2021 SC Legislative Safety Net Proviso Report

Developed by the

University of South Carolina Institute for Families in Society

Under Contract to the SC Department of Health and Human Services

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DISCLOSURE

In accordance with guidelines established by HIPAA and related data use agreements between agencies, the data behind the visualizations and products presented within this presentation are not publicly available. Access to this data for research or other purposes is handled under other mechanisms, i.e., South Carolina Department of Health and Human Services (SCDHHS) or Revenue and Fiscal Affairs (RFA).

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A. Background

This report provides an analysis of the Safety Net Proviso for Fiscal year 2019 -2020. It addresses the part of SC Proviso H4100 related to “evaluation of the state's safety-net providers that includes, at a minimum, Federally Qualified Health Centers, Rural Health Clinics, and to the extent applicable to funding received by the state, free clinics.” In response to the Safety Net Proviso (Appendix A), this report will examine South Carolina’s urban/suburban/rural continuum, highlight general population trends, and evaluate distance to care to each of the 3 safety net facilities (Federally Qualified Health Centers, Rural Health Centers, and Free Medical Clinics). With a population of over 5 million residents, South Carolina is the 24th most populous state in the US and the 40th largest state in terms of geographic area. South Carolina covers 30,109 square miles across 46 counties, with a 2020 estimated population of 5,118,425 people – with 728,561 living in rural South Carolina (USDA-ERS, 2021).

What is the definition of a healthcare safety net? The safety net is not an organized national entity, but rather a composite of different agencies, organizations, and individuals in each community across the country (Baxter and Mechanic, 1997, Health Affairs, 2018). Using an updated definition (Lewis & Altman, 2000) the Institute of Medicine (IOM) defines the safety net as “those providers that organize and deliver a significant level of health care and other needed services to uninsured, Medicaid and other vulnerable patients.”

The mix of financing, concentration of organizational responsibility for care for low-income and uninsured groups, and the demand for uncompensated care are different in every community. The mix of services also differs depending on the community's provider base, its commitment to serving low-income and uninsured groups, and individual providers' ability to participate (HRSA, 2000). These providers maintain an “open-door” policy not based on insurance status ensuring healthcare services to the most vulnerable population groups within South Carolina. To ensure access to health care services is essential to address the role of rurality and safety net providers in mitigating the impact of health professional shortage areas.

A Health Professional Shortage Area (HPSA) is a geographic area, population, or facility with a shortage of primary care, dental, or mental health providers and services designated by Health Resources and Services Administration (HRSA). South Carolina has 70 Medically Underserved Areas with more than 30% of the population living in a Primary Care Health Professional Shortage Area (HPSA), over 10% living in a Mental Health HPSA, and more than 20% living in a Dental Care HPSA (HRSA, 2021). See Appendix B for an illustration of the geographical areas meeting a HPSA designation within South Carolina by Primary Care, Dental Care, and Mental Health. The maps document the potential challenges facing South Carolina in assessing health care services as designated by HRSA within geographical areas with low-income populations with high needs and provider shortages. Among safety net providers are 65 general acute care hospitals. These hospitals, along with a network of 190 in-state Federally Qualified Health Centers (FQHC) and private specialists provide critical health care services for South Carolina residents.

The data framing the analysis of this report were pulled from many difference resources to provide a full picture of the residential makeup, geographic size, critical medical care information for South Carolina. The US Census Bureau releases data from its decennial census as well as their annual surveys at many different

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geographic levels. The American Community Survey (ACS) was used to provide updated information on residential demographics. The Rand McNally Road Atlas for 2021 was used to establish the geographic size and scale of South Carolina. Information on the medically underserved areas of South Carolina and the specific health professional shortage area (HPSA) data and maps come from the Health Resources & Services Administration (HRSA). HRSA is also the organization that funds the Federally Qualified Health Centers (FQHCs).

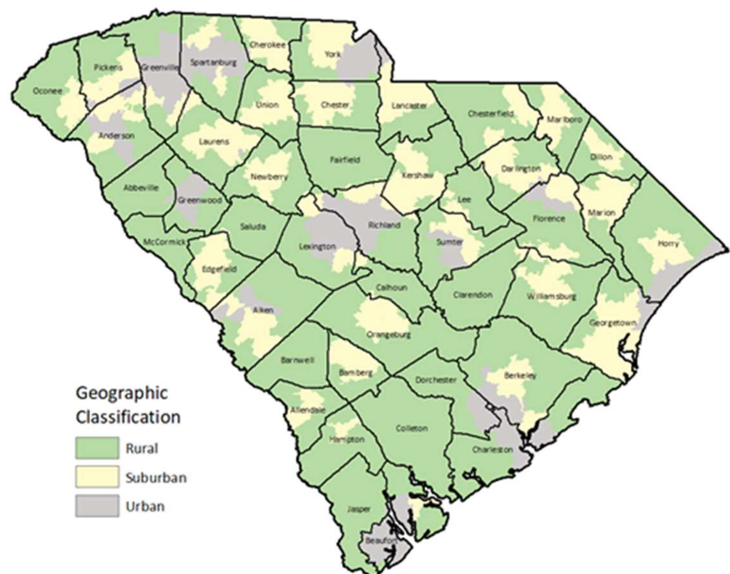
B. South Carolina's Urban/Suburban/Rural Continuum

Geographic access to care can be quite different in large urban centers, suburban areas, and remote rural regions. Distinguishing urban, suburban, and rural areas in South Carolina provides greater ability to discern important geographic differences in healthcare accessibility for South Carolina Medicaid FFS enrollees.

