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Folder Title:
4-28-98 [Health Care, Transportation - 1997-1998]

Stack: **Row:** **Section:** **Shelf:** **Position:**

American Disability Prevention and Wellness Association
111 Clarmar Road
Fayetteville, NY 13066

Phone: 315-446-3660 *Fax: 315-449-1034*

1998 Application and Membership Renewal Form

Name and Title:_____

Organization (if any):_____

Street:_____

City:_____ **State:**_____ **Zip Code:**_____

Work Phone:_____ **Home Phone:**_____

FAX:_____ **E-mail No.:**_____

Committees in which I am interested: ___Membership ___Legislation

___ Conference ___Publications ___Long Range Planning

Membership Fees
Please check one:

___ *Individual: $50* ___ *Organization: $250*

___ *Student/Retiree: $25*

Please make membership fee check out to ADPWA and send it to:

Dr. Michael Marge, President
ADPWA
111 Clarmar Road
Fayetteville, NY 13066-1602

Your Membership Fees are tax-deductible.

From: Ljcaskey <Ljcaskey@aol.com>
Date: Wed, 15 Apr 1998 17:09:51 EDT
To: funchess@bcm.tmc.edu
Subject: Accessible Transit Information

Hi! You came to the right place because Oakview is in the SCAT service area (Ojai, Ventura, Oxnard, Port Hueneme and the unincorporated areas of the county between these cities, i.e., Oakview).

SCAT ACCESS is the ADA paratransit service. Reservations are made 1-14 days in advance and the fare is $2.00 (one-way), and of course attendants ride free. The reservation number is 805-649-4421. Lucy is the manager (service is contracted through Laidlaw) and if Lex has any problems he should ask for her and throw my name around! They can be picked up at the Ventura Amtrak station (actually just a platform with a cover, not a station) and be taken to Oakview. They will need the exact address of Mac's Mom's when scheduling the pick up.

We have very little ridership on Saturday and Sundays so it is easy to schedule trips. You mentioned they may come on a Sunday. The service is extremely busy on weekdays so people are expressing having difficulty in getting reservations even a week in advance. The statistical reports show 5-10 trip denials per month because there are no vehicles available. We are looking at adding another vehicle to improve customer satisfaction (although not out of compliance with ADA). I would be interested in getting Lex's feedback on the system with his MetroLift experience and ADA authoring experience.

The bad news is that the taxi company does not have any accessible vehicles so SCAT ACCESS (or the regular bus) is the only option for a person in a wheelchair that cannot transfer to a seat.

I will send you a map so he can see where the train station is and where Mac's Mom lives and other areas of interest.

You didn't say what type of hotel Lex prefers (price range). The Holiday Inn in Ventura is convenient to the train station (2 blocks), 3 blocks from historic downtown Ventura and close to the freeway to get to Oakview. It is a highrise right on the beach by the Ventura Pier. The station is about 20 minutes from Oakview. There is also a Doubletree Inn in Ventura that is convenient and a Ramada Inn in downtown (4 blocks from train station) Ventura but I don't know what it is like (probably typical).

Let me know when they firm up their schedule so I can alert Lucy to provide the VIP treatment!

If you need more information or assistance please do not hesitate to call me. You should also give Lex my home number in case he has a problem and needs help.

Talk to you soon!

Love,
Laura

Laura Caskey home: (805) 647-5058

ofc # (805) 647-4241

NRH
NATIONAL
REHABILITATION
HOSPITAL
RESEARCH CENTER

April 2, 1998

Mr. Lex Frieden
TIRR
1333 Moursund
Houston, TX 77030-3405

Dear Lex,

Thanks for making my visit to Texas so enjoyable. Your staff at ILRU were wonderful in making me feel at home. I enjoyed having the chance to spend time with them. I was also glad we had a few opportunities to meet. The people you suggested I interview all proved extremely valuable, each in his or her own way. And your papers were outstanding. I came away with a lot of materials that will speed along my dissertation research and writing.

I am pleased that we were able to work out a situation where I could work for you and produce a final product in the form of an archival inventory. I wanted to elaborate in writing the organization of your papers and the rationale behind it. Attached please find a polished print copy of the inventory, as well as a floppy copy.

I view the work I did with your papers as the first, albeit major, step toward depositing the papers in an official archive. I say this because I am not a professional archivist and believe you will, for final public access, be best served by trained librarians. My objectives were to get the records organized to a point where:

1) You (and anyone else at ILRU) can readily and efficiently locate papers for your own use;
2) You can make determinations about what you do and do not want to be handed over to an archivist;
3) Archivists will be able to systematize the papers into a cataloguing system with an established organizational framework.

Fortunately, I have absorbed bits and pieces about assembling a manuscript collection. The first cardinal rule for archivists is to impose minimal reorganization on the papers. That is, to the extent that there is an organizational framework on the part of the papers' owner, archivists want to follow it as much as possible. The idea is that there is intrinsic value for researchers to see how an individual organized his or her papers. Thus, for example, if someone such as yourself organized correspondence according to each individual project, as opposed to creating a single, comprehensive file for all correspondents, an archivist would not extract all letters and make a comprehensive file of correspondence.

Mailing Address
102 Irving Street, NW
Washington, DC 20010-2949

Street Address
1016 16th Street, N.W.
Fourth Floor
Washington D.C. 20036
(202)466-1900

Fax (202) 466-1911

The NRH Research Center is a division of
the Medlantic Research Institute

MEDLANTIC RESEARCH INSTITUTE
Member of the Medlantic Healthcare Group

We agreed on the telephone that I could use my judgment to create an organizational framework, according to which archivists will develop a cataloging system. Nevertheless, I too tried to make minimal changes. As a general rule, if you had a group of papers collected in a file folder with a label, I kept that set of papers together. (In some cases, I split bulky files into two folders and labeled them sequentially.) For papers that were loosely boxed without folders, on the other hand, I took greater liberties to file them in folders, label them, and keep them with similar types of manuscripts. There are no longer any loose papers (with the exception of one item at the very end of the collection that I suspect you will discard). All papers are grouped in new and newly-labeled file folders (though some large, bound items simply follow a folder).

As the inventory illustrates, I organized papers into several major subject headings. I made an effort to keep all the papers of a single subject together, for example papers related to New Options. I consolidated all conferences into a single section. I also assembled all papers (i.e., articles and unpublished papers) into a single section. I suspect the inventory should speak for itself, but please contact me if you have any questions. Should you have a major disagreement about the way papers are organized, we could work with the archivist to make alterations.

Please note also that, generally speaking, I did not throw anything away. There were some obviously useless items (for example, a computer printout of computer games mixed in with the NCD papers) that I took liberty to dispose of. But I would prefer to have you make those determinations.

You will find that there are some very similarly-labeled folders that might be made more consistent. The source for this potential confusion is that file folders that ultimately made it into the same general subject heading often came from many of the different 20+ boxes of papers. I labeled each folder as I went through each box, and thus did not have all similar papers in front of me at the same time for consistent labeling. I chose not to re-label my original labels because I wanted first for you to have a chance to evaluate the organizational structure. Given the current state of your papers, an archivist will be able to re-label folders with a clear understanding of the "big picture." Also, an archivist will almost definitely use all new file folders anyway.

On the inventory itself I have explained the way the papers are assembled. There are, altogether, 24 boxes (which makes for nice symmetry in your office). Fifteen of these are labeled LF-# (after Lex Frieden). Nine are labeled LFP-# (after Lex Frieden Publications). I had a little bit of overflow of the publications, which I stored at the end of LF-15. I mention on the inventory that there is some confusion about how to determine primary authorship for the publications. We can talk about that at a point where you want to try to prepare an inventory/bibliography of every item in that collection. Currently, they are labeled alphabetically according to a sensible author. Items in binders that would not stand vertically in the file boxes are stored in LFP-9 (and overflow into LF-15).

We had talked about using plastic boxes for the collection. But since I was beginning to box papers on my first weekend there, it made sense just to stick with the cardboard boxes. They cost less than a dollar a piece, for a total of about $20.00. You could easily transfer the papers to more durable containers and reuse the boxes for something else.

You will find a few items on the bookshelf that I moved into your office. On the bottom shelf there are a series of books that look like graduate school texts. I did not box these because they did not seem relevant to the disability-content of the rest of the manuscripts. There is also a box full of old file folders. Many of them are pretty beat up, but I thought ILRU might have some use for them. Finally, there is a box with some non-print materials, such as plaques and office supplies. I was not sure what to do with these.

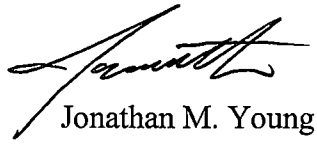
I hope this helps you in understanding how I approached and completed the project. Please do not hesitate to check with me regarding anything that is unclear.

Enclosed please find, in addition to the inventory, a release form for our interview. It is essentially identical to the one you signed for the NCD interview. Please sign, date, and return it to me at your earliest convenience. Call if you have questions.

As always, Lex, it has been a pleasure to work with you. And I am grateful for your eagerness to help underwrite my dissertation research in Texas. Your papers truly represented a gold mine for me. No doubt many other researchers will rely upon them as well.

I wish you and your family all the very best.

Sincerely,



Jonathan M. Young

Hi!
I hope this is helpful.
Gotta run.
Laura

Document Originally
Attached to
Following Page

II. PROJECT BACKGROUND, GOALS AND OBJECTIVES

Background

This project is a practical response to the paucity of useful information that consumers, particularly those with disabilities, need to make a thoughtful choice among different health care plans. Our aim is to supply relevant information in such a way that actually changes the way people choose among different plans. In other words, the ultimate purpose of this project is to create well-informed consumers of health plans. By consumers, we mean end users of health care services rather than institutional purchasers and other intermediaries.

In the classical economic theory of "perfect competition", the independent well-informed consumer plays a central role in the competitive health care marketplace by judiciously choosing among similar products based on their price and quality. In the current healthcare marketplace, however, several factors directly undermine the role of well-informed consumer (Weisbrod, 1983). The project described below was conceived to respond to these factors aand to take into account those market conditions described below that do not enhance consumer knowledge.

First, **health care plans do not offer standardized benefits.** Without a homogenous product, effective price competition is difficult to achieve, and consumers must compare apples with oranges rather apples with apples and oranges with oranges. Needless to say, health care plans are far more complex than fruit. Sweetness, flavor, and texture are nothing compared to deductibles, copayments, annual and lifetime maximums, physician reputation, convenience, and curtesy. Indeed, to switch metaphors, health care plans often are characterized as moving targets, impossible to pin down as to coverage and price. This presents a serious obstacle to providing reliable and valid information to consumers.

