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OA/ID Number: 52057
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Folder Title:
ILRU [Independent Living Research Utilization] [1998] [1]

Stack:

Row:

Section:

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Position:

ILRU Development Plan

Overview--ILRU is a program of The Institute for Rehabilitation and Research (TIRR), a not-for-profit 501(c)(3) rehabilitation hospital and research institute located in the Texas Medical Center. It is also affiliated with Baylor College of Medicine, Houston, Texas. Founded in 1977, ILRU is the preeminent research, training, and technical assistance program in the world focusing on independent living, civil rights, and health policy issues affecting the lives of people with disabilities.

Since its beginning, ILRU has successfully conducted a comprehensive program of extraordinarily productive activities, most of which have been sponsored by grants from federal agencies and from major foundations. In the future, grant funding will become far less reliable as a means of supporting endeavors of this nature. Further, grant funding severely restricts the possible realm of scientific and social inquiry through its narrowly directed focus. Given these circumstances, it is imperative that ILRU develop a stable and permanent base of support in order to perpetuate the vital role which it plays in the lives of people with disabilities and in the forum of public policy.

By securing private sponsorship for its activities, and by establishing an endowment to ensure a perpetual base of core support, ILRU will be able to continue and expand its important work into the 21st Century. Sponsorship and endowment opportunities are listed below:

Named center--the ILRU program will be named a center in honor of the donor or donors who endow the program at a level of five million dollars.

Academic chair--the director of ILRU, currently Lex Frieden (a professor at Baylor College of Medicine and Senior Vice President of TIRR), will be granted a named academic chair in honor of the donor or donors who endow the chair at a level of one million dollars.

Named programs--ILRU will conduct a concentrated program of activities in one or more of the following areas, depending upon the level of sponsorship received.

- Independent living
- Disability rights
- Healthcare policy
- Media utilization and public awareness
- International outreach

Activities conducted in these focus areas will be named in honor of the donor or donors who endow the focus area at a level of five hundred thousands dollars.

Television series--*Real Life*, a successful PBS series, will be expanded by adding an additional twelve episodes to the existing four-part series. Sponsorship of the new programs will require a gift of two hundred thousand dollars.

Perpetual web site--ILRU will establish and maintain a site on the world wide web dedicated to the provision of comprehensive and up-to-date information about a wide variety of independent living related issues. Sponsorship of this resource link will require a gift of one hundred thousand dollars.

Further Information--for further information about these opportunities and the programs at ILRU, contact Lex Frieden at 1333 Moursund, Houston, Texas 77030, Voice Telephone (713) 797-5284, FAX (713) 799-7095, email lfrieden@bcm.tmc.edu.

Taj I was having a hard time with this ..font, bold title etc.

A Brief Note From the Editors of SWDBTAC News on the 8th Anniversary of the ADA

The ADA is a law still in its infancy. Dire predictions about its costs and burdens have proved unfounded. Many in the media have highlighted the "sensational" ADA stories without providing all of the facts. Every day, at the Center, we hear from people who have just heard of the ADA, or have subscribed to some of the misinformation that is so readily available from the mainstream press. Unfortunately, most people don't hear the stories that we hear every day. The stories of people rejected from employment, educational opportunity and access to so many areas of ^{our} society that most take for granted simply because they have a disability. We hear from individuals being denied jobs, who were more than qualified and who did not even require an accommodation of any kind, except, perhaps, for a simple change in the sensitivity level of those responsible for hiring. In this time of backlash against the ADA, a portion of our job has become "defending the ADA" which requires that we clear up the misperceptions about the law which abound. We can tell you, from our numerous contacts with individuals all over the region that this ^{is} most important civil rights law ^{is} desperately needed and it has made an impact. One of the most gratifying parts of our job is witnessing, first hand, the sense of empowerment one can give someone by simply telling them that there is a law which prohibits them from being treated differently simply because of their disability. We also know from people who call us back of the freedom and changes putting the information into action has ^{brought} wrought in their lives. Not only do we hear about important changes which have occurred in individual lives but we have begun to see changes in society itself. There is a higher level of awareness of disability issues and evidence of actual physical changes. Even with the debate and anti- ADA backlash, at least one can say the community of people with disabilities are finally being included at some of the "tables" where these discussions are taking place after decades of complete exclusion. Still, change is not coming fast enough. ^{It} will take time to eradicate all of those seemingly neutral policies and traditions which have forced people with disabilities to live for decades as second class citizens, on the fringes of society. For those who demand data to justify a law that simply asks that people with disabilities not be discriminated against, who demand an economic quantification of its success, it does exist. A report from the President's Committee on

Employment of People with Disabilities indicates that more individuals with disabilities are employed in the workplace than ever before. In 1994 more than one million more people with disabilities were employed than had been only three years before. All providers of ADA information still have much to do to raise the level of awareness in all areas of society of disability, the ADA and other laws which protect them from discrimination. Unlike other groups who have faced discrimination, people with disabilities face many barriers unique to them. People with disabilities are not one homogeneous group that experiences the same type of discrimination in the workplace or require the same type of accommodations. There are numerous distinct subgroups within the overall population of people with disabilities. In addition, there are individuals with disabilities that are subjected to multiple forms of discrimination because of their minority status. Attitudes toward certain disabilities differ. Individuals with hidden, unfamiliar or more stigmatized disabilities often face greater barriers in the workplace. We are seeing a judiciary struggling with the concept of disability, the language of the ADA, and incomplete understanding of traditional disability support programs. Many cases also illustrate the philosophical problems courts are having trying to interpret the ADA as a "traditional" civil rights statute, not understanding that different treatment may be required to level the playing field, that this treatment is necessary to promote equal results. Workplace "traditions" are used as an excuse not to provide accommodation. This struggle with workplace tradition reflects, in some ways, courts' early struggles with gender-based discrimination cases which seem comical now. In an early sex discrimination case, *Phillips v. Martin Marietta Corp.*, the court held that Martin's refusal to hire women with preschool-age children was not discrimination because employers were simply recognizing the different responsibilities each sex had in establishing employment policies. This was viewed as a neutral criterion. The appeals court also looked at "normal" sex roles and child care practices. This case demonstrates that accepted workplace traditions and social "norms" can change. These changes must occur as the ADA is successfully implemented and institutionalized in our society.

AWK -
Ward
may be
about
ADA

X-Sender: lfrieden@bcm.tmc.edu
Date: Fri, 03 Jul 1998 22:00:38 -0500
To: funchess@bcm.tmc.edu
From: Lex Frieden <lfrieden@bcm.tmc.edu>
Subject: Fwd: web site feedback

>Date: Fri, 03 Jul 1998 18:55:34 -0700
>From: June Isaacson Kailes <jik@pacbell.net>
>Reply-To: jik@pacbell.net
>Organization: Disability Policy Consultant
>X-Mailer: Mozilla 4.04 [en] (Win95; I)
>To: "Frieden, Lex" <lfrieden@bcm.tmc.edu>,
> "jik@pacbell.net" <jik@pacbell.net>
>Subject: web site feedback.

>General comments:
>-MUCH IMPROVED

>SOMETINGS NEED:

- >-need dates
- >-need source of material - author, date, etc
- >- slow modern people won't like all that clicking

><http://www.ilru.org/mgdcare/confrprt.htm>-NICE!!

><http://www.ilru.org/mgdcare/hcm/index.html>

>combine these into one with index on top - annoying to have to keep clicking!!

><http://www.jik.com/pwdmc1.html> - REAL HOT!

>June Isaacson Kailes 310.821.7080

> 310.827.0269 FAX

>Disability Policy Consultant jik@pacbell.net

>June's website <http://www.jik.com>

>IL Net <http://www.ilru.org>

>RTC Aging with Disability <http://www.usc.edu/go/awd>

>U.S. Access Board <http://www.access-board.gov>

>California Assist Tech System <http://www.catsca.com>

Lex Frieden e-mail: <lfrieden@bcm.tmc.edu>

X-Sender: lfrieden@bcm.tmc.edu
Date: Sat, 11 Jul 1998 08:50:44 -0500
To: funchess@bcm.tmc.edu
From: Lex Frieden <lfrieden@bcm.tmc.edu>
Subject: Fwd: Gerben and my comments on your web site

>From: blo1@mhg.edu
>Date: Fri, 10 Jul 1998 15:53:05 -0500
>To: lfrieden@bcm.tmc.edu
>Cc: gxd3@mhg.edu
>Subject: Gerben and my comments on your web site
>X-Mailer: TFS Gateway /310000000/310103131/310103401/310103371/
>X-Engine: "TFS Engine Release 3.12 Build 101e"
>X-MIME-Autoconverted: from quoted-printable to 8bit by hermes.bcm.tmc.edu
id OAA22114

>
>Hello Lex: Gerben and I both had the opportunity to review your web site in
>the last week or so. Overall, we found the depth and breadth of material
>presented quite impressive. Hopefully, our comments will make it even more
>so.

>
>Please let me know if any of our comments are unclear.

>
>A link that takes you back to the top should be added at the bottom of each
>page. This avoids having to "escape" several times to get back to the
>beginning. Additionally, when you have become linked to someone else's
>website and you "go back to the top" you end up at the top of that
particular
>site, not the ILRU site. That can get confusing for the "surfer".

>
>The link, "What questions do I ask?" seems to be a bad link. It leads
>nowhere. It is on the Resources page.

>
>Medicaid and Managed Care is also an inoperable link.

>
>The link labeled, "Medicare and Managed Care" is really about Medicare and
>rehabilitation. It should be re-labeled as such, or removed from the site.

>
>There should be a disclaimer when you leave the ILRU site and become linked
>to another site that says, ILRU/NRH is not responsible for the information
on
>this link. This is commonly done so that the original organization is not
>responsible for any inaccuracies on the other site.

>
>The "research projects of the RTC links back to the executive summary and
>should actually link to the NRH-RC home page for more information.

- >
- >The link to the Medicaid study in New York is a 1995 report. This is dated
- >and probably should be removed, since they are in process of implementing MC
- >in New York.
- >
- >
- >These comments are more content oriented:
- >
- >Update verb tense in the introduction to the web site. In some cases,
- >activities we have completed are are currently underway are described as
- >future activities.
- >
- >There is no title for the T4 project. It also needs to be updated to
- reflect
- >that we've already had the consumer conference.
- >
- >We should add a list of advisory committee members on the web site.
- >
- >Under the link, "Who uses Managed care?" it says tht people who purchase
- >manage insurance are likely to use managed care. This is not really true.
- >It's mostly employers, people on Medicaid, and about 15 percent of people on
- >Medicare.
- >
- >Under the "learning to speak the language" section where it talks about
- carve
- >outs: There are two types of carve outs, service based and population
- based.
- > It only mentions one type. Other than that, this section was very good.
- >Did June put this together?
- >
- >Under "common problems and solutions" the text refers to "this handout." If
- >we wrote this, we may want to modify it to say earlier on this site.
- >
- >We notice a number of things that appear to be written by someone else.
- >There should always be clearly referenced.
- >
- >The Understanding disabilities" has lots of inaccuracies. The section
- >assumes that "people with disabilities" means a significant level of
- >disabilities. It says that people with disabilities should be encouraged to
- >live in their own homes, etc. often need assistance with ADL's etc. This is
- >true for only a small percentage of pwd. There are also many
- >mis-statements in the section, "building a user friendly service system:
- >for example, that mental illness is a life long disability. It can be, but
- >is not necessarily. We should review this section more carefully to decide
- >whether it should be included.

- >
- >The link on the ILRU health care reform conference should either be deleted,
- >summarized, or prefaced with a statement that "although this happened several
- >years ago, the issues are still relevant. The section on "progress since
- >the conference" is not of general interest and should probably be deleted.
- >Also, the references are dated. On balance, we recommend either summarizing
- >the conference results and eliminating the rest, or else eliminating this
- >whole section.
- >
- >Stu Hanson's report is very good, but someone needs to look at the
- >formatting. (Gerben says) It is not visually friendly -- mixed up columns,
- >etc. There are references to numerous appendices in this report that are
- >labeled as XX.
- >
- >The summary of our conference is still pretty rough. It needs to be marked
- >Draft and needs to have limited access. It's difficult to follow, does not
- >have parallel sentence structure, and otherwise needs to be cleaned up.
- >
- >Hope these comments are helpful. Please call me if you have additional
- >questions.
- >
- >Bonnie
- >

Lex Frieden e-mail: <lfrieden@bcm.tmc.edu>

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The Institute for Rehabilitation and Research
Director -- ILRU Program <http://www.ilru.org>
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X-Sender: lfrieden@bcm.tmc.edu
Date: Fri, 03 Jul 1998 22:01:46 -0500
To: funchess@bcm.tmc.edu
From: Lex Frieden <lfrieden@bcm.tmc.edu>
Subject: Fwd: Re: work in progress and update

>Date: Fri, 03 Jul 1998 19:09:42 -0700
>From: June Isaacson Kailes <jik@pacbell.net>
>Reply-To: jik@pacbell.net
>Organization: Disability Policy Consultant
>X-Mailer: Mozilla 4.04 [en] (Win95; I)
>To: Pamela Dautel <riverheart@hotmail.com>
>CC: lfrieden@bcm.tmc.edu, "jik@pacbell.net" <jik@pacbell.net>
>Subject: Re: work in progress and update

>

>see below!!

>Gee I just noticed it's 7pm, bye

>Pamela Dautel wrote:

>

>> Hi June (hope you have a great 4th!)

>>

>> What you sent looks great. The items you added to the website are very
>> informative. I have two comments:

>>

>> 1) Under "How to choose a plan", it might be helpful to first have
>> the consumer assess their health care needs:
>> - Questions to ask yourself to assess your current and near-term future
>> health care needs (guide them through the process of fully assessing
>> their health situation).

>

>Here's what I've written so far about that, what do you think... can you add?

>

>When you have a choice, how do you choose the best health care plans and
>services for your needs?

>

>Pay specific attention to benefits that are most important to you. Read the
>plan's summary of benefits carefully. Ask the suggested questions, throughout
>this material, that are most important to you.

>

>How do you know what is most important to you? It is difficult to do, but try
>to clarify and project your health care needs and priorities beyond your
>routine or day-to-day requirements.

>

>Think about medical conditions or problems that you are currently being
>treated for, or have recently been treated or given your current conditions
>what health concern may arise in the future.

- >Do you need to consider family-related genetic risks, exposure to
- >environmental hazards, or lifestyles, issues such as smoking, alcohol
- >consumption, diet, etc.?
- >
- >Some people with disabilities are reporting unexpected changes in their
- >energy and activity levels as they age. Most people with major physical
- >disabilities of at least 30 years duration note some tenderness and soreness
- >in joints, muscles and tendons which have been carrying the extra load of
- >impaired physical function from other parts of the body. Heavy use or overuse
- >of certain body parts to compensate for lost motor ability in other body
- parts
- >can lead to problems over time (Kailes, Health..., p.7).
- >
- >People who have lived with disability long-term are developing secondary
- >conditions and/or experiencing their existing disability becoming more
- >significant. Secondary conditions are those that occur because of the
- >pressures of the primary disability and may include pain; fatigue;
- decrease in
- >skills, performance, mobility, strength or balance; fractures; pressure
- sores;
- >etc. What's coming into sharp focus for many is that the changes brought
- about
- >by regular aging (yet to be clearly defined) can play havoc with a person's
- >ability to function. Don Lollar gives this example: there are some people who
- >have cerebral palsy who, after years of practice, have perfected balance and
- >walking. This carefully perfected balance in the body easily gets lost as a
- >natural part of the aging process. For example, spinal curves flatten,
- tendons
- >and ligaments lose flexibility, muscles lose strength, and the righting and
- >protective reflexes slow. These changes may be just enough to cause falls
- that
- >result in injuries such as fractures and other conditions that totally affect
- >this precariously achieved balance (p. 59).
- >
- >Will you need: access to specialists, frequent use of emergency room
- >treatment, rehabilitation, home health , personal assistant services,
- physical
- >therapy or occupational therapy, cancer treatment (because it runs in your
- >family), and/or long term care? do you have a condition that might result in
- >trips to the emergency room--asthma, heart condition?
- >
- >It is very important to be aware of what the plan's information will not tell
- >you? Most descriptive materials (advertising, marketing materials) use
- >language and terms are not clear. In addition, disability-related information
- >is not there or it is very vague. So you are really going to have to search

>for answers to some of your questions.

>

>Report cards and member satisfaction surveys can be misleading. They typically

>do not address many of the issues important to people with disabilities.

>Report cards and satisfaction surveys usually do not include: people with

>disabilities in the development, testing and data interpretation of

>disability-sensitive quality indicators. They also do not include

>disability-specific information that reflects evidence of flexibility and

>responsiveness to people with disabilities.

>

>People who have routine medical needs are usually most satisfied with HMO

>care. But those who have unusual or serious conditions often complain that

>the system is slow and bureaucratic, and that doctors often don't fully

>explain options. In addition providers operate under encouragements that

>involve keeping you within the limitations of the plan (Kristof)..

>

>If you require a diagnostic test that is not available within the plan, or the

>services of specialists who are not in the network, you may get next-best

>services. You can go outside the network for care. But if you do you will

>usually pay the full or partial cost yourself (Kristof)..

>

>The following list of questions can help guide your assessing a health care
>plans' disability experience and network capacity.

>

>

>>

>>

>> 2) "Strategies for Managing Your Health - becoming your own health
>> advocate" (have you considered encouraging them to do medical
>> research?):

>> - Inform yourself (and your doctor) about the latest medical
>> advancements that may affect your health:

>> - medical data bases available on the web

>> - obtaining research articles at Medical Libraries (journals)

>> - Know what questions to ask your doctor

>>

>> >Just so you know I've been working hard on the rtcmc project:

>>>

>> >Checkout the ** items - new

>>>

>> ><http://www.jik.com/pwdmc1.html>

>>>

>> >Understanding Managed Care

>> > Glossary

>>> Basics
>>> How to Pick a Plan
>>> How to Evaluate Your Current Plan
>>> Strategies for Managing Your Managed Care
>>>** What to Look for in Health Care Providers

>>> Qualifications
>>> Physical Access
>>> Communicate Access
>>> Financial Access
>>> Qualities and Attitudes
>>> Rating Providers
>>> Dangerous Warning Signs
>>>** Active Consumers

>>>

>>>

>>>also been working on extensive drafts of

>>>

>>>MANAGED CARE the basics including:

>>>-Health Care plan rules are constantly changing

>>>-types of plans

>>>- Fee-for-service

>>>- Managed care plans

>>>- Preferred Provider Organizations (PPOs)

>>>- differences between managed care and fee-for-service plans

>>>- Managed care advantages and disadvantages

>>>

>>>how to choose a plan:

>>>- Where to get good information

>>>- Quality

>>>- Choice of doctors and hospitals

>>>- Cost and Services

>>>- Travel

>>>- Rights and Protections

>>>

>>>

>>>managed care issues for people with disabilities and specific
>> conditions

>>>-disability expertise

>>>-physical, communication, and services access

>>>-access to specialists

>>>-availability of durable medical equipment and supplies

>>>-Health, Wellness and Prevention Services

>>>-Protection and rights

>>>-Prescription Drugs

>>>-Emergency Help

>>>

>>>

>>>--

>>>>June Isaacson Kailes 310.821.7080

>>>>310.827.0269 FAX

>>>>Disability Policy Consultant jik@pacbell.net

>>>>June's website <http://www.jik.com>

>>>>IL Net <http://www.ilru.org>

>>>>RTC Aging with Disability <http://www.usc.edu/go/awd>

>>>>U.S. Access Board <http://www.access-board.gov>

>>>>California Assist Tech System <http://www.catsca.com>

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>>>

>>> Get Your Private, Free Email at <http://www.hotmail.com>

>

>

>

>--

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>June's website <http://www.jik.com>

>IL Net <http://www.ilru.org>

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>California Assist Tech System <http://www.catsca.com>

>

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STATE OF CALIFORNIA

OFFICE MEMO
STD. 100 (REV. 10-91)

cc: Pamela ✓

DATE 5/13

TO

Lex Frieden

ROOM/STA. NO.