The US Census Bureau classifies all individuals in the nation as either "urban" or "rural" residents. Those living in census-designated urbanized areas of 50,000 or more people or urban clusters of 2,500 to 49,999 people are classified as "urban." All other residents are classified as "rural."

Based on this definition, IFS has developed a geospatial classification system specific to South Carolina to distinguish urban, suburban, and rural ZIP Code Tabulation Areas (ZCTAs) in the state. ZCTAs are Census enumeration units that spatially approximate United States Postal Service (USPS) 5-digit ZIP Code mail delivery areas. ZCTA-level urban/rural class breaks were established to 1) maximize spatial correlation with a county-level urban/rural classification system based on Metropolitan/ Micropolitan Statistical Area definitions, and 2) highlight urban/suburban/rural variation within counties. Classifications are based on the percentage of the ZCTA's population that is Urban as per the Census 2010.

Figure 1: Urban, Suburban, and Rural ZIP Code Tabulation Areas in South Carolina



The IFS classification system reflects the level of urbanization (i.e., the relative mix of urban and rural residents) in each of the state's 424 ZCTAs. In this 3-class taxonomy, urban/suburban/rural classes are specified as follows: **Urban:** greater than 72.5% urban; **Suburban:** between 43.0% and 72.5% urban (inclusive); **Rural:** less than 43.0% urban. The addition of a "suburban" designation highlights the growing suburban areas nationally and in South Carolina. The suburban growth results from a more rapid population growth than rural or urban areas growth. See Figure 1.

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C. South Carolina General Population Trends, 2013 to 2019

An examination of general population trends in South Carolina provides context for the assessment of the state's Medicaid FFS population and can inform planning for future population change (growth or decline) across the urban/suburban/rural continuum. Based on US Census Bureau/American Community Survey (ACS) 5-year estimates, the state's total population rose from roughly 4.68 million in 2013 to 5.02 million in 2019, an increase of approximately 7% (Figure 2).

Slower population growth occurred in suburban (~5%) and rural areas (<1%). While the rural adult population increased by more than 3% from 2013 to 2019 (Figure 3), the child population in rural areas decreased by about 6% (Figure 4).

Figure 2. Total Population in SC, 2013 to 2019

Figure 3. Adult Population (Ages 18+) in SC, 2013 to 2019

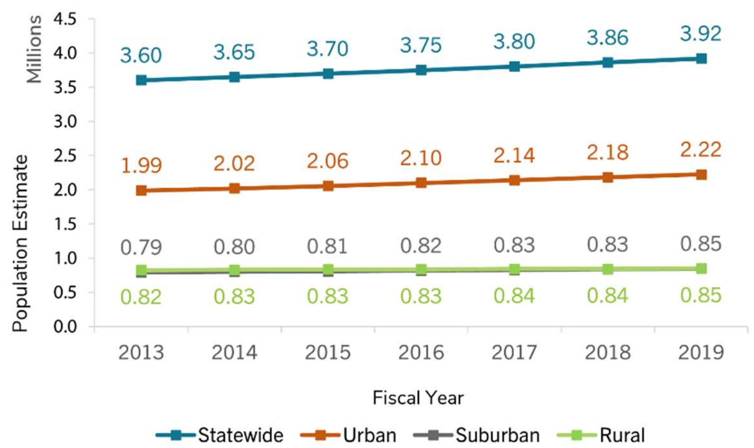

Figure 4. Child Population (Ages 0-17) in SC, 2013 to 2019

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D. Safety Net Facilities

A safety net facility is one that provides care to all individuals regardless of their insurance status or ability to pay. Safety net facilities in South Carolina include Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs) and Free Medical Clinics (FMCs). One of the goals of the Safety Net Proviso was to increase the state's safety net providers. For each of the three safety net providers, a map showing locations of 2013 and 2019 facilities is provided along with the rural, suburban, urban categories presented earlier.

Table 1. Safety Net Facility Locations by Year and Percent Change

Safety Net Facility Locations by Year

	2013		2018		2020		% Change 2013-2020	
	Rural	Total	Rural	Total	Rural	Total	Rural	Total
Federally Qualified Health Centers (FQHCs)	59	127	61	157	67	174	14%	37%
Rural Health Clinics (RHCs)	60	119	38	86	32	82	-47%	-31%
Free Medical Clinics (FMCs)	5	51	18	74	18	75	260%	47%