Second, **insufficient information exists that indicates what would happen if health care coverage is not purchased compared with what would happen if it was obtained.** AHCPR currently supports Patient Outcome Research Team (PORT) research to assess the efficacy of specific medical treatment procedures and shared decision-making programs (Casper et. al., 1992) have been developed to involve the patient in making treatment decisions. Report cards based on mortality data and consumer satisfaction comparison ratings have attempted to fill this gap. Unfortunately, the reliability and validity of these data are frequently challenged (GAO, 1994) although some efforts have begun to standardized consumer satisfaction ratings (RTI, 1995) and set national accreditation standards (NCQA, 1994). Other information such malpractice data exists but is not available (with some good reasons) to the general public.

Third, **decision-making is often relinquished to agents who are sellers and providers of health care coverage** or, like company benefit managers, represent interests other than the end user of the health care plan. As we describe in our guidebook marketing representative can often mislead individuals about coverage availability; brokers may represent a limited number of plans from which they receive commissions; and company benefit managers must pay heed to the financial needs of the firm as well as the interests of the employee.

In addition to these direct factors, several conditions in the health care marketplace indirectly, but substantially, exacerbate the problems consumers face in making thoughtful choices about health care plans (DeJong and Sutton, 1994). In the health care industry, providers and payers rather than consumers set prices. A second condition is the prevalence of experience rating which forces health plans to compete on the basis of risk and price rather than quality. These health care plans design their coverage package and price to appeal to low users of health care services and discourage enrollment by high user of services such as individuals with disabilities. A third, related, condition is absence of risk or case-mix adjustment to reflect the different utilization rates of consumers. Without risk adjustment, plans have little incentive to enroll or subscribe high user groups such as people with disabilities. A fourth problem is the underrepresentation of consumers in the governance of the health care system. The boards of private health care plans are dominated by physicians and business people. Even accrediting agencies like the National Committee on Quality Assurance subtantially involve consumers in setting standards and evaluating health plans.

This analysis helped us the shape the goals and objectives of this project. It also led us to formulate two key principles that would guide us in designing the decision support system. Foremost, we sought to create information that is based on the actual experiences of people with disabilities. We believed that people want to hear how other similarly situated individuals evaluate their health care options and go about choosing a health care plan. While this seemed key, we also believed that people would prefer additional input and lots of it. It would be our job to transform these data into useable information by reducing distilling it and packaging it in engaging ways.

Project Goals and Objectives

The goal of this SBIR project is to develop a **Decision Support System** to help people with disabilities, particularly those with physical disabilities, choose health care plans that best meet their needs. Given the scarcity of resources, especially during Phase I, we decided to focus on individuals between the ages of 18 and 65 with severe mobility impairments. Examples of specific conditions include:

amputations post polio

cerebral palsy	spina bifuda
cystic fibrosis	spinal cord injuries
multiple sclerosis	head injuries
muscular distrophy	stroke

Persons with these conditions tend to have a common constellation of health problems such as decubitus ulcers, urinary tract infections, respitory tract infections, and osteoporosis.

The Decision Support System, tentatively entitled **Choosing A Health Care Plan for Independent Living**, will include both "low tech" products such as brochures, guidebooks, and workbooks, as well as a "high-tech" products such as a videos and an interactive CD-ROM program. In their final form, these products will be available in a variety of accessible formats including braille, audiotape, closed-captioning, and voice activated computer diskettes. While each informational format will be designed to stand alone, they will be linked by common content. For example, both the draft guidebook and the prototype CD-ROM program developed in Phase I contain anecdotes of how health plan information can mislead consumers in to believing that services they thought would be available actually are not. In the guidebook this information is conveyed in text; whereas in the CD-ROM program it is convey in a voice narrative presented as a radio call in show. The brochure we will develop during Phase II will distill some of the information presented in the guidebook.

During Phase I, we focused our efforts on producing two major products: (1) a detailed guidebook including worksheets for assessing the cost and adequacy of different health plan and a glossary of terms, and (2) a CD-ROM program presenting a wide array of information ranging from a physician's perspective on the health care needs of individuals with physical disabilities to the personal experiences similarly situated people have had in choosing a health care plan.

To accomplish the goals of this project, we sought to complete three major objectives.

(1) **Determine the information needs of people with physical disabilities.** This objective addresses how people with disabilities assess the key features (price, benefits, restrictions, etc) of a health care plan, relate these elements to their own health care needs, and assess quality of care.

(a) What are the salient factors people with disabilities consider in choosing a health care plan?

(b) What are the trade-offs people with disabilities consider in choosing a health care plan?

(c) What sources of information do people with disabilities use in choosing a health care plan?

To achieve this objective, we relied mainly on focus group interviews with persons with disabilities. These focus groups were conducted in the Oakland, Calfornia, and Houston, Texas to vary consumers input from those from a highly competitive and richly developed and predominantly managed care marketplace to a less developed fee-for-service environment. We also conducted key informant interviews with health care and disability experts including experts with disabilities across the country.

(2) **Validate the content of the decision support system**. This objective is aimed at developing a decision support system that has a high likelihood of improving consumer awareness and fostering independent decision-making among people with physical disabilities. Specific questions include:

(a) What factors should we consider in optimizing the reliability, comprehensiveness, accuracy, objectivity, and usefulness of the decision support system?

(b) What outcomes should we expect to observe from consumers exposed to the guidebook and CD-DOM program?

To answer these questions, the project team conducted open-ended key informant interviews with researchers, policy experts, and disability advocates/consumers.

(3) **Develop a prototype of the decision support system**. Early in the project, we realized that we did not have sufficient resources to develop a variety of low- and high-tech products. Accordingly, we focused our efforts on developing a substantial "low-tech" guidebook and a comprehensive CD-ROM product. One measure of the success of this project is how success the project team has been in producing prototype versions of the guidebook and CD-ROM program. Specific research questions include:

(a) Can we demonstrate the feasibility of developing a decision support system consisting of "low tech" and "high tech" products?

(b) What are the substantive and technical strengths and weaknesses of the decision support system, particularly the "high tech" prototype?

For several reason, we decided to allocate scarce project resources to obtaining an independent review of the technical and substantive apsects of the CD-ROM version of **Choosing A Health Care Plan For Independent Living**. Because the content of the CD-ROM duplicates some parts of the guidebook, independent review of both products would be redundant. Furthermore, we anticipate that all

Agencies reviewers would have the expertise to evaluate the guidebook, but few would have the expertise to assess the technical merits of the CD-ROM program. Finally, even though the technology will soon become widely available, we perceived that not all Agency reviewers could readily view the CD-ROM program. Thus we hired **independent** consultants to provide a detailed review.

In the next section we describe the methods used to achieve these objectives.

For people with disabilities, choosing a health care plan poses problems due to:

(1) insufficient disability-relevant information about various health plans;
(2) lack of clarity about the specific types of services provided by different plans and the direct and indirect costs to the consumer;
(3) physical, sensory, or cognitive impairments that limit access to or understanding of the infromation provided; and
(4) inability to project the long-term consequences of various choices in terms of maintaning health and functional capabilities an in terms of cost to the consumer making the choice.

III. PROJECT METHODS

OVERVIEW

In this chapter, we describe the variety of methods used to pursue project objectives. We conducted focus groups and key informant interviews to understand how people with disabilities think about health care choices. In addition, we conducted key informant interviews with a national sample of researchers, policy experts, product developers, and advocates in the fields of health care and disability. Based on input from these sources, we drafted sections for a written guide to choosing a health care plan and drafted scripts and other materials for use in the CD-ROM. Starting with these draft materials we engaged in an iterative process combining the content and technical aspects of each products. The most challenging aspect of this process was blending of content and format of the CD-ROM. At the end of the project, we also sought an independent review of the CD-ROM from disability and computer technology experts.

To ensure against geographic and market provincialism, focus groups were conducted in Oakland, California and Houston, Texas. Differences between the population of the two states are shown in Table 1. State and national population data shows that a lower percentage of Texans have completed high school than

have Californians and all U.S. residents. However, the percentage of Texans who have completed college is equal to that of the entire U.S. population. The rate of severe work disability and mobility difficulties are about the same for both states, while the rate of self-care difficulties is higher in California. On the other hand, the rate of need for assistance in Instrumental Activities of Daily Living (IADL) or ADL is higher in Texas.

Table 1 about here

Differences in the health care markets in Texas and California are shown in Table 2. This table indicates clearly that Health Maintenance Organizations (HMOs) are far more prevalent in California than in Texas, but that Preferred Provider Organizations (PPOs) are more prevalent in Texas. These data suggest that Californians are more likely to be oriented toward HMOs than are Texans. Conversely, Texans are less likely to experience health care through a HMO and more likely, we believe, belong to a PPO or fee-for service plan.

(Table 2 about here

Aware that this orientation might bias the results of the focus groups, we were careful to take it into account during the analysis of focus group data. We were also concerned that the guidebook, which was developed by the Houston-based study team would be oriented toward fee-for-service and PPO plans, and that the CD-ROM developed in California would reflect HMO experiences. To avoid these biases, the two principal investigators exchanged draft verisons of the guidebook and CD-ROM scripts, talked frequently via the telephone, and had two extended face-to-face work session in Houston. Later, we report on how successful we were in integrating these perspectives.

FOUCS GROUP DISCUSSIONS

In order to learn more about how people with physical disabilities choose among different health care plans, BPA and ILRU conducted focus group discussions in Oakland and Houston, respectively. These group discussions addressed four broad topics related to choosing a health care plan, namely:

1) What are the salient factors that people with physical disabilities consider in choosing a health care plan?

2) What issues arise among people with physical disabilities in obtaining quality health care as defined above?

3) What sources of information do people with physical disabilities rely on in selecting a plan? and

4) What formats (brochures, videos, computer software, etc.) are preferred?

Two focus groups were conducted at each site; one group was composed solely of women while the other group was composed of men and women. All individuals had physical disabilities (e.g. paraplegia, multiple sclerosis, etc.) and/or chronic illnesses (e.g., diabetes, enlarged heart, etc.). The Houston groups, however, had more participants with severe mobility impairments. All participants resided in the East Bay area of Northern California (Berkeley, Oakland, Hayward, etc.) or the metropolitan Houston area.

