for payment beyond those specified in Idaho Code (Section 31-3502(18)) was dental care (mentioned by 11 counties). Vision, hearing, and elective surgical procedures were also mentioned.

- Counties were asked to rank the most pressing health care needs to be addressed if additional funds were secured (ranked with 1 as highest priority).

	Rank Order	Average Score
Subsidized health insurance	1	1.3
Primary health care	2	2.5
Mental health care	3	2.6
Substance abuse treatment	4	3.3

- Other coverage needs mentioned were: dental, prescription drug assistance, refugee medical, general hospitalization, medical emergencies and accidents, and jail medical.

- 18 of the 39 reporting counties (46%) keep medical indigency program data in an electronic format. Fourteen counties keep both applicant and claims data electronically. Another 3 counties keep only claims data in an electronic format. All but 7 of the reporting counties maintain a log of applicants.

CASE ABSTRACT RESULTS

COUNTY PARTICIPATION IN THE CASE ABSTRACT DATA COLLECTION

- 29 counties participated in the case abstract phase of the study resulting in a participation rate of 67%. One county (Camas) did not have any eligible cases to abstract. Benewah, Bingham, Bonneville, Boundary, Butte, Canyon, Caribou, Cassia, Custer, Lemhi, Lincoln, Owyhee, Shoshone and Teton counties did not participate in the case abstract phase of the study.

Counties submitted 559 case abstracts. Of those, 23 were omitted from the study because payment had been denied, thus the case did not meet study criteria as a "recipient" of services paid by the county. Another five cases that were for payment of burial or cremation were also excluded leaving a final sample of 534 cases.

SAMPLE DEMOGRAPHICS

Despite differing time periods, characteristics of the study sample drawn from cases during the County Fiscal Year (CFY) were fairly similar to those of cases reported by the State Catastrophic Health Care Cost Program for the 2001 State Fiscal Year (SFY), with a few exceptions. Differences in the representation of recipients age 65 or greater and by diagnostic codes for mental health conditions are noted. The following table (Table 1) compares characteristics of the study sample with cases summarized for SFY 2001 by the State Catastrophic Health Care Cost Program.

Table 1: Percent of cases by demographic characteristics among study sample compared with SFY 2001 Catastrophic Health Care Cost Program Summary data

		Study Sample of County Cases CFY 2001		SFY 2001 Summary from Catastrophic Health Care Cost Program	
		Number	Percent	Number	Percent
Age					
	0-10	0	0.0	23	0.4
	11-20	43	8.1	221	4.2
	21-30	101	18.9	877	16.7
	31-40	115	21.5	1188	22.6
	41-50	135	25.3	1380	26.2
	51-64	128	24.0	1140	21.6
	65+	7	1.3	438	8.3
	Unknown	5	0.9	0	0.0
Gender					
	Male	255	47.8	2593	49.2
	Female	278	52.1	2674	50.8
Family/Household Size		Family Size		Household Size	
	1	312	58.4	2920	55.4
	2	119	22.3	1376	26.1
	3	36	6.7	450	8.5
	4+	67	12.6	521	9.9
Diagnostic Code[#]					
	10 Accident	76	14.3	501	9.5
	20 Coronary	65	12.2	339	6.4
	30 Birth	2	0.4	19	0.4
	40 Cancer	37	6.9	218	4.1
	50 Respiratory	19	3.6	113	2.1
	60 Mental Health	70	13.1	1425	27.1
	70 General	139	26.0	2045	38.8
	80 Chronic Disease	36	6.7	181	3.4
	90 Infectious Disease	8	1.5	47	0.9
	100 Neurology	4	0.7	39	0.7
	200 Digestive System	75	14.0	340	6.5
	Unknown	3	0.6	0	0.0

*Note: CFY is October-September; SFY is July-June.

[#]Diagnostic code categories established by Catastrophic Health Care Cost Program.

RECIPIENT DEMOGRAPHIC CHARACTERISTICS

- 58% of sample recipient cases had a family size of one.
- Adults comprise the vast majority of cases with 90% between ages 21 and 64. The average age among cases was 40.5 years.
- Among the sample, 96% of cases were either U.S. citizens or legal non-citizens who had resided in the U.S. greater than five years. The federal welfare reform act precludes states from claiming Medicaid matching for medical assistance provided for most categories of immigrants for the first five years of residence except for emergency services. However, since the medical services paid by the counties do not involve federal Medicaid match, the restriction does not apply to them. In fact, they are required by state statute to care for the medically indigent residents of their counties.
- 64% of cases were not married (including single, divorced, separated, or widowed).

Table 2: Study Sample of County Cases CFY 2001, N=534

	Number	Percent of Total N
Citizenship		
US Citizen	499	93.4
Not US Citizen	31	5.8
Citizenship unknown	4	0.7
If not a citizen,		
Legal non-citizen	15	2.8
Undocumented	15	2.8
Legal status unknown	1	0.2
Legal non-citizen length of res		
In US > 5 yrs	13	2.4
In US < 5 yrs	1	0.2
Length of res unknown	1	0.2
Marital status		
Married	187	35.0
Single	202	37.8
Divorced/Separated	127	23.8
Widowed	15	2.8
Unknown	3	0.6
Population group		
Child < 18	3	0.6
Parents w children <18 home	119	22.3
Adults no child <18 home	411	76.9
Unknown	1	0.2
Income as a percent of poverty		
<51%	192	36.0
51-100%	108	20.2
101-150%	101	18.9
151-185%	50	9.4
186-200%	17	3.2
>200%	59	11.0
Unknown	7	1.3
Employment at time of application		
Case employed:		
Yes	252	47.2
No	275	51.5
Unknown	7	1.3
Spouse employed		
Yes	118	22.1
No	84	15.7
Unknown or not applicable	332	62.2

RECIPIENT SOCIOECONOMICS

- Recipients with family income below the poverty line accounted for 56% of cases (Table 3). Another 28% had incomes 100-185% of the poverty line.

- Adults without minor children in the home (categorized as childless adults) comprised the large majority of cases accounting for 77% of cases. Only 3 cases in the sample were children under the age of 18.