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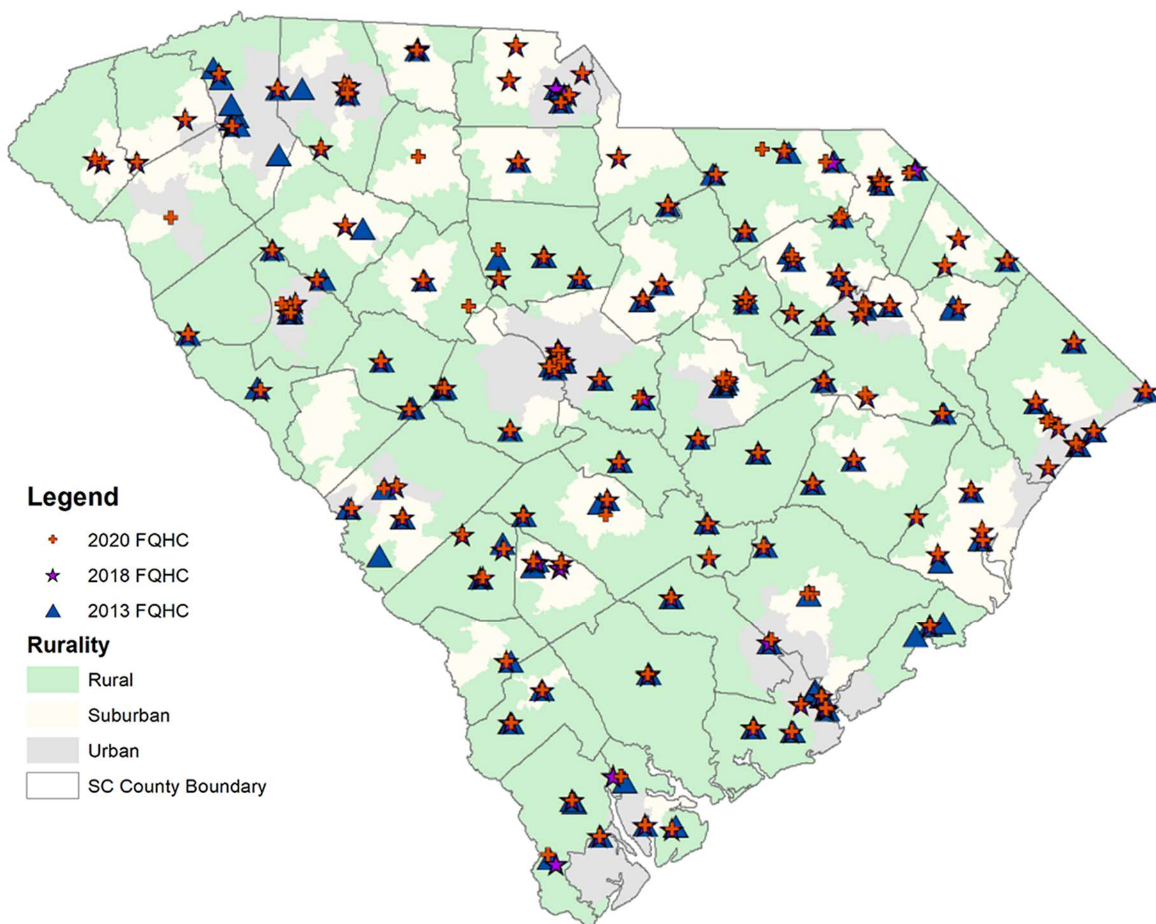
Federally Qualified Health Centers (FQHCs)

In 2013, there were 127 FQHCs of which 59 were located in rural ZCTAs. In 2018, there were a total of 157 FQHCs; a 24% increase from 2013. In 2020, that number grew to be 174 FQHCs; a 37% increase from 2013. The rural FQHCs from 2013 to 2020 increased by more than 13% for a total of 67 rurally located facilities. The location of these FQHCs in 2013, 2018, and 2020 are mapped in Figure 5 below.

Using Euclidean distance (i.e. straight-line) service areas from FQHC facilities in 2013, there were only four ZCTAs not within 30 miles of an FQHC. These four ZCTAs were rural and accounted for almost 20,000 residents. The additional FQHCs added by the end of 2018 and 2020 accounted for complete statewide coverage—in other words, all residents were within 30 miles of an FQHC.