FROM

Brenda Premo

PHONE NUMBER

ATSS ☐

ROOM/STA. NO.

SUBJECT

FYI

Memorandum

Date: May 8, 1998

To: Brenda Premo, Director
Department of Rehabilitation
830 K Street

From: Office of the Director
714 P Street, Room 1253
657-1431

Subject: Consumer Coalition for Quality Health Care

Thank you very much for forwarding me the Consumer Coalition for Quality Health Care materials. This is material that will be very useful to us as we work to implement Governor Wilson's 16 point agenda for managed care reform in this legislative session (attached).

In my preliminary review of these materials, including the model legislation, we appear to be well aligned in our approach to many reforms. I will be sure to share copies of these materials with other key members of the managed care reform team at the Department of Corporations and the Consumer Services Agency

Brenda Premo

Page 2

who are also working diligently to implement effective managed care improvement reforms this year.

Thanks again for passing this along to me.

A handwritten signature in black ink, appearing to read "Kim", with a stylized flourish at the end.

S. Kimberly Belshé
Director

Attachment

OFFICE OF GOVERNOR PETE WILSON
FACT SHEET



"We have the ability to fundamentally enhance the quality of care our fellow Californians receive. Let's work together and act sensibly, in unison, to realize that goal."

*-- Governor Pete Wilson
January 28, 1998*

IMPROVING MANAGED CARE FOR CALIFORNIANS

Californians have increasingly turned to managed care for their health care needs: nearly 85 percent of insured Californians are currently under managed care health coverage. Over three out of four of them express satisfaction with their health plans, according to surveys. Even so, consumer complaints about benefits, medical care and delays have become more pronounced in recent years.

Governor Wilson, who has signed numerous laws to improve health care for Californians, is announcing his support for managed care reforms intended to assure accessible, affordable and quality health care, while avoiding quick fixes that could bankrupt the health care system and punish the very people the reforms were intended to help. These proposals are designed to:

- Safeguard or improve high quality of care;
- Prevent health care access from being diminished; and
- Protect the long-term economic health of California.

THE GROWTH OF MANAGED CARE

Americans in recent years have increasingly turned to various types of managed care in seeking health insurance coverage for themselves and their families. The trend shows no signs of slowing:

- The number of managed care enrollees nationwide has tripled from 22 million in 1985 to 67 million currently;
- Managed care enrollment posted its two biggest growth years ever in 1996 (16 percent) and 1997 (13 percent);
- Nationally, 85 percent of workers at firms with 10 or more employees are now enrolled in managed care, up from 77 percent in 1996 and 52 percent in 1993;
- Californians' membership in managed care plans has accelerated from 8.7 million in 1990 to 13.7 million in 1996.

California has been a leader in managed care, demonstrating to the nation that control of costs and quality of care are not mutually exclusive. Most Americans – and Californians – express satisfaction with their coverage:

- Nationally, 56 percent of managed care enrollees say they are completely or very satisfied with their providers, while only 19 percent report being dissatisfied, according to a 1997 survey by the National Committee for Quality Assurance.
- 76 percent of enrollees in California reported overall satisfaction with their coverage, according to a survey by the Governor's Managed Care Task Force.

The reasons for this growth include cost efficiency:

- Cost remains the biggest barrier to obtaining health insurance, even for workers, according to a joint UC Berkeley-UCLA health care study released last week which found that half of all uninsured Californians are in families headed by a full-time worker.
- Employers credit managed care with bringing their health insurance costs down from an inflation rate of 10-15 percent in the early 1990s, to less than 5 percent the past three years.

...improved services:

- According to the Governor's Managed Care Task Force, the best managed care practices have resulted in "improved measurement of outcomes, continuity and coordination of care, disease management, prevention and health promotion."

...and an emphasis on prevention and early diagnosis:

- Medicare HMO patients were diagnosed at much earlier stages than fee-for-service patients with melanoma, breast, cervix, and colon cancer, *American Journal of Public Health* reports.

Despite its growth and popularity, managed health care has not been immune from problems, including those that plague all other forms of health insurance – managed or unmanaged, for-profit or not-for-profit. Forty-two percent of Californians complained of some kind of problem in the last year, according to the Managed Health Care Improvement Task Force survey. These complaints ranged from paperwork to the quality of medical care to reporting delays to difficulty in seeing a specialist. Many states are now passing reforms of the managed care industry, tackling issues such as financial incentives for physicians and health plans, continuity of care, access to economic information, direct access to specialists, and the right to appeal denials of payment for care, according to the *Journal of the American Medical Association*.

GOVERNOR WILSON'S RECORD

Predating the current calls for reform, Governor Wilson has a solid record of addressing the problems of managed health care.

In 1997:

The Governor signed a law **improving the ability of consumers to get medical information**, including requiring the public disclosure of malpractice judgments, settlements and hospital disciplinary actions that result in the loss of a doctor's medical privileges (AB 103, Figueroa); and a law **requiring physicians to discuss appropriate prostate examinations and tests** (SB 1, Burton). Also in 1997, the Governor signed the **Newborn and Mothers Health Act**, providing that HMOs and health insurers may not restrict benefits for inpatient hospital care for less than 48 hours for normal deliveries, and 96 hours for Cesarean deliveries, if a physician determines that it is medically necessary in consultation with the mother (AB 38, Figueroa).

In 1996:

The Governor signed a law **disciplining HMOs and health insurers for imposing "gag" rules on physicians who advocate medically appropriate care** (SB 1805, Rosenthal), and another **protecting the ability of health care providers to discuss proposed treatments**, including those not covered by a consumer's health care plan (AB 3013, Alby). He also signed laws to **prohibit financial incentives that encourage the denial or delay of necessary care; to require HMOs to disclose their basic method of paying providers** (AB 2649, Thompson); **to require written policies on second opinions** (AB 3251, Gallegos); **to require expert review of experimental therapies and treatments denied to the terminally ill** (AB 1663, Friedman/Knowles); and **to improve the managed care arbitration process, including granting waivers for hardship cases** (SB 1660, Rosenthal).

In 1995:

The Governor instituted a toll-free consumer government hotline for complaints or information about managed care (AB 73, Friedman). The Governor also signed **reforms of managed care dispute procedures**, setting a 30-day timeframe for grievance resolution, requiring expedited resolution in emergency cases (SB 689, Rosenthal), and requiring HMOs to have provisions for dispute resolution mechanisms (AB 1840, Figueroa) and a **mechanism to resolve disputes with providers** (SB 454, Russell). That year, the Governor also signed legislation requiring HMOs to have **written policies regarding continuity of care** (AB 1152, Bordonaro); requiring they **disclose specialty care referral and utilization review procedures** to enrollees (AB 1266, Goldsmith); and prohibiting HMOs from **paying employees on the basis of the number of claims denied or the amount of money saved by denials** (AB 73, Friedman).

In 1994:

The Governor signed laws (SB 1832, Bergeson) requiring HMOs to **disclose the criteria and process used to deny any request for certain treatments; requiring claims reviewers to have the appropriate clinical expertise when reviewing denied claims on appeal; requiring plans to give providers a reason when provider contracts are terminated during the contract year; and prohibiting denial of claims for services that are pre-authorized by the plan.**

1994 continued: The Governor also required HMOs to make OB/GYNs available as primary care physicians, provided they meet criteria for serving as primary care physicians (AB 2493, Speier); required HMOs to provide expedited face-to-face conferences for terminally ill enrollees denied experimental treatment (AB 3244, Epple); and required HMOs that use arbitration to provide specific disclosure on enrollment forms (AB 3260, Bornstein).

In 1993:

The Governor signed legislation prohibiting HMOs from penalizing physicians for advocating medically appropriate care for their patients (AB 1676, Margolin).

In 1992:

The Governor signed legislation requiring HMOs to disclose the rationale for denying any claim (AB 2082, Felando). He also signed legislation providing funds for government oversight of managed care by increasing the annual cap on per-enrollee licensing fees paid by health care service plans (SB 3355, Assembly Judiciary Committee).

THE MANAGED CARE TASK FORCE

In 1997, Governor Wilson and the Legislature formed the Managed Health Care Improvement Task Force to report on the challenges and opportunities of improving managed health care. According to the Governor, "I wanted the task force's advice on how the public sector could establish a framework of laws, then step aside and allow the markets to do what they do best in every other industry: drive continuous quality improvement and control costs."

The 30-member panel, chaired by Stanford University business and health policy professor Alain Enthoven, was charged with comprehensively researching managed health care in California and providing recommendations regarding the appropriate role for government in monitoring and regulating managed care. On January 5th the task force completed its legislative and administrative recommendations.

THE HIPC MODEL

Governor Wilson understands the need for reform and improvement of the managed health care system, as well as the need to keep California's economy and competitiveness in good health.

The HIPC Model for Improved Coverage:

In 1992, the Governor signed legislation (AB 1672, Margolin) creating the Health Insurance Plan of California (HIPC), the nation's first statewide small business health insurance purchasing pool. Small employers (3-50 employees originally; 2-50 employees currently) are eligible for HIPC's purchasing cooperative, which is designed to expand health insurance and managed care choices available to working families and their dependents.

Since its inception, over 7,300 businesses and employer groups have signed up, reducing their health care costs by as much as 40 percent. HIPC currently provides insurance to more than 136,000 participating individuals, many of whom were previously uninsured.

In 1996, the Governor began the process of encouraging additional growth of purchasing pools by signing legislation (SB 1559, Peace) to authorize private voluntary health insurance purchasing groups to compete in the small group employer health care market with the HIPC.

Building on this successful model, in 1997 the Governor signed into law the Healthy Families plan to provide comprehensive, market-based health insurance coverage for children from working poor families that are unable to afford coverage but do not qualify for Medi-Cal benefits. Like HIPC, Healthy Families allows market competition to give families increased health care choice and flexibility, while providing government oversight to ensure quality and accountability.

GOVERNOR'S 1998 MANAGED CARE REFORMS

The Governor favors managed care reforms that, like HIPC and Healthy Families, rely on the free market instead of government mandates. To assure health care quality and protect access for workers, while providing the maximum amount of benefits to the largest possible number of Californians, the Governor is prepared to work with the Legislature to enact the following reforms:

Improving Oversight of Managed Care

- **Concentrated Oversight:** To improve quality control, accountability and efficiency, a new department whose sole focus is managed care oversight should be established. This new entity should be led by an individual regulator, whose sole mission would be to improve accountability, provide high quality of care and ensure solvency. Such an entity would be able to more flexibly respond to innovations in the rapidly evolving managed care marketplace. The department should work closely with the best minds in the medical community to ensure that the highest standard of medical science is practiced.
- **Quality of Care Information:** Consumers in most cases are unable to compare health plan and provider quality based on objective, scientific information. The new managed health care regulator should be authorized to obtain and publish standardized information on the results of treatments and providers, enabling consumers to obtain appropriate comparative information to drive improvements in the quality of care.

"The challenge now is to reform California's managed care system so more consumers enjoy trust and confidence..., and more Californians without coverage can receive quality, affordable health care."

-- Gov. Pete Wilson
January 28, 1998

Improving the Quality of Managed Care

To improve the quality of managed health care, the Governor recommends focusing on the patient/physician relationship, health plan performance and medical integrity:

- **Medically Necessary Treatment:** Many managed care disputes arise when a doctor recommends a particular treatment and the health plan denies coverage. To engender more confidence in the system, the Governor will work with the Legislature to develop improvements to the current managed health utilization review process.
- **Improved Continuity of Care:** In cases where the contractual relationship between a doctor and health plan has ended, patients with serious conditions should be allowed to complete a specified course of treatment with his or her physician after that physician is no longer part of the plan. Doctors would still be required to comply with all of the conditions of the health plan.
- **Extended Referrals to Specialists:** Many HMOs control costs by requiring patients to see a primary care doctor, or "gatekeeper," to obtain a referral to a specialist. Patients requiring specialized care over a long period of time for life-threatening, degenerative or disabling conditions should, in many cases, be allowed to get extended referrals to specialists. This would eliminate unnecessary and time-consuming duplicate visits by patients, while allowing plans to coordinate care and control costs by monitoring the referrals.
- **Prescription Drugs:** Because the fastest-growing health care expense today is prescription drugs, health plans have developed lists of approved drugs to be prescribed, called formularies. A drug formulary allows the health plan to negotiate bulk discounts, reduces the costs of stocking different drugs that are therapeutically equivalent, and requires doctors to use less expensive drugs. To ensure that patients have continued access to medically-necessary drugs, the Governor supports health plans disclosing which drugs they will pay for, as well as ensuring that decisions to put certain drugs on their formularies are based on medical effectiveness and not just cost considerations. In addition, a reasonable appeals process should be available to consumers.
- **Meeting the Needs of Women:**
 - ⇒ **Access to OB/GYN:** Most women receive an annual reproductive health exam provided by a specialist, such as an obstetrician/gynecologist (OB/GYN). The Governor supports providing women with the option of direct access to an OB/GYN without having to first go through a gatekeeper physician. Managed care plans should also be given the flexibility to develop different types of direct access arrangements that will allow them to control costs and coordinate care to women.
 - ⇒ **Mastectomy Stay:** To enhance the quality of care for women undergoing mastectomies and to enable treating physicians to determine the most appropriate care for their patients, the Governor believes that length of stay in a health facility should be determined by the patient's physician in consultation with the patient.
 - ⇒ **Contraception:** Coverage of contraceptive benefits in group policies should be assured. A conscience clause should be included, exempting employers and other organizations from this requirement on religious or conscientious grounds.

Improving the Effectiveness of Managed Care

Many of the difficulties the public experiences with managed care have less to do with the health care they receive than with how the managed care system operates, including the way it provides information to consumers. The Governor recognizes the need to improve disclosure and standardize information, expand consumer choice of providers, remove unnecessary bureaucratic processes, and expedite grievance and second opinion procedures.

- **Benefits Disclosure Matrix:** People often find it difficult to understand the similarities and differences among various health plans, despite existing laws which require health plans to disclose their benefits packages with some uniformity. To enable consumers to compare health plans, benefits packages and exclusions should be presented in a uniform matrix, similar to the disclosure matrix used by the Public Employees Retirement System (PERS).
- **Provider Payments and Incentives:** Many patients are concerned that managed health organizations reward doctors for denying or limiting necessary care through payment or incentive systems. To enhance consumer confidence, general payment methods and incentives should be clearly and concisely disclosed.
- **Expanding Provider and Coverage Choice:** Individuals and small employers lack the clout of large companies in negotiating health benefits packages and favorable rates. To expand consumer choice, the development of purchasing groups should be encouraged. Innovative consumer payment arrangements also should be explored to further expand consumer choice.
- **Uniform Dispute Resolution Standards:** When problems arise with managed care, arbitration is preferable to the costly and time-consuming court system. Consistent standards for arbitration and dispute resolution procedures should be developed and implemented to ensure fairness and resolve disputes in a timely fashion.
- **Grievance Procedures:** Many patients are confused by health plan grievance procedures and therefore fail to participate in the dispute resolution system. As a result, they are denied needed care or are forced to turn to the court system. Health plans and medical groups should, upon enrollment, provide consumers with full disclosure of grievance procedures. They should also assist patients in appealing decisions or filing grievances.
- **Second Medical Opinions:** Many consumers desire second medical opinions to confirm a physician's diagnosis. A second physician's opinion, when medically necessary, should be available to patients. If the plan's network does not include a provider qualified to give the second opinion, then an out-of-network doctor may be used.
- **Independent Review of Medical Necessity Decisions:** An independent, third-party review process can provide unbiased, expert-based reviews of requests for coverage of treatments for serious conditions that were denied because they were not deemed "medically necessary." The independent review process should be designed to ensure that all parties are able to use the review process responsibly.

STATE OF CALIFORNIA

OFFICE MEMO
STD. 100 (REV. 10-91)

Copy to Panula

DATE
5/13/1998

TO

Lex Frieden

ROOM/STA. NO.

FROM

Brenda Premo

PHONE NUMBER

ATSS ☐

ROOM/STA. NO.

SUBJECT

Lex I would like you to meet these
folks, there is potential for colaberation.
Also, distance learning.

May 12, 1998

Professor Elie Wiesel
Mellon Professor of Humanities
Boston University
745 Commonwealth Avenue
Boston, MA 02215

Dear Professor Wiesel:

Our last correspondence with you was brief, so we wanted to provide you with more information about an award that we would like to set up in your honor. After speaking with your assistant, Martha Hauptman, she suggested that we draft a letter to provide you with details of our purpose in contacting you.

First of all, speaking on behalf of Dr. Pumerantz, I would like to thank you for responding to previous correspondences. The hectic pace of your schedule obviously limits your time. We also would understand if you were unable to visit our campus to present the award that we would like to name in your honor. What we propose to do is to establish an "Elie Wiesel Humanism in Healing Award," that would be presented on an ongoing basis at our institution. Applicants for this award would be selected based upon merit and involvement in efforts to improve a local, national or worldwide community.

If you give us your permission to establish this award, we would make the first presentation to President George Bush at our convocation in August. He is selected as the initial recipient based on his signing of the Americans for Disabilities Act. Our University is in the process of establishing a Center for Disability Issues and the Health Professions. The goal of this center is to recommend modifications in curriculum that would improve doctor-patient relationships for individuals with disabilities. A separate goal is to establish this center as an indispensable national resource for those interested in gaining realistic answers about disabilities.

Once again, we do not mean to place pressures on your demands. With your consent, we will establish this award program.

Sincerely,

Suzane Bricker
Grant Writer & Foundations Associate
Ph (909) 469-5525

May 12, 1998

President George Bush
10000 Memorial Drive
Suite 900
Houston, Texas 77024

Dear President Bush:

We invite you to be the keynote speaker at our Convocation ceremony in August, where we will officially inaugurate our Center for Disability Issues and the Health Professions. You would honor us by your presence and by sharing your unique reflections on the historical step you took in the signing the Americans with Disabilities Act.

The decision to establish a Center for Disability Issues and the Health Professions emphasizes Western University of Health Sciences' commitment to quality education. We embrace a philosophy of compassionate health built upon a foundation of scientific excellence. Western University, located in Pomona, California, educates healthcare professionals in a culture that prepares them to be skilled, compassionate and humanistic givers, who are sensitive to their patients' needs.