Table 3: Poverty level group (income as percent of poverty level) by population group cross tabulation

		Population Group				Total
Poverty level group		Child <18	Parents w children	Childless Adults	Unknown	
<51%	Count		**24**	**168**		**192**
	% within Poverty level group		12.5%	87.5%		100.0%
	% within Population Group		20.2%	40.9%		36.0%
51-100%	**Count**		**48**	**60**		**108**
	% within Poverty level group		44.4%	55.6%		100.0%
	% within Population Group		40.3%	14.6%		20.2%
101-150%	**Count**		**29**	**71**	**1**	**101**
	% within Poverty level group		28.7%	70.3%	1.0%	100.0%
	% within Population Group		24.4%	17.3%	100.0%	18.9%
151-185%	**Count**	**2**	**7**	**41**		**50**
	% within Poverty level group	3.0%	14.0%	82.0%		100.0%
	% within Population Group	66.7%	5.9%	10.0%		9.4%
186-200%	**Count**		**4**	**13**		**17**
	% within Poverty level group		23.5%	76.5%		100.0%
	% within Population Group		3.4%	3.2%		3.2%
>200%	**Count**		**7**	**52**		**59**
	% within Poverty level group		11.9%	88.1%		100.0%
	% within Population Group		5.9%	12.7%		11.0%
Unknown	**Count**	**1**		**6**		**7**
	% within Poverty level group	14.3%		85.7%		100.0%
	% within Population Group	33.3%		1.5%		1.3%
Total	**Count**	**3**	**119**	**411**	**1**	**534**
	% within Poverty level group	0.6%	22.3%	77.0%	0.2%	100.0%
	% within Population Group	100.0%	100.0%	100.0%	100.0%	100.0%

- 48% of cases were employed at the time of application (Table 4).

Table 4: Employment status by poverty-level group, N=527*

Poverty level group		Employed		Total
		No	Yes	
<51%	**Count**	**147**	**40**	**187**
	% within Poverty Group	78.6%	21.4%	100.0%
	% within Employed	53.5%	15.9%	35.5%
51-99%	**Count**	**53**	**54**	**107**
	% within Poverty Group	49.5%	50.5%	100.0%
	% within Employed	19.3%	21.4%	20.3%
100-149%	**Count**	**41**	**60**	**101**
	% within Poverty Group	40.6%	59.4%	100.0%
	% within Employed	14.9%	23.8%	19.2%
150-185%	**Count**	**20**	**29**	**49**
	% within Poverty Group	40.8%	59.2%	100.0%
	% within Employed	7.3%	11.5%	9.3%
186-200%	**Count**	**1**	**16**	**17**
	% within Poverty Group	5.9%	94.1%	100.0%
	% within Employed	.4%	6.3%	3.2%
200+%	**Count**	**11**	**48**	**59**
	% within Poverty Group	18.6%	81.4%	100.0%
	% within Employed	4.0%	19.0%	11.2%
Unknown	**Count**	**2**	**5**	**7**
	% within Poverty Group	28.6%	71.4%	100.0%
	% within Employed	.7%	2.0%	1.3%
Total	**Count**	**275**	**252**	**527**
	% within Poverty Group	52.2%	47.8%	100.0%
	% within Employed	100.0%	100.0%	100.0%

* 7 cases with employment status unknown not included

- 81% of cases had total countable assets of less than $1,000 (Figure 2). Assets were counted using Idaho Medicaid methodology which omits the value of the first vehicle and also the second if it is used for employment purposes. The value of the primary home residence was not counted.

- The value of counted assets ranged from $0 to a high of $180,500 with an average of $2,072 per case.

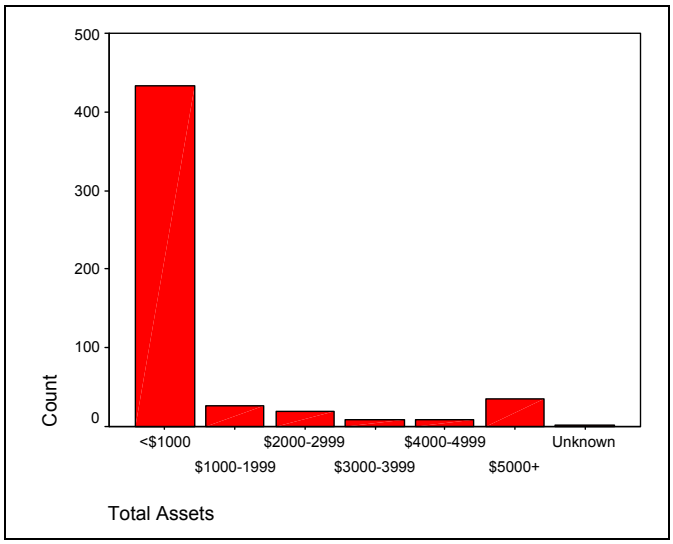

Figure 2: Number of cases by total countable assets (using Idaho Medicaid methodology)

TYPES OF MEDICAL SERVICES PAID

- 80% of cases included payment for inpatient hospitalization. Emergency room service was the second most frequently occurring type of service paid (Table 5).

Table 5: Types of services paid in study sample, N=534

	Number	Percent of Total N
Types of Services Paid		
Inpatient hospital	427	80.0
Emergency room	325	60.9
Outpatient lab or x-ray	234	43.8
Outpatient therapies (PT, OT, RT, speech, etc.)	48	9.0
Physician office visits	293	54.9
Prescription drugs	59	11.0
Mental health or substance abuse treatment	60	11.2
Dental	12	2.2
Vision	3	0.6
Durable medical equipment	8	1.5
Home health care	8	1.5
Skilled nursing facility	2	0.4

- Other kinds of services paid included emergency transport by air or ground ambulance, outpatient chemotherapy, anesthesia service, insurance premiums, and outpatient surgery.

- 76% of recipient cases were emergent with application occurring after a medical incident. Only 19% were non-emergent applications submitted prior to incurring medical service. Another 3% of cases were 180-day delayed cases (cases where eligibility determination was postponed pending outcome of applications for other forms of public coverage).

- Adults without minor children at home (childless adults) were slightly less likely to apply for assistance before the occurrence of medical services than were parents with minor children (Table 6). Childless adults accounted for 73% of the non-emergent cases while accounting for 77% of cases overall. Parents with minor children, on the other hand, represented 27% of non-emergent cases while accounting for 22% of total cases.

- The distribution of cases by poverty level was similar for types of application (emergent versus non-emergent) to the general distribution by poverty level. Thus, recipients did not appear more likely to present as an emergent case based on their level of income.