Figure 5. FQHC locations 2013, 2018 and 2020



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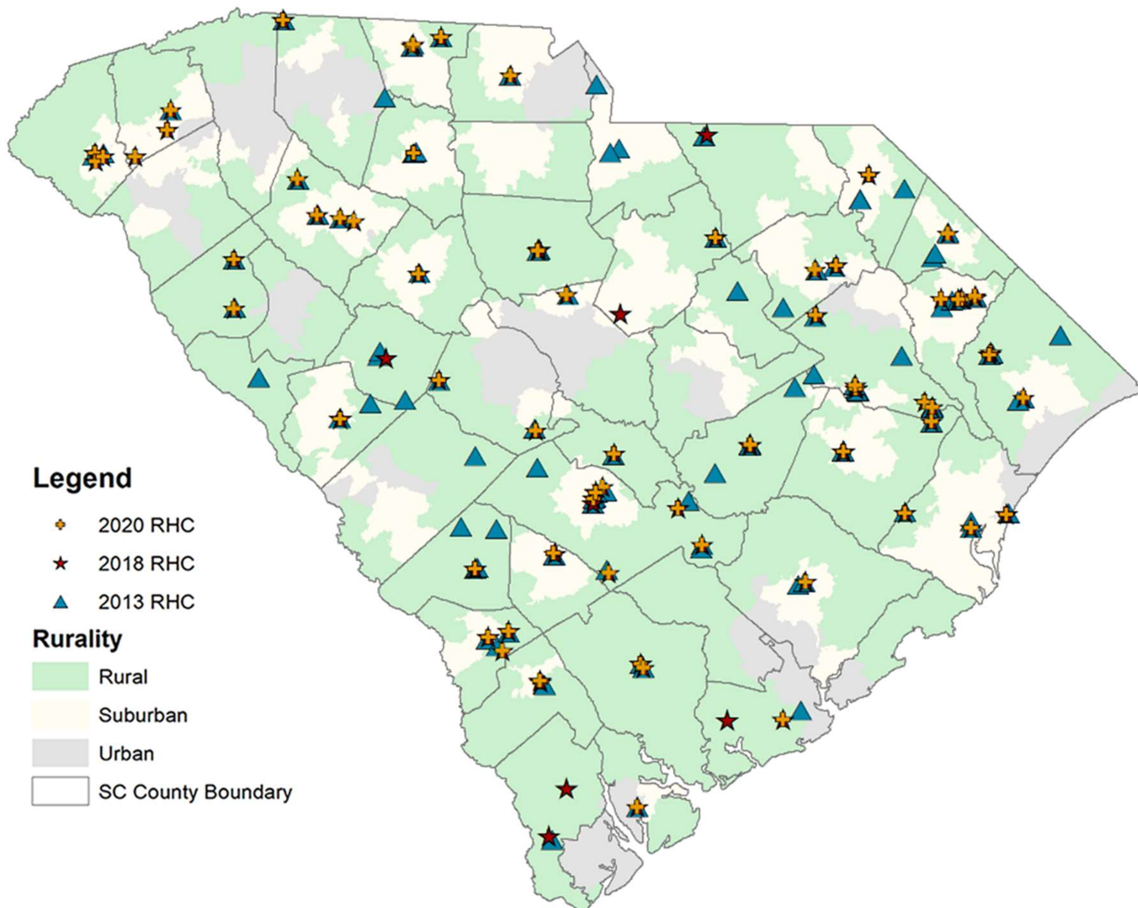
Rural Health Clinics (RHCs)

Rural Health Clinics underwent a 31% decrease in the number of facilities in South Carolina from 2013 (N=119) to 2018 (N=86) and then to 2020 (N=82). The rural locations of these RHCs dropped by 47% from 60 locations in 2013 to 32 locations in 2020. Figure 6 below displays the locations of the RHCs in 2013, 2018, and 2020.

When measuring if residents had access to RHCs, 30-mile Euclidian distance was assessed. Even with a 31% decrease in facilities, there was no change in access statewide. All residents had an RHC within 30 miles of their ZCTA in 2013 and in 2020.

Figure 6. RHC locations 2013, 2018 and 2020



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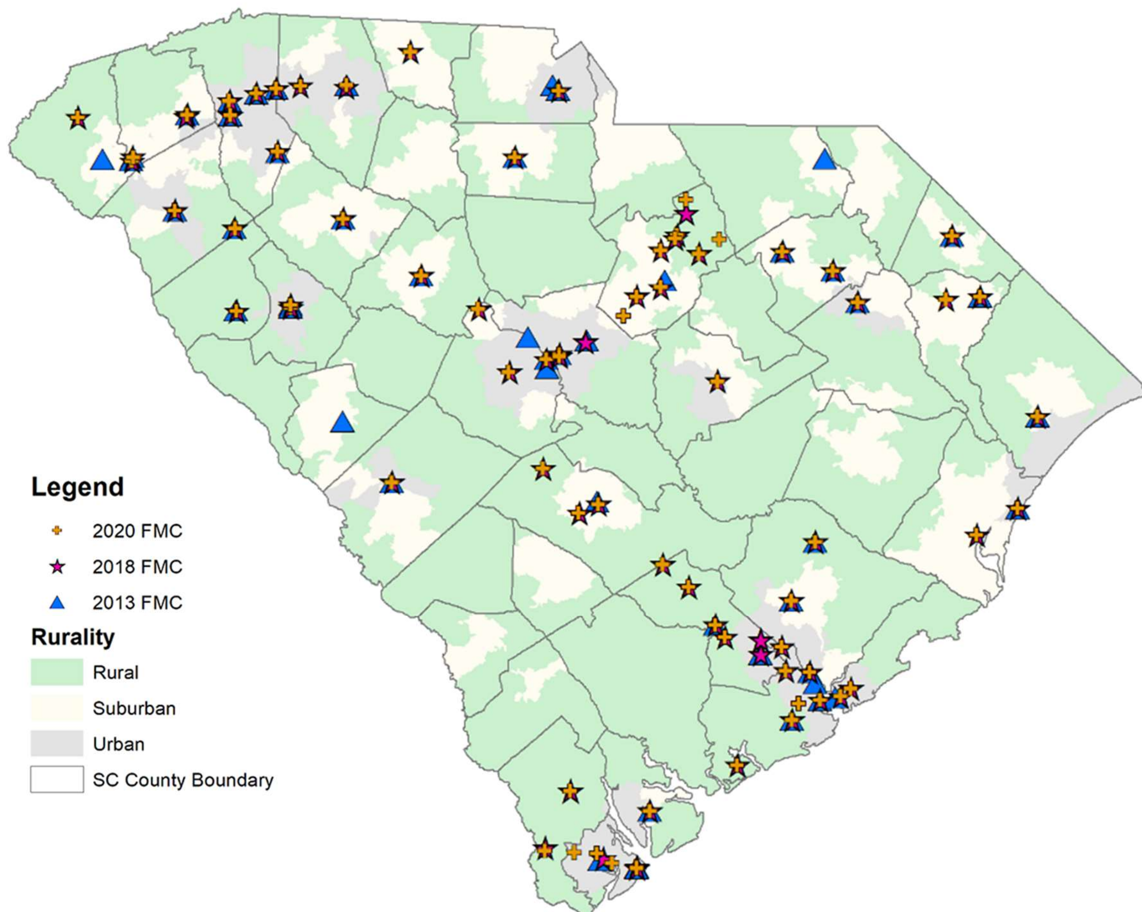
Free Medical Clinics (FMCs)