To compliment the goals of this institution, we are in the process of working to establish an "Elie Wiesel Humanism in Healing Award;" named after the famous noble laureate. Our intent is to make the first presentation of this award to you during your appearance on our campus in August. However, we are still corresponding with Mr. Wiesel's office, and anticipate a possible delay in receiving an answer, since he is out of the country.

Meanwhile, we are continuing to develop the center, which we believe, will provide a vital national resource to those interested in gaining realistic answers about disabilities. Recently, we held a Conference on Health Services Needs of People with Disabilities. The focus of this conference was to establish a broad foundation for educational and other reforms in the health professions. Attendees were asked to become part of the center's initial advisory board. Two of these individuals were present to watch you sign the American for Disabilities Act, and another was appointed by President Reagan as physician of the year.

Thank you in advance for your time and attention to this matter. We look forward to your response.

Sincerely,

Philip Pumerantz, Ph.D.



WESTERN UNIVERSITY OF HEALTH SCIENCES

WesternU • 309 E. Second Street • Pomona, California • 91766-1854 • (909) 469-5365

OFFICES OF PHILANTHROPY FAX COVER SHEET

DATE: 05-12-98
TO: Brenda Premo
OFFICE: _____
PHONE: _____
FAX: (916) 327-4567

PAGES (includes cover): 3
FROM: Subaru of America
Grants and Foundations
OFFICE: _____
PHONE: (909) 469-5525
FAX: (909) 469-5357

MESSAGE:

FyI

If you have any trouble receiving this fax, please call originator and report the problem. Thanks.

Pring Andrew
Sue Shivers
Greg Albrit

W. Gayman - Spence
Shore Foundation
Bill Walker

Bob Parker

Ed Thornton

Wynne Humphrey

Bill Hume and Brock Farbell

Joe Williams

Malice Foundation

Justin Post

Charles Ingram

New Tulsa Foundation

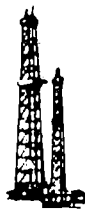
Tulsa Dealer Ball

Woodruff

Howard Wolf

Pat Overlander

Check with Fred Newman about Olive
check with Bridge
check with Pete



Giddings Sands Motel

1600 East Austin - Giddings, Texas 78942

need to retire while working full time
need to retire at highest salary
need disability retirement for SSDI, BCM,
and medicare

disability retirement due to ~~bladder~~ bladder
leakage, and skin weakness

loss of grants means untimely retirement
ageing with disability will cause need to
work part time
SSDI and medicare changing except for those who
are grandfathered

talk to Dr Carter

see results of personal endowment
appeal - Oklahoma Foundations

talk to lawyer and development office at BCM about
endowing own position with insurance of disability
retirement

Tuesday, June 27, 1995

Lex:

1) Wendy called looking for a VIP to do the "Welcome to Houston" message at their National Association of ADA coordinators on September 19 at a hotel in Houston out by IAH. Greg Abbott will talk for lunch. I told her you would just be getting back from Jakarta and I didn't know if jet lag would be involved.

2) Beth Walberg, 668-0940 saw the REAL LIFE show on managed care this weekend. She asked if she could get a copy of the show on tape. She'd like to get info whether TIRR or other organizations Lex is associated with are supporting certain managed care legislation. She is "unfortunately, a consumer of managed care." She thought John Banja was very good and asked for his telephone number. She asked when the show was taped because there was some legislation that Governor Bush vetoed about that time. She asked if we had a legislative aide.

3) We're having more problems involving people with hearing impairments. I may have told you that we had a referral of a woman with hearing loss and a stroke. Apparently she came over and we weren't ready for her. They were expecting an interpreter at the front door. Normally, the patient comes over with the family and they discuss the patient's needs, etc., and then an interpreter is brought in. The problem this time was communication. Nobody told the family. The son was with the mother and instead of interpreting for the mother, just sat there to make a point about having an interpreter present. The son got very upset with the social worker and that's when Jeanenne (Guest Relations Person) was brought in. In the meantime, the social worker got upset with the Social Work secretary (Evelyn) about not having these arrangements made--but, they've never done it this way before--and the SW Secretary roared to the Grants Administration Secretary "if Lex doesn't find me a job, I'm going to quit--I can't work without Frances!" I'm sorry--all I said was that I'd ask Lex if there were going to be any openings at ILRU! To top it off, this patient's son knows Lex and Laurie Redd--Paul Fincher--and he called the ADA Technical Assistance Center. They arranged to have a Sign Shares Interpreter come in, but they only have Class I interpreters and he wanted a Class 3 (because it says in TIRR's patient Handbook (produced by Social Work) that TIRR will provide a Class 3 interpreter.

Laurie called about it. She was an advocate for him and called Kathleen. Basically nobody was telling him the plan. I think what got him most was that he was very relieved when they found out they were going to TIRR because he wouldn't have to have all these battles! You may want to ask Laurie about it.

Per Jeanenne, they are getting a TTY telephone in her room and a close-captioned television set in there, too.

4) I finished my survey of health benefits, but couldn't remember what you suggested putting in the "List ways BCM could make your benefits program more valuable to you and your family."

OVER

Rehab is changing to
rapidly

want to do full time
advocacy

don't want to lose benefits
which I have paid for

want to spend some time
in life relaxing

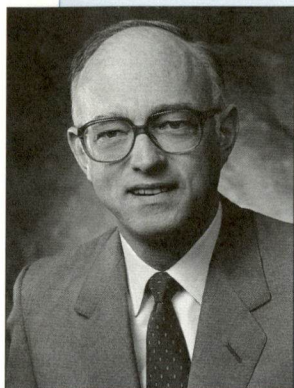
worked full time 22 years
paid for the benefits through
contributions



Clarion Hotel
Grand Pacific



Harbourview



FROM THE PRESIDENT

Expanding Research Space in an Environment of Fiscal Restraint: Does It Make Sense?

Groundbreaking ceremonies for the Albert B. Alkek Graduate School of Biomedical Sciences building served as a reminder of the important issues that must be addressed before a decision is made to expand research capacity. These issues relate both to Baylor's vision for the future and to important national scientific and economic forces.

All academic medical centers face intense pressures from the joint challenges of managed care and weakening federal support for research. Even with a modest increase in its State appropriation, Baylor will operate without a budget increase in the coming year.

With all these factors in mind, why construct a new building that will be devoted primarily to research?

Baylor ranks among the nation's leaders in biomedical research, and the College's faculty and administration have developed a strategic plan that depends upon maintaining and enhancing this position of leadership. Research quality is determined by two principal elements. First, and foremost, is a faculty of genuine excellence; second is the resources to carry out the faculty's work. Even in a highly-competitive environment, if these two components are in place, research support, both public and private, will follow.

Many of the research-intensive medical schools with which Baylor competes for scientists and research support have acquired new research space in the last five years and are, as a consequence, highly competitive for these two vital resources. Baylor's last research expansion was the Vivian and Bob Smith Medical Research Building, occupied six years ago. It will be at least eight years from that time before new space can be occupied in the Alkek building, and the College has no space left for expansion between now and then.

The space expansion in the 1980s made possible major new investments in molecular genetics and neuroscience. Had space been unavailable, the College's current distinguished position in these disciplines would not have been realized. Having unfinished "shell" space available also has enabled the College to attract grants and contributions from foundations and private donors, such as the Howard Hughes Medical Institute, the W.M. Keck Foundation, the Cullen Foundation, the Shell Oil Foundation, and Tenneco, to name a few. Within the context of protecting and strengthening Baylor's strategic position in research, yes, expanding research capacity does make sense.

Spencer, Busch, and DuPont Named to New Chairs

Chairs endowed in Cardiology, Pharmacology, and Internal Medicine.

The Baylor Board of Trustees has approved three new academic chairs, each endowed at \$1 million: The T.L.L. Temple Family Chair of Clinical Cardiology; the Michael E. DeBakey, M.D., Chair in Pharmacology; and the H. Irving Schweppe, Jr., M.D., Chair in Internal Medicine.

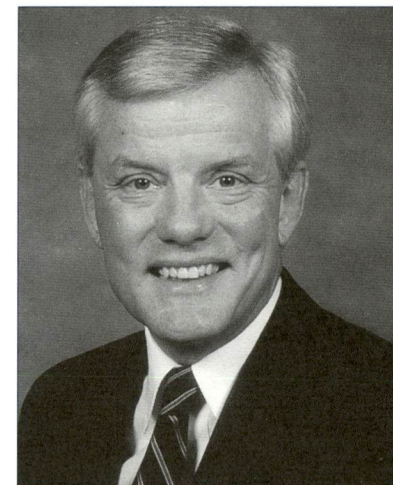
"Baylor is fortunate to have benefactors who share our vision for continued growth and excellence," said J.A. Elkins, Jr., Chairman of the Baylor Board.

William H. Spencer III, M.D., was named to the Temple Chair, funded by the T.L.L. Temple Foundation of Lufkin; Harris Busch, M.D., Ph.D., is the recipient of the DeBakey Chair, funded in part by the DeBakey Medical Foundation; and Herbert L. DuPont, M.D., was named to the Schweppe Chair, which was created by an endowment held by St. Luke's Episcopal Hospital to benefit the Baylor-affiliated St. Luke's Medicine Service.

"Dr. Spencer, Dr. Busch, and Dr. DuPont are academic leaders," said Baylor President William T. Butler, M.D. "The chairs will ensure further advances in research, training, and education in key disciplines."

Spencer

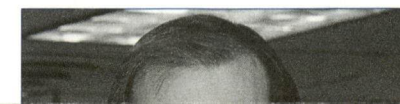
A Baylor Professor of Medicine, Spencer is Director of the Pacemaker



Spencer



Busch



William T. Butler, M.D.

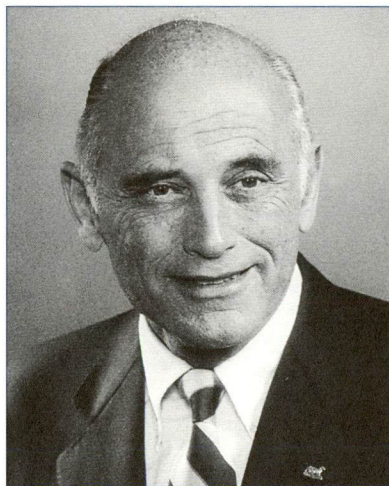
Plastic Surgery Head Resigns

Spira will remain active on the Baylor faculty.

Melvin Spira, M.D., D.D.S., will resign as Head of the Division of Plastic Surgery—a position he has held since 1976—on July 1. He will retain his faculty appointment of Professor of Plastic Surgery and will work full-time on his clinical practice, teaching, and research responsibilities.

"I've run the Division for a number of years and I'm ready to do other things," said Spira, who is also editing a handbook on plastic surgery.

"Melvin Spira possesses immeasurable skills as a plastic surgeon and an enthusiasm for passing on those skills to his students," said Baylor President William T. Butler, M.D. "We are very grateful for his nearly two decades of leadership as Head of the Division of Plastic Surgery."



Spira

A member of the Baylor faculty since 1961, he is Chief of Plastic Surgery at The Methodist Hospital, St. Luke's Episcopal Hospital, and Ben Taub General Hospital.

An M.D. graduate of the Medical College of Georgia, Spira served an internship at Duke University Hospital in Durham, NC, and residencies at Duke and Jefferson Davis Hospital in Houston. He earned his D.D.S. degree from Northwestern University Dental School in Chicago.

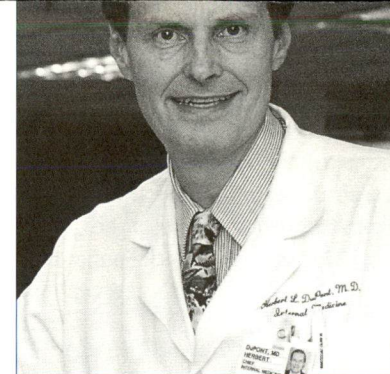
Spira is a former Chairman of the American Board of Plastic Surgery, a Past

President of the American Association of Plastic Surgeons, and was recently honored by the Baylor Medical Alumni Association as a Distinguished Faculty Member. □

and Arrhythmia Section at The Methodist Hospital. He received his M.D. from Duke University School of Medicine. He serves on the editorial board of *Clinical Cardiology*, and is a member of the International Medical Educational Corporation Advisory Board, the American Medical Association, and the Texas Medical Association.

Spencer is a Fellow of the American Heart Association Council on

(Continued on page 3)



DuPont

In Memoriam: Abner McCall

Abner V. McCall, J.D., Baylor College of Medicine Trustee Emeritus and Baylor University President Emeritus, died June 11. He was 80.

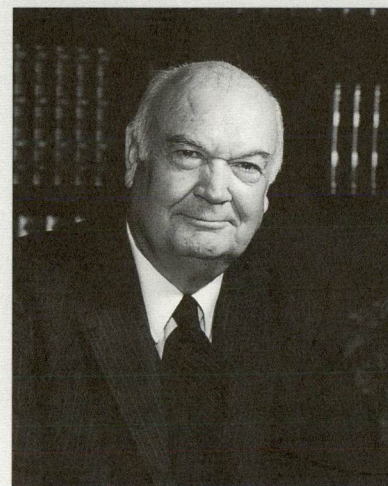
"We've lost a Board member of historic importance to Baylor College of Medicine," said Chairman J.A. Elkins, Jr. "Abner McCall was President of Baylor University in Waco when Baylor College of Medicine

separated from the University in 1969. His support for the independence of the medical school in the interest of its growth, and his signature on the Articles of Incorporation for Baylor College of Medicine serve as a reminder of the role he played in helping the College achieve international prominence."

McCall had been a Baylor Trustee since 1969. He was elected to emeritus status in 1986, and was awarded a trustee medallion in 1988.

A native of Perrin, TX, McCall received his J.D. degree from Baylor University and an LL.M. from the University of Michigan. Before he became President of Baylor University in 1961, he served as Dean of Baylor's Law School and then as Executive Vice President. He had been President Emeritus since 1985.

McCall had also been President of the Scottish Rite Foundation of Texas and a Trustee of the Baylor Medical Foundation. In 1979, the Texas Legislative Conference named him "Texan of the Year." □



McCall

REFLECTIONS...

"There Was Never a Point at Which You Were Done Studying..."

The "three P's" made my four years of medical education at Baylor successful: professors, peers, and patients.

The Baylor faculty is excellent. My teachers served as role models of good physicians, and provided goals to work toward in the clinic as well as the classroom.

From my fellow classmates, I gained strong friendships based on common interests and shared experiences. Long nights on call at the hospital and late-night study sessions pulled many of us together. We learned to face the illnesses—and sometimes death—of our patients.

Working with patients taught me as much about myself as they did about medicine. In fact, my positive experiences taking care of children with cancer influenced my decision to enter a residency in pediatrics. The kids' ability to deal with extremely tough issues like death is amazing, as is their resilience and ability to recover from really horrible illnesses.

Friends at other medical schools are envious of the training I received at Baylor, because nothing else compares with the Texas Medical Center. The wide variety of settings and hospitals I worked in exposed me to all areas of medicine—from private and public

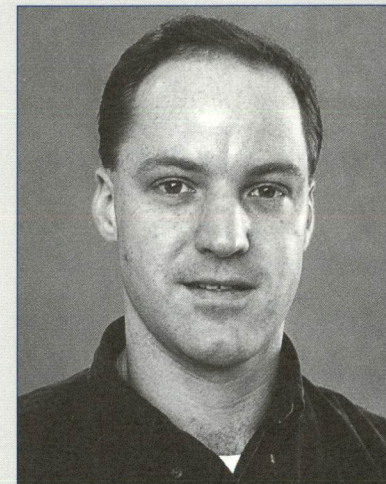
hospitals to clinics in the suburbs and physicians in private practice.

Having just received my M.D., I look back proudly on the hard work it took to earn that degree. I remember picking up a course syllabus that seemed like a stack of papers two feet thick on the first day of medical school. I went home thinking I had to start studying right away, even though the second- and third-year students kept telling me to relax the first few weeks of school. There's nothing you can do that first year to get over the anxiety.

Keeping up with the large volume of material was a constant challenge. During exam week, it was common not to get more than two or three hours of sleep each day. Those were the nights you set three alarms: one next to the bed, one across the room in case you fell back asleep after turning off the first one, and a battery-operated alarm in case the electricity went out.

There was never a point at which you were done studying, because there was always more that could be learned. You strived for the point at which you felt prepared enough for the task at hand.

The hardest thing about medical school was learning to feel dumb without losing self-esteem. When the other med students and I first went onto the hospital wards, we were asked ques-



tions we couldn't possibly answer. But we're such compulsive people that we *wanted* to know all the answers.

As physicians in a world where medical discoveries are made daily, we will never be finished learning. But with the knowledge I've acquired during the past four years, I feel "prepared enough" to enter the next stage of medical education: my residency at Baylor.

*Brad C. Weselman, M.D.
Class of '95*

Center for Ethics Renamed and Expanded

New Center for Medical Ethics and Health Policy will focus more on outcomes research; Brody will remain Director.

In light of changes in the health care environment, and to encourage inter-departmental research on resulting

tions and practices considered unnecessary or wasteful. Several groups of Baylor researchers currently involved in this area will work more closely with the Center and form new

The Center will also offer secondary appointments to clinicians interested in medical ethics and health policy, coordinate monthly research seminars, and try to find funding for

policy issues, Baylor's Center for Ethics, Medicine, and Public Issues has been given a new name and additional responsibilities.

Along with studying traditional ethics, the Center for Medical Ethics and Health Policy will be involved in broader policy issues like health care reform and medical practice guidelines based on outcomes research.

"Primarily, the new name recognizes a change in the Center's research focus," said Baruch A. Brody, Ph.D., the Center's Director since its establishment in 1982.

The Center will be more involved in outcomes research, which studies medical interven-

closely with the Center and form a cohesive research group.

Outcomes research is part of evaluative clinical sciences—one of three new areas of interdepartmental research to which Baylor committed as part of the Executive Faculty's strategic plan last year. The Center for Medical Ethics and Health Policy will give Baylor the opportunity to play an active role in evaluating the outcomes of different interventions.

The shift in research reflects the changing role of health care and the increased involvement of the Center's faculty in this area over the past few years.

research seminars, and try to find funding for research efforts. □

Addition

The late George L. Jordan, Jr., M.D., was omitted from the list of Baylor Distinguished Service Professors in the April issue of *Baylor Medicine*. Jordan was named a Distinguished Service Professor of Surgery in 1978. □

New Trustees *(Continued from front page)*

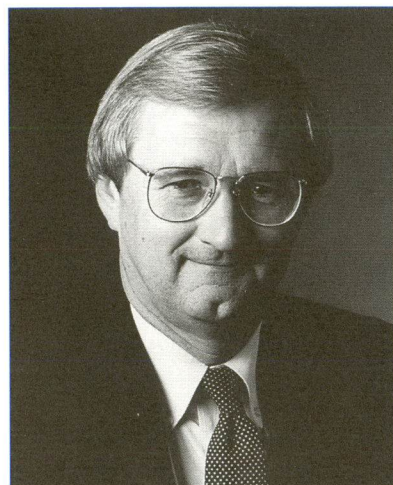
Fine Arts, and the American Petroleum Institute. He is a Director and former National Chairman of Junior Achievement, Inc., and was Chairman of the United Way of the Texas Gulf Coast 1993 campaign.