Each group discussion was recruited using an identical protocol (see Appendix A: Focus Group Telephone Screening Instrument, Participant Recruitment, and Moderator's Guide). Recruitment activities included posting of notices in Independent Living Centers and other organizations for people with disabilities such as Easter Seals. We also used word-of-mouth and advertised at wheelchair manuafacturing and repair shops.
In Oakland, meetings were held on at BPA's meeting room facilities. ILRU sponsored groups were held at a centrally located hotel in Houston. Each group was moderated by an individual with a physical disability. Training of the moderators and assistant moderators was provided by the Principal Investigator, and detailed protocols were used to insure uniformity (See Appendix XX).

At 5:45 PM, prior to each group meeting, participants were asked to complete a short questionnaire assessing their demographics characteristics and how they rated the quality of health care they have received under their current health care plan. The seventeen items were derived from several sources including health plan satisfaction surveys and a survey of disabled employees conducted by ILRU. A light dinner buffet was provided to all participants and the formal discussion began at 6:10 PM. Participants were given $25 each and reimbursed for extraordinary transportation needs. Each group was audio-taped. Immediately following each focus group, the principal investigator or co-principal investigator debriefed the moderator and assistant moderator. A summary of each group was prepared based on notes from the debriefings, flip chart notes from each session, and the audio-tapes.

Our original plan was to conduct two rounds of focus groups in each site, partly to guard against "bad" groups and partly to explore new questions that might arise in the first round of discussions. However, we found this unnecessary. Each group was conducted without major problems, results from each group tended to be confirmed by the results from the other groups, and many of these results resonated with results obtained from other focus groups of consumers conducted by the National Committee on Quality Assurance and the Research Triangle Institutes consumer satisfaction survey design project (see Chapter IV).

KEY INFORMANT INTERVIEWS

We contacted experts in the fields of disability, health care, and disabaility advocacy in order to explore several key technical issues and to confirm the insights provided by focus group participants. We provided each expert with a synopsis of the project and description of the goals and components of the CD-ROM version of the Decision Support System. Specific discussion topics included:

(1) Salient factors someone with a physical disability should consider in choosing a health care plan?

(2) What kinds of information someone with a disability would consider most useful in choosing among competing plans?

(3) Suggestions about any existing material we should review?

(4) Suggestions for making the product stimulating, objective, and useful?

(5) Should we take strong positions on what health care plans are good and bad for people with disabilities?

(6) How can this product be designed to help consumers protect themselves against misinformation provided by health plans and other behaviors that are not in the best interests of people with disabilities?

We compiled a list of approximately 40 individuals gleaned from the academic and trade literature on health care and disability and 30 leaders in the disability arena. In exchange for their mailed-back comments, we promised to send them a summary of this report, and to acknowledge their input without implying endorsement of any product. We also promised to contact by phone those persons who did not return a written response. When circumstance allowed, the Principal Investigator conducted in-person interviews with a small number of these experts. Of the 70 individuals contacted, 45 provided some kind of response.

PRODUCT DEVELOPMENT

The development of the draft guidebook and prototype CD-ROM program ia best described as an iterative process in which substantive issues are considered in terms of the ability of the media (print or CD-ROM) to communicate the essential meaning of the issues derived from the focus groups and key informant interviews. While these source provided essential ideas for form and content of the CD-ROM, several questions remained:

(1) What should be the specific style of each product?
(2) What title best captures these aims?
(3) How should the content be arranged? and (4) What icons, graphics, and other presentation techniques are most appealing?

To answer these questions, we brainstormed among ourselves and, when necessary conducted informal interviews with technical experts and a small number of focus group members and other experts in the disability field.

We based the guidebook on a basic outline of important features of a health care plan and the important issues people with disabilities must encounter in choosing a plan. We developed definitions of important health care terms and concepts that should help to resolve plan coverage, price, and quality questions in terms of consumer needs. We also designed worksheets to resolve difference between service needs and plan coverage, quality needs and quality delivered, and costs and resources. After several drafts, these issues were translated into a draft document answering a series of questions that a typical but highly skeptical consumer might ask about health care plan.

The CD-ROM program also began with drafting preliminary descriptions of the basic theme and each component of the program. Initial ideas were inspired by comments made by focus group members and from feedback form our sample of experts. For example, both experts and consumers recommended that it would we very useful to have a physician's views of the health care issues people with physical disabilities are likely to encounter over the life course. A series of medical questions was then generated and a plan was prepared to video-tape a physician. These descriptions were circulated among key members of the project team for comments.

Perhaps the most challenging aspect of this process was the technical feasibility of specific ideas for each component of the CD-ROM. For example, we had planned to prepare several videos of persons with disabilities discussing their reasons for choosing their particular plan. We also wanted to include other video segments in the program. However, the current CD-ROM technology severely limits the number of video minutes in a given CD. Thus we were forced to reduce the number of video segments and limit their length. As we encountered these limitations, we gradually began to get a clear idea of what we could accomplish in a prototype CD-ROM program given the current level of resources.

INDEPENDENT REVIEW

Given the advance nature of CD-ROM technology, it was imperative to obtain an independent assessment of our prototype. Accordingly, we asked

three experts to review the CD-ROM program and submit criticisms and comments to AHCPR based on their expertise. Each experts was asked to assess the CD-ROM program along the follwing terms:

1. **Comprehensiveness**. Please assess the comprehensiveness of the product in addressing the information needs that people with disabilities have or should have in choosing a health care plan. Are there other areas that should be addressed? What areas need more emphasis?

2. **Accuracy and Consistency**. How accurate is the information presented in the program? Are there glaring errors or misstatements? Is the information internally consistent?

3. **Objectivity**. To what extent is the information presented in the program objective and unbiased? How do you think HMOs, PPOs and other plans will react? How do you think the disability community will react? Will a typical user discern a bias that will discourage her or him from using the product?

4. **Accessibility**. Please assess the tone, content, formats, and other aspects of the program with respect to its "user-friendliness."

5. **Entertainment Value**. Do you think that this program is stimulating? How would you make it more interesting and fun to use?

6. **Impact**. Does this product have the potential to affect the decisions people make about health care? How should that impact be measured?

7. **Weaknesses**. From your perspective, what are the overall weaknesses in this CD-ROM project?

8. **Strengths**. Overall, what are the strengths of this CD-ROM product?

9. What other comments and criticism do you have?

By the end of the project, two of the three experts had responded. Comments form the third reviewer will be included with the Phase II proposal.

In the following Chapter we present the results of our project efforts.
third

IV. **RESULTS**

OVERVIEW

In this chapter, we present the results of the research activities (focus group discussions and key informant interviews) and briefly describe the prototype guidebook and CD-ROM developed during Phase I. We also provide the comments and criticisms of the CD-ROM submitted by our independent reviewers. A draft copy of the guidebook may be found in Appendix XX. A single copy of the CD-ROM version (disk and accompanying documentation) has been submitted to the AHCPR project officer. A detailed description of each component of the CD-ROM may be found in Appendix XX.

FOCUS GROUPS

Composition.

Table 3 displays the demographic and health characteristics of the focus group participants as well as how they rate the quality of care received from their current plan. Although the participants from the two sites were similar with respect to age, gender, and marital status, the Houston participants were more educated and self-reportedly healthier.

An important difference, as we expected, was that no one in the Houston group belonged to a HMO, while no one in the Oakland groups subscribed to a fee-for-service plan. Participants in the Houston women's group reported much higher satisfaction with their health care care plan and rated the quality care received higher than any of the other group participants.

(Table 3 about here)

Factors and Trade-Offs in Choosing a Health Care Plan?

Participants identified six types of factors they considered important in choosing a health care plan:

Costs factors included premiums and deductibles, hidden and out-of-pocket costs.

Accessibility included accessibility of physician' office, the availability of a low examining table, out-of-area coverage, no pre-existing condition restrictions, and the availability of the primary care physician.

Adequacy factors included the availability of competent resources and equipment; coverage for durable medical equipment (especially wheelchairs, protheses, and orthotics) alternative care (e.g., acupuncture, chiropractic), and emergency coverage for durable medical equipment;

and variety of other services such as preventive care, psychiatric care, and attendant care. Those individuals whose disability occured as a result of a work injury, or who incurred another injury while on the job, were highly critical of the inadequate way health plans handle workers' compensation claims. Attendant care, considered by many disability experts to be the cornerstone of maintaining one's functional capacity, was not afforded a high rank by many participants. While they frequently or continuously required personal assistance, many participants simply assumed that health care plan are not responsible for this kind of care.

Quality of Care factors covered many of the same factors identified in the literature including continuity of care, timeliness, respect and curtesy, accuracy of information, etc. What may distinguish these participants for other non-disabled consumers is the urgency of factors like quickness of assessment, waiting, delays in obtaining durable medical equipment, the physician's expertise in the specific disability, and the doctor's ability to listen to the consumer (if the doctor is not familiar with the disability). More than a few participants articulated that it was just as important that the primary care physician understood health problems like respitory illnesses that it was for she/he to be an expert in a pariticular condition such as muscular dystrophy.

Other factors mentioned by our participants included reputation/prestige, open-mindedness and flexibility of professional staff, problems with getting approval/referral especially for basic needs such as durable medical equipment. Many people agreed with the sentiment the best health care plan is "a plan where you dont'have to fight." As other research indicates, participant attitudes toward there own health care took on an air of negativity as the discussion focused on specific instances of care. One horror story begat another. In wo groups, participants seemed divided between those who viewed these negative anecdote as exceptions, and those who believed them representativew of the plan. One women characterized her plan as "horrible" with respect to the treament she received for her brain injury, and wonderful when it can to diagnosing and treating her breast cancer. For a problem that any women might have, treatment was very competent and gracious; for a disability, especially one often perceived as resulting from irresponsible behavior, treatment was disorganized and decidedly ungracious.

In identifying what they consider to be important components of quality of health care, each group of participants made the distinction between what they considered to be ideal health care delivery and what they considered to desirable health care in the real world. When asked to explain the difference, many participants told us that they were so used to inadequate care that they

just did not think it was possible to have access to high quality and adequate care.

As the discussion of salient factors in choosing a health care plan evolved, a spectrum of health care plan savviness emerged among participants in each group. Many people, especially women, were sophisticated consumers of health care. For them, issues such as whether the health plan abortions, permitted referrals for acupuncture and other alternative services, and provide specialized information menopause and estrogen treatment played an important part in how they assessed the care they received. These people offered articulate advice about choosing a health care plan: "ask a very detailed question about an obscure service need such as acupuncture and see how they handle it," and how to maximize services: "make two back-to-back appointments with the same physician. This way you'll have enough time to get onto the examining table and be able to ask the doctor questions afterward."