Free Medical Clinics saw the greatest increase in facilities from 2013 to 2020. The number of FMCs increased 47% from 2013 (N=51) to 2018 (N=74) and to 2020 (N=75). The rural locations went from 5 in 2013 to 18 locations in 2020, which was a 260% increase. Figure 7 below displays the locations of the FMCs in 2013, 2018, and 2020.

In 2013, residents in 10 ZCTAs (8 rural and 2 suburban) were not within 30 miles (measured by Euclidean distance) of an FMC. This accounted for almost 22,000 residents. By 2018 and 2020, more than 17,000 of these residents had an increase in access and were within 30 miles of an FMC. Only the 4,200 residents of one suburban ZCTA are still not within 30 miles of an FMC for both 2018 and 2020.

Figure 7. FMC locations 2013, 2018 and 2020



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E. Summary

In summary, the Safety Net Facilities in South Carolina have expanded and maintained their reach to rural areas even with the loss of some facility locations. Safety Net Facilities play a pivotal role in providing care to the underserved rural population. These findings do not address ongoing challenges faced by safety net providers to address the social determinants of health needs of a South Carolinians requiring services from safety net providers. Rather, the findings indicate “no decline” in the existing capacity to meet the needs of South Carolinians. The findings document a slight increase in the numbers of safety net clinics in rural areas associated with high population needs. It does not address the association between increasing providers through funding mechanisms supporting the safety net, e.g., graduate medical education (GME) support for rural areas. Also, this report does not examine the economic impact of additional funding to safety net providers in maintaining or expanding the number of safety net providers. Although there is not a one-to-one causality, the findings indicate a stabilization and increase of services associated with the Safety Net Proviso supporting increased access and services.

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Appendix A

THE SAFETY NET PROVISO

H. 4100
General Appropriations Bill for Fiscal Year 2021-2022
Ratified Version

...

33.22. (DHHS: Rural Health Initiative) From the funds appropriated to the Department of Health and Human Services for the Rural Health Initiative in the current fiscal year, the department shall partner with the following state agencies, institutions, and other key stakeholders to implement these components of a Rural Health Initiative to better meet the needs of medically underserved communities throughout the state. The department may leverage any and all available federal funds to implement this initiative. Recurring and non-recurring funding for the Rural Health Initiative may be carried forward by the department and expended for the same purpose.

(A) The Department of Health and Human Services shall incentivize the development of primary care access in rural and underserved areas, leverage Medicaid spending on Graduate Medical Education (GME) by implementing methodologies that support recommendations contained in the January 2014 report of the South Carolina GME Advisory Group, and continue to leverage the use of teaching hospitals to ensure rural physician coverage in counties with a demonstrated lack of adequate access and coverage through the following provisions:

(1) Rural and Underserved Area Provider Capacity - the department shall partner with the University of South Carolina School of Medicine to develop a statewide Rural Health Initiative to identify strategies for significantly improving health care access, supporting physicians, and reducing health inequities in rural communities. In addition, the department shall also contract with the MUSC Hospital Authority in the amount of $1,500,000, and the USC School of Medicine in the amount of $2,000,000 to further develop statewide teaching partnerships. The department shall also expend $5,000,000 in accordance with a graduate medical education plan developed cooperatively by the Presidents or their designees of the following institutions: the Medical University of South Carolina, the University of South Carolina, and Francis Marion University.

(2) Rural Healthcare Coverage and Education - The USC School of Medicine, in consultation with statewide rural health stakeholders and partners, shall continue to operate a Center of Excellence to support and develop rural medical education and delivery infrastructure with a statewide focus, through clinical practice, training, and research, as well as collaboration with other state agencies and institutions. The center's activities must be centered on efforts to improve access to care and expand healthcare provider capacity in rural communities. The department shall authorize at least $2,000,000 to support center staffing as well as the programs and collaborations delivering rural health research, the ICARED program, workforce development scholarships and recruitment, rural fellowships, health education development, and/or rural practice support and education. Funding released by the department pursuant to this section must not be

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used by the recipient(s) to supplant existing resources already used for the same or comparable purposes. No later than February first of the current fiscal year, the USC School of Medicine shall report to the Chairman of the House Ways and Means Committee, the Chairman of the Senate Finance Committee, and the Director of the Department of Health and Human Services on the specific uses of funds budgeted and/or expended pursuant to this provision.