Williams, a native Houstonian, is President of Alkek Oil Corporation and M&A

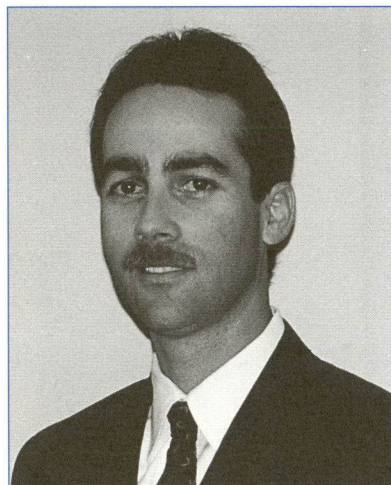
Properties, a company that oversees varied ranching interests. He received a B.B.A. from Southwestern University and an M.B.A. from St. Mary's University in San Antonio.

Williams has been associated with Alkek Oil Corporation for several years, previously managing the company's supply and distribution.

"Baylor's Board of Trustees has long benefited from the combined leadership of its diverse and talented members," Chairman J.A. Elkins, Jr., said. "Mr. Hendrix and Mr. Williams are welcome and valuable additions to the Board." □



Hendrix



Williams

Arnold Appointed Chairman-Elect

Daniel C. Arnold was appointed as Chairman-Elect of the Board of Trustees at Baylor College of Medicine's annual meeting in May. He will assume the Chairmanship at the annual meeting next May, when the incumbent Chairman, J.A. Elkins, Jr., will become Chairman Emeritus.

Arnold has been active on Baylor's Board since 1969, having served as Chairman of the Institutional Affiliations Committee and as a member of the Executive Committee of the Board since that time, and having chaired the \$175 million New Century Campaign recently.

The Baylor Board of Trustees also announced two other administrative changes:

J. Hugh Liedtke, a Trustee since 1969, has assumed emeritus status. He is also Chairman Emeritus of Pennzoil.

The Rt. Rev. Maurice M. Benitez, D.D., elected to the Board in 1980, retired. In February, he also retired as Bishop of the Episcopal Diocese of Texas, a position he had held since 1980. □

See Page 11
for Subscription
Information

Complimentary
Issue

Ellerbe Becket and DOJ Reach ADA Settlement Agreement

"Unobstructed Sight Line" Issue Clarified

One of the nation's largest architectural firms has agreed to design future facilities so that all or almost all of the wheelchair seating locations provide persons with disabilities sight lines over the heads of people standing in front of them.

The agreement settles a lawsuit brought by the Department of Justice in October 1996. The suit alleges Ellerbe Becket violated the Americans with Disabilities Act (ADA) by designing six stadiums and arenas that failed to provide fans with disabilities who use wheelchairs lines of sight comparable to those of the general public. The facilities named in the suit were: the Fleet Center in Boston, the Marine Midland Arena in Buffalo, the Gund Arena in Cleveland, the Corestates Arena in Philadelphia, the Rose Garden in Portland, and the MCI Center in Washington, D.C.

Ellerbe Becket countered that ADA regulations were unclear and open to interpretation as to what precisely was be-

ing required and that all of its sports facilities provided a substantial number of elevated sightlines for spectators in wheelchairs.

See Agreement, page 3



An example of the controversial sightlines (the Olympic Stadium in Atlanta).

Interest and Innovation in Acoustical Wayfinding

Ever try to hear an announcer over a loudspeaker when you're battling the cacophony of a subway system, train station, or an airport on a crowded day? Ever try to find your way around in a building designed with 45 degree angles and no visual landmarks? When extraneous noise is excessive, when visual relationships are difficult to comprehend, and you must rely on acoustical cues, it's usually not easy to find your way around.

Acoustical design should go way beyond ambiance. It should take into consideration every person that enters a public place — people with disabilities, the aging population, and people with visual and hearing impairments.

Structuring the environment to help people with visual impairments get from one point to another is called wayfinding. Architects, designers and builders could use acoustics to do this.

"Wayfinding is synonymous with the orientation component of orientation and mobility," says Bruce Blasch, a research health

See Acoustical Wayfinding, page 4

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The Past is But Prologue

This month marks the 8th anniversary of the Americans with Disabilities Act. Since its inception, we've seen dramatic changes in both the interpretation of the law and the expectations of the public. In particular businesses have been surprised by recent interpretations of what is considered reasonable and affordable to make facilities accessible to people with disabilities and people with disabilities are growing increasingly frustrated with their perception of the slowness or lack of enforcement.

All the while, ADA case law and the enforcement records are piling up. In addition to the cases discussed in FedWatch (page 3), consider:

- The National Collegiate Athletic Association (NCAA) and the Professional Golf Association (PGA) have both been ruled to be "public accommodations," making them responsible for complying with provisions of Title III of the ADA in their events and programs.

- The US Architectural and Transportation Barriers Compliance Board's (Access Board's) proposed design criteria for playgrounds promises accessibility to children throughout the country at a cost estimated in the hundreds of millions for elementary schools, day care centers and municipal recreation facilities, not to mention businesses (such as fast food restaurants with play areas).

- Many cultural and civic organizations with volunteer support will now have to make readily achievable modifications to their employee areas as well as their public areas, according to DOJ.

- Additional companion seating in front of the accessible seating locations (beyond the minimums required in the ADA Standards for Accessible Design (ADA Standards) is being required at the SCOPE arena in Norfolk, Va. as part of their settlement agreement with the DOJ.

- A newly constructed second floor addition for the Town of Tyrone, N.Y. is to be abandoned for all activities other than storage, since it didn't comply with the path of travel requirements of the ADA Standards.

During this same period, *Mouth*, the bimonthly magazine that describes itself as the "voice of the disability nation," and *Mainstream*, the "magazine

of the able-disabled" have lambasted the DOJ for their lack of lawsuits enforcing the ADA. People with disabilities are growing impatient with the speed of change in our society. They are becoming organized and initiating lawsuits in every state of the union, challenging businesses and municipalities to provide equal access for everyone.

This is an important time to follow the development of accessibility criteria and legal interpretations of the ADA. After eight years we are finding many nuances of the basic requirements being redefined and expanded. The passage of the ADA was an important landmark, but this observer believes that it was only the prologue for a massive reevaluation of how we design buildings, products and systems in the United States.

Letter to the Editor

California Code Change

In California, a state building change has been proposed to eliminate the hardship exemptions for Path of Travel components of alterations projects. Since 1981, path of travel upgrades to altered areas have been exempted, if the total cost of the alteration was below a cost threshold. Re-set yearly, the threshold has climbed steadily since the 1980s.

This effort is an attempt to bring California code into compliance with the Americans with Disabilities Act Standards for Accessible Design as the state attempts to have its code certified by the Department of Justice. This could have significant impact on the commercial and office rental stock in California. Eighteen years of tenant improvements were performed with this exception. Many jurisdictions continued to permit the exemptions after the passage of the ADA. Typically restroom, drinking fountain and public telephone access were exempted. Under the ADA, these may now require mitigation.

Public comment on the proposal can be sent to: Calif. Building Standards Commission, 1300 I Street, 7th Floor, Sacramento, CA 95814.

John Paul Scott, AIA

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Letters to the Editor

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Franchisor Liability

Federal courts are apparently split on whether or not franchisors are liable for Americans with Disabilities Act (ADA) violations.

The U.S. District Court for the Central District of Illinois ruled in *United States v. Days Inns of America* that nationwide hotel franchisors, Days Inns of America Inc. (DIA) and its parent company Hospitality Franchise Systems Inc. (HFS), are responsible for violations of the ADA's new construction requirements at a Days Inn hotel in Champaign, Ill. Because of the extent of their supervisory role in carrying out the franchise agreement, the court found franchisors DIA and HFS liable because they had "designed and constructed" the facility and alternatively because they "operate" it. The court ordered that the case proceed on identifying specific violations of the ADA's Standards for Accessible Design and assessing damages.

In another case brought by the Department of Justice (DOJ), the US District Court for the Eastern District of California ruled that franchisors DIA and HFS were not responsible for new construction violations at Willows, Calif. Days Inn hotel. DOJ is appealing that decision and a similar, earlier ruling by the U.S. District Court for the District of South Dakota that the franchisors were not liable for violations at the Wall, S.D. Days Inn.

Acoustics in Classrooms

The US Architectural & Transportation Barriers Compliance Board (Access Board) has published a request for information on acoustics in response to a petition to establish requirements for acoustics in

classrooms. The deadline for comments is July 31. For more information contact www.access-board.gov

Access Board Accepting Comments on Play Facilities

The Access Board is accepting comments on its Notice of Proposed Rulemaking on Play Facilities. The proposed guidelines were developed by a regulatory negotiation committee made up of representatives of people who would be affected by the guidelines. The deadline for comments is July 29.

DOJ Settles with Branson, Mo. Restaurant and Architect

DOJ entered into a settlement agreement with the Paradise Grill restaurant in Branson, Mo., resolving a complaint alleging that the restaurant was not designed and constructed in compliance with the new construction standards of the Americans with Disabilities Act. The owner and architect agreed to make the necessary changes to the parking facilities, main entrance, signage and restrooms. In addition, the architect paid \$1,000 and the owner paid \$1,500 in civil penalties.

HUD Takes Action

For the first time, the US Department of Housing and Urban Development (HUD) is requiring an Illinois builder to spend \$61,000 to fix eight ground floor condominiums that are not in compliance with the Fair Housing Act. The architect will pay \$9,000 to settle housing discrimination accusations. ■

... the court found franchisors DIA and HFS liable because they had "designed and constructed" the facility and alternatively because they "operate" it.

UK Mandates Visitable Homes

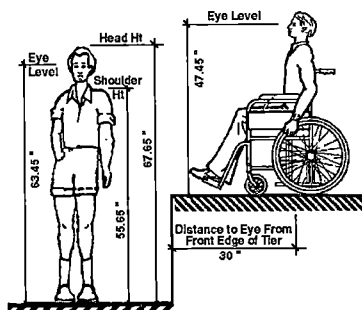
This spring the British Parliament passed legislation requiring that every new home must have an entrance without steps, a downstairs bathroom, sufficiently wide halls, doorways passable by wheelchairs and other elements of universal design.

"There will be direct benefits of increased convenience, accessibility and sociability for disabled people," according to UK Construction Minister Nick Raynsford. "The measures will also help significantly those people who are temporarily disabled through accident or injury, the elderly and those with young children in prams or push carts." The requirements will take effect in the spring of 1999. ■

Agreement, from page 1

The agreement was approved by the U.S. District Court in Minneapolis and announced by DOJ on April 27, 1998.

New Agreed Upon Dimensions Line of Sight



Acoustical Wayfinding, from page 1

scientist at the Atlanta VA Medical Center and one of the editors of *Foundations of Orientation Mobility*. "As mobility specialists, we teach people to use the environment to make their way around. We pay attention to things like building design that will facilitate them being oriented and moving around safely."

David Lubman, a California acoustical consultant advises, "We should incorporate everyone when we design a space or building. We seem to make the same mistakes over and over. We forget that high noise or reverberation makes it impossible for [people with hearing impairments or visual impairments] and people with limited English proficiency to hear and find their way around."

Standard noise criteria have worked well in some respects, says Lubman, but it is based on three assumptions. Those assumptions are:

- all users possess normal hearing,
- communication is intended for normal social discourse, and
- talkers and listeners are native to the American language.

"The open office spaces, bigger malls and larger airports are places that make it hard to localize sounds. This makes it even more of a

Reduced reverberation means access

by Robert Nichols and Gerald Henning

Auditory communication in the New York City railway system stations is difficult for patrons with normal hearing and almost impossible for those with hearing limitations. Noise from people and trains reverberates around the stations, making it extremely difficult to determine the direction from which the sound is emanating — a primary means of orientation for people with the visual impairments.

Our study of the railway system found that the reverberant noise levels in a typical New York City railway station are very high — so high, in fact, that it is difficult for those with no hearing loss to clearly decipher public announcements made over the audio system. These levels are due in large part to the prevalence of non-absorptive construction and finishes such as concrete, steel, and ceramic tile.

We found that high levels of reverberation in the stations could be cost-effectively reduced with the installation of various sound absorptive materials in strategic wall and ceiling locations. If implemented, everyone who relies on the railway system for transportation will benefit from clearer audio communications. For people with hearing and visual impairments, however, reduced reverberation in railway stations means access, self sufficiency and a better quality of life.

Editor's Note: This is an excerpt from an article about a research project written by Robert Nichols, president of Nichols Design Associates Inc. and Gerald Henning, vice president of Miller Henning Associates Inc. The complete report is available from Nichols Design email NDARCH@pipeline.com or call 703.519.2198 (v/tty/fax). 

Blasch agrees, "Sound is a major component for visually impaired persons. My feeling is that the environment is actually getting worse for them. Open office spaces, malls and large airports are places where it difficult to localize sounds."

Advances In Acoustical Wayfinding

There have been some innovative advances in acoustical wayfinding. For instance, acoustical wayfinding is now used at crosswalks in some cities in the form of beeping or chirping sounds. "Walk" and "Don't Walk" signs beep to let people know when it's okay to walk. In many airport moving walkways, an automated voice will prompt users when they approach the end of the walkway.

"You could apply these advances to many public places," says Jeff Loether, founder and president of Electro-Media Design, Ltd. in Rockville, Md. "For instance, if a person gets too close to the edge of a train track, it could trigger a low growling noise or some other warning sound."

Another way of preventing the public from entering restricted spaces is to use low-level music, explains Loether. "The background music is played in the corridors and other public circulation areas so the music invites the public to be there. If they wander to an area where they shouldn't be, the music will stop."

Blasch points out other hi-tech wayfinding devices like the GPS—Global Positioning System. GPS systems give users their position from satellites. Arkenstone, a nonprofit organization that develops and distributes equipment to help people with visual and reading impairments, developed a GPS system interrelated with a mapping system where pedestrians can program their destination and get a verbal output describing the routes to get there.

"There are some limitations to these systems, but they have potential," says Blasch. "GPSs don't always work in big cities because tall buildings may affect reception from the satellite. But, we aren't far off if we incorporate a device like this with cellular triangulation—using cell phone technology."

"There's also been a lot of research at [the Massachusetts Institute of Technology] on computers the size of a pager so you can literally wear it on your belt," says Blasch.

However, as Blasch points out, there are so few people who are legally blind in our population, turning out any kind of new technology in an affordable way is very difficult. "The thing to do is to tie the technology into something that everyone can use," says Blasch. "This can bring the cost way down." He

See Acoustical Wayfinding, page 5

Acoustical Wayfinding, from page 4

notes that cruise control was originally developed for people with disabilities.

A Sign of the Times

Another commercially available item called Talking Signs® is cropping up across the country. Talking Signs® technology is an infrared wireless communications system that provides remote directional human voice messages to people with visual and print disabilities.

Short audio messages are broadcast by invisible infrared light beams from permanently installed transmitters to near-by hand-held receivers. The receiver decodes the signal and delivers the voice message through its speaker or headset. The system works indoors and outdoors.

For example, upon entering a lobby, a user might detect "information desk" when pointing the receiver directly ahead, "public telephones" when pointing to the right and "stairs to the second floor" when pointing to the left. The technology was pioneered and developed at Smith-Kettlewell Eye Research Institute, Rehabilitation Engineering Research Center in San Francisco.

Talking Signs® installations include Bay Area Rapid Transit (BART) and City Hall in San Francisco; the Lighthouse Inc. in New York City; Texas School for the Blind; and many others around the world, including in Japan and Scotland.

Designer Be Aware

There are many common sense ways to include wayfinding concepts in architectural design. First, when designing a project, look at it from a practical point of view, says Blasch.

"Be aware and recognize when a problem is being created," Blasch explains. "Think, 'how can I design [this space] to reduce the environmental demand on different disability groups or people with limitations?' Be aware of the technology that's available."

One device that won't help, says Lubman, is installing 'white' or 'pink' noise in an open environment. While it creates a more private environment for others, it's "warfare" for people with visual and hearing impairments.

Another critical element is lighting, says Blasch. He points out that 85 percent of all people who are legally blind have some vision so lighting is important.

Signage is also critical. It needs to be distinct, and placed consistently in the environment.

Finally, he says, have a logical layout. "If there's a building with numerous 45 degree turns, it's very difficult to maintain orientation," he says. "Use significant landmarks, something that makes it easy to

find your way.

The Future Sounds Bright

There's great potential in the growth of acoustical wayfinding. Blasch shares an idea he calls "Cybercrumbs." "It's like using bread crumbs to find your way back," he says. "We are looking to install wafer-type devices along the walls or baseboards [in buildings] to give feedback on direction."

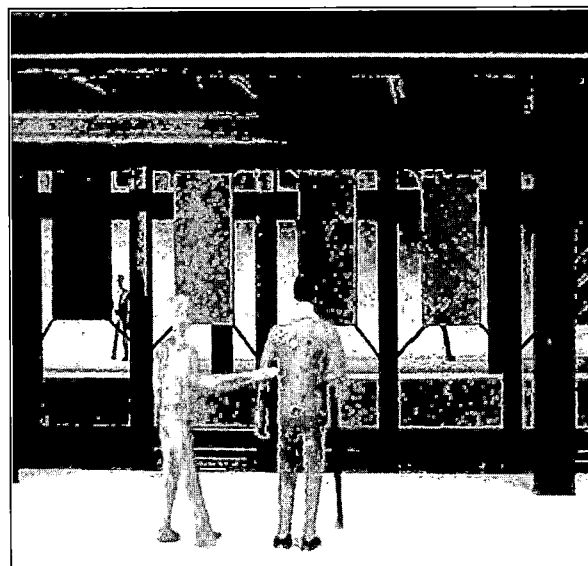
One such system is the Raynes Rail™, a handrail system that guides people through a facility using Braille messages. Designed by Coco Raynes, the rail provides continuous messages on its inner face. It describes the floor plan and corridor patterns and announces the location of offices, ramps, stairs and elevators.

Another option, Blasch explains, is voice output kiosks. People can access the kiosk for their location and determine how to get from one point to another. A voice-activated system was installed in Olympic Park in Atlanta. The problem, says Blasch, was that the technology wasn't sophisticated enough to pick up on different accents and languages.

Research at Georgia Tech includes detectable tactile surfaces. Designers can design surface areas differently so a visually impaired person detects the difference between the edge of a railway track and a regular walkway.

"I think buildings are going to get a lot smarter," adds Loether. "Buildings are going to know who is where. Door jams will know who walks through the door. There will be interactive response buildings so when you go to the receptionist's desk and ask for Mr. Smith's office, they give you a badge. As you walk down the hall and approach a "T," the sensors in the wall will tell you what direction to go. The building will actually guide you to where you want to go. It's in our future."

"It's like using bread crumbs to find your way back," he says. "We are looking to install wafer-type devices along the walls or baseboards to give feedback on direction."



A Nichols Design for improved acoustical design at Penn Station in New York City.

Marketing a Universally Designed Home

It's Common Sense, But Will It Sell?