Table 6: Type of application by population group and poverty level group

		Type App				Total
Population group		Emergency	Non-emergent	180-Day Delayed	Unknown	
Children <18	**Count**	**2**		**1**		**3**
	% within Population Group	66.7%		33.3%		100.0%
	% within Type App	0.5%		6.3%		0.6%
Parents w children < 18 in home	**Count**	**83**	**27**	**7**	**2**	**119**
	% within Population Group	69.7%	22.7%	5.9%	1.7%	100.0%
	% within Type App	20.5%	26.7%	43.8%	15.4%	22.3%
Childless adults	**Count**	**318**	**74**	**8**	**11**	**411**
	% within Population Group	77.4%	18.0%	1.9%	2.7%	100.0%
	% within Type App	78.7%	73.3%	50.0%	84.6%	77.0%
Unknown	**Count**	**1**				**1**
	% within Population Group	100.0%				100.0%
	% within Type App	0.2%				0.2%
Total	**Count**	**404**	**101**	**16**	**13**	**534**
	% within Population Group	75.7%	18.9%	3.0%	2.4%	100.0%
	% within Type App	100.0%	100.0%	100.0%	100.0%	100.0%
Poverty level group		Emergency	Non-emergent	180-Day Delayed	Unknown	Total
<51%	**Count**	**147**	**29**	**8**	**8**	**192**
	% within Poverty level group	76.6%	15.1%	4.2%	4.2%	100.0%
	% within Type App	36.4%	28.7%	50.0%	61.5%	36.0%
51-100%	**Count**	**80**	**23**	**5**		**108**
	% within Poverty level group	74.1%	21.3%	4.6%		100.0%
	% within Type App	19.8%	22.8%	31.3%		20.2%
101-150%	**Count**	**75**	**23**		**3**	**101**
	% within Poverty level group	74.3%	22.8%		3.0%	100.0%
	% within Type App	18.6%	22.8%		23.1%	18.9%
151-185%	**Count**	**39**	**11**			**50**
	% within Poverty level group	78.0%	22.0%			100.0%
	% within Type App	3.5%	10.9%			9.4%
186-200%	**Count**	**14**	**3**			**17**
	% within Poverty level group	82.4%	17.6%			100.0%
	% within Type App	3.5%	3.0%			3.2%
>200%	**Count**	**44**	**11**	**2**	**2**	**59**
	% within Poverty level group	74.6%	18.6%	3.4%	3.4%	100.0%
	% within Type App	10.9%	10.9%	12.5%	15.4%	11.0%
Unknown	**Count**	**5**	**1**	**1**		**7**
	% within Poverty level group	71.4%	14.3%	14.3%		100.0%
	% within Type App	1.2%	1.0%	6.3%		1.3%
Total	**Count**	**404**	**101**	**16**	**13**	**534**
	% within Poverty level group	75.7%	18.9%	3.0%	2.4%	100.0%
	% within Type App	100.0%	100.0%	100.0%	100.0%	100.0%

SAMPLE EXPENDITURES

- Table 7 presents the distribution of total expenditure by diagnostic code compared to the SFY 2001 State Catastrophic Health Care Cost Program summary. The ratio of sample total expenditure to total expenditure reported in the SFY 2001 State Catastrophic Health Care Program Summary is 1:3. Thus, it is not surprising that the distribution of expenditure by diagnostic code is fairly similar to that of the State Catastrophic Health Care Program.

Table 7: Distribution of sample total expenditures by diagnostic code compared with SFY 2001 Catastrophic Health Care Cost Program Summary data

	Study Sample of County Cases CFY 2001	SFY 2001 Summary from Catastrophic Health Care Cost Program
	Percent of Total Expenditure	
Diagnostic Code		
10 Accident	17.5	18.5
20 Coronary	20.1	20.0
30 Birth	0.8	0.6
40 Cancer	13.4	11.9
50 Respiratory	3.4	4.4
60 Mental Health	5.3	11.4
70 General	16.2	15.6
80 Chronic Disease	8.8	4.0
90 Infectious Disease	1.0	0.9
100 Neurology	1.4	1.1
200 Digestive System	11.5	11.5
Unknown	0.8	0.0

*Please note: CFY is October-September; SFY is July-June.

- The counties paid 47% of the total expenditures among sample cases while the Catastrophic Health Care Cost Program paid 53% (Table 8).

Table 8: Distribution of study sample expenditures between counties and State Catastrophic Health Care Program

	Amount Expended	Percent of Total Combined Expenditures
Expenditures		
Total by counties	$3,467,965	47.0
Total by State Catastrophic	$3,905,811	53.0
Total combined	$7,373,776	100.0

- Total expenditure was $10,000 or less for 65% of the cases (Table 9). The State Catastrophic Health Care Cost Program paid on 35% of the cases.

- There were no cases where the Catastrophic Health Care Program paid bills over $5,000 for tobacco-related health care costs.

Table 9: Number of Cases by Total Expenditure

Total Expenditure	Number	Percent	Cumulative Percent
<$2,500	95	17.8	17.8
$2,501-5,000	98	18.4	36.1
$5,001-7,500	102	19.1	55.2
$7,501-10,000	50	9.4	64.6
$10,001-12,500	21	3.9	68.5
$12,501-15,000	31	5.8	74.3
$15,001-20,000	34	6.4	80.7
$20,001-30,000	39	7.3	88.0
$30,001-40,000	28	5.2	93.3
$40,001+	36	6.7	100.0
Total	534	100.0	

- Total expenditure per case in the sample ranged from $28 to $227,543 with an overall mean cost per case of $13,809 (Table 10). The median total expenditure, however, was $6,525.

Table 10: Expenditures by poverty level group, N=534

Poverty Level Group	N	Mean	Std. Deviation	95% Confidence Interval for Mean		Minimum	Maximum
				Lower Bound	Upper Bound		
<51%	192	$9,375	$12,161	$7,644	$11,106	$28	$70,261
51-100%	108	$11,728	$16,101	$8,656	$14,799	$204	$115,834
101-150%	101	$15,377	$24,797	$10,482	$20,272	$67	$123,225
151-185%	50	$15,728	$18,424	$10,492	$20,964	$607	$93,776
186-200%	17	$18,509	$16,717	$9,914	$27,104	$2,123	$64,893
>200%	59	$24,492	$34,476	$15,508	$33,477	$1,600	$227,571
Unknown	7	$29721	$39,939	-$7,253	$66,696	$1,108	$113,571
Total	534	$13,809	$20,803	$12,040	$15,577	$28	$227,571

- The average (mean) total expenditure per case increases with increasing levels of income (Figure 3). Differences between the lowest and highest groups were significant ($p<.001$). This finding most likely reflects the effect of methodology used by counties to determine eligibility for assistance. Ability to pay is weighed against the amount of medical bills incurred.