(3) Rural Medicine Workforce Development - The department, in consultation with the Medical Education Advisory Committee (MEAC), shall support the development of additional residency and/or fellowship slots or programs in rural medicine, family medicine, and any other appropriate primary care specialties that have been identified by the department as not being adequately served by existing Graduate Medical Education programs. The department shall ensure that each in-state member of the Association of American Medical Colleges is afforded the opportunity to participate in MEAC. New training sites and/or residency positions are subject to approval as specified by the Accreditation Council for Graduate Medical Education (ACGME). The department may also accept proposals and award grants for programs designed to expose resident physicians to rural practice and enhance the opportunity to recruit these residents for long-term practice in these rural and/or underserved communities. Up to $500,000 of the recurring funds appropriated to the department for the Rural Health Initiative may be used for this purpose. Additionally, the department shall use up to $200,000 of the recurring funds appropriated for the Department of Aging's Geriatric Physicians Loan Forgiveness program.

(4) Statewide Health Innovations - At least $2,500,000 must be expended by the department to contract with the USC School of Medicine and at least $1,000,000 to Clemson University to develop and continue innovative healthcare delivery and training opportunities through collaborative community engagement via ICARED, Clemson Rural Health Programming, and other innovative programs that provide clinical services, mental and behavioral health services, children's health, OB/GYN services, and/or chronic disease coverage gaps. In consultation with statewide rural health stakeholders and partners, the department must ensure collaborative efforts with the greatest potential for impact are prioritized.

(5) Maternal Mortality Reduction - Prior to the expiration of the COVID-19 public health emergency, the department shall ensure that 12-month postpartum coverage is preserved by making the election offered pursuant to Section 1902(e)(16) of the Social Security Act. The Department of Health and Human Services shall collaborate with the South Carolina Maternal Mortality and Morbidity Review Committee to develop a method of evaluating the effectiveness of this provision.

(B) The department shall continue to investigate the potential use of DSH and/or any other allowable and appropriate source of funds in order to improve access to emergency medical services in one or more communities identified by the department in which such access has been degraded due to a hospital's closure during the past five years.

(1) In the current fiscal year, the department is authorized to establish a DSH pool, or carry forward DSH capacity from a previous period as federally permissible, for this purpose and/or if deemed necessary to implement transformation plans for which conforming applications were filed with the department pursuant to this or a previous hospital transformation or rural health initiative proviso, but for which additional negotiations or development were required. An emergency department that is established within 35 miles of its sponsoring hospital pursuant to this or a previous hospital transformation or rural health initiative proviso and which receives dedicated funding pursuant to this proviso shall be exempt from

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any Department of Health and Environmental Control Certificate of Need requirements or regulations. Any such facility shall participate in the South Carolina Telemedicine Network.

(2) The department may solicit proposals from and provide financial support for capital expenditures associated with the replacement of two or more rural hospitals, not to exceed one-quarter of the total project capital budget. Such a plan must be submitted by a hospital system approved to advise a rural transformation project, and the project must be subject to ongoing advisement by the submitting facility, or subject to acquisition by the advising facility. The advised facility must be designated as a critical access hospital in a county experiencing not less than four percent decrease in population between the most recent decennial censuses and have been deemed eligible to participate in the rural transformation pool in a prior fiscal year. The department shall require such written agreements which may require project milestone, last-dollar funding, and other stipulations deemed necessary and prudent by the department to ensure proper use of the funds.

(C) The Revenue and Fiscal Affairs Office and the Area Health Education Consortium's Office of Healthcare Workforce Analysis and Planning shall provide the department with any information required by the department in order to implement this proviso in accordance with state law and regulations. Not later than January 1, of the current fiscal year, the department shall submit to the President of the Senate and Speaker of the House of Representatives an evaluation of the state's safety-net providers that includes, at a minimum, Federally Qualified Health Centers, Rural Health Clinics, and to the extent applicable to funding received by the state, free clinics.