How do you market a universally designed home to the general population? The key, according to Jackie Simon, with Avery Hess Realtors in Rockville, Md., is getting people to look ahead, beyond their immediate needs.

"People need to consider what their needs might be five or 10 years from now. So often, empty nesters — active and able in their 50s — move into a three-story townhouse. Ten years down the road, they start to feel the signs of aging, and that home becomes less suitable for them," she says.

"We're a nation of people in denial. We don't want to think about slowing down. We don't recognize that any one of us could become very seriously disabled in just the blink of an eye, or through just the normal aging process. As a result, we're not prepared if something happens," says Simon.

Avery Hess instituted its Barrier-Free Living Environments Program about eight years ago. Simon, the parent of a person with quadriplegia and the staff accessibility expert, locates flexible housing for people, and helps people assess whether their existing homes can feasibly be made accessible. She has developed a continuing education course for realtors, which teaches them how to work with people with disabilities. The course also helps realtors determine whether a certain property is appropriate for someone with special needs.

"Invisible" Design Changes

The institutional look of accessible housing is no longer the norm. More typical today are common-sense design approaches that most consumers don't actually notice.

Ron Wetzel, president of Amherst Homes in Cincinnati — which has been marketing upscale universally designed homes for the past 18 months — explains: "Most people don't realize how extensively the design has been modified until the changes are pointed out."

Simon agrees, "There has been a tremendous change in consciousness. Many of the accessible features that used to be available in the past were very institutional in appearance. People rejected them, even though they needed them, because they were not aesthetically pleasing."

Wetzel notes, "A big movement you're going to see in single-family housing is toward friendlier, more flexible designs. That's because the large, aging baby boomer market is going to demand designs that will allow them to stay in their homes longer."

According to Wetzel, design modifications in-

clude things such as raised vanities for people who have bending problems, the removal of the step at the shower and widened doorways. "We use pocket doors in some of the smaller bathroom areas. This enables someone on the outside of the bathroom to reach someone who has fallen on the inside. If you have a door that swings in, you'd have to tear the door down to get to someone inside," he says.

He notes that his company now places the circuit breaker panel in the garage, rather than in the basement, for easier access. Also, the step leading from the garage into the house has been replaced with a ramp.

And what design changes has Simon seen? "If I had my druthers, every home would be required to have a shower instead of a tub in at least one of the bathrooms," she says. "The shower would be wide enough to fit a wheelchair. I also think that automatic door and window openers are important features for older people. Anything that prevents people from having to climb, stretch or reach."

She adds, "I'd also like to see 36-inch-wide doors become a universal design standard. It would be more cost-effective, because you would only have to inventory one size of doors. People in half-a-million or million-dollar homes expect them. But people in \$125,000 houses get a 27-inch or a 24-inch door leading into a bathroom. And they are confronted with major costs if modifications need to be made."

Universal Design Criteria

To help promote the concept of universal design with the public, Wetzel believes that the building community needs to develop some basic criteria that builders can easily implement.

To that end, the National Association of Home Builders (NAHB) has formed a committee that will explore the development of universal design criteria. According to Wetzel, the make up of the committee will include production and custom builders "because each segment has different concerns and different budgets with which to contend."

He notes that the goal is to create a universal design logo — similar to the the Good Housekeeping seal. Builders, providing that they follow the approved criteria, could then use the logo.

Challenges To Overcome

Even with the development of universal design criteria, there are still some hurdles that need to be overcome.

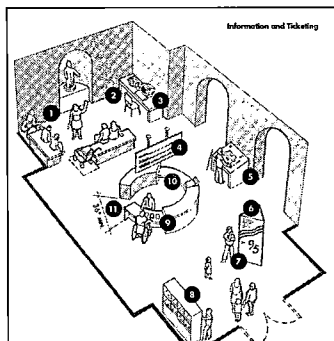
According to Simon, "Some of the builders who

"Most people don't realize how extensively the design has been modified until the changes are pointed out."

Ron Wetzel
Amherst Homes

Everyone's Welcome: The ADA and Museums

With help from a technical assistance grant provided by the US Department of Justice, Civil Rights Division, John P.S. Salmen, AIA has written a comprehensive guide to museum accessibility for the American Association of Museums. The 168-page book provides an explanation of the application of the Americans with Disabilities Act (ADA) for museums then presents a nine-step building block process that can be used by any museum, zoo or historic/cultural/



arts facility to implement a successful ADA program. The book provides extensive illustrations and examples of accessible and universally-designed exhibits and communication technologies, plus an exhaustive list of resources. The publication is available with an accompanying video tape from the American Association of Museums at 202.289.1818.

Common ADA Errors and Omissions in New Construction and Alterations

This publication, prepared by the U.S. Department of Justice, Civil Rights Division, Disability Rights Section, delineates a variety of the Americans with Disabilities Act Standards for Accessible Design errors/omissions and the commonly resulting situation. These items include issues such as parking, stairs and transient lodging. To receive a copy or for more information contact the ADA Information Line at 800.514.0301 (voice) or 800.514.0383 (tty) or www.usdoj.gov/crt/ada/adahom1.htm.

Designing for the Disabled

Designing for the Disabled, a publication featured in the last issue of *Universal Design Newsletter*, Vol. 3, No. 6, can be purchased through Butterworth Heinemann at 781.904.2500.

Reaching Out: A Creative Access Guide for Designing Exhibits & Cultural Programs for Persons Who Are Blind or Visually Impaired

This two part video, developed by Elga Joffe and Mary Ann Siller, is intended specifically for libraries, museums and other cultural facilities. It illustrates the principles and techniques of making information accessible to everyone, including people who are blind or visually impaired.

Part 1 of the video offers examples of accessible programming, and shows the interaction between visually impaired visitors and their environments in cultural facilities. In addition, it demonstrates how technology can be used to provide information access and enhance an organization's ability to reach the entire community. Part 2 shows how staff can be trained to help facilitate achieving fully accessible environments and programs.

Accompanying the video is an easy to follow print guide, offering specific information including: facility design, signage, lighting, multimedia displays, computer information access and personal training.

For more information, contact the American Foundation for the Blind Press at 800.232.3044; fax 212.502.7774.

Home Planning for Your Latter Years; New Designs, Living Options, Smart Decisions, How to Finance It

This publication was authored by William K. Wasch, consultant and co-founder of the Independence Resource Center in Middletown, Conn.

Written from the first-hand experience of the author, this book covers the following topics of retirement: home planning expectations, options, resources, modifications, building new, and retirement communities. Included are various appendices on: product information, housing and community services information, consultants, and video and slide resources. Also included are references and suggested readings.

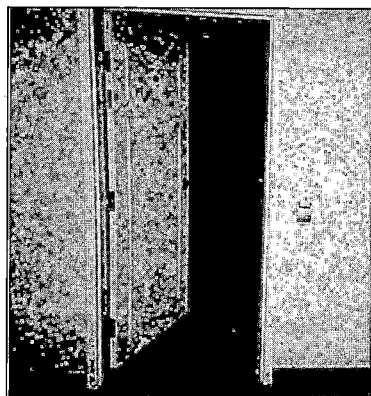
For more information, contact: William K. Wasch Associates at 150 Coleman Rd, Middletown, CT 06457 phone 860.346.2967 or Amazon.com. 

Everyone's Welcome presents a nine-step building block process that can be used by any museum, zoo or historic/cultural/ arts facility to implement a successful ADA program.

? **Problem:** When renovating a standard (non-accessible) hotel guest room to be accessible, how do you provide the required clear floor space at the entry door when you have walls on both sides that restrict the maneuvering space?

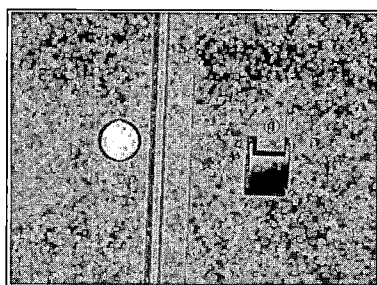
**Universal Design
Newsletter
provides a one-
year free
subscription for
any tip which we
publish. We look
forward to
receiving and
publishing your
tips.**

TIP: The design team of Kennedy Paige Associates Inc. of Miami Beach, and Karim Masri, owner of the Astor Hotel in Miami Beach ran into this very problem in the recent renovation of that property. Their solution was radical, elegant and true to the facility's art deco design



of the 1930s property. Instead of moving walls or doors, they left the entry door in its original position and installed an automatic door operator.

This system eliminated the need for maneuvering space at the door, and created an upscale amenity that impresses the most demanding of guests. There is no handle on the outside of the guestroom entry door. A swipe of the keycard both unlocks the door and activates the automatic opener, making it easy to roll your luggage or wheelchair directly into the room. To exit the room you can either push a button on the wall or operate the standard lever handle on the inside face of the door. ■



Housing, from page 6

start designing universal homes get too excited, and put every imaginable accessible product in the home. Suddenly, it is no longer affordable."

Another problem, Simon notes, is helping realtors understand and report the accessibility characteristics of their listings. "Often, realtors don't recognize the market value of these characteristics, and as a result, they aren't noting them in their listings."

But help is on the way. According to Simon, the metropolitan-wide multiple listing system now includes a place for accessibility characteristics. "For example, we can now list doorways, level entries, kitchen and bathroom modifications, elevators, ramps and the availability of accessible parking. A group of us worked very hard to get these changes enacted," she says.

Simon adds, "I think people are just beginning to realize that this is a huge, untapped market." ■

Businesses Finding Help through DBTACs

Increasing numbers of companies are finding that people with disabilities represent a goldmine of topnotch workers as well as a market of consumers for their products and services.

Companies have received help in reaching this influential market through their local Disability and Business Technical Assistance Center (DBTAC). Funded by the US Department of Education's National Institute on Disability and Rehabilitation Research, this service provides Americans with Disabilities Act (ADA) information for businesses, individuals, schools and state and local governments.

Callers to the toll-free service are linked with experts who provide confidential information and referral, technical assistance, training and materials on all aspects of the ADA. DBTACs sponsor training programs and seminars on ADA issues, and provide literature and videos on a variety of ADA topics. DBTACs can provide information on creative ways to accommodate a recently disabled employee at minimal cost; how to differentiate between a service animal and a pet; and how to make services more attractive to people with disabilities.

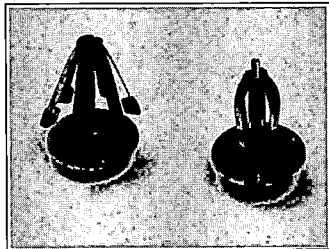
To reach your regional DBTAC, call 800.949.4232 or link to the national website at www.icdi.wvu.edu/tech/ada.htm.

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PRODUCTS

WingIt Grab Bar Fasteners

WingIt Grab Bar Fasteners from Pinnacle Innovations, are designed to enable grab bars to be retrofitted to walls and tub enclosures without the installation of blocking or reinforcement, eliminating the need to open existing walls. The WingIt is a revolutionary design for a blind fastener that is preassembled and ready to install. This patented fastener is designed to efficiently distribute grab bar forces to create a rigid attachment. WingIt exceeds the weight support criteria established by the American Standards Institute (ANSI) in document A117.1-1980 and in Title III of the Americans with Disabilities Act (ADA).



applications as parking ramps, ATM machines, lobbies and entries, campus and roadside emergency stations, stadiums, and convention centers. The system can also be used with central monitoring station equipment.

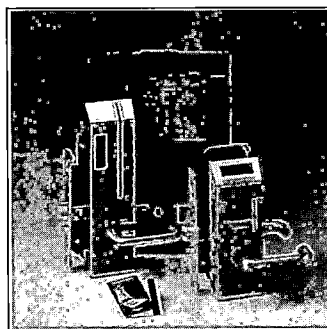
Standard features include touch tone or pulse dialing, second number dialing in the event of no answer or a busy signal, grade two Braille labeling for individuals with visual disabilities. These weather-resistant phones transmit a unique location identification code, are remotely programmable, and can be programmed to auto answer incoming calls. The E-1600 can be supplied in special colors or with special graphics and models K-1600-EHF and E-1600-02 can be supplied with special graphics.

System 900 Stand-alone Electronic Access Control

The ILCO Unican Corporation's System 900 Stand-alone Electronic Access Control is a swipe-style lock designed to secure doors without the cost of direct wiring.

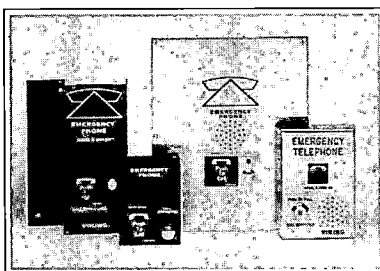
Available in mortise or cylindrical models, these battery-powered locks accept any magnetic stripe card. The software can accommodate any keycard and can be customized to satisfy customer requirements. The

lock system requires an IBM-compatible laptop or PC running MS-DOS 5.0 or higher, a swipe style low coercivity keycard encoder, a swipe-style infrared lock programming module, and the System 900 software.



ADA Compliant Emergency Phones

The 1600 Series ADA Compliant Emergency Phone, from Viking Electronics Inc., is designed to provide hands-free emergency communication over the public switched telephone network. Available in four different chassis, this phone meets the Americans with Disabilities Act requirements for elevator telephones and is also suitable for such



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See coverage of
**Designing for the 21st Century:
An International Conference on
Universal Design of
Information,
Products and
Environments** in the
October issue of
Universal Design
Newsletter



The New Products column was provided by the ABLEDATA project, a computerized database of information on assistive equipment which is funded by the National Institute on Disability and Rehabilitation Research and is administered by Macro International, Inc., Silver Spring, MD.

Universal Design in Telecommunications

By Frank G. Bowe, Ph.D.

The product doesn't only help people who have physical disabilities but also people who have or fear repetitive strain injury and people who just prefer to avoid

We are now beginning to see universal design in telecommunications. A good example is a software program that contains names, phone numbers, fax numbers and email addresses.

Such contact-management programs allow users to "dial" numbers without physically having to touch a telephone receiver. They are very helpful for people who have physical disabilities, of course, but they are also simply convenient for all

Universal design is showing up in a variety of computer software programs. Dragon Systems, of Newton, Mass., has a new software program on the market called Naturally Speaking. It allows users to produce computer text simply by talking. The program features "continuous speech recognition," which means that it can handle conversational speech and does not require the user to pause between words. IBM has a similar program, known as ViaVoice. This program works with application software — letting users issue commands such as "open file" just by talking. These offerings are remarkably affordable.

Naturally Speaking, for example, retails for just \$150 — and it can be picked up right off the shelves of most computer stores. Dragon Systems' earlier offering, called Dragon Dictate, now priced between \$400 and \$1,700, requires users to speak...like...this.... When the software was first introduced a few years ago, it cost \$10,000+ in addition to the price of the PC. Today's improved version is now just \$150. The product doesn't only help people who have physical disabilities but also people who have or fear repetitive strain injury and people who just prefer to avoid typing. That, too, is universal design at work.

For the 60 percent of American homes that still lack PCs there are some non-PC-based universally designed communications devices.

Bell Atlantic offers its residential phone customers a service called VoiceDialing which lets people dial phone numbers by speaking the name of the person being called into the phone receiver's mouthpiece. The software in the central phone office recognizes the speech, matches the spoken name with a phone number, and dials. The process takes place, not in the

customer's phone, but rather in the company's central switching office. The service costs about \$4 a month and can be a real boon for someone who is mentally disabled, because he or she can easily place calls to parents, counselors, friends, and emergency numbers simply by speaking a word. It also helps people whose physical disabilities make dialing numbers difficult or impossible. But -- and this again is the beauty of universal design -- it is just as convenient for people with no disabilities, such as a person using a cellular phone while driving, or a busy parent calling a spouse while washing the dishes or holding a child.

A new federal law is accelerating the development of these kinds of universally designed products and services in the area of telecommunications. Section 255 of the Telecommunications Act of 1996 (PL 104-104) requires that new telecommunications products and services be made accessible to and useable by people with disabilities, if it is "readily achievable" to do so.

The U.S. Architectural and Transportation Barriers Compliance Board recently developed "guidelines" to interpret the language of Section 255 into steps that designers and engineers can follow.

It will be interesting to see how makers of telecommunications products and services respond to the Section 255 mandate. Hopefully, they will think in terms of universal design and ask themselves: "How can we make this product or service useable by a wide range of diverse users?" That is the question Bell Atlantic is asking about the services it offers. The company has adopted a corporate-wide policy of universal design.

If Section 255 is implemented the way Congress intended, telecommunications-product vendors such as Ericsson, Motorola, Lucent Technologies, Northern Telecom, and others will start making products that are useable by a wide audience — including people with disabilities.

The next few years promise to be quite interesting for anyone who follows telecommunications. Let us join in hoping that Section 255 will, in time, lead to creative solutions much as the Americans with Disabilities Act has given us innovations in the design of buildings and transportation vehicles. 



Contact management programs allow users to "dial" by simply speaking.

ware in the central phone office recognizes the speech, matches the spoken name with a phone number, and dials. The process takes place, not in the

Frank G. Bowe, Ph.D. is a professor of special education at Hofstra University in Long Island, New York.



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CALENDAR

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months before
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Sept 9-11: Principles of Access a training course sponsored by the National Center on Accessibility will be held in Denver. The course will introduce park and recreation professionals to the fundamentals of accessibility. For more information checkout the NCA website at www.Indiana.edu/~nca or call 800.424.1877 (v/tty).

Sept. 10: The US Architectural & Transportation Barriers Compliance Board in Washington, DC will hold a one-day conference recognizing the 30th anniversary of the Architectural Barriers Act. The conference will review the history of the ABA, explaining the future of federal standards. For more information contact the Access Board at 202.272.5434 (v) or 202.272.5449 (tty).

Oct. 26-28: Access to Outdoor Developed Areas, a training course sponsored by the National Center on Accessibility will be held in Martinsville, Indiana. The course will discuss the most current information on the evolving accessibility guidelines as they relate to outdoor developed areas for people with disabilities. For more information checkout the NCA website at www.Indiana.edu/~nca or call 800.424.1877 (v/tty).

Nov. 16-20: International Workshop on Universal Design to be held in Yokohama, Japan and sponsored by the Building Research Institute. Discussions will

cover product/dwelling/building design for transportation and the environment. Socio-political discussions will cover topics such as cultural dependence/independence of universal design. For more information fax +81.298.64.2989 or send e-mail to skose@kenken.go.jp.

Nov. 17 - March 14: Unlimited By Design at the Cooper-Hewitt Museum, New York, will be the first major exhibition of products, services and environments designed to meet the needs of all people throughout their lifespans. This Cooper Hewitt museum is part of the Smithsonian Institute.

Dec. 7-11: Universal Design, a two-track training course for designers and interpretive specialists is being sponsored by the National Center on Accessibility and will be held in Houston. General sessions will explore the principles of Universal Design and separate architectural and interpretive tracks will provide hands on experience and in-depth discussions of pertinent topics for each group. For more information, checkout the NCA website at www.Indiana.edu/~nca or call 800.424.1877 (v/tty).

July 12-16, 1999: Vision '99 International Conference on Low Vision will be held in New York City and is being sponsored by the Lighthouse Inc. The call for papers is due Nov 30, 1998. For more information contact the Lighthouse Inc. at 212.821.9482 (v) or via e-mail at vision99@lighthouse.org.