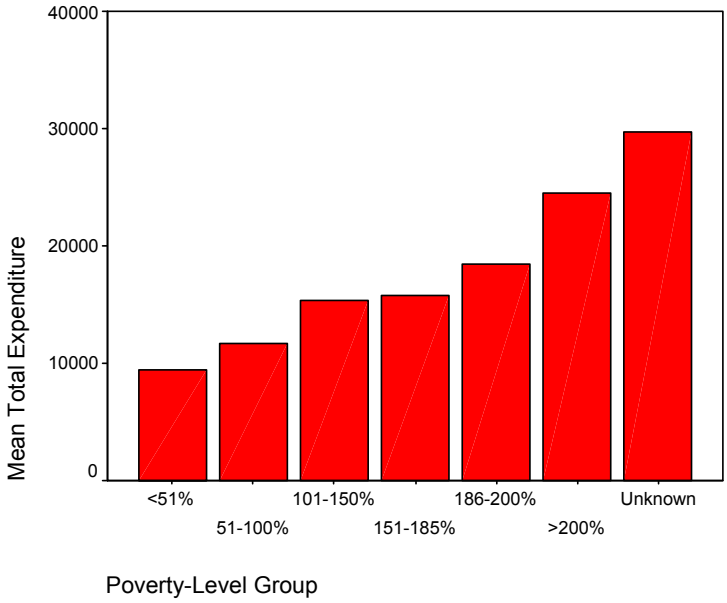

Figure 3: Expenditures by poverty level group

- The average expenditure per case paid by county funds was $6,494 while the average expenditure paid from State Catastrophic Health Care Program funds was $7,314 (Table 11). Because county costs are capped at $10,000 per case, there is less variability in county costs based on income level. However, mean state costs per case range from a low of $3,727 to a high of $16,227 in the highest income group.

Table 11: Poverty level group by county-paid, State-Catastrophic-Fund-paid, and total expenditure

Poverty level group		Bills County Paid	State Cat Fund Paid	Total Expenditure
<51% N=192	**Mean**	**$5,648**	**$3,727**	**$9,375**
	Sum	$1,084,460	$715,493	$1,799,953
	Minimum	$28	$0	$28
	Maximum	$15,773	$60,261	$70,261
51-100% N=108	**Mean**	**$6,320**	**$5,407**	**$11,728**
	Sum	$682,593	$584,010	$1,266,604
	Minimum	$204	$0	$204
	Maximum	$17,658	$105,834	$115,834
101-150% N=101	**Mean**	**$6,221**	**$9,155**	**$15,377**
	Sum	$628,356	$924,692	$1,553,049
	Minimum	$67	$0	$67
	Maximum	$11,141	$113,225	$123,225
151-185% N=50	**Mean**	**$7,508**	**$8,220**	**$15,728**
	Sum	$375,424	$410,995	$786,419
	Minimum	$607	$0	$607
	Maximum	$13,389	$83,776	$93,776
186-200% N=17	**Mean**	**$9,246**	**$9,263**	**$18,509**
	Sum	$157,181	$157,468	$314,649
	Minimum	$0	$0	$2,123
	Maximum	$37,447	$36,212	$64,893
>200% N=59	**Mean**	**$8,265**	**$16,227**	**$24,492**
	Sum	$487,664	$957,391	$1,445,055
	Minimum	$1,600	$0	$1,600
	Maximum	$10,788	$217,571	$227,571
Unknown N=7	**Mean**	**$7,470**	**$22,252**	**$29,721**
	Sum	$52,287	$155,761	$208,049
	Minimum	$1,108	$0	$1,108
	Maximum	$10,000	$103,571	$113,571
Total N=534	**Mean**	**$6,494**	**$7,314**	**$13,809**
	N	534	534	534
	Sum	$3,467,965	$3,905,811	$7,373,776
	Minimum	$0	$0	$28
	Maximum	$37,447	$217,571	$227,571

- Average combined (county and state) expenditures for childless adults differed from parents slightly (Table 12), but the difference is not significant (p=0.460). The difference for children also is not significantly different from the other groups because the mean for children is based on only three cases.

Table 12: Average combined (county and state) expenditure by population group

Population Group	N	Mean	Std. Deviation	95% Confidence Interval for Mean		Minimum	Maximum
				Lower Bound	Upper Bound		
Children <18	3	$42,561	$61,747	-$110,827	$195,948	$1,500	$113,571
Parents w children < 18 in home	119	$11,212	$12,895	$8,871	$13,553	$101	$70,261
Childless Adults	411	$14,271	$22,030	$12,135	$16,408	$28	$227,571
Unknown	1	$46,344	.	.	.	$46,344	$46,344
Total	534	$13,809	$20,803	$12,040	$15,577	$28	$227,571

HYPOTHETICAL IMPACT OF A SUBSIDIZED HEALTH INSURANCE PROGRAM

- A health insurance program targeted to employed, uninsured adults with **incomes below 185%** of the poverty line could potentially have impacted as many as **34% of recipients** of county and/or State Catastrophic Health Care Program medical assistance in CFY 2001 (182 of 534 cases), **if** the program had reached them (their employer was eligible for the product and chose to participate) and if 100% enrolled. Such a program could potentially have averted 29% of the total county-state expenditures (the portion of total expenditure accounted for by those recipients). The proportion of these cases that would have been employed in a small business cannot be determined from county data.

- A program targeted to uninsured adults with **incomes below 185%** of the poverty line **regardless of employment status** could potentially have impacted **84% of recipients** (449 of 534 cases). Such a program could have averted combined county-state expenditures amounting to 73% of total expenditures **if all** cases had enrolled.

- The potential impact on county and state expenditures would have been as summarized in Table 13; however, it should be noted that this scenario is hypothetical and highly generalized. Actual impacts would be affected by program design and consumer choices.