People in this category were very adept atr getting what they wanted from their health care providers using a combination of screening skills for provider selection and knowledge of system operations to exert pressure on providers and payers in order to obtain services and products needed to maintain their health. Notwithstanding this apparent adroitness in obtaining needed services from a system that generally provide for few options, there were significant problems cited by group members. One participant receivng COBRA coverage from her most recent employer reported that because she could not obtain health care coverage from any other provider in the Houston area, she was forced to relocate to another area of the state.

Others belonged to a less sophisticated group of consumers with respect to exposure to choice of health care plans. As one participant put it, "I really have a lot of work to do. I really don't know anything about how to choose a health care plan." The lack of savvy was more prevalent in the Houston groups where choices are more limited and a greater percentage of participants had spent more years enrolleed in Medicare and/or Medicaid. We concluded that our efforts to deign products to assist individuals in selecting health care plans need to be relevant to people who have not faced with choices before and may have realatively little understanding of the influence of various factors on the quality, adequacy, and accessibility of health care services.

Despite the differing levels of knowledge and sophistication, each group agreed that costs was the most important factor influencing their choice of health care. For those in traditional fee-for-service plans, costs were followed by inclusion or exclusion of pre-existing conditions, provider experience with disability, coverage of personal assistance services, and range of covered services. Participants who are enrolled in HMOs were not concerned about pre-

existing coverage and tended to rank range of covered services above all factors except costs.
These findings are similar to findings obtained in focus groups with consumers conducted by the National Committee on Quality Assurance (Shelton, personal interview, 1995).

Sources of Information

Without question the consensus among all agroups as that the best information on health care plans could be obtained from persons with disabilities similar to one' own who had experience with the plans under consideration. Any information generated by groups or methods that did not include significant involvement of people with disabilities was suspect, including information from compnay benefit managers, well-meaning relatives, friends and co-worker with disabilities. Furthermore, participants preferrd information based on the actual experiences of other similarly situated persons over didactic information even though it may be provided by disability-specific consumer organizations like Independent Living Centers and the Muscular Dystrophy Association. At the same time, however, other sources of information were perceived as useful including marketing brochures, newspaper articles, health plan staff, and health fairs. In conjunction with information and advice from peers, these additional sources were not only views as useful but also as necessary. We interpreted these comments as a demand for reliable and valid data.

Problems with Plan-Provided Information

Focus group members clearly had difficulty with the information that was provide to them by the health care plan itself. Several individuals complained often of lack of forthrightness and sometimes quite bitterly of misinformation. Participants identified several aspects of a health plan for which they wanted detailed information, namely how the plan deals with workers' compensation claims, track record of how they have treated people in the past, what plan facilities provide what services, availability of medication without additives, access to medial records, right to sue, and evidence of gross negligence? Once again, these comments reflected concern for reliable, comprehensive, and accurate information.

KEY INFORMANT INTERVIEWS

One purpose of the key informant interviews was to confirm information provided by focus group participants. Although there was general agreement with repect to salient factors people with disabilities should conider in choosing a health care plan, our experts raised additional concerns and framed old issues in different language. Expert respondents emphasized access to speciality care along with the range or completeness of benefits. Some respondents added that the ability to assign a specialist (e.g. pulmonologist) as a primary care physician more important than allowing easy access to specialists. Reasoning like this led

many respondents to identify choice of physician as a critical factor in choosing a plan. Some experts were able to cite specific data such as "women with disabilities see specialists more often than able-bodied women and they use emergency rooms more often, probably due to barriers to primary care."

It was in the area of information requirments that our key informants provided the most valuable advice. Like the focus group members, key informants identified the need for same types of plan information (premiums, coverage, restrictions, etc.) and the need for subjective ratings based on the experience of people with disabilities, they also emphasized the need for external objective ratings (e.g. NCQA type accreditation) that also takes into account the uniques needs of high users of health care services. And like our focus group participants, the experts expressed a strong concern for reliability and validity, albeit from a professional, research-oriented perspective.

What our key informants made very clear, however, was just how difficult it is to achieve even minimum levels of reliability and validity. Many respondeents emphaized the importance of standardizing plan comparisons and avoid methological biases by adminstering the same assessment tools in the same way. Likewise, in the analysis, use same decision rules and control for (in the case of ratings and report cards) for differences in health status. Other took a more philosophical approach, commenting that "health care is a morel enterprise so 'objectivity' may be impossible, and "just present the facts as best they can be determined. There are a lot of gray areas.

The key informants were strongly opinionated about whether the decision support system should take strong positions on what health care plans are good or bad for people with disabilities. Answers ranged from "Yes, to a great extent," to "be careful, unless you feel absolutely solid about comparability of data," to "I don't think it is at all appropriate. These is no 'best' plan for all individuals with disabilities." While the range of responses was wide, the most common response was simply to provide as much relevant information as possible for the user to make up his or her mind. When warranted, specific problems can be raised about specific plans as long as there are data to support the claim. This appeared to bring us full circle to the reliability and vaildity problems discussed earlier.

Finally, we inquired about what outcomes we should expect from someone who uses the decision support system. Some expected total skepticism that such an intervention would really motivate people to change. Others thought that the information would motivate people to change plans and that one could observe measurable indications such as reduced out-of-pocket expenditures and increased satisfaction with health care received. Still others suggested self-reported satisfaction with the information system and testing individuals along the line of a health insurance IQ test.

PRODUCT DEVELOPMENT

As stated earlier, our goal was to develop **examples** of a set or range of informational materials under the rubric of **Choosing a Health Care Plan for Independent Living** that in conjunction with other "low tech" and "high tech" products are intended to reach a wide range of people with disabilities. The print-oriented guidebook and multimedia CD-ROM are not finished products. Rather, they are stylized examples of more fully developed and beta-tested products we will complete during Phase II.
Much work remains to be completed. In this section we describe the two prototypes developed during Phase I.

Guidebook Version

A complete draft version of the guidebook version of **Choosing a Health Care Plan for Independent Living** is provided in Appendix F. Figure 4-2 displays the cover page of the guidebook. It represents the reality that many people with disabilities face choices in health care. Overtime, we believe that more and more persons with disabilities, even those with the most severe disabilities who qualify for Social Security Insurance (SSI) and Social Security Disability Insurance (SSDI) may be empowered to choose among different health care plans.

Figure 4-3 displays the table of contents of the guidebook verwion of **Choosing a Health Care Plan for Independent Living**. The guidebook consists of four sections. Section One is a question and answer discussion of health care plans based on major topics raised during the focus groups and by key informants. We strive to provide examples and facts while offering advice and examples questions that consumers should heed or ask of market representatives and other purveyors of plans. The question and answer technique is intended to goad readers to be inquiring and skeptical. Section Two provides worksheets for consumes to assess their health care plans. This sections helps the consumer to specify features of a health care plan. Section Three is a glosary of important term in the health care field. Section Four provides contact infomation on state insurance departments. These agencies are usually the first regulatory agency to direct complaints.

CD-ROM Version.

The prototype CD-ROM version of **Choosing a Health Care Plan for Independent Living** was designed to provide interactive access to a wide range of information on choosing a health care plan. The CD-ROM program is

designed to work on both Apple and PC platforms. Figure 4-4 displays the opening screen of the program - a picture of an an idealized study carrel such that one might find in the most modern of libraries. The carrel contains a TV screen, a boombox radio, a set of books, a clipboard upon which are several topics, and a light switch which allows the user to exit the program. After the program credits and disclaimer role through the TV screen, a narrator welcomes the user and tells she/he that moving the arrow over any item on the screen will cause a brief explanation of the contents of that item to appear on the TV screen. By double clicking on the item, the user can enter a specific subprogram. A narrator then explains how to use each subprogram. To exit any given subprogram, the user may double click on the EXIT sign.

In the prototype, we opted for a study carrel scenario. We also considered two alternative metaphors/scenarios, namely (1) a modern marketplace or an aisle in a supermarket, and (2) A booth at a health faire. During Phase II we will have the opportunity to develop these scenarios and submit them to focus group for guidance.

Below is a brief description of the contents of each item in the study carrel.

Credits/Disclaimer: authors, acknowledgements, credits, and a a warning that people should consult a medical professional about medical problems.

Books: Glossary: same as glossary in print version

Legal Guide: Questions and Answers regarding one's rights to health care benefits and employment under the Americans with Disabilities Act of 1990.

Resource Guide: Books and other material related to health care and disability

Bibliogaphy: A list of academic and popular literature on health care, consumer choice, and disability

Radio: Health Plan Talk Radio Questions and Answers: a talk format designed to raise common questions about health plans based on real questions, complaints and advice consumers might have about choosing a health care plan and making the best of the situation once one has enrolled.

Clipboard: Introduction: A five minute video of Lex Frieden, Vice President of The Texas Institute for Rehabilitation and Research and former chair of the President's Council on Employment and Disability. Lex argues

why it is important for people with disabilities to become well-informed consumers of health care plans.

Ask the Doctor. A ten minute video of Dr. Jonathan Strayer of the Baylor College of Medicine in Houston, Texas. Dr. Strayer answers questions about the health care needs of people with physical disabilities over the life course. The user may select form a menu of questions address the health care needs of specific age groups and those of men and women.

Self Assessment of Coverage: This series of questions asks the user to indicate what health care services they needed during the last twelve months and whether the user's health care plan covered (full, partial, or not at all) that service. A "coverage quotient" bar at the bottom of the screen keeps a running total of the percentage of health care needs covered.

Self Assessment of Quality: A series of questions mostly drawn from AHCPR-developed national survey of consumer satisfaction asking the user to rate his/her current plan on 19 dimensions of quality of care (Poor to Excellent). Upon completing the questionnaire, the user may then view a bar chart of his/her ratings ("My Plan"). The user may also see how other people with disabilities rate their plan. In the prototype we show two other ratings (Rob/Prucare and Maureen/Kaiser North). In the fully developed product we will add many more personal ratings as well display averages.

Comparing Personal Experiences: Two videos of individuals (Rob and Maureen) with disabilities answering specific questions about their reasons for choosing their current plan. The user may view the entire video of each individual or may opt to hear the answer to specific questions. In the more fully developed product, we will provide more of these personal experience videos including videos of people who have disenrolled due to cause.