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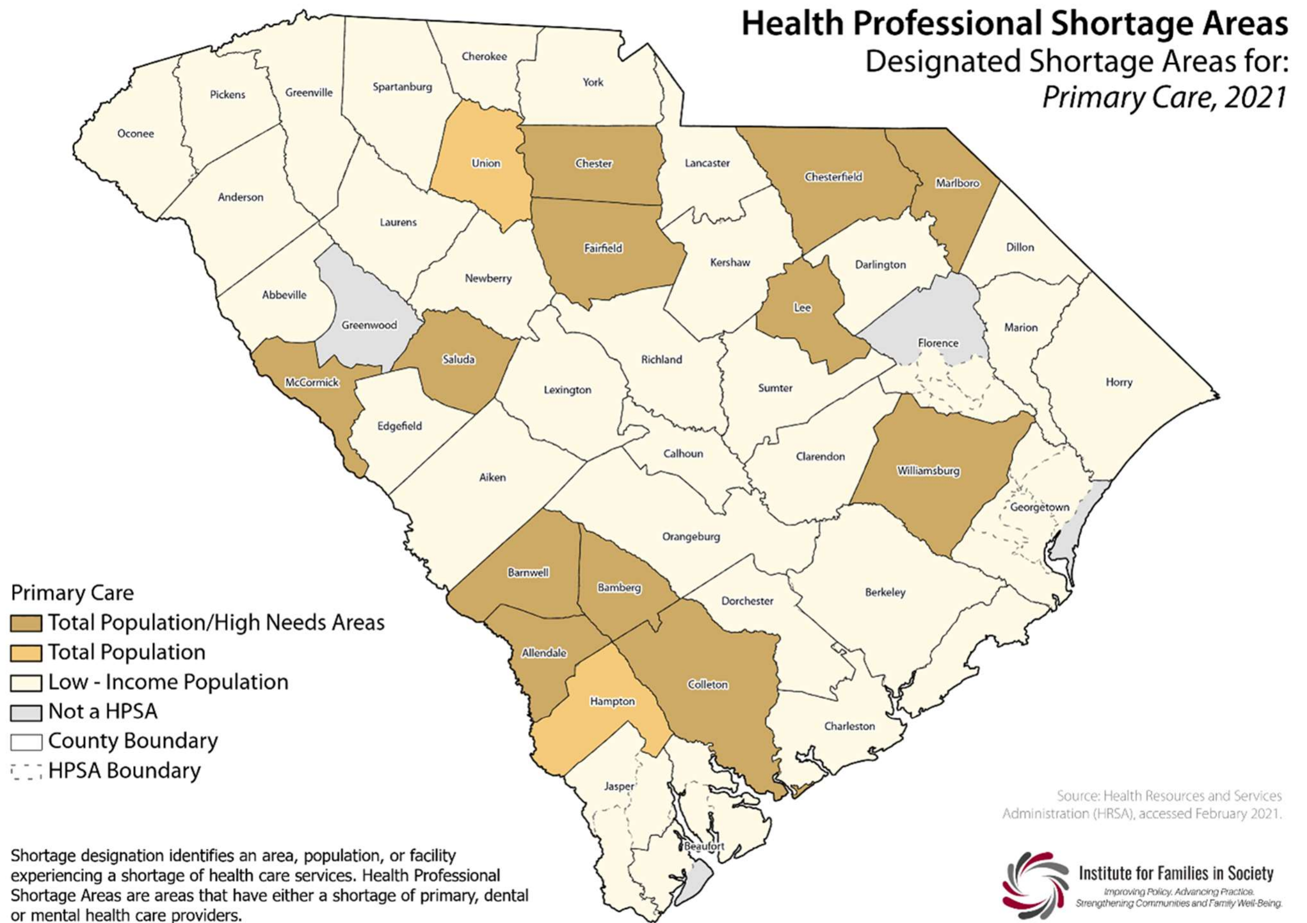
Appendix B: SC Health Professional Shortage Areas – Primary Care, 2021



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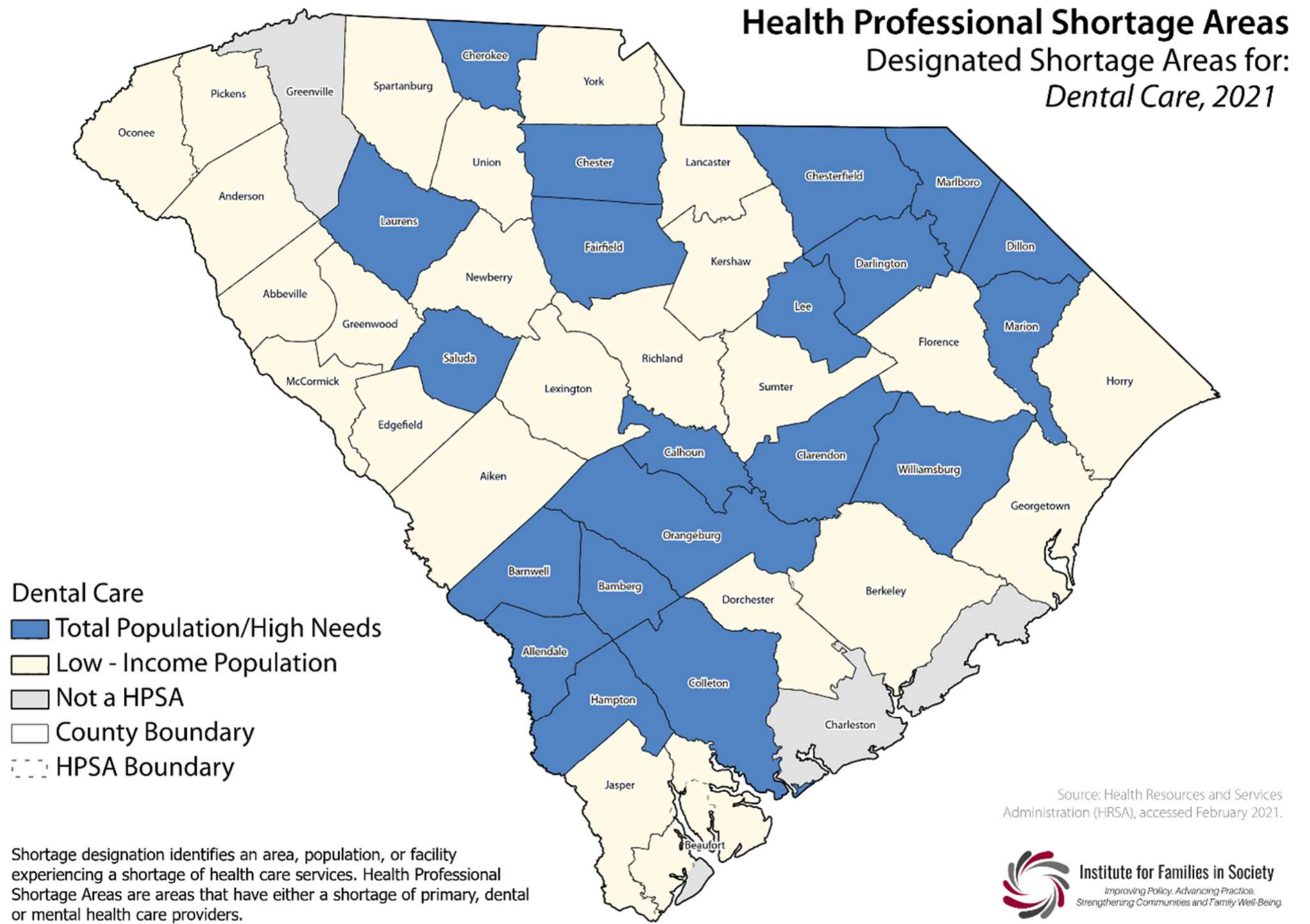
Appendix B: SC Health Professional Shortage Areas – Dental Care, 2021