Table 13: Portion of CFY 2001 expenditures attributed to adult recipients with incomes below 185% of the poverty line

	Sum of sample expenditures and percent of total expended		
	County	Cat Fund	Total combined expenditures
Adult cases <185% poverty level (N=449):			
Employed (N=182)	$1,170,892	$990,502	$2,161,394
% of total case expenditures	34%	25%	29%
Total <185%	$2,759,333	$2,632,579	$5,391,913
% of total case expenditures	80%	67%	73%
Total case expenditures (N=534)	$3,467,965	$3,905,811	$7,373,776

DISCUSSION

The proportion of applications denied (43%) suggests that criteria specified in Idaho law are quite restrictive. The application is lengthy and requires extensive documentation as proof. In addition, the application of liens on real and personal property may also discourage applicants. Thus, it is assumed that many more cases exist that would not be represented in the application totals and subsequent pool of eligibles.

Study results can only be generalized to counties participating in the study. As is demonstrated by the variability in per capita case rates found in this research, counties vary in the numbers and types of applications approved for payment. A number of factors may help explain this variability.

County Commissioners have some discretionary authority over which medical indigency cases are approved for payment. Some counties approve a broader array of types of services. For example, during the county survey phase of the study it was discovered that at least one major difference among county programs was the number of prescription-only cases that were approved for payment. When this was explored further, it was explained that the county typically approved these kinds of cases in order to prevent more serious illnesses and consequent higher costs of care.

Another source of variability among county programs results from differences in practice among hospitals in the kinds of cases referred to the counties for payment. For example, some hospitals receive county funding or other public funds generated through local hospital

district levies and are expected to serve indigent populations; therefore, they may be less likely to refer lower cost cases to the county for payment.

An assumption in this study is that counties followed instructions in obtaining a random sample of cases for the case abstract phase of the study. The comparability of sample demographics and total expenditure by diagnostic code to summary data from the State Catastrophic Health Care Cost Program provide evidence supporting the validity of this assumption.

This assumption is also supported by the similarity in the distribution of cases by type of application between survey results and sample cases. Excluding cases that were for additional payment of bills subsequent to a previously approved case, the percent of cases that were emergent was 75% in the county survey results compared to 76% among the sample case abstracts.

Differences in the distribution of cases by age group (particularly the 65+ age group) and by diagnostic codes between the study sample and cases tabulated in the SFY Catastrophic Program Summary may reflect the exclusion of prescription-only cases from the study sample that would have been included in the SFY Catastrophic Program Summary. Another factor that may affect the comparability of the sample case abstracts and the Catastrophic Program summary data is differences in categorization of cases by diagnostic code. Two researchers independently categorized the sample cases; however, it is possible that health professional researchers may have categorized them differently than county or State Catastrophic Program staff. Also, the statistics reflect somewhat differing time periods and cases because the county fiscal year differs from the state fiscal year.

The impact of excluding prescription-only cases from the study sample has some interesting implications. When comparing state catastrophic fund program summary data with case abstracts, the data suggest that the prescription-only cases were more prevalent among cases over age 65, as well as among mental health cases. The difference in average county expenditure per eligible case between the county survey at $3,705 when prescription-only cases were included, and the average county expenditure of $6,494 among the case sample that excluded prescription-only cases suggests that the prescription-only cases tended to inflate the numbers of eligible cases but were low expenditure cases relative to other kinds of cases. The median average expenditure of $5,298 per case among counties found in the county survey suggests that a few counties with larger numbers of lower cost cases pull down the mean average expenditure per case statistic.

Findings on demographic and socioeconomic characteristics of recipients can only be attributed to the portion of county medical indigency cases that are not prescription-only cases since they were excluded from the case abstract phase of the study.

IMPLICATIONS FOR POLICY DEVELOPMENT

The majority of medical indigency cases are among the very poor. In the study sample, 36% of the total cases were among adults with incomes less than one-half the poverty level. Another 20% had incomes up to the poverty threshold. Idaho Medicaid covers only certain categories of the poor. To be eligible for Idaho Medicaid, a poor person must be under age 19 or pregnant, have minor children in the home, or be aged, blind or disabled (Idaho Department of Health and Welfare, 2001). Thus, non-disabled, childless adults are not covered at any level of poverty. Poor adults with minor children in the home are not eligible if their income is above a threshold roughly equivalent to 31% of the poverty level.

States have the option of expanding Medicaid eligibility for parents with minor children in the home through an amendment to its Medicaid state plan (Birnbaum, 2000). With a federal waiver, states can expand Medicaid coverage to childless adults; however, states must not increase federal expenditure in excess of what program expenditures would be without the waiver (Centers for Medicare and Medicaid Services, 2001).

Federal Medicaid rules also allow states to implement a Medically Needy program to expand coverage to persons who incur medical expenses and "spend down" their income to certain threshold levels. These persons would be eligible for Medicaid under one of the categorical groups, except that their income and/or resources are above the eligibility level set by their state (Centers for Medicare & Medicaid Services, 2002). With this approach, children under age 19 and parents with minor children could be covered at eligibility levels higher than what is current Idaho policy. In the study sample, parents and children comprised 23% of cases.

If Medicaid were utilized to expand coverage to poor persons, federal monies would be captured to match state expenditure at a rate of 70% federal to 30% state. Current policy in Idaho utilizes county and state monies to pay 100% of expenditures for county medical indigency services. It should be noted, however, that many more persons may qualify for coverage under a new Medicaid program than would have accessed the current county medical indigency program.

The impacts of health insurance coverage expansions for children are evident in the composition of medical indigency cases. Children under age 18 accounted for less than 1% of the medical indigency cases. Further exploration of more cost-effective means of paying for health care for Idaho's poorest adult citizens seems warranted.