Comparing Health Plan Ratings: This component uses charts to compare the benefit structure of a typical HMO, PPO and FFS plan. It also reports the accreditation rating of various plans in the region (limited currently to HMOs reviewed by the Nation Committee on Quality Assurance). We also provide a chart comparing the consumer satisfactions rating developed by the Bay Area Business Group on Health for the specific plans in the prototype. Definitions of the terms used in the charts are provide as are explanation of how NCQA accredits plans and how BBGH measures consumer satisfaction.

Menu Bar. At the top of the studdy carrel is a "Menu Bar" from which different menu may be "pulled down" by double clicking on the item.

Options: This feature allows the user to select a closed-captioned, spanish translation, or voice activated version of the CD-ROM program. The current prototype does not yet have these features. These and other techniques to make the CD-ROM more accessible will be added to future versions of the program.

Plan Info: Brief descriptions of specific health plans. Current list includes Aetna (PPO), Health Net (HMO), Kaiser North (HMO), PruCare of California (HMO), TakeCare (HMO), John Alden Life (FFS), and Employers Health Insurance (FFS). These blurbs are based on marketing material provided by the plans. They are not intended to be comprehensive or necessarily accurate. We are just passing on how each plan describes itself.

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(1) Know Bugs and Limitations
(2) Getting Started
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V. **CONCLUSIONS**

OVERVIEW

In this chapter, we summarize the major research findings and product development results of this project. We also discuss the implications of the findings for consumer choice research and the feasibility of conducting further product development under Phase II of the SBIR program.

SUMMARY AND IMPLICATIONS OF MAJOR RESEARCH FINDINGS

Based on focus group interviews conducted in Oakland and Houston, people with physical disabilities share common priorities and methods of choosing among different health care plans. First, they share a common hierarchy of concerns at the top of which is the costs (premiums, copayments, deductibles, and hidden out-of-pocket expenses). For those with experience mainly in fee-for-service plans, the cost factor is closely followed concerns about pre-existing condition restrictions, then the range of covered services with emphasis on durable medical equipment and personal assistance. Quality of care, while necessary, ranked last in this hierarchy. Participants who are enrolled in HMOs were not concerned about pre-existing condition exclusions, but otherwise shared the same hierarchy of values in choosing a health care plan.

While there seem nothing suprising about these findings, what stood out was the urgency expressed in the need for durable medical equipment and personal assistance. Without them, participants reported that there health status and functional capacity would worsen, and they would find it difficult to fulfill their social roles as husband, wife, lover, friend, and worker.

Despite these expression of concern, it is remarkable that many participants looked fatefully at choosing a health care plan. Many expressed belief that choice was genuine. And most distinguished between what is ideal (e.g., personal assistance as a health care cost), desirable (full vs. partial coverage for durable medical equipment), and real (only partial reimbursement for durable medical equipment and no custodial personal assistance). Many people, matter-of-factly, simply did expect any health care plan to provide what they really need.

Another major finding is the clear expression of the need for reliable and vaild information upon which to base their decision to suscribe or eneroll in a given health care plan. For focus group participants, reliable and valid information meant information based on the experiences of people like themselves. At the same time, other sources of information, including professional assessments of quality of care, were welcomed and oftened highly valued, as long as this

information is consumed in conjunction with the real life experiences of one's peers.

Expert feedback also emphasized the need for reliable and valid information, and just how difficult it is to achieve. Our experts seemed to be telling us that many informational products and services including popular guidebooks, consumer ratings, and other services have poor reliability and questionable credibility. We should be care to develop valid and reliable measures of quality of care, administer them with the same rigor that a well-designed consumer survey is administered, use consistent decision rules in the analysis of the data, and control for different levels of health care utilization and other factors.

SUMMARY AND IMPLICATIONS OF PRODUCT DEVELOPMENT RESULTS

During Phase I, the project team designed and develop one "low tech" amd one "high tech" component of a decision support system to help people with physical disabilities choose health care plans. The "low tech" product is a complete guidebook consisting of questions and answers about choosing health care plans, worksheets, a glosary of important terms, and a resource guide. The 'high tech" product is an interactive CD-ROM program consisting of text, narration, videos, a radio program, and self-assessment exercises.

Although the guidebook and CD-ROM are not flawless, we feel that they are subtantially valuable and practical contributions to the goal of enhancing consumer among people with disabilities. We have demonstrated that useful "low-tech" and "high tech" products can be developed with limited resources that not only respond to the information needs of people with disabilities as articulated by our focus group participants, but also can be prepared in engaging and interactive formats. For these reasons, we have met or exceeded every objective and goal of this Phase I project.

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Many people contributed to this project. Foremost were those people who attended our focus groups in Oakland and California. Belying the belief that the "only thing focus group participants share is a desperate need for $25," our participant freely shared their experiences and worked hard to analyze their underlying preferences for health care. We would also like to thank Nancy Ferreyra in Oakland and Joyce Frieden in Hoston for their help in recruiting focus group participants. Last but not least, we would like to thank Maureen Donahoe and Robert Mudd for volunteering to share their thoughts about choosing a health care plan.

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A HEALTH CARE PLAN DECISION SUPPORT SYSTEM FOR PEOPLE WITH DISABILITIES

FINAL REPORT

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State Reports

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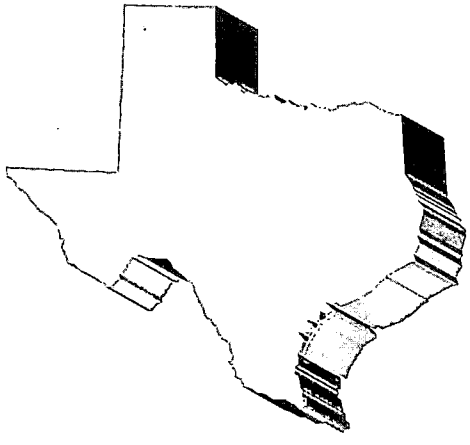

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This report is part of The Urban Institute's *Assessing the New Federalism* project, a multi-year effort to monitor and assess the devolution of social programs from the federal to the state and local levels. Project codirectors are Anna Kondratas and Alan Weil.

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 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.

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About the Series

Assessing the New Federalism is a multi-year Urban Institute project designed to analyze the devolution of responsibility from the federal government to the states for health care, income security, employment and training programs, and social services. Researchers monitor program changes and fiscal developments, along with 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 reports on the case studies conducted in the 13 states, home to half of the nation's population. The 13 states are Alabama, California, Colorado, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington, and Wisconsin. Two case studies were conducted in each state, one focusing on income support and social services, including employment and training programs, and the other on health programs. These 26 reports describe the policies and programs in place in the base year of this project, 1996. A second set of case studies to be prepared in 1998 or 1999 will describe how states reshape programs and policies in response to increased freedom to design social welfare and health programs to fit the needs of their low-income populations.

The income support and social services studies look at three broad areas. Basic income support for low-income families, which includes cash and near-cash programs such as Aid to Families with Dependent Children and Food Stamps, is one. The second area includes programs designed to lessen the

dependence of families on government-funded income support, such as education and training programs, child care, and child support enforcement. Finally, the reports describe what might be called the last-recourse safety net, which includes child welfare, homeless programs, and other emergency services.

The health reports describe the entire context of health care provision for the low-income population. They cover Medicaid and similar programs, state policies regarding insurance, and the role of public hospitals and public health programs.

In a study of the effects of shifting responsibilities from the federal to state governments, one must start with an understanding of where states stand. States have made highly varied decisions about how to structure their programs. In addition, each state is working within its own context of private-sector choices and political attitudes toward the role of government. Future components of *Assessing the New Federalism* will include studies of the variation in policy choices made by different states.

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Highlights of the Report[1]

Texas is a big, diverse state, with a large low-income population, high levels of uninsurance, and many foreign-born residents, largely from Mexico. Politically, it is very conservative, with fairly minimal health and welfare programs beyond what is required to draw down a federal match. Cash welfare and taxes are highly unpopular, but health care is viewed more favorably, and the state would like to expand Medicaid eligibility if it can do so without spending more money. Most state officials acknowledge that health and welfare benefits in Texas are less than what are provided in many other states, and few observers are concerned about the state ever becoming a "welfare magnet." Texas officials were supportive of a Medicaid block grant because they believed that funding was adequate and would not require reductions in eligibility or services. Currently, there is very little competition for budgetary resources between the elderly/disabled and families with children. Funding for each group is largely driven by the requirements of federal entitlement programs, a situation that would change drastically under a Medicaid block grant.

Medicaid expenditures grew rapidly between 1990 and 1995, although the rate of increase has fallen sharply since then. Medicaid expenditures increased by 40.9 percent a year between 1990 and 1992, and by 12.0 percent between 1992 and 1995. Although the huge increase in 1990–92 is largely explained by state efforts to maximize federal revenues through the disproportionate share hospital (DSH) program, enrollment and expenditures per enrollee also increased sharply during this period.[2] Expenditure increases are now in the single digits, and enrollment is flat.

Medicaid eligibility is quite restrictive, and the state funds only a very small medical program for the low-income population ineligible for Medicaid. The

state has followed a middle-of-the road policy on immigrants, seeking to maintain services to current beneficiaries but not attempting to fill the gap created by federal termination of coverage. Policy on Medicaid eligibility has been driven by a desire to limit state spending while expanding the number of people covered. To that end, the state has been pursuing a Medicaid research and demonstration (a so-called "Section 1115") waiver since 1995, with the goals of protecting DSH payments, expanding coverage, and drawing down additional federal funds. Particularly motivating the state in 1995 was the fear that federal changes in the Medicaid DSH program would result in substantial reductions in federal funds. The state's plan would use local funding for indigent care for the state match to draw down federal funds; thus, no additional state spending would be required. Although the initial proposal was never approved by the Health Care Financing Administration (HCFA), more importantly, the proposal lacked political support by local hospital districts that were concerned about loss of control over their funds and the potential use of their money to fund managed care or other nonpublic hospitals. A revised, more modest proposal that focuses on low-income children and that requires newly eligible individuals to receive their care through provider networks organized by "public-funding entities" was submitted to HCFA in November 1996, but rejected in August 1997.