Universal Design Newsletter

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Adopting and Adapting Managed Care for Medicaid Beneficiaries: An Imperfect Translation

Robert E. Hurley

Medical College of Virginia/

Virginia Commonwealth University

Susan Wallin

The Urban Institute

Occasional Paper Number 7

Assessing
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*An Urban Institute
Program to Assess
Changing Social Policies*



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This report is part of The Urban Institute's *Assessing the New Federalism* project, a multi-year effort to monitor and assess the devolution of social programs from the federal to the state and local levels. Alan Weil is the project director and Anna Kondratas is deputy director. The project analyzes changes in income support, social services, and health programs. In collaboration with Child Trends, Inc., the project studies child and family well-being.

The project has received funding from the Annie E. Casey Foundation, the Henry J. Kaiser Family Foundation, the W.K. Kellogg Foundation, the John D. and Catherine T. MacArthur Foundation, the Charles Stewart Mott Foundation, the Commonwealth Fund, the Stuart Foundation, the Robert Wood Johnson Foundation, the Weingart Foundation, the McKnight Foundation, and the Fund for New Jersey. Additional funding is provided by the Joyce Foundation and the Lynde and Harry Bradley Foundation through a subcontract with the University of Wisconsin at Madison.

The nonpartisan Urban Institute publishes studies, reports, and books on timely topics worthy of public consideration. The views expressed are those of the authors and should not be attributed to The Urban Institute, its trustees, or its funders.

The authors would like to thank the many state and local officials and others who participated in interviews and provided information. They also acknowledge the Urban Institute health policy staff who prepared the background papers that served as the source for state-specific information.

Assessing the New Federalism

A *ssessing the New Federalism* is a multi-year Urban Institute project designed to analyze the devolution of responsibility for social programs from the federal government to the states, focusing primarily on health care, income security, job training, and social services. Researchers monitor program changes and fiscal developments. In collaboration with Child Trends, Inc., the project studies changes in family well-being. The project aims to provide timely, nonpartisan information to inform public debate and to help state and local decisionmakers carry out their new responsibilities more effectively.

Key components of the project include a household survey, studies of policies in 13 states, and a database with information on all states and the District of Columbia, available at the Urban Institute's Web site. This paper is one in a series of occasional papers analyzing information from these and other sources.

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Adopting and Adapting Managed Care for Medicaid Beneficiaries: An Imperfect Translation

Introduction

The managed care revolution of the past decade can be characterized as the aggressive pursuit of better value by purchasers of health services. Reduced rates of premium growth for private purchasers, especially large employers, attest to the apparent success of self-interested, best-price buying. Most purchasers have used managed care organizations (MCOs) to carry this out and to promote a systematic suppression of the cost-shifting that has been rife in the health care arena. In fact, it appears likely that most savings achieved to date are the result of fierce price and payment negotiation, rather than significant changes in patterns of care delivery.

Concerted efforts have been under way for more than a decade, and in a few states much longer than that, to adopt and adapt features of commercial managed care for the Medicaid program. Justifications for pursuing managed care are variously attributed to access expansion, quality enhancement, or improved accountability. But it is difficult not to conclude that cost-savings (and by implication, increased value if quality does not decline) have also been a principal motivator for Medicaid agencies to undertake major managed care initiatives. The Medicaid program's tradition of being the most penurious of payers makes the embrace of managed care with its cost-saving potential a natural fit.

But there are many reasons why managed care in the Medicaid context could hold less promise and encounter greater challenges than observed in the private sector. Some of these reasons relate to demographic, social, and clinical differences between Medicaid beneficiaries and employed groups. There are also significant differences in benefit packages and the expected duration of enrollment between commercial and Medicaid-covered persons. Medicaid beneficiaries have less discretionary income, which may interfere with using cost participation to shape choice of plans and demand for services. The traditionally low provider payment levels that have resulted in the limited and skewed nature of provider participation may affect the ability of plans to develop and negotiate with provider networks. Moreover, the fact that the Medicaid program has been saddled with numerous responsibilities *beyond just purchasing care for those it covers* poses an even greater threat to enabling MCOs to use leverage to get better prices for services.

Medicaid agencies face significant constraints in promoting managed care and competition among managed care plans. In fact, much of the recent history of Medicaid managed care illustrates the delicate balance of the program trying to be an aggressive buyer on behalf of its beneficiaries, without colliding with many other roles that Medicaid agencies have assumed or been assigned. These roles include protecting the safety net for persons without health insurance coverage; funding many community-based human service providers that bill Medicaid directly for client care; financing many state-sponsored services for mentally ill and developmentally disabled persons; and substantially funding medical education in public academic health centers. In addition, Medicaid agencies in many states play an integral advocacy role in assuring access to care for vulnerable populations and in advancing policies to address within-state disparities in access to care. This list of responsibilities weighs heavily on agencies as they discover that Medicaid's version of managed care requires greater caution and more deliberate attention to secondary consequences than the private-sector version or, for that matter, the Medicare experience. Furthermore, Medicaid managed care is being carried out in a politically charged and highly visible public arena that magnifies the contentious nature of negotiations and transactions in managed care.

This paper examines, through the findings of case studies conducted in 13 states as part of the Urban Institute's *Assessing the New Federalism* (ANF) project, how states have approached a number of the key areas in which adaptation of commercial managed care to the Medicaid program is necessary. The states cover a broad spectrum ranging from the very largest (California, New York, Florida, and Texas) to mid-sized (Michigan, New Jersey, Massachusetts, Wisconsin, Minnesota) to a number of other states (Washington, Colorado, Mississippi, and Alabama). They constitute, by design, wide geographic and political variation and varied development of public health and human service capacity.

The paper begins with a brief review of the general approach to Medicaid managed care taken by states. Next it covers some of the areas in which

private-sector managed care meets distinctive challenges in Medicaid, and it derives several related questions that can be examined from the unique perspective of the ANF state-specific case studies. Variation among states on these questions is described to illustrate how attentive states have been to them and, in some instances, how successful they seem to have been in finding solutions. Finally, the paper draws broad conclusions about further developments and implications of Medicaid managed care, based on the accumulated experience of the 13 states in their efforts to adopt and adapt managed care.

Medicaid Managed Care—Is It More Medicaid than Managed Care?

The dramatic growth of Medicaid managed care, particularly in the past five years, has been well documented.^{1,2} Only a little over half of the enrollment is in capitated managed care in conventional HMOs, illustrating that Medicaid continues to rely on multiple models to gain some of the benefits of managed care for both the program and its beneficiaries.³ There is considerable descriptive evidence of the administrative challenges, setbacks, controversies, and successes states have encountered as part of the rapid buildup.⁴ There is far less evidence on the impact of Medicaid managed care, and much of it is from early models undertaken well before these alternative delivery systems emerged as the dominant form of care, at least for the commercial population.⁵ Moreover, evidence of the impact of HMO enrollment on the cost-savings for Medicaid is particularly inconclusive.⁶ In most cases, presumed savings have not been assessed relative to the favorable selection into health plans that may occur in voluntary enrollment situations, the most common form of HMO experience in Medicaid.

It is perhaps a testament to a near-blind faith in managed care that it has grown so rapidly with little convincing evidence as to its ability to provide states with more value for their expenditures. While premiums of private purchasers have leveled off or even declined, savings in Medicaid are more difficult to confirm and may also be more elusive to realize. A number of states anticipating that substantial savings could be recycled for other purposes, such as eligibility expansion, have found that savings have not fully materialized.⁷ Low-base Medicaid rates suggest that either savings have to be limited or serious provider or plan participation problems will arise—an area in which Medicaid has had ample and painful experience in the past. Indeed, problems with the willingness of many health plans to accept rates or participate at expected levels have slowed the pace of implementation or planned expansion.⁸ Finally, some aspects of Medicaid, such as limited cost-sharing by beneficiaries, prevent HMOs from achieving savings by influencing use of services through financial incentives for members as they do with private membership.

Ironically, in recent years there seems to be more reticence around continued expansion of Medicaid managed care because it *might be saving dollars*



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that have been used to achieve other public purposes or that come out of rates that have been viewed as marginally adequate at best. The widespread concern that disproportionate share hospital (DSH) dollars should not be incorporated into capitation rates to MCOs because they might not reach providers of indigent care is a good example of this ambivalence. More generally, safety net providers have voiced their fears that they may not be incorporated in MCO networks, or that, once in the networks, their payments may be sharply reduced, compromising their ability to render uncompensated care.⁹

Interagency tensions are growing as state efforts to use federal matching funds to finance mental health or developmental disability programs are being jeopardized by managed care initiatives.¹⁰ At the local level, after more than a decade of "Medicaidization," local health and human service agencies (which have been counseled to respond to financial pressures by obtaining a Medicaid provider number and billing for covered services) face an uncertain future when Medicaid funds are channeled through private MCOs that might not credential these providers for their networks.¹¹ For academic health centers, major recipients of both DSH dollars and medical education subsidies, the stakes for a Medicaid conversion to managed care are substantial, particularly given the limited experience many of these centers have had with commercial managed care.¹²

These challenges raise several questions about how state Medicaid programs can adopt managed care initiatives and adapt the experience from commercial managed care. It is reasonable to expect that, as major health service purchasers, Medicaid agencies will approach the task of converting from payers to aggressive, value-based purchasers by emulating many of the activities of private employers who have embraced capitated managed care. Medicaid agencies will have to make a number of judgments regarding the suitability of local health service market conditions to accept and respond to the demands of managed care. There will have to be adequate capacity in terms of MCOs and providers with the experience and sophistication to develop products that will attract membership and contribute to successful cost and care management. For public and private purchasers buying care in multiple and varied markets, purchasing strategies will need to be adapted across markets. In addition, a managed care strategy must also be linked to other benefits-related developments that a purchaser may have planned or be implementing to ensure that managed care initiatives are not in conflict with other program objectives. Thus, the first question to be examined from the experience of the thirteen states in the ANF project is as follows: *To what extent have Medicaid agencies customized their development of managed care initiatives to local market conditions and consciously positioned their approaches in a broader context of relevant policy changes?*

Private companies that convert their health benefits programs to managed care models have considerable latitude in the planning, timing, and sequencing of development and implementation. Often conversion to managed care is undertaken because of perceived financial pressures due to rapidly rising

health premiums. Firms typically exhibit deliberateness and caution to minimize employee disgruntlement, friction with unions, or perhaps adverse publicity and backlash from community providers. This caution seems to be grounded in recognition that change is sometimes difficult, especially when it relates to something as personal as health care. A measured approach also reflects a need to signal providers that change will be forthcoming and they will need to respond accordingly, such as developing MCO affiliations. Implementation must be done with deftness and foresight to deflect resistance and promote behavioral adjustment on the part of all affected parties, particularly when an initiative is new and threatening. Whether states approach these challenges differently from private purchasers is important to explore. Medicaid agencies have many diverse constituencies whose aims may be conflicting, they operate in a highly public and sometimes politicized environment, and they are frequently under tight schedules to implement initiatives to achieve savings. *Do states have overall strategies to design and implement managed care initiatives, and how well are they able to phase in long-term strategies given the policy and political environments in which they operate?*

The desire of purchasers to have more customized products and financing methods for their health benefits than were offered by traditional indemnity insurers has been a major driver of the managed care revolution. Recent evidence indicates that managed care companies continue to diversify their product portfolios to respond to buyers who may want a full spectrum of arrangements to offer employees. Product proliferation suggests that a broader choice set is available, allowing employees to select the models that will provide them with maximum value. Sophisticated self-insured purchasers may provide options that go beyond what capitated plans may offer and that, in some instances, are intended to protect the purchaser from experiencing the consequences of adverse selection in non-risk options. Compared to private purchasers, Medicaid agencies have an even more diverse clientele for whom they wish to do value purchasing, including persons with chronic disease and disability who have health and human service needs beyond those found in the typical managed care plan. Given the lack of cost participation by beneficiaries, the types of models offered and the bases for choosing plans will also be different from commercial experience. These contrasts pose the following question: *How and why do states adopt the particular models of managed care they have chosen, and on what bases have they determined which populations to cover through various models?*

Private purchasers commonly select MCOs using, among other criteria, so-called geo-access matching of network providers with employees' place of residence. In addition, large and influential purchasers may have the clout to induce or encourage MCOs to incorporate into their networks providers that are frequently used by the employee workforce or, conversely, to avoid deselection of such providers when networks are being downsized or reconfigured. MCOs may protest that these demands compromise their negotiating leverage with providers, but buyers that are big enough are likely to prevail. A similar experience is evident in the Medicaid program, as states normally require



MCOs to incorporate traditional providers in networks to comply with access or cultural compatibility standards. Given the nature of private-sector managed care, the aims of most employers extend only to meeting the needs of active workers, retirees, and their dependents—not those of other consumers of services. But, as noted above, Medicaid agencies are perceived by many as protectors of safety net providers and advocates for access to care for indigent persons not eligible for Medicaid, substantially complicating pursuit of the lowest cost possible for beneficiaries. Consequently, plans selected by Medicaid agencies may face significant constraints on their ability to do best-priced buying as they act as agents for states that have multiple goals. From this discussion arises the following question: *What kinds of accommodations are states making when selecting MCOs to avoid conflicts with the multiple roles that Medicaid agencies play?*

Historically, private purchasers have paid prices for health care services well in excess of the costs to produce them, largely because of provider-based cost-shifting.¹³ It is hardly surprising then that aggressive negotiation has been the major instrument employed by MCOs to obtain better prices. Selective contracting, steering of volume, realignment of incentives, explicit service standards, and ambitious utilization management practices have been variously employed to extract cost and service concessions from providers who fear the consequences of not being included in networks. The success of MCOs in building membership volume can be translated to still greater leverage at the time of contract renegotiation.

This more lives—more leverage notion would also seem to apply to public purchasers, except that Medicaid, in particular, has already been engaged in these practices as a fee-for-service purchaser. In some respects, Medicaid could be facetiously referred to as the “mother of all preferred provider organizations (PPOs),” dealing with a limited subset of providers who have agreed to accept deeply discounted fees and to subject themselves to utilization management to minimize inappropriate use. Thus, lowering rates and shrinking networks to expand leverage are far more difficult to engineer when Medicaid has already taken these steps. Medicaid agency leverage is further weakened by the conditions they impose on plans concerning whom to include in their networks, as noted previously. Looming over this entire relationship is the political and practical uncertainty of doing business in the public domain with state governments. Such concerns point out the need to address the following question: *In what ways are states approaching the rate-setting and contracting processes, given their tradition of historically low payment rates in Medicaid and the skepticism of MCOs and providers about the adequacy of payment and the reliability of public purchasers as business partners?*

Private purchasers of health benefits for employees and their dependents display a mix of paternalism and passivity, especially when they can offer an array of options that honor choice and preference for the sponsored individuals. Employers do this against a backdrop of both public regulatory and private accreditation mechanisms to afford a measure of comfort with what and from

whom they are buying. Beyond this, employers typically invest in brokers and consultants to facilitate plan and product selection. Relatively few of them invest substantial resources in performance-assessment efforts, presuming that employees will literally vote with their feet if plan performance disappoints. Medicaid approaches may differ substantially on this dimension for several reasons. Compared to privately insured persons, beneficiaries may be far more vulnerable, their needs more diverse, and their experience with and capacity for exercising choice more limited. They may also lack resources to go "out of plan" if dissatisfied with access or care. Thus, oversight of plan performance for Medicaid beneficiaries takes on added importance. However, resources needed to mount oversight and monitoring initiatives may be unavailable or severely restricted, particularly during a period of downsizing in public sector employment. These concerns underscore the importance of considering what states are doing to gear up for these distinctive responsibilities: *How are states performing and adapting to their expanded responsibilities of MCO oversight and consumer protection brought on by the rapid expansion of Medicaid managed care?*

These six questions provide a template for exploring several themes and variation on these themes across the states being examined as part of the ANF program.

Data Source: *Assessing the New Federalism*

On-site case studies were conducted in the aforementioned 13 states as part of a much larger project of the Urban Institute to examine the issues and implications of devolution and the evolving relationship between state and federal health policy.¹⁴ Medicaid managed care was one of several areas in which data were collected through interviews with multiple informed parties within and outside of state government. While all states had some experience with managed care, the variability was substantial.

The site visits were conducted between late 1996 and mid-1997. The interviews examined the evolution of Medicaid managed care in each state, including the goals of managed care initiatives, the selection and design of models, and the application of these models to various eligible populations. Specific issues included choice of providers and plans as well as contracting terms and rate development in states with capitated models. Efforts to develop oversight and program monitoring were also reviewed. In addition, specific attention was focused on how managed care initiatives take into account the needs of safety net providers. The following discussion draws on the summaries of these interviews.

State Variation in Adapting and Adopting Managed Care

The 13 states reflect enormous variation in their experience with and use of Medicaid managed care. Mississippi, Texas, and Alabama have limited or



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narrow experience with pilot programs of relatively recent duration, while Wisconsin, Minnesota, and Michigan have more than a decade of large-scale experience. New York, California, Massachusetts, and Florida have had a wide range of long-standing activity in Medicaid managed care, but now have under way or are on the verge of starting new and far more ambitious initiatives with statewide enrollment. It is this spectrum of experience that permits the six questions developed earlier to be examined.

To what extent have Medicaid agencies customized their development of managed care initiatives to local market conditions and consciously positioned their approaches in a broader context of relevant policy changes?

Market Readiness

Although many of the 13 states can cite long-standing experience with Medicaid managed care—back to 1967 (New York) or 1972 (Michigan and California)—most had little experience with programs of substantial scale until the late 1980s. Accelerating enrollment is an even more recent development. In many instances, the early pilot projects were small, and were attempts at symbolic HMO participation with little interest or intent to expand, largely because managed care was so undeveloped, even for private purchasers. Medicaid managed care has consistently lagged behind the commercial market, in part because of the difficulties Medicaid has had in generating provider participation, and in part because of the lack of interest among commercial MCOs because of traditionally low rates.

As noted in the subsequent discussion of strategy, many Medicaid agencies have had to consciously encourage managed care development in order to have credible plans with which to contract. The current experience of Texas, where commercial managed care has only recently surged, illustrates the extent to which Medicaid depends on private buyers to create the market conditions to attract plans. In Alabama and Mississippi, which have the least-developed managed care markets among the 13 states, limited provider capacity and strong political sentiments appear to be significant obstacles to capitated managed care in general, and for Medicaid beneficiaries in particular. States with very high HMO penetration, such as California, Minnesota, and Massachusetts, have progressed further in Medicaid managed care, but they have not relied exclusively on capitated models, nor have they expanded beyond major urban locations.

As multi-site employers pursuing managed care across disparate markets have discovered, it is difficult for states to achieve program and coverage uniformity because of differences in market capacity and maturity. In particular, Medicaid agencies have had to wrestle with urban and rural variability. HMO enrollment remains a largely metropolitan phenomenon, as only in these markets can substantial health plan capacity be found. Much of Medicaid capitated managed care has stopped at the boundaries of urban areas. Urban parts of

Florida, Massachusetts, Wisconsin, Minnesota, and Michigan have had long-term and large-scale experience with capitated models. Other areas in these states, however, often have no managed care, or perhaps only primary care case management (PCCM) programs. For example, Milwaukee and Minneapolis have had mandatory HMO enrollment for Aid to Families with Dependent Children (AFDC) beneficiaries for more than a dozen years, but state Medicaid agencies have only recently begun to expand this model to the remainder of their respective states.