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APPENDIX A: COUNTY MEDICAL INDIGENCY PROGRAM SURVEY INSTRUMENT

Please return this survey by July 17 to: Center for Health Policy, Boise State University, 1910 University Dr, Boise ID 83725-1800, **FAX** (208) 334-2052. **Thank you for your assistance.**

County Name		
Mailing Address of County Welfare Program		
Name of County Clerk	Telephone	Email
Name of Welfare Program Director	Telephone	Email
Name of person completing this survey	Telephone	Email

1. Total number of **applicants** for indigent medical services with dates of application during FY 2001 (10/1/2000 through 9/30/2001)?		
2. Total number of those applicants determined **eligible** for medical services paid by the county?		
3. Of those found eligible, what number were emergency cases, how many were non-emergency, how many were additional requests, how many 180-day delayed?	Total number **emergency** cases: Total number **non-emergency** cases: Total number additional requests: Total number 180-day delayed:	
4. What was the **total county expenditure** for medical claims paid for those eligibles?	$	
5. If federal matching funds were secured for some of these services thus increasing the funds available for health services, what health care needs in your county would be of highest priority for use of those additional funds? Rank with 1 being of highest priority. Please add and rank any other priority health needs not listed.	Health insurance for uninsured _____ Mental health care _____ Primary & preventive health services _____ Substance abuse treatment _____ Other (specify) _____ _____	
6. In your county, what medical services are typically **NOT** approved for payment? Section 31-3502(18) specifies necessary medical services to not include bone marrow transplants; organ transplants; elective, cosmetic or experimental procedures; normal, uncomplicated pregnancies and well-baby care; Medicare copayments and deductibles; and services provided by or available from state, federal and local health programs.	• • • • • • • Continue list on back of page, if necessary.	
7. In your county, are any of the medical indigency program data available in an electronic format (computerized data file)? If yes, what types of data? Check all that apply.	YES	NO
	Individual applications?	
	Claims payments?	
	Other?	
8. Does your county keep a log (computerized or hard copy) of applicants for services?	YES	NO

APPENDIX B: MEDICAL INDIGENT CASE ABSTRACT PROCEDURE

This part of the study requires detailed information on individual recipients of services paid by the Medical Indigency Program. For each county, this information will be collected **only on a specified number of cases**, i.e., a random sample of cases. We know this data collection will require effort on your part and have attempted to make the procedure as painless as possible.

For _____ **County**, the requested sample size of cases to be abstracted is __.

Case Abstract Procedure:

1. To determine which cases to include in your specified sample, you will need a log or listing of **recipients of medical indigency services** from which you can identify the particular cases to pull records for.

   From that list, consider only those cases with an application date during FY 2001, i.e., applications received between October 1, 2000 and September 30, 2001.

   Do not include applications that were "additional requests" or were for prescription drugs only.

2. To select the cases to abstract, simply pick every **__th case at regular intervals** from your list until you have your sample (this was derived by dividing the total number eligible cases by sample size to arrive at every "nth" case to abstract). If the total number of cases in your county for FY 2001 was less than 30, then you will be selecting each case.
3. Make **2-sided copies of the attached Medical Indigent Case Abstract form** so that you will have one blank form for each case in your specified sample.
4. Pull the records for each selected medical indigency case in the sample.
5. For each case in the sample, complete the attached Medical Indigent Case Abstract form.
6. Mail the collected case abstracts for the specified number of cases in your county sample to the:

   Center for Health Policy
   Boise State University
   1910 University Dr
   Boise ID 83725-1800

   For your convenience, we have provided a mailing label with our address.

We would appreciate your efforts to complete and send the case abstract data to us by September 27 at the latest. If that poses a difficulty or if you have questions about this procedure, please contact: Helen Stroebel at (208) 345-8097 or email at stroebel@mindspring.com.

Thank you for your assistance in completing this study of recipients of county-funded medical services.

MEDICAL INDIGENT CASE ABSTRACT

Instructions: Please complete this abstract form for each recipient of county-funded medical services included in the specified sample of cases for your county.

INFORMATION FROM THE UNIFORM COUNTY MEDICAL ASSISTANCE APPLICATION		
1. Date application received:	*Include only those received between Oct 1, 2000 and Sept 30, 2001*	
2. Type of application (from the *Uniform County Medical Assistance Application).* Circle appropriate type.	*Do not include applications that were "Additional Requests"*	Emergency within 30 days Non-emergency 10-day prior 180-day Delayed
3. Was this recipient a US citizen? (from the *Personal Information* section of the ***Uniform County Medical Assistance Application***)	YES	NO
4. If not a US citizen, was this recipient a legal non-citizen? (Was a Social Security # or Alien # listed in the *Personal Information* section of the ***Uniform County Medical Assistance Application***)	YES	NO
5. Recipient's gender (from the *Household* section of the ***Uniform County Medical Assistance Application***)	Male	Female
6. Was this recipient employed at the time of application? (from the *Income Information* section of the ***Uniform County Medical Assistance Application***)	YES	NO
7. Was the recipient's spouse employed at the time of application (if married)?	YES	NO
Information From Other Medical Indigency Case Forms		
8. Total amount **paid by the county** for this case (from the *Request for Payment - County Payment* form).	$	
9. Total amount **paid by the State Catastrophic fund** for this case (from the *Request for Payment - Catastrophic Fund Payment* form).	$	
10. Types of services for which payment was made (summarize the list of bills paid by both the county and the State Catastrophic Fund to **check all types of services that were paid**). .	☐ Inpatient hospitalization ☐ Emergency room ☐ Outpatient diagnostic lab/x-ray ☐ Outpatient therapies (PT, OT, RT, Speech, etc) ☐ Physician office visits ☐ Prescription drugs ☐ Mental health/substance abuse treatment ☐ Dental ☐ Vision ☐ Durable medical equipment ☐ Home health care ☐ Skilled nursing facility ☐ Other:_____	

INFORMATION FROM THE STANDARDIZED CLERK'S STATEMENT OF FINDINGS		
11. Recipient's age:		
12. Recipient's marital status	□ Married □ Single	□ Divorced/Separated □ Widowed
13. Household members by relationship and age (do **not** list names):	*Relationship to applicant*	*Age(s)*
	Spouse	
	Children other than applicant (incl natural, adopted, & step-children)	
	Parents (natural or adoptive, if applicant is minor)	
	Others	
14. Diagnoses (please write in):	Admitting diagnosis:	
	Discharge diagnosis:	
	Pertinent chronic health conditions:	
15. Has this person resided in the US at least 5 yrs?	YES	NO
16. **Earned** Income (total monthly gross income from wages, tips, salary, commissions, other earned income of applicant and spouse or parents if applicant is a minor):	Applicant	$
	Applicant spouse	$
	Parents (if minor)	$
17. **Unearned** Income by type (monthly):	SSI	$
	Child support income	$
	All other (soc security, work comp, veteran benefits, inheritance, dividends, rentals, etc.)	$
18. Child care expenses (monthly amount)	$	
19. Asset values (list the equity value of each):	Financial assets (cash, savings, stocks, mutual funds, annuities, proceeds from sale of resource, etc.	$
	First car	$
	Second car	$
	Home residence	$
	All other real/personal property (other vehicles, properties, livestock, etc.)	$

Thank you for your assistance in completing this study of recipients of county-funded medical services.