The health care financing and delivery system in Texas is changing rapidly. First, in recent years, the state has substantially increased Medicaid funding for safety net hospitals by aggressively expanding its Medicaid DSH program, using intergovernmental transfers from local hospital districts to cover the state match. DSH spending now accounts for almost a fifth of total Medicaid expenditures, making federal changes in the program of great concern. Second, overall enrollment in managed care is growing rapidly, and responding to demands for cost reduction is a major concern of providers. Increasing enrollment in Medicaid managed care is the centerpiece of the state's cost-containment strategy, although it also expects enrollment to have positive effects on quality and access. At this point, commercial health maintenance organizations (HMOs) are competing actively for the Medicaid business as a way of increasing market share, and the state has not had to rely on Medicaid-only managed care organizations. Savings of about 10 percent compared to the fee-for-service system have been obtained. Third, Texas has a high percentage of for-profit hospitals, raising concerns about the provision of uncompensated care and the use of formerly nonprofit assets. Fourth, almost 24 percent of the nonelderly population is uninsured, which is one of the highest rates of any state in the country.

A large number of public hospitals, funded at the local level by property taxes, play a critical role in providing care for the Medicaid and uninsured populations and partly compensate for the low levels of insurance coverage. Many of these hospitals feel threatened by Medicaid managed care. Although the Medicaid-contracting HMOs are required to contract with traditional safety net providers for three years, enrollment of Medicaid beneficiaries in these plans is likely to reduce utilization of public hospitals, both because HMOs seek to reduce hospital utilization and because patients may be channeled to other hospitals with lower payment rates. Although from the perspective of

the Medicaid program this decline in the use of public facilities may result in reduced costs, more consumer choice, and better quality of care, the loss of Medicaid patients would be a major problem for these safety net hospitals because there would be fewer paying patients over which to spread the cost of providing care to uninsured patients. Without Medicaid patients, public hospitals would require far larger local contributions, something not likely in the current political environment. As a result, facilities could close or reduce services, diminishing access to care by the uninsured population. In response, the Texas legislature in 1997 passed a law requiring Medicaid to contract with HMOs formed by public hospital districts. A significant number of community health centers serving a large number of Medicaid and uninsured patients, which have relatively high Medicaid payment rates because of existing federal rules, face similar problems but have not been afforded similar protection by the legislature.

Finally, long-term care for the elderly and people with disabilities is a critical component of the state's involvement in health care and accounts for about 30 percent of Medicaid spending on services. Historically, long-term care has been dominated by institutional care. In an effort to alter this, the state's policy initiatives center on expanding the supply of home and community-based services for both the elderly and younger people with disabilities. At the same time, the number of persons in state mental hospitals and intermediate care facilities for the mentally retarded is declining, and the state has aggressively maximized Medicaid reimbursement for previously state-only funded programs. The state is also planning a major demonstration project in Houston that will integrate acute and long-term care services through managed care. Beyond system reform, the state has relied heavily on traditional methods of controlling long-term care expenditures, including a moratorium on new nursing home construction and low nursing home reimbursement rates.

Thumbnail Sketch of Texas

Texas is a diverse state with a large low-income population and many foreign-born residents. Politically, it is very conservative, with a lot of power residing in the legislature. Aside from wanting savings to fund tax cuts and the threat of reduced federal funding, there is no Medicaid budget crisis, and current program projections are for very modest rates of increase in expenditures. The Balanced Budget Act of 1997 reduces federal disproportionate share hospital (DSH) payments to Texas by $200 million in 2002 compared to 1998, an amount that is significant but unlikely to cause a major crisis.

Sociodemographic and Economic Overview

Texas is a big state, both in terms of population and geography. Almost 19 million people live in its almost 262,000 square miles (table 1). Texas has 254 counties, 196 of which are considered rural; of these, 62 are considered "frontier." Despite this vast amount of territory, 81 percent of the population lives in metropolitan areas. Partly as a result of the large distances between cities, there is a great deal of diversity in health and human service capacity and delivery systems. It is commonly believed that major areas of the state—in and around Austin, Dallas, Houston, El Paso, and Lubbock, for example—are each unique, requiring different policy approaches. While some areas of the state are bustling and prosperous, others face enormous problems, with unemployment rates as high as 50 percent and a lack of basic services, such as running water and sewage disposal.

Immigrants are an important part of the Texas population and have been increasing in number. Not surprisingly, given the state's geographic location, a

high proportion of the immigrant population is from Mexico. This is especially true in places on the border, such as El Paso. Although almost a third of the Texas population is Hispanic, the vast majority are American citizens. Some cities, such as Houston, also have large numbers of immigrants from Asia and other areas. Non-Hispanic whites constitute only slightly more than half of the population of Texas.

Economic Status

The economy in Texas has been doing well, with relatively low unemployment. However, the state has a high level of poverty. Unemployment in 1996 was 5.6 percent, slightly higher than the national average of 5.4 percent (table 1). The proportion of the total population and of children below the federal poverty line is considerably higher in Texas than in the country as a whole; per capita income is somewhat lower than the national average but grew faster than that for the country overall between 1990 and 1995.

Political Landscape

Texas is generally fiscally conservative. Republicans control the governorship and the state Senate. In contrast, the Democrats have a comfortable majority in the House. There is a substantial amount of bipartisan cooperation.

Structurally, Texas state government is characterized by a weak governor and a strong legislature. The governor, for example, does not prepare an annual budget. Part-time legislators meet for only 140 days every other year. Legislative committees are assigned topics to study between sessions. In practice, a great deal of power resides with the Legislative Budget Board, which is chaired by the lieutenant governor and consists of members of the leadership of the House and Senate. This group proposes budgets and is empowered to reallocate funds when the legislature is out of session.

Budgetary Environment

There is a very strong antitax environment in Texas, and welfare is viewed with disfavor; health care has more support. There is no income tax, although local property taxes are relatively high. During the 1995–96 biennium, the state enacted major welfare reform and authorized an ambitious Medicaid expansion and managed care demonstration. New spending was very limited.

For the 1997–98 biennium, the budget was also fairly constrained. Governor George W. Bush made local property tax relief and restructuring the tax system major priorities. Approximately a third of the funds for local property tax relief would have come from Medicaid savings. The legislature enacted a $1 billion property tax cut over two years (but did not restructure the tax system). The loss of local revenues was offset by increasing state education funding.

Table 1 *State Characteristics*

	Texas	United States
Sociodemographic		
Population (1994-95)[a] (in thousands)	18,732	260,202
Percent under 18 (1994–95)[a]	29.6%	26.8%
Percent 65+ (1994–95)[a]	9.6%	12.1%
Percent Hispanic (1994–95)[a]	31.0%	10.7%
Percent Non-Hispanic Black (1994–95)[a]	12.0%	12.5%
Percent Non-Hispanic White (1994–95)[a]	54.2%	72.6%
Percent Non-Hispanic Other (1994–95)[a]	2.9%	4.2%
Percent Noncitizen Immigrant (1994–95)[a]	11.3%	9.3%
Percent Nonmetropolitan (1994–95)[a]	18.8%	21.8%
Population Growth (1990–95)[b]	10.2%	5.6%
Economic		
Per Capita Income (1995)[c]	$21,206	$23,208
Percent Change in Per Capita Personal Income (1990–95)[c,d]	23.2%	21.2%
Percent Change in Personal Income (1990–95)[c,e]	35.3%	27.7%
Employment Rate (1996)[e,f]	65.2%	63.2%
Unemployment Rate (1996)[f]	5.6%	5.4%
Percent below Poverty (1994)[h]	17.6%	14.3%
Percent Children below Poverty (1994)[h]	25.8%	21.7%
Health		
Percent Uninsured—Nonelderly (1994–95)[a]	23.9%	15.5%
Percent Medicaid—Nonelderly (1994–95)[a]	12.6%	12.2%
Percent Employer Sponsored—Nonelderly (1994–95)[a]	58.0%	66.1%
Percent Other Health Insurance—Nonelderly (1994–95)[a,i]	5.5%	6.2%
Smokers among Adult Population (1993)[j]	23.8%	22.5%
Low Birth-Weight Births (<2,500 g) (1994)[k]	7.0%	7.3%
Infant Mortality Rate (Deaths per 1,000 Live Births) (1995) [l]	6.6	7.6
Premature Death Rate (Years Lost per 1,000) (1993)[m,n]	55.0	54.4
Violent Crimes per 100,000 (1995)[o]	663.9	684.6
AIDS Cases Reported per 100,000 (1995)[j]	23.9	27.8
Political		
Governor's Affiliation (1996)[p]	R	
Party Control of Senate (Upper) (1996)[p]	14D-17R	
Party Control of House (Lower) (1996)[p]	82D-68R	

a. Two-year concatenated March Current Population Survey (CPS) files, 1995 and 1996. These files are edited by the Urban Institute's TRIM2 microsimulation model. Excludes those in families with active military members.

b. U.S. Bureau of the Census, *Statistical Abstract of the United States: 1996* (116th edition). Washington, D.C., 1996. 1995 population as of July 1. 1990 population as of April 1.

c. *State Personal Income, 1969-1995.* CD-ROM. Washington, D.C.: Regional Economic Measurement Division (BE-55), Bureau of Economic Analysis, Economics and Statistics Administration, U.S. Department of Commerce, October 1996.

d. Computed using mid-year population estimates of the Bureau of the Census.

e. Personal contributions for social insurance are not included in personal income.

f. U.S. Department of Labor. *State and Regional Unemployment, 1996 Annual Averages.* USDL 97-88. Washington, D.C., March 18, 1997.

g. Employment rate is calculated using the civilian noninstitutional population 16 years of age and over.

h. CPS three-year average (March 1994–March 1996 where 1994 is the center year) edited using the Urban Institute's TRIM2 microsimulation model.

i. "Other" includes persons covered under CHAMPUS, VA, Medicare, military health programs, and privately purchased coverage.

j. Normandy Brangen, Danielle Holahan, Amanda H. McCloskey, and Evelyn Yee. *Reforming the Health Care System: State Profiles 1996.* Washington, D.C.: American Association of Retired Persons, 1996.

k. S.J. Ventura, J.A. Martin, T.J. Mathews, and S.C. Clarke. "Advance Report of Final Natality Statistics, 1994." *Monthly Vital Statistics Report*; vol. 44, no. 11, supp. Hyattsville, MD: National Center for Health Statistics, 1996.

l. National Center for Health Statistics. "Births, Marriages, Divorces, and Deaths for 1995." *Monthly Vital Statistics Report*; vol. 44, no. 12. Hyattsville, MD: Public Health Service, 1996.

m. ReliaStar Financial Corporation. *The ReliaStar State Health Rankings: An Analysis of the Relative Healthiness of the Populations in All 50 States,* 1996 edition, Minneapolis, MN: ReliaStar, 1996.

n. Race-adjusted data, National Center for Health Statistics, 1993 data.

o. U.S. Department of Justice, FBI. *Crime in the United States, 1995.* October 13, 1996.

p. National Conference of State Legislatures. *1997 Partisan Composition, May 7 Update.* D indicates Democrat and R indicates Republican.