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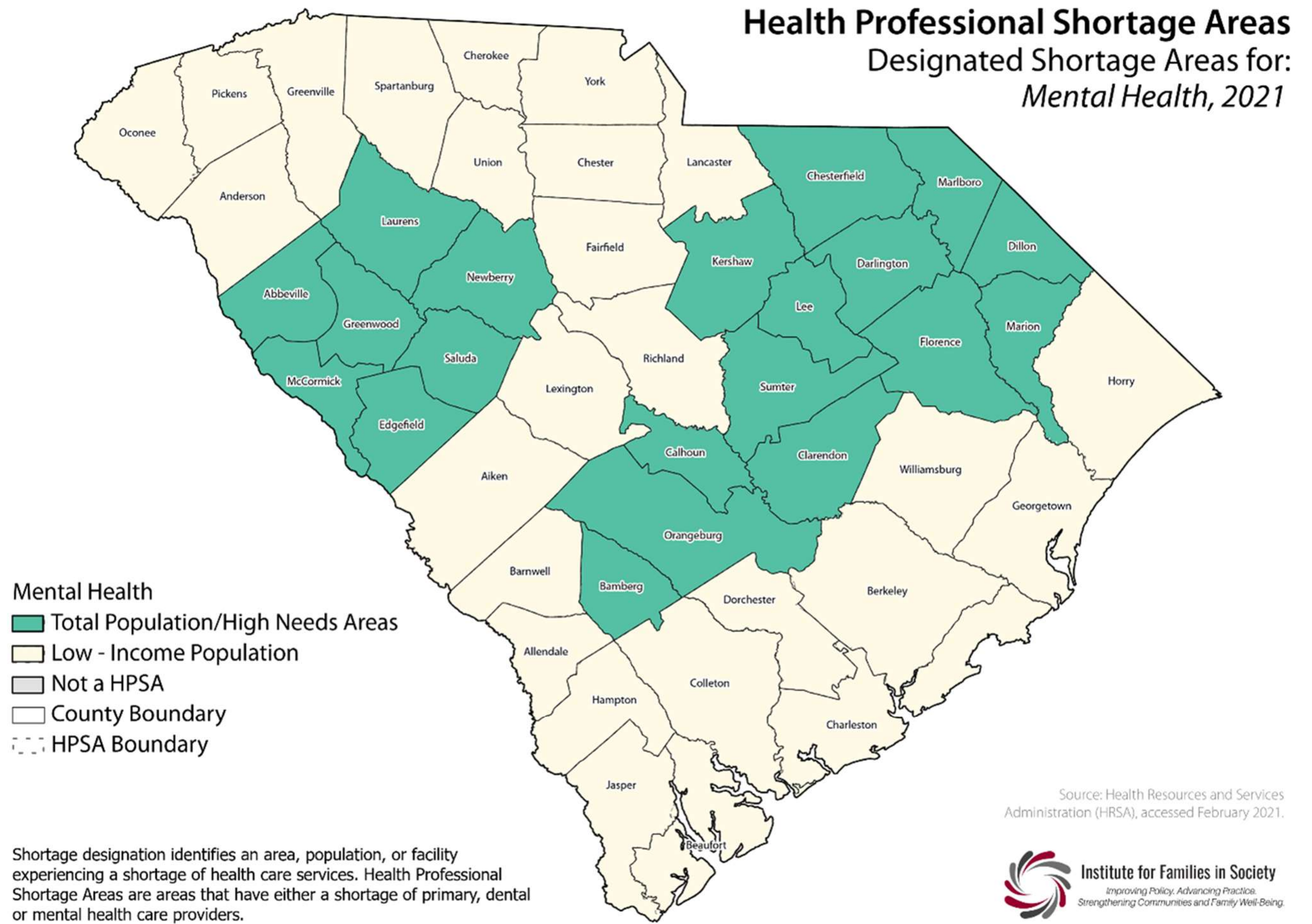
Appendix B: SC Health Professional Shortage Areas – Mental Health, 2021



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