APPENDIX C: COUNTY SURVEY RESULTS

						Type of Application						
County	Number Applicants	Number Approved (Recipients)	County Denial Rate	County Population, 2000	County Case Rate per capita	Number Emergency	Number Non-emergency	Number Additional Requests	Number 180-day Delayed	County Emergency Percent	Total Expenditure	Avg exp/recip
Ada	854	459	46.3	300,904	1.5					NA	$ 2,466,856	$ 5,374
Adams	9	7	22.2	3,476	2.0	6	1	0	0	85.7	$ 57,055	$ 8,151
Bannock	276	109	60.5	75,565	1.4	78	31	12	18	56.1	$ 524,950	$ 4,816
Bear Lake	11	2	81.8	6,411	0.3	2	0	0	0	100.0	$ 14,731	$ 7,365
Benewah			NA	9,171	NA					NA	NA	NA
Bingham	129	40	69.0	41,735	1.0	19	18	0	3	47.5	$ 282,336	$ 7,058
Blaine	63	19	69.8	18,991	1.0	52	9	0	2	82.5	$ 71,711	$ 3,774
Boise	23	16	30.4	6,670	2.4	21	1	0	1	91.3	$ 235,333	$ 14,708
Bonner	205	46	77.6	36,835	1.2	36	10	3	2	70.6	$ 213,298	$ 4,637
Bonneville			NA	82,522	NA					NA	NA	NA
Boundary	29	13	55.2	9,871	1.3	10	3	0	3	62.5	$ 87,751	$ 6,750
Butte	10	5	50.0	2,899	1.7	5	0	1	0	83.3	$ 47,362	$ 9,472
Camas	3	0	100.0	991	0.0	0	0	0	0	NA	NA	NA
Canyon	311	115	63.0	131,441	0.9	0	0	0	0	NA	$ 609,237	$ 5,298
Caribou	14	13	7.1	7,304	1.8	4	5	4	0	30.8	$ 34,531	$ 2,656
Cassia	132	58	56.1	21,416	2.7	44	14	0	0	75.9	$ 287,251	$ 4,953
Clark	7	2	71.4	1,022	2.0	7	0	0	0	100.0	$ 11,233	$ 5,616
Clearwater	25	11	56.0	8,930	1.2	9	2	10	0	42.9	$ 33,905	$ 3,082
Custer	13	7	46.2	4,342	1.6	4	3	0	0	57.1	$ 48,834	$ 6,976
Elmore	52	25	51.9	29,130	0.9	23	2	0	2	85.2	$ 178,755	$ 7,150
Franklin	2	2	0.0	11,329	0.2	2	0	0	0	100.0	$ 20,000	$ 10,000
Fremont	42	24	42.9	11,819	2.0	13	5	0	6	54.2	$ 143,474	$ 5,978
Gem	40	23	42.5	15,181	1.5	19	4	3	3	65.5	$ 432,925	$ 18,823
Gooding	75	38	49.3	14,155	2.7	18	19	1	0	47.4	$ 491,280	$ 12,928
Idaho	59	39	33.9	15,511	2.5	39	11	8	1	66.1	$ 199,959	$ 5,127
Jefferson	63	32	49.2	19,155	1.7	28	3	11	1	65.1	$ 327,763	$ 10,243
Jerome	167	76	54.5	18,342	4.1	63	10	2	3	80.8	$ 304,215	$ 4,003
Kootenai	2058	1430	30.5	108,685	13.2					NA	$ 1,689,419	$ 1,181
Latah	96	56	41.7	34,935	1.6	49	47	14	2	43.8	$ 150,373	$ 2,685
Lemhi	100	89	11.0	7,806	11.4	80	9	0	0	89.9	NA	NA
Lewis	16	10	37.5	3,747	2.7	10	0	0	0	100.0	$ 50,146	$ 5,015
Lincoln	27	17	37.0	4,044	4.2	18	7	0	1	69.2	$ 34,309	$ 2,018
Madison	66	38	42.4	27,467	1.4	27	5	5	1	71.1	$ 170,809	$ 4,495
Minidoka	86	51	40.7	20,174	2.5	42	6	2	3	79.2	$ 566,258	$ 11,103
Nez Perce	94	53	43.6	37,410	1.4	28	21	3	1	52.8	$ 233,923	$ 4,414
Oneida	1	1	0.0	4,125	0.2	1	0	0	0	100.0	$ 10,000	$ 10,000
Owyhee			NA	10,644	NA					NA	NA	NA
Payette	92	47	48.9	20,578	2.3	16	31	7	0	29.6	$ 162,613	$ 3,460
Power			NA	7,538	NA					NA	NA	NA
Shoshone			NA	13,771	NA					NA	NA	NA
Teton	8	3	62.5	5,999	0.5	3	0	0	1	75.0	$ 9,001	$ 3,000
Twin Falls	364	237	34.9	64,284	3.7	311	0	0	11	96.6	$ 1,722,316	$ 7,267
Valley	26	17	34.6	7,651	2.2	9	8	2	0	47.4	$ 75,262	$ 4,427
Washington	17	17	0.0	9,977	1.7	2	15	0	0	11.8	$ 29,362	$ 1,727
Total	5665	3247		1,293,953		1098	300	88	65		$ 12,028,535	$ 3,705
Mean			44.9	29,408	2.3					69.1	$ 325,096	$ 6,371
Median			46.2	12,795	1.7					70.6	$ 162,613	$ 5,298
Minimum			0.0	991	0.0					11.8	$ 9,001	$ 1,181
Maximum			100.0	300,904	13.2					100.0	$ 2,466,856	$ 18,823
Percent		57%				71%	19%	6%	4%			