Roadmap to Rest of Report

The rest of the report is divided into eight topics. The next two sections briefly describe the policy, budgetary, and administrative context of Medicaid and other health care programs for the low-income population in Texas. This description is followed by an assessment of how Texas views its role in providing health care and other services to the low-income population and how that might change if it were given additional flexibility to run Medicaid and other programs. After this section is an analysis of eligibility for third-party health care coverage for the low-income population, particularly Medicaid. Two sections on financing and delivery of health care to the low-income population follow, after which there is a discussion of long-term care for the elderly and disabled. Finally, there is a discussion of the major health care challenges Texas faces in the future.

Setting the Policy Context

The state's health care agenda is driven by two competing concerns—cost containment and improving access. Although a lower priority than in 1995–96, health care remains important because of its budgetary implications. The rate of increase in Medicaid costs has slowed dramatically, but the state continues to be concerned about controlling Medicaid expenditures. Medicaid is a very substantial portion of Texas's state spending and dominates state health policymaking.

The state's strategy for controlling health care costs depends very heavily on enrolling Medicaid beneficiaries into managed care organizations, a move that the state believes will also improve quality of care and access. At the same time, the state has continued to pursue eligibility expansions through a Medicaid research and demonstration waiver, even though its proposals met with local and federal resistance and failed to be approved.

The Health Care Environment

There are two characteristics of the health care environment in Texas that are crucial to understanding the politics and policy of health care in Texas. First, counties, through hospital districts, play an extremely important role in providing health care for the uninsured and Medicaid beneficiaries. Hospital districts have taxing authority (through the property tax) and run public hospitals and clinics. In addition, the University of Texas, especially the campus

in Galveston, plays an extremely important role in providing charity and Medicaid care. These public hospital districts fill some of the gap that is created by low Medicaid eligibility. Local hospital districts are deeply worried that the expansion of Medicaid managed care will result in their losing Medicaid patients, who are crucial for the hospitals' financial stability.

Closely associated with the role of public hospitals, the state has aggressively maximized Medicaid DSH funds, which account for about 19 percent of Medicaid spending. The federal legislative intent of DSH payments was to provide financial relief to hospitals that serve a large number of low-income patients. Intergovernmental transfers from the hospital districts provide most of the state match for DSH payments, and public hospitals receive most, but not all, of the money going to hospitals. Thus, the reductions in federal DSH funds recently passed by Congress could adversely affect these hospitals.

A second characteristic of the health care environment in Texas is that the health care marketplace is in turmoil. Enrollment in health maintenance organizations (HMOs), which served less than 20 percent of the population in 1995, is growing rapidly. Competition among HMOs is fierce, and a shake-out is widely expected. At this point, Medicaid is viewed as a better payer of hospitals than are HMOs. Commercial HMOs are very interested in the Medicaid business as a way of gaining market share. In addition, there are a lot of mergers and conversions of nonprofit facilities to for-profit status.

State Health Care Indicators

Texas is about average among states in the health status of its population, but it has a higher proportion than average of uninsured. In the ReliaStar ranking of the relative healthiness of the populations in all 50 states, Texas ranked 24th in 1996 and 33rd in 1995.[3] Texas has about the same infant mortality, low birthweight, and premature death rates as the national averages (table 1). Despite these rankings, Texas has many areas that are extremely poor and have major health problems. For example, relatively unique to southern Texas are areas called *colonias*, which have substandard housing, unpaved roads, and limited or no access to potable water, waste water disposal systems, and garbage collection. Many residents of the *colonias* are undocumented aliens.

The lack of health insurance is a major problem in Texas, with 23.9 percent of the nonelderly population uninsured in 1994–95, compared with 15.5 percent for the nation as a whole. In addition to low Medicaid coverage, this high rate of uninsurance is due to the low proportion of people with employer-sponsored health insurance—only 58.0 percent of the nonelderly population in Texas, compared with 66.1 percent for the country as a whole.

Although many urban areas, such as Houston and Dallas, have a large number of health care providers, the state as a whole has significantly fewer providers than the national average. For example, in 1994, while there were 81

generalist physicians per 100,000 population in the United States, there were only 61 generalist physicians per 100,000 population in Texas. In 1995, 112 entire counties and parts of 22 others were considered health professional shortage areas.[4]

State Health Programs

In Texas, the Health and Human Services Commission oversees all acute and long-term care policy. It was created in 1991 in order to consolidate policymaking in one entity, but operational responsibility remains with a variety of departments. The Texas Department of Human Services (TDHS), which previously was responsible for most Medicaid programs, now oversees long-term care and Medicaid eligibility determinations. Its acute care counterpart, the Texas Department of Health (TDH), oversees all acute care Medicaid and core public health functions. Mental health and mental retardation programs, many of which also are funded by Medicaid, are located in the Texas Department of Mental Health and Mental Retardation (TDMHMR). Other health-related departments include the Commission on Alcohol and Drug Abuse, the Department on Aging, the Rehabilitation Commission, and the Council on Early Childhood Intervention Services.

Medicaid

As in other states, Medicaid in Texas is the dominant health care program, accounting for 11.3 percent of state general-fund spending (table 2). State Medicaid expenditures grew by 17.2 percent per year from 1990 to 1995. This is faster than the overall state spending growth of 11.0 percent per year but less than state spending on corrections, which grew 26.5 percent annually. Combining state and federal sources of funds, spending on Medicaid grew 20.2 percent annually, compared with 9.3 percent for the total budget from 1990 to 1995. Growth in Texas Medicaid expenditures outpaced the national averages for 1990–92 and 1992–95 (see table 3); this is true for both acute and long-term care services and across all beneficiary groups. Growth in DSH expenditures from 1990 to 1992 was explosive, with expenditures increasing from $4.8 mil-

Table 2 *Texas Spending by Category, 1990 and 1995 ($ in Millions)*

Program	State General-Fund Expenditures[a] 1990	1995	Annual Growth	Total Expenditures[b] 1990	1995	Annual Growth
Total	$13,671	$23,074	11.0%	$23,485	$36,710	9.3%
Medicaid [c,d]	1,183	2,612	17.2	3,069	7,713	20.2
% of Total	(8.7)	(11.3)	—	(13.1)	(21.0)	—
Corrections	740	2,399	26.5	775	2,454	25.9
% of Total	(5.4)	(10.4)	—	(3.3)	(6.7)	—
K–12 Education	5,407	8,936	10.6	6,374	10,505	10.5
% of Total	(39.6)	(38.7)	—	(27.1)	(28.6)	—
AFDC	146	191	5.5	413	521	4.8
% of Total	(1.1)	(0.8)	—	(1.8)	(1.4)	—
Higher Education	2,680	4,451	10.7	3,900	4,890	4.6
% of Total	(19.6)	(19.3)	—	(16.6)	(13.3)	—
Miscellaneous [e]	3,515	4,485	5.0	8,954	10,627	3.5
% of Total	(25.7)	(19.4)	—	(38.1)	(28.9)	—

Source: National Association of State Budget Officers, *1992 State Expenditure Report* (April 1993) and *1996 State Expenditure Report* (April 1997).

a. State spending refers to general-fund expenditures plus other state fund spending for K–12 education.

b. Total spending for each category includes the general fund, other state funds, and federal aid.

c. States are requested by the National Association of State Budget Officers (NASBO) to exclude provider taxes, donations, fees, and assessments from state spending. NASBO asks states to report these separately as "other state funds." In some cases, however, a portion of these taxes, fees, etc., are included in state spending because states cannot separate them. Texas reported no other state expenditures in 1990 and $556 million in 1995.

d. Total Medicaid spending will differ from data reported on the HCFA 64 for three reasons: first, NASBO reports on the state fiscal year and the HCFA 64 on the federal fiscal year; second, states often report some expenditures, e.g., mental health and/or mental retardation, as other health rather than Medicaid; third, local contributions to Medicaid are not included, but would be part of Medicaid spending on the HCFA 64.

e. This category includes all remaining state expenditures (e.g., environmental projects, transportation, housing, and other cash assistance programs) not captured in the five listed categories.

lion to $1,513 million. The rate of increase in total Medicaid spending averaged 12.0 percent per year from 1992–95, compared with 9.9 percent nationally. Expenditures grew rapidly because of a large increase in the number of beneficiaries, state decisions to increase DSH, and efforts at Medicaid maximization. Since 1995, the rate of increase has fallen to about 7.5 percent a year.

As is true nationally, spending for acute care in Texas grew faster than spending for long-term care from 1990 to 1995. In Texas, however, spending was already more skewed toward acute care than long-term care. Texas now spends 70 percent of its Medicaid funds on acute care services, compared with 60 percent nationally. In 1990 the share was 60 percent for acute care, compared with 53 percent nationally.