Evolving Policy Context

The complexities and demands of large-scale implementation infrastructure are such that even states with considerable Medicaid managed care history struggle with leveraging this experience effectively. Most of the early programs were voluntary, meaning they did not entail autoassignment of nonselectors or exclusion of plans or providers. Nor did they use sophisticated rate setting or competitive bidding, which probably worked to the advantage of plans that could market themselves to produce favorable selection in voluntary programs. In recent years, states have learned a good deal about regulating market practices, managing enrollment (often through brokers), contract and rate development, and bidding and procurement processes. This means that states that are later developers of managed care initiatives have been able to accelerate the design and implementation phases by drawing on the experiences of others. For example, it is particularly notable how many states assert their aim to adopt a competitive bidding strategy similar to that in Arizona, once their own markets and systems mature sufficiently to support this. Likewise, many states now want to convert most or all of their Medicaid managed care to prepaid models as managed care markets have evolved and matured.

Many Medicaid managed care initiatives have been encased in broad state reform strategies. Washington, Minnesota, Colorado, Florida, and New Jersey intend to use savings from managed care to expand access for persons without Medicaid coverage. This kind of commitment sets high expectations for Medicaid managed care programs and creates a natural momentum to keep the expansion on track—often by gaining buy-in through the promise of expanded coverage from providers and advocates who might otherwise resist these developments. Another dimension of the evolving policy context is that a number of states (New York, New Jersey, California, and Colorado) have recently updated and expanded their MCO regulatory efforts to facilitate market maturation and consumer protection for commercial and Medicaid beneficiaries. Thus, to some extent, Medicaid can ride the crest of the managed care wave rather than attempt to be a market leader. A final contextual issue is the movement toward privatization of public human services. In many respects, expanding HMO enrollment in Medicaid has the effect of privatizing a public program one beneficiary at a time—a development highly compatible with broader contemporary trends.



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Do states have overall strategies to design and implement managed care initiatives, and how well are they able to phase in long-term strategies given the policy and political environments in which they operate?

The case studies also provide an opportunity to reflect on the extent to which states have crafted coherent and deliberate long-term approaches to moving large numbers of beneficiaries into managed care arrangements. Unlike their private-sector counterparts, Medicaid agency executives operate in a much more politically volatile climate and face greater constraints on their administrative discretion. On one hand, they are particularly susceptible to fiscal pressures and tight schedules that are budget driven and may be viewed with disfavor by providers, plans, and beneficiaries. On the other hand, there is ample evidence from many states that clear, well-reasoned planning can build credibility, solidify support, and signal the need to make transitions and change behaviors. Florida, New Jersey, Washington, and Texas had overt strategies to entice commercial and other MCOs to participate by offering relatively attractive rates with modest demands to build contractor capacity as a precondition to program expansion. Michigan, Massachusetts, and Colorado have nurtured low-intensity models like primary care case management as a means to promote provider readiness for subsequent conversion to capitated arrangements or, in the case of Texas and Mississippi, to deflect organized resistance to capitated models.

Using explicit timelines for implementation brings these strategies to life and puts traditional Medicaid providers on notice that they have to prepare for coming changes. Particularly in the case of safety net providers who, because of their payer mix, have not yet encountered extensive managed care contracting or conditions, unequivocal signals can provoke strategic responses on their part, as in Florida and Wisconsin. Responses include prepaid plan formation, consolidation with similarly situated providers, and internal clinical and administrative adjustments to enhance attractiveness to potential contracting plans. Phasing strategies may also be necessary because of problems with MCO network capacity. This is the case in New York City, where serious concerns exist about whether the participating plans have developed large enough primary care networks to serve the large number of enrollees that mandatory enrollment will bring.

Conversion of programs from voluntary to mandatory status has proven to be especially challenging. California and New York illustrate how simply making careful default assignments for large numbers of beneficiaries is a major undertaking. A few states have phased in mandatory HMO enrollment directly from small voluntary enrollment programs, as seen in some regions of California. More commonly, states make the transition through mandatory PCCM models, as in Washington, Colorado, and Michigan, as providers and beneficiaries become more experienced in and accepting of using managed care. New Jersey, Wisconsin, and Minnesota have committed to mandatory HMO enrollment but have done so in specific markets according to defined timetables. Decisions about excluding services and populations, as discussed in the next section, may be critical to devising plans that are realistic and can succeed by

pursuing a course of least resistance. Nearly all of the states have taken the path of least resistance relative to rural areas where, at most, PCCM programs have been or are being implemented (Florida, Colorado, Massachusetts).

Notwithstanding the variety in approaches, a strategic plan appears to contribute to successful implementation. Explicit plans and timetables provide affected parties—purchasers, providers, plans, and beneficiaries—with important information as they deliberate, adjust, and adapt to forthcoming changes. Conversely, vacillation in development and implementation may foster skepticism, which in turn may encourage resistance to change. Or it may discourage involvement of those anticipating change and new opportunities that change may bring. Significant delays in program implementation can literally drive potential contractors out of a market—a concern openly voiced in Colorado and Texas.

How and why do states adopt the particular models of managed care they have chosen, and on what bases have they determined which populations to cover through various models?

The Transition toward Full-Risk Models

As in the case of private-sector managed care, it is evident that one model cannot fit all populations or market situations in the Medicaid context. While some models, like full-risk HMO contracting, are similar across public and private purchasers, Medicaid has devised other distinctive managed care models, such as the PCCM arrangement with or, more typically, without any financial risk-sharing. Developed initially in Michigan and Utah more than 15 years ago, the PCCM model has proved to be a remarkably robust, albeit limited, model that has gained widespread use throughout the country. It is the main managed care manifestation in a few states, including Alabama and Mississippi, and is used in tandem with other models in many more states, including at least 9 of the 13 ANF states. At a minimum this model has provided beneficiaries with a contractually obligated guarantee of access to a medical home 24 hours a day, 7 days a week—not a trivial contribution. And there is credible evidence to suggest the PCCM-based model has produced modest net savings while paying fee-for-service along with a case management fee.¹⁵

Massachusetts and Florida have been strongly wedded to the PCCM model as a competitive alternative to HMOs for Medicaid enrollees and to benchmark HMO performance. Michigan, Washington, and New York (particularly upstate) have relied on partially capitated PCCM programs as transitional strategies until markets have matured to the point where full-capitation models become available and attractive to providers. Even more commonly, PCCM has held strong appeal in states such as Alabama and Florida that want to use managed care on a statewide basis, but see few prospects for capitated arrangements in rural areas in the near future. Moreover, the PCCM model has allowed community health centers and local health department clinics to participate without having to make major operational changes or risk loss of favorable compensation methods.¹⁶



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The limitations of PCCM, including minimal care management, lack of incentives for integration, and the fact that financial risk remains with the Medicaid agency, have led states such as California and Colorado to decide to move to full-risk arrangements as soon as possible. States that operate parallel programs, such as Massachusetts, Colorado, and Michigan, are attempting to shift more beneficiaries into HMOs by autoassignment and other mechanisms. Florida and Texas are essentially giving beneficiaries equal choice between models and defaulting only to the PCCM. The problem with this approach is that it may impede growth of HMOs while contributing to adverse selection for the Medicaid agency in its residual fee-for-service PCCM program. Few states (Massachusetts and Michigan may be exceptions) appear to have sufficient data or analytical capacity to determine if this, in fact, is happening.

Whether building from a PCCM program or from a limited capitation pilot project, the movement to full capitation is widely evident across the ANF states. Such an approach provides the sought-after risk-shifting to MCOs and the guarantee of savings that only mandatory full capitation can provide. It also conforms Medicaid managed care more with commercial managed care initiatives, which comports with the avowed goal of trying to capture for Medicaid the managed care gains of private-sector purchasers. Another important consideration is that a full-capitation approach can permit states to offload administrative functions like provider payment and customer and provider relations to prepaid plans in order to facilitate downsizing of state government and privatization of some previously public-sector functions.

Special Population Accommodation

The limitations of simply adopting commercial managed care models into Medicaid are perhaps most apparent when comparing the Medicaid population with privately insured individuals. A substantial portion (approximately 70 percent) of Medicaid beneficiaries are young, healthy individuals who are generally similar in medical needs to the employed persons and their dependents found in private groups. But a sizable part of the 35+ million Medicaid beneficiaries have far more substantial health and other human service needs than are commonly found in commercial groups, due to serious chronic disease or disability. These beneficiaries represent nearly 70 percent of Medicaid expenditures.

Most Medicaid beneficiaries with disabilities and serious chronic illnesses have remained in the fee-for-service system, where they have enjoyed a high degree of freedom to move among providers and, in many cases, self- or family-designed care systems that may include clinical, social, and other supportive services. Resistance to enrollment in managed care models, even low-intensity models like PCCM, has been high among beneficiaries, their families, advocates, and specialized providers who have traditionally delivered much of their care. In addition, considerable heterogeneity among these individuals makes developing sizable programs infeasible for commercial MCOs. Commercial managed care organizations enrolling such members have

typically dealt with their needs with individualized high-cost or catastrophic case-management approaches.

A high percentage of the most needy of these individuals have dual eligibility for Medicaid and Medicare, creating substantial, if not insurmountable, obstacles to designing authentic capitated managed care models. Finally, in some instances persons in institutional settings (nursing homes, intermediate care facilities for the mentally retarded, or foster care) are excluded because of the unsuitability of managed care models for their situations, or because the logistics of managed care for them are impractical. A rare exception to this can be found in some of the "county operated health system" programs in California, where nursing home services are part of the capitated program, and in Minnesota, which is in the process of developing an experimental program.

Consequently, most states have exempted beneficiaries with disabilities or serious chronic illness from mandatory programs and have merely allowed them to enroll on a voluntary basis if they so choose, even in California and Minnesota, which have the highest HMO penetration rates in the country. Massachusetts and Wisconsin have operated small pilot capitated programs to gain experience in contracting, performance monitoring, care coordination, and, perhaps most significantly, risk-adjustment for capitated rates for these beneficiaries. Similarly, New York plans capitated programs for certain targeted subgroups of the SSI population. New Jersey is deferring enrollment of persons with disabilities or serious chronic illness until full implementation of capitated care for AFDC/TANF (Temporary Assistance for Needy Families, AFDC's successor) beneficiaries is completed. Still other states seem content to make PCCM programs mandatory for Supplemental Security Income (SSI) beneficiaries, at least until more evidence emerges that HMOs can ably serve them and states can find ways to pay appropriately for their care.

In addition to this population exemption strategy, states are using benefit or service carve-outs, most commonly for mental health services, to avoid conflicts with special needs populations. Although there are many variants of this approach, these arrangements essentially separate coverage for mental health services from the physical health benefit package and from the purview of plans or providers responsible for physical health services. Several states, including Florida, Michigan, and New York, have or are devising carve-out programs for managed mental health services. Massachusetts has one of the most widely known programs, though it is only for beneficiaries in the PCCM model. Colorado is one of the few states seeking to integrate its mental health carve-out into fully capitated plans.

Decisions surrounding mental health carve-outs often have administrative and interagency rationales that may supersede clinical ones.¹⁷ Purchasing mental health benefits is often a complex, contentious, and politically charged issue because so many services to the mentally ill have traditionally been publicly financed and provided. This is a particularly good example of how Medicaid managed care differs from commercial managed care, where behavioral benefits



are typically sharply limited in part because the public mental health safety net plays the role of a catastrophic coverage plan. State Medicaid officials must be acutely concerned about their potential to dismantle or undermine this mental health safety net. The decision to carve out mental health is often seen as the least disruptive option.

What kinds of accommodations are states making in selecting MCOs to avoid conflicts with the multiple roles Medicaid agencies play, including protectors of safety net providers?

The transformation from passive payer to aggressive purchaser positions large buyers, both private and public, to contribute more directly to shaping health care markets and the configuration of delivery systems. Purchasers wield considerable power over the financial viability of providers. Most private purchasers and their managed care agents, however, remain intent on getting the best value for those they cover, with less regard for how providers fare in the process. Substantial excess capacity in many provider markets, especially in metropolitan areas, facilitates aggressive price negotiation.

Medicaid's position in this regard is clearly more difficult. Provider participation is limited to begin with, and many high-volume Medicaid providers are in underserved markets and often in precarious financial positions. They are also less likely to have already adapted to the demands of managed care because of low commercial payer exposure. Consequently, infrastructure and other system upgrades may not yet have been made. They are also far more likely to be rendering a sizable amount of indigent care given their location, reputation, and mission. As a result, many of these providers have been targeted for special subsidy programs to aid them in meeting both their Medicaid and indigent care responsibilities, including DSH payments and cost-based reimbursement for federally qualified health centers (FQHCs). These integral components of the financing system of the safety net raise the stakes surrounding Medicaid managed care substantially.

Most states have taken care to ensure a role for high-volume Medicaid providers in both risk- and non-risk-based managed care models. FQHCs have participated in PCCM programs for many years, and most have been able to join HMO networks. In several states such as New York, Massachusetts, Florida, and California, they have formed alliances that have ultimately created their own health plans. Alabama, Michigan, New York, and Texas have provided special opportunities for high-volume hospitals and academic health centers to develop their own plans to facilitate retention of Medicaid revenues or to use Medicaid managed care to foster conversion to integrated delivery systems. Likewise, bids from commercial HMOs often require, or reward in scoring, the incorporation of high-volume Medicaid providers, including hospitals, in their networks.

More overt attempts to preserve and protect these providers include extracting DSH dollars from capitation payments and passing them directly to providers or to plans formed by or for them, as is the case in Minnesota. Many states have

a policy of making FQHCs “whole” by paying them the difference between reasonable costs and the rates paid to them by MCOs, as is done in Wisconsin. Washington enabled FQHCs to participate as prepaid plans by providing them with access to stop loss insurance. Michigan allows newly formed prepaid entities, many of which consist of traditional Medicaid providers, up to 18 months before they must obtain a license as a bona fide risk-bearing organization.

In what is probably the boldest and most controversial effort to preserve public-sector providers, California devised its two-plan model for use in several counties that have their own health care delivery systems. Under this model, in which a county-sponsored plan competes for Medicaid enrollees with a private MCO, larger payments are made to the county-sponsored plan than to the private or “mainstream” plan because the former must incorporate all safety net providers. The very protracted period to make this model operational was intended to give these new systems time to develop the wherewithal to be successful cost and care managers. The model was motivated in part because of the distinctive problems faced by California’s county health systems, which are the providers of last resort for a substantial undocumented alien population. Texas is another state that is currently wrestling with equally complicated dynamics vis-à-vis public hospitals. State and local officials recognize that capitated managed care may threaten some of the elaborate and complex methods that use local hospital district taxes to maximize Medicaid matching funds and to allocate funds from DSH pools. Development and implementation of Medicaid managed care are being modified to address these concerns.

These special accommodations for traditional Medicaid providers have fostered a new generation of predominantly Medicaid prepaid MCOs. Ironically, many states (Michigan, New York, Texas, California, New Jersey, Wisconsin, and Minnesota) have explicitly asserted their desire to avoid undue reliance on Medicaid-only plans, even though several used time-limited 75/25 waivers, when they were required, to allow start-up Medicaid-only plans to participate. These new plans seem to reflect a kind of de facto acceptance that predominantly Medicaid plans may be inevitable, or at best a necessary compromise to ensure that providers with substantial Medicaid and indigent care commitments are not unduly jeopardized. Criticisms about the lack of a level playing field have been raised by commercial plans, which seem increasingly skeptical about states’ interest in doing business with them. But surprisingly little criticism has been forthcoming from beneficiaries and advocates. For the most part, they have not yet taken umbrage with the probability that this tilt may distance Medicaid beneficiaries from mainstream plans and providers.

In what ways are states approaching the rate-setting and contracting processes, given their tradition of historically low payment rates in Medicaid and the skepticism of plans and providers about the adequacy of payment and the reliability of public purchasers as business partners?

Determining the appropriate methods and amounts to pay managed care plans and providers is very challenging for Medicaid agencies. In part this is



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because they have already achieved below-market prices for many services, albeit while sacrificing broad provider participation and, some would suggest, access to high-quality providers. Additionally, some payment arrangements are a function of federal requirements or legislative or judicial mandates and thus non-negotiable. Practically speaking, contracting with capitated managed care plans appeals to Medicaid agencies because it liberates them from some of the payment strictures they operated under in the traditional Medicaid program, such as the recently repealed Boren amendment. In the case of PCCM programs, the payment of a case management fee on top of fee-for-service has been viewed as a long-overdue fee increase.

In developing capitation payments for HMOs, states have had to set rates that do not exceed the upper payment limit (UPL), based on fee-for-service experience, while still trying to attract plans to enter into contracts. In the early days of capitated Medicaid managed care, rates were very crude, typically with minimal adjustments even for age, gender, eligibility category, or region, and may have systematically overpaid plans because they tended to attract lower cost beneficiaries, especially when direct marketing was permitted. States are candid about their willingness to have accepted such outcomes in the interest of attracting prepaid organizations, since without them further market development or competition was not possible. Many of these same states acknowledge, however, that now that there are many participants and rate-setting sophistication is far less rudimentary, they have begun to tighten rates, with Florida and New York instituting double-digit rate rollbacks. In addition, in many states there are explicit plans to move to competitive bidding as soon as possible in the hope that market-determined rates can be achieved.

It is striking how pervasive the desire to institute competitive bidding is among the ANF states. It seems grounded in a belief that this is where Medicaid managed care should be going, a viewpoint that has been nurtured by actuarial and other consultants. New Jersey, Washington, Michigan, Colorado, Florida, New York, and California are all in the midst of trying to convert from an administered rate to competitive bidding in which price is one of the prominent criteria, though some states, such as Florida, have had serious problems and legal challenges. States appear to believe that competition can and will intensify under this approach and that state budgets and beneficiaries could gain. There is also a general realization that the dwindling fee-for-service base makes reliance on administered rates less meaningful and reliable. Some states seem reluctant to proceed down this road, in part because they worry that if the rates to plans are too low, provider payment will suffer accordingly, setting in motion a number of the issues raised in the earlier discussion of safety net providers.

Health plan trade associations that participated in some of the case study visits raised concerns about the wisdom of competitive bidding. They commonly pointed out that the UPL is much lower than would be paid for commercial populations (California's rates are a dramatic example of this) because most states historically have paid providers at well below market rates. In addition, high-use rates among some beneficiaries have been declining, and in some

instances managed care may improve access for persons needing additional care. Both of these developments indicate that savings possible through aggressive utilization management are limited. They also note that contractual requirements in the Medicaid program exceed those in commercial contracts. Other administrative functions are more burdensome because of high beneficiary turnover and the need for substantial educational and supportive services not commonly rendered under commercial contracts. So despite lower payments, the Medicaid product proves more costly.