County	Health Insurance Rank	Mental Hlth Rank	Primary Care Rank	Subst Abuse Rank	Other Issue Rank	Other Needs
Ada	3	2	1	4	5	Refugee medical services for longer period of time
Adams						
Bannock	1	2	3			
Bear Lake	1	2	3	4		
Benewah						
Bingham	2	3	4	5	1	Elderly medication
Blaine	1	2	4	3	5	
Boise	1	3	2	4		
Bonner	2	3	1	4		
Bonneville						
Boundary	1	3	2	5	4	Dental
Butte	1	3	2	4		
Camas						
Canyon	1	4	2	3	5	Rent, utilities, burial
Caribou	3	1	4	2		
Cassia						
Clark	1	4	2	3		
Clearwater		3	2	4	1	General Hospitilization
Custer	1	2	3	4		
Elmore	1	2	3			
Franklin						
Fremont	1	2	4	3		
Gem	1	3	4	5	2	Medical emergency/accident
Gooding	1		2	3		
Idaho	3	2	1	4		
Jefferson	1	4	2	3		
Jerome	1	2	4	3		
Kootenai	2		1	3	4	Dental
Latah	1					
Lemhi	1	2	4	3		
Lewis	1	4	2	3	5	Jail Medical
Lincoln	2	5	3	4	1	
Madison	1	2	2	3	1	Prescription drug coverage
Minidoka	2	1	4	3		
Nez Perce	1	2	4	3		
Oneida	1	3	2	4		
Owyhee						
Payette	1		3	2		
Power						
Shoshone						
Teton	1		1	1		
Twin Falls	1	1	2	3		
Valley	1	3	1	2		
Washington	1	4	2	3		
Total	45	79	86	107	34	
Mean	1.3	2.6	2.5	3.3	3.4	

County	Services Typically Not Approved
Ada	All that listed in section 31-3502
Adams	As specified in 31-3502(18)
Bannock	Medical for veterans paid by the VA□Non-emergency surgery that can wait a year
Bear Lake	Cosmetics□Elective surgery□Non-emergency surgery□C-Section deliveries
Benewah	
Bingham	See Section 31-3502(18)
Blaine	As per statute
Boise	Elective□Transplant□Cosmetic procedures
Bonner	Services that are out of state□Non-emergent□Non preapproved□Section 31-3502(18)
Bonneville	
Boundary	Dental unless teeth are infected and approval only extraction of teeth.□Pregnancies/Child birth (uncomplicated)□Bone marrow/organ transplant□elect./cosı
Butte	We follow the code
Camas	
Canyon	Section 31-3502(18)
Caribou	Those listed plus dental except for relief of pain (extraction)
Cassia	Non emergent without approval as per 31-3502(18)□Pregnancies□Dental
Clark	
Clearwater	Idaho Code 31-3502
Custer	N/A
Elmore	section 31 3502 (18)
Franklin	We have a limited amont of cases. Most are emergency cases
Fremont	sec.31-3502(18)
Gem	Dental (Only pay for emergency pain relief, i.e extraction)□Vision□Prosthesis□Hearing aids, appliances
Gooding	Dental□Eye care/glasses□Available from State, Federal, and Local□All listed under IC31-3502(18)
Idaho	Abortion□Sexchange□Hearing Aids□Dental Implants□Each application is considered separately
Jefferson	Dentures□Hysterectomy
Jerome	None□Health and welfare
Kootenai	Well baby/child□Normal pregnancy & delivery□Preventive, restorative dental procedures□all in the section 31-3502(18)
Latah	Section 31-3502(18)
Lemhi	Medicare Copays□Medicaid eligible□Elective surgerys
Lewis	Listed in Section 31-3502(18)
Lincoln	Non emergency Medical□Applicants with health insurance□Dental Services
Madison	Section 31-3502(18)
Minidoka	Normal Child Birth□Nursing home care□All others listed in 31-3502 (18)
Nez Perce	County would not cover any services not covered by Catastrophic Healthcare Services
Oneida	
Owyhee	
Payette	All services listed in Section 31-3502 (18)
Power	
Shoshone	
Teton	Volunteer mental health□section 31-3502(18)
Twin Falls	Dental□Eye Exam□Eye Glasses
Valley	Dentures□Prescription drugs□Voluntary mental
Washington	Illegal Alien□No Jurisdiction□Qualifies for Health and Welfare□Withdrawl□Denial

County	Electronic Data	Applications Electronic	Claims Electronic	Other Medical Data	Other Data Electronic	Applicant Log
Ada	Yes	Yes	Yes	Yes	Mental Health data	Yes
Adams	No	No	No	No		Yes
Bannock	No	No	No	No		Yes
Bear Lake	No	No	No	No		Yes
Benewah						
Bingham	No	No	No	No		Yes
Blaine	No	No	No	No		Yes
Boise	No	No	No	No		Yes
Bonner	No	No	No	No		No
Bonneville						
Boundary	No	No	No	No		Yes
Butte	Yes	Yes	Yes	No		Yes
Camas	No	No	No	No		No
Canyon	No	No	No	No		Yes
Caribou	No	No	No	No		Yes
Cassia	Yes	Yes	Yes	Yes	Various reports	Yes
Clark	No	No	No	No		No
Clearwater	No	No	No	No		No
Custer	No	No	No	No		Yes
Elmore	Yes	Yes	Yes	No		Yes
Franklin	No	No	No	No		No
Fremont	Yes	Yes	Yes	No		Yes
Gem	Yes	Yes	Yes	No		Yes
Gooding	Yes	No	Yes	Yes	Statement/accounts rec.	Yes
Idaho	No	No	No	No		Yes
Jefferson	Yes	No	No	No		Yes
Jerome	No	No	No	No		Yes
Kootenai	Yes	Yes	Yes	No		Yes
Latah	Yes	Yes	Yes	No		Yes
Lemhi	No	No	No	No		Yes
Lewis	Yes	Yes	Yes	No		Yes
Lincoln	Yes	Yes	Yes	No		Yes
Madison	Yes	Yes	Yes	No		Yes
Minidoka	Yes	Yes	Yes	Yes	Computer arts program	No
Nez Perce	No	No	No	No		Yes
Oneida	No	No	No	No		Yes
Owyhee						
Payette	Yes	No	Yes	No		No
Power						
Shoshone						
Teton	Yes	No	Yes	No		Yes
Twin Falls	Yes	Yes	Yes	Yes	All reports etc.	Yes
Valley	Yes	Yes	Yes	No		Yes
Washington	No	No	No	No		Yes