Despite high Medicaid growth rates in the early 1990s, Texas spent less than the national average per eligible person in 1995 ($2,488 vs. $3,202, or 78 percent of the national average) (see table 4). Only six states had lower non-DSH

Table 3 *Medicaid Expenditures by Eligibility Group and Type of Service, Texas and United States ($ in Millions)*

	Texas					United States				
	Expenditures			Average Annual Growth		Expenditures			Average Annual Growth	
	1990	1992	1995	1990–92	1992–95	1990	1992	1995	1990–92	1992–95
Total	$3,265.3	$6,485.0	$9,118.9	40.9%	12.0%	$73,662.2	$118,926.0	$157,872.5	27.1%	9.9%
Benefits										
Benefits by Service	$3,080.2	$4,749.2	$7,185.4	24.2%	14.8%	$69,168.7	$97,602.4	$133,434.6	18.8%	11.0%
Acute Care	1,854.1	3,110.7	5,005.0	29.5%	17.2%	36,904.5	55,059.9	79,438.5	22.1%	13.0%
Long-Term Care	1,226.1	1,638.6	2,180.4	15.6%	10.0%	32,264.2	42,542.5	53,996.1	14.8%	8.3%
Benefits by Group	$3,080.2	$4,749.2	$7,185.4	24.2%	14.8%	$69,168.7	$97,602.4	$133,434.6	18.8%	11.0%
Elderly	$1,035.4	$1,527.8	$2,142.7	21.5%	11.9%	$23,334.3	$31,757.9	$40,087.4	16.7%	8.1%
Acute Care	320.3	485.5	742.2	23.1%	15.2%	4,925.4	6,911.5	9,673.7	18.5%	11.9%
Long-Term Care	715.1	1,042.4	1,400.5	20.7%	10.3%	18,408.9	24,846.4	30,413.7	16.2%	7.0%
Blind and Disabled	$902.3	$1,322.0	$2,188.5	21.0%	18.3%	$25,771.6	$35,684.6	$51,379.4	17.7%	12.9%
Acute Care	392.8	728.1	1,411.7	36.1%	24.7%	12,929.2	19,483.6	29,760.7	22.8%	15.2%
Long-Term Care	509.5	593.9	776.8	8.0%	9.4%	12,842.4	16,201.0	21,618.7	12.3%	10.1%
Adults	$558.2	$883.8	$1,267.3	25.8%	12.8%	$8,765.0	$12,710.1	$16,556.9	20.4%	9.2%
Children	$584.2	$1,015.6	$1,587.0	31.8%	16.0%	$11,297.8	$17,449.8	$25,410.9	24.3%	13.3%
DSH	$4.8	$1,513.0	$1,513.0	1668.6%	0.0%	$1,340.9	$17,525.6	$18,988.4	261.5%	2.7%
Administration	$180.3	$222.8	$420.5	11.2%	23.6%	$3,152.6	$3,797.9	$5,449.4	9.8%	12.8%

Source: The Urban Institute, 1997. Based on HCFA 2082 and HCFA 64 data.

Table 4 *Medicaid Expenditures per Enrollee by Eligibility Group, Texas and United States*

	Texas					United States				
	Spending per Enrollee			Average Annual Growth		Spending per Enrollee			Average Annual Growth	
	1990	1992	1995	1990–92	1992–95	1990	1992	1995	1990–92	1992–95
Total	**$1,751**	**$2,057**	**$2,488**	**8.4%**	**6.5%**	**$2,397**	**$2,729**	**$3,202**	**6.7%**	**5.5%**
By Group										
Elderly	$4,203	$5,598	$6,669	15.4%	6.0%	$6,839	$8,422	$9,738	11.0%	5.0%
Cash	2,546	3,116	3,928	10.6%	8.0%	3,329	4,017	4,818	9.8%	6.2%
Noncash	7,747	9,718	10,235	12.0%	1.7%	10,377	12,192	13,521	8.4%	3.5%
Blind and Disabled	$5,321	$6,116	$7,449	7.2%	6.8%	$6,378	$7,320	$8,022	7.1%	3.1%
Cash	4,248	5,064	6,574	9.2%	9.1%	4,969	5,927	6,686	9.2%	4.1%
Noncash	17,232	16,843	14,270	–1.1%	–5.4%	12,047	12,574	12,660	2.2%	0.2%
Adults	$1,408	$1,776	$2,109	12.3%	5.9%	$1,301	$1,518	$1,728	8.0%	4.4%
Children	$617	$768	$949	11.5%	7.3%	$770	$931	$1,178	9.9%	8.2%

Source: The Urban Institute, 1997. Based on HCFA 2082 and HCFA 64 data.

expenditures per beneficiary than Texas in 1995. In part, this reflects limited benefits; for example, Texas restricts coverage to 30 days for inpatient hospital stays and three prescriptions per month for adults. The per capita spending difference has narrowed since 1990, when Texas spent 73 percent of the national average per enrollee.

Department of Health and Department of Human Services

The Texas Department of Health is responsible for Medicaid acute care operations (e.g., hospital and physician reimbursement and managed care) in addition to core public health activities (e.g., disease control and prevention, health care quality and standards, environmental health, and personal services such as children's health, primary care, and nutrition). In fiscal year (FY) 1998, 85 percent of the $6.3 billion TDH budget is for the Medicaid program; 61 percent of the budget is federally funded (Medicaid and non-Medicaid).[5]

The Department of Human Services oversees Medicaid eligibility and numerous long-term care services primarily for elderly beneficiaries, in addition to Food Stamps, Aid to Families with Dependent Children (AFDC)/Temporary Assistance to Needy Families (TANF), domestic violence, and disaster assistance programs. In addition, the department regulates nursing homes and other long-term care facilities. Funding for long-term care derives from Medicaid and social services block grants. Seventy percent of the DHS budget is federally funded.[6] For FY 98, 70 percent of the department's $3.4 billion in expenditures are appropriated for Medicaid programs.

Department of Mental Health and Mental Retardation

The Texas Department of Mental Health and Mental Retardation oversees most of the state's long-term care services for nonelderly populations. It operates 9 state hospitals, 12 state schools, and 5 state centers for mentally ill and mentally retarded persons and funds 36 community mental health/mental retardation centers. Its programs encompass targeted case management, rehabilitative services, diagnostic services, home and community-based services, and institutional care. For FY 98 the department's operating budget is $1.65 billion (37 percent for mental health and 63 percent for mental retardation services).[7] The state has kept funding flat, arguing that the shift from institutional to community-based services has meant savings. In addition, the state has used Medicaid to fund many TDMHMR programs that had previously been financed with all state funds.

although they sometimes served as negative examples. There is a strong preference for "homegrown" solutions, and initiatives in other states are often dismissed as unworkable in Texas.

Although Medicaid is associated with welfare, health care is thought to be slightly different from cash assistance. Medicaid is viewed somewhat as an insurance program, rather than a pure welfare program. There is a general acceptance of the notion that people ought to be able to obtain needed health care services; Texans, however, are unwilling to pay enough in taxes to fund a very generous Medicaid program. Texas relies instead on an extensive network of public hospitals, financed through property taxes. Thus, the extensiveness of services depends on local wealth and willingness to pay taxes; there is no intrastate cross-subsidization across local areas. While policies to increase the number of welfare beneficiaries are so politically unpopular that they are never proposed, policies that would increase the number of Medicaid eligibles are politically acceptable if the state does not have to spend more money. For example, the state's Medicaid research and demonstration waiver proposal would substantially increase the number of children receiving Medicaid. Because many elderly Medicaid nursing home and home care beneficiaries were originally middle class, long-term care is very important in maintaining public support for Medicaid.

One reason for the better political support for Medicaid compared to cash assistance is that there are several well-financed health care provider groups that are financially dependent on Medicaid funds and lobby to protect the program, while few groups lobby in support of welfare. In the health arena, the for-profit nursing home association was widely believed to be the most powerful interest group. Physicians and hospitals were also said to have considerable political power, much more than the HMO and home care associations.

Consumer advocacy groups are not very strong but are more important than in some other states. While the American Association of Retired Persons' presence in the state is recent and there are few other advocacy groups to represent the interests of the elderly, older people are believed to be a powerful political force. Groups representing people with disabilities have tried to increase their power by joining together to form a consortium. Advocates for low-income families and children lack political influence. According to one observer, advocacy groups in Texas "tend to want to 'get along' rather than playing to win. They play to not lose."

Medicaid and Federal-State Relations

Like many other states, Texas would like more flexibility in running its Medicaid program, but it has learned to live within the current constraints. The proposed Medicaid block grant was generally viewed positively by state officials because the funding level was thought to be adequate and it would

have provided more flexibility. Changing to a block grant would, however, dramatically change the financial incentives for the state, which are now largely driven by strategies to maximize federal Medicaid revenues.

Federal-State Relations under Existing Law

Relations with the federal Health Care Financing Administration (HCFA) were generally good. Some state officials, however, thought the requirements to apply for Medicaid waivers were burdensome and time consuming and limited the ability of the state to "try things out" before implementing them statewide. In general, state officials found existing federal rules concerning the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, nursing home and hospital reimbursement, and managed care to be bothersome, but most respondents did not voice much passion concerning their repeal. Finally, Texas officials were not interested in additional flexibility to reduce Medicaid eligibility.

Medicaid Block Grants

The governor and most state officials interviewed supported the Medicaid block grant legislation that was passed by Congress (but vetoed by President Clinton). They liked the flexibility and believed that they would not have to reduce eligibility or services, partly because Medicaid caseloads have been lower than anticipated. Observers criticized Congressional Budget Office and Office of Management and Budget baseline projections of Medicaid spending as being unrealistically high.

While state officials expressed no desire to substantially cut the program, the higher Medicaid match rate included in the "Medigrant" plan would have meant that Texas would have drawn down its allocated federal funds faster than under the current formula.[8] State funding without a federal match requirement is extremely difficult to obtain; thus, the Medigrant plan might have resulted in reduced state general revenue spending for Medicaid.

In contrast, advocacy groups were opposed to the block grant, fearing the loss of funds and the legal leverage to require the state to do what they believed was right. Although the nursing home industry felt that a block grant would not adversely affect them because of their political influence and because they believed they provide a cost-effective service, other provider groups, such as the hospital industry, were more concerned about possible negative consequences.

Intergroup Competition for Resources

In terms of resource allocation among groups, there is currently very little competition between the elderly and nonelderly populations or between acute and long-term care. There is some competition between nursing homes and home and community-based services, with the for-profit nursing home association arguing that home care is not a cost-effective substitute for nursing home

care. Instead of competition, spending for each group is determined by its own set of federal mandates and entitlements, and the legislature does what it has to do to meet those requirements. As such, there is competition for resources between entitlement and nonentitlement programs, with the entitlements generally winning.

Although there is not much competition among groups now, virtually everyone believed that would change dramatically under a Medicaid block grant because resource allocation would become a zero-sum game—one group's gain must come as a result of some other group's losing resources. In general, most observers thought that the elderly would do well under a block grant. Even though the elderly do not have a strong lobbying presence, the for-profit nursing home association would likely be a critical factor in the expected success of the elderly in claiming resources. In contrast, it was widely believed that low-income families with children would not do well.

Medicaid Maximization

There are few state-funded health service programs outside of those that require state matching in order to receive federal funds. The maximization of federal Medicaid funds is viewed as a legitimate approach to obtaining a "fair share" of federal dollars, which is defined as the state receiving at least as much in federal funds as it pays in federal taxes. Programs that require full state funding without a federal match receive intense scrutiny and are much more difficult to fund. Texas, like many other states, has diligently "Medicaidized" many of its services (e.g., maternal and child health and services for children with special health care needs). That is, it has sought to obtain a federal Medicaid match for as many previously all-state funded services as possible. Unlike some other