Beyond rates, a broader concern is that Medicaid agencies and health plans have had difficulties in establishing long-term business partnerships (an issue that Colorado and New Jersey have explicitly attempted to address). Many MCOs find doing business in the public sector is marked by volatility and arbitrariness. For example, in competitive bidding states may award bids based on rates that are simply inadequate due to bidders' naiveté or lack of candor, and more credible plans may, as a result, be excluded. In addition, previously described accommodations made to allow newly developed, provider-sponsored, Medicaid-only plans to bid for and win contracts without any track record of managing risk could ultimately drive out established plans. Only Minnesota currently requires HMOs to participate in Medicaid as a condition of licensure. A few others have used financial incentives/sanctions (New York) or tied access to other state government lines of business to Medicaid participation (Washington).

Unlike private purchasers, who are more likely to buy standardized managed care products, Medicaid agencies are more extensively engaged in specifying products to be acquired. This is because of public procurement and contracting policies and because agencies believe it is necessary to ensure beneficiary needs are being met. Most states think they have made progress in devising more sophisticated contracts over time, detailing more completely the structure and operation of the delivery systems from which they wish to purchase. Capacity, access, and service standards are becoming more explicit, data and reporting requirements more rigorous, and consumer protection features more demanding. Counterbalancing this progress, at least in the minds of some observers interviewed in the case studies, is a question about whether states possess the staff and other resources to monitor and enforce these contracts effectively.

How are states performing and adapting to their expanded responsibilities of MCO oversight and consumer protection brought on by the rapid expansion of Medicaid managed care?

Compared with private-sector managed care, public-sector managed care programs encounter more oversight and consumer-protection responsibilities due to public accountability and the vulnerabilities of the beneficiary populations. Two areas in which states have experienced problems that have called out for better oversight and consumer protection are marketing and enrollment practices and the assignment of persons who do not choose to plans or



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providers in mandatory programs. Approaches to both of these problems are promising and are instructive about a third and somewhat broader issue of how ably states are mounting comprehensive program monitoring efforts.

In the early phases of voluntary HMO enrollment, states permitted plans considerable latitude in terms of marketing practices, materials, and inducements since the plans faced a challenging task of drawing beneficiaries out of familiar fee-for-service into unfamiliar managed care. But this laissez-faire approach had some notable negative consequences. It invited and, in effect, rewarded aggressive and sometimes misleading and unethical marketing behavior. The full extent of such behavior is unclear, but it seemed to reach its culmination when a series of newspaper exposés in Florida documented some of its most unsavory features. In the wake of this series, many states sharply curbed direct marketing, eliminated plan-based enrollment processes, instituted review and approval processes for marketing materials, and more aggressively policed and sanctioned plans when practices became suspect. Not only were these marketing practices confusing and exploitive of beneficiaries, but many were also intended to foster favorable selection into plans that, in turn, resulted in financial losses for Medicaid agencies.

Medicaid agencies across the country have adopted a major innovation in recent years: the use of independent enrollment brokers or benefits counselors to provide information, education, and choice support for beneficiaries. These contractors have appeal both because of their independence and because they can provide states with a substantial cadre of personnel to assist with rapid buildup (California and New York are good examples of this) without adding new state agency employees. Brokers are frequently engaged by state agencies as a response to criticism from legislators, advocates, and providers who fear that accelerated implementation of prepaid managed care invites both exploitation and massive confusion. Only a few states, including Wisconsin and Minnesota, have not joined in this movement, though Minnesota did use a broker when its initial programs began in the mid-1980s. Although their track records have been uneven and many contracts are very recent, a number of states, such as New Jersey and Massachusetts, see enrollment brokers as an integral feature of their successful conversion to managed care. Controversy has arisen in a few states (California, for example) around broker performance and the value brokers add. This is an area, therefore, that will merit future attention.

Brokers have also been valuable because in mandatory programs, unlike private-sector managed care, there is the need to ensure that all persons are enrolled in a plan or with a physician in PCCM models. There are wide variations in the level of default or autoassignment, as this allocation of nonselectors to plans or providers is called, though this may be due to differences in definitions and process differences among states rather than a true measure of success in assigning beneficiaries.¹⁸ Autoassignment has become a policy instrument used by states in various ways, in part because some evidence suggests that autoassignees enjoy better health and thus represent good risks to prepaid plans. Some states, such as Michigan, award assignees based on best bid scores;

others, such as New York and California, make a disproportionate assignment to plans that are sponsored by or include safety net providers. Still others, such as Colorado, autoassign to HMOs rather than PCCM programs when they are side-by-side options to increase HMO enrollment. Some states, such as Florida and Texas, default to PCCM programs rather than HMOs because they want to encourage HMOs to compete effectively to attract beneficiaries, or because political pressure is being brought to bear by medical associations.

Adding to the challenges of contracting, rate development, marketing, and enrollment are those of ongoing program monitoring and oversight of quality of care. Nearly all states are increasing their resource investment, including personnel and contracted services, to bolster their program administration. This is not surprising, as nearly 40 percent of the Medicaid population is now enrolled in managed care arrangements. But there are problems with meeting some of the skill needs of a value-purchasing organization with largely bill-paying experience. The slow pace at which states have enhanced their quality monitoring activities—a pattern that has been evident in Medicaid managed care for more than a decade—illustrates how difficult it is to gear up at a time when state government is being downsized or many attractive opportunities in the private sector (often with MCOs) beckon. As in the case with enrollment brokers, many states are increasing their reliance on external review organizations to perform core quality-monitoring functions.

As part of the larger backlash against managed care, beneficiary advocates and other critics are questioning whether enough resources are being invested in plan oversight and whether data that have authentic value in assessing plan performance are being collected and analyzed. Nearly all of the states studied reported moderate to severe difficulties in collecting encounter data from capitated plans. Ultimately, because such data may be necessary for both program monitoring and future rate development, most states have interest in resolving these difficulties.

Discussion and Implications

The review of the experiences of the 13 ANF states reveals many differences between Medicaid managed care and private-sector managed care, as well as some important similarities. Clearly the emphasis for Medicaid has been on adapting the features and techniques of managed care to suit its particular needs. The need for customization is hardly surprising given the continuing evolution of managed care, as MCOs attempt to satisfy the demands of aggressive purchasers. As managed care continues to expand in Medicaid, and there seems little reason to believe it will not, it will be important to determine the extent to which Medicaid's versions of managed care become more like commercial models or the extent to which differences in fact grow. Customization



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of private-sector managed care that Medicaid has undertaken to date merits recapitulation.

First, Medicaid agencies have had to moderate their managed care initiatives to allow private-sector managed care to create both acceptance and momentum in local markets. It is very difficult for Medicaid to lead the market into managed care because its provider constituency is often limited in numbers and financially needy. Until recently, few of these providers have had substantial managed care exposure. They commonly lack the wherewithal to readily develop their own managed care products, and may only be motivated to do so if their current Medicaid revenues are threatened. Moreover, it is difficult to attract plans into Medicaid managed care, especially commercial HMOs, unless they have concurrent opportunities to develop or expand on a private-sector business. Reliance solely or predominantly on a Medicaid line of business may simply be too daunting for plans to accept. One implication of this is that Medicaid agencies' efforts to promote capitated managed care in rural areas where most commercial plans have not ventured and most providers have had little experience may be more difficult than imagined, and the yield from doing so may be very limited.

Private-sector experience may be less instructive in creating Medicaid initiatives to bring managed care to special-needs populations. In this instance, Medicaid may not be able to await private-market "softening" of resistance, simply because private employers are not covering many of these persons and certainly not on the same scale as Medicaid (and to a lesser extent Medicare). Costs to the Medicaid program of these beneficiaries are so high that states will likely not continue their policies of exemption or population and service carve-outs. Therefore, Medicaid agencies will likely have to emerge as the market leaders and promoters of innovation for these persons. It will be challenging, but critical, for them to foster and nurture experimentation and innovation in this area.

Second, most of the states reviewed in this paper have developed strategic plans of varying degrees of specificity to guide their development and implementation of managed care for Medicaid beneficiaries and have attempted to remain faithful to them. But this is very challenging when the entire constellation of forces and factors needed for success are difficult to assemble, manage, and maintain. Managed care programs are complicated, multi-faceted initiatives that depend on coordinating model design, RFP or contract development, rate setting, contractor selection, beneficiary education, marketing and enrollment, and ongoing monitoring capacity—each of which has its own complex features. The cumulative experience of states seems to have increased awareness of the scope of activities to be undertaken and the skill sets needed to carry them out. There are emergent industries of enrollment brokers, marketing and consumer education specialists, rate consultants, and quality monitoring agencies to fill these needs.

Strategic planning also serves the function of galvanizing thinking among all affected parties in advance of implementation. In some instances, this means broadly based input on design and development features that improve the initiative and achieve buy-in and support from those who might have been resistors. Texas, for example, held more than 20 public hearings around the state to introduce its plan. An open process may lead to a major redesign when resistance mobilizes and may push the program structure in a different direction, such as the two-plan model experience in California. On the other hand, if the planning is not done openly or the rollout is seen as heavy-handed, then opposition may coalesce, potentially leading to protracted negotiations. New York's initial Section 1115 waiver-based plan is cited by critics as an example of too little community participation. The counter-argument to such deliberateness is to move ahead expeditiously to prevent resistance from developing a united front. But the program may then expend enormous resources in remedial redesign correction and relationship repair.

Third, the variety of models in use in Medicaid managed care is hardly surprising, given the diversity of beneficiaries, goals, resources, and constraints with which state agencies work. Moreover, early efforts to devise models that addressed pressing concerns, such as using PCCM to achieve guaranteed access to care, may reflect that this was as much managed care as Medicaid could provide at that time, when private managed care was not yet flourishing. Private purchasers have been successful in encouraging managed care organizations to contract aggressively with health care providers for price and service concessions that could be translated into lower premium increases. As discussed in detail in this paper, Medicaid faces significant disadvantages in using its lives for leverage to negotiate still lower rates or to threaten to deselect providers who will not accept terms when provider participation is limited to begin with. And the overall inadequacy of fee-for-service rates makes Medicaid capitation rates based on them unattractive to many MCOs.

Most states now seem on track to move a substantial portion, if not all, of their AFDC/TANF and related beneficiaries into capitated managed care, though the PCCM model still has significant support in Florida, Texas, Alabama, and Massachusetts. The models for SSI beneficiaries are likely to be less standardized and could even cause a resurgence in PCCM models, particularly if risk-adjustment methods for these persons remain unresolved, or if beneficiaries and advocates remain skeptical of the degree to which capitated MCOs can meet their needs. In general, states will probably continue with multiple models, especially given within-state geographic diversity. The array of products and customization mirrors the experience of many large, multi-site private employers, which may have multiple competing HMOs in markets where they have large workforce concentration; PPOs or other looser forms of managed care in areas where small groups of employees are clustered; and even indemnity coverage for widely dispersed workers, such as members of the salesforce.



Fourth, perhaps the most notable and, in some ways, most difficult adaptations to managed care found in the Medicaid program revolve around selecting and qualifying plans and providers. The difficulty lies in part with the fact that some providers on whom Medicaid has greatest dependence have a critical dependence on Medicaid. Thus efforts to reduce or redirect Medicaid spending can have ominous consequences for providers with long-standing commitments to Medicaid beneficiaries. Geography, mission, and tradition also mean that many of these institutions provide a substantial amount of care to persons without insurance, including Medicaid beneficiaries when they lose coverage. Medicaid has been the conduit through which public policymakers in many states have transferred dollars to these providers for their indigent care. As Medicaid alters its patterns of purchasing, or delegates purchasing to private MCOs, there will be cascading effects for persons with and without Medicaid coverage, and for the providers to whom they have traditionally turned for care.

The contortions in Medicaid managed care because of safety net and related concerns are both impressive and daunting. The creativity and diligence displayed to keep safety net providers "in the game" are notable and necessary, when viewed from the vantage point of these providers who contend they need time and assistance to adapt to a managed care world. Many of them assert correctly that they labor under considerable disadvantage because of their indigent care commitments. But the danger that lurks about this strategy to accommodate safety net providers is that it may put Medicaid beneficiaries at risk of having to remain permanently in delivery systems determined by where they have had to get their care in the past. This may deny beneficiaries the opportunity to use managed care as a means to get improved access to mainstream plans and providers. It is far from clear to what extent managed care could deliver on this promise of mainstreaming. But if state policies give substantial, sustained advantages to plans built around traditional Medicaid providers, then commercial plans could leave this market and mainstreaming will become unlikely.

Fifth, capitated managed care in Medicaid will likely continue to be plagued by concerns about rate adequacy because capitation rates cannot by law exceed the fee-for-service base that has been so discredited in the past. Part of the difficulty for capitation rates seems to lie in the fact that they accumulate low payment rates for an entire package of services and bundle them into a single payment amount that underscores its inadequacy, as seen in the negative reaction to capitation rates in California. Providers in the past may have been willing and able to cost-shift among different lines of business to subsidize at least some Medicaid care. But it is far less likely that prepaid health plans will do this over an extended period of time, particularly as they experience declining profitability in commercial accounts. Moreover, plans that seek to limit their Medicaid membership to minimize financial exposure may conclude that the cost of compliance with increasing demands of Medicaid contracts exceeds any expected gains.

It remains to be seen what effects overt efforts to allow high-volume Medicaid and other safety net providers to become capitated providers will have on

rate setting and cost-savings over time. Many of these providers may be willing to accept whatever rates are proffered by Medicaid to maintain revenue flows to institutional providers or to allow them to build membership rapidly. Because many providers are so inexperienced at risk, cost, and care management, it is hard to be sanguine about their ability to live within these rates or meet other contractual performance terms such as detailed reporting requirements. States may be stymied, therefore, in extracting contract compliance and future savings, and, in some instances, may have to increase rates to protect providers from financial crisis. Such concerns are not nearly so apparent in private-sector purchased managed care.

Sixth, Medicaid agencies have made real progress in tackling problems of enrolling large numbers of beneficiaries, promoting informed choice, and devising methods to allocate to managed care arrangements persons who do not make affirmative choices. While progress in each of these areas has been uneven across state programs, significant collateral learning among states is evident. The most pernicious marketing practices have been effectively eradicated in most states, and states have proceeded to tackle more subtle and insidious challenges, including the need to develop effective consumer education and information-sharing mechanisms. Enrollment broker contracting and competence seem to be growing as this embryonic industry meets both manpower and expertise needs for states at a time when state workforces are being reduced. In addition, states have determined several thoughtful ways both to execute autoassignment and to use it as an instrument for public policy purposes.

States freely admit to lagging in the development of quality oversight and other monitoring functions, though it is difficult to conclude that they differ much from their private-sector counterparts in these domains. What may be different is that Medicaid agencies feel compelled to do more than private purchasers because of their beneficiaries' vulnerability and the extent to which their choices may be more restricted either by program design or by their limited personal resources. So the burden to pursue an ambitious set of oversight functions weighs more heavily on public policymakers and program managers than on private-sector purchasers. Whether Medicaid agencies can muster the resources needed to do this in a period of waning public-sector employment remains to be seen.

Conclusion

State Medicaid agencies have achieved considerable success in adopting and adapting managed care for their beneficiaries, particularly over the last half decade. This is evident not only in the aggregate number of enrollees, which has increased more than fivefold over this time period; agencies have also displayed creativity in program development and design and reasonable caution, in most cases, in the scale and pace of implementation. The models employed have both dovetailed with and departed from those in private-sector managed



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care for reasons related to market conditions, administrative limitations, and beneficiary needs. Perhaps most notably, Medicaid agencies have been able to engineer major managed care arrangements for their beneficiaries, while, by and large, leaving in place most of the indigent care safety net. But continued expansion of managed care for persons with public and private coverage remains on a potential collision course with the cost-shifting that finances much of the uncompensated care in this country. It will be important to continue to monitor Medicaid's experience on this path.

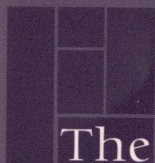
Notes

1. Health Care Financing Administration. 1996. *Medicaid Managed Care Enrollment Report*. Baltimore, MD.
2. Hurley, R., L. Kirschner, and T. Bone. 1997. "Medicaid Managed Care." In P. Kongstvedt (editor), *Essentials of Managed Health Care 2nd Edition*. Gaithersburg, MD: Aspen Publications, Inc.
3. Health Care Financing Administration. 1996. *Medicaid Managed Care Enrollment Report*. Baltimore, MD.
4. Gold, M., M. Sparer, and K. Chu. 1996. "Medicaid Managed Care: Lessons from Five States." *Health Affairs* 15(3): 153-166.
5. Hurley, R., D. Freund, and J. Paul. 1993. *Managed Care in Medicaid: Lessons for Policy and Program Design*. Ann Arbor, MI: Health Administration Press.
6. Buchanan, J., A. Leibowitz, J. Keeseey, J. Mann, and C. Damberg. 1992. *Cost and Use of Capitated Medical Services. Evaluation of the Program for Prepaid Managed Health Care*. Santa Monica, CA: RAND.
7. Gold, M., M. Sparer, and K. Chu. 1996. "Medicaid Managed Care: Lessons from Five States." *Health Affairs* 15(3): 153-166.
8. Meyer, H. 1997. "Medicaid: States Serve Up a Real Turkey." *Hospitals and Health Networks* 71(22): 22-24, 26, 28.
9. Lipson, D., and N. Naierman. 1996. "Effects of Health System Changes on Safety Net Providers." *Health Affairs* 15(2): 33-48.
10. Bachman, S., and B. Burwell. 1997. *Medicaid Carve-Outs: Policy and Programmatic Considerations*. Princeton, NJ: Center for Health Care Strategies, Inc.
11. Hurley, R., and D. Draper. 1998. "Managed Care for Medicaid Beneficiaries: An Overview." In P. Halverson, G. Kaluzny, and C. McLaughlin (editors), *Managed Care and Public Health*. Gaithersburg, MD: Aspen Publications, Inc.
12. Iglehart, J. 1994. "Rapid Changes for Academic Medical Centers." Part 1, *New England Journal of Medicine* 331(20): 1391-1395, and Part 2, *New England Journal of Medicine* 332(6): 407-411.
13. Medicare Payment Advisory Commission (MedPac). 1998. *Report to the Congress: Medicare Payment Policy*. Washington, D.C.
14. Holahan, J., S. Zuckerman, A. Evans, and S. Rangarajan. In press. *Medicaid Managed Care: Variation in State Approaches*. Washington, D.C.: Urban Institute.
15. Hurley, R., D. Freund, and J. Paul. 1993. *Managed Care in Medicaid: Lessons for Policy and Program Design*. Ann Arbor, MI: Health Administration Press.
16. Hurley, R., and D. Draper. 1998. "Managed Care for Medicaid Beneficiaries: An Overview." In P. Halverson, G. Kaluzny, and C. McLaughlin (editors), *Managed Care and Public Health*. Gaithersburg, MD: Aspen Publications, Inc.
17. Bachman, S., and B. Burwell. 1997. *Medicaid Carve-Outs: Policy and Programmatic Considerations*. Princeton, NJ: Center for Health Care Strategies, Inc.
18. Horvarth, J., and N. Kaye. 1996. *Enrollment and Disenrollment in Medicaid Managed Care Program Management*. Portland, ME: National Academy for State Health Policy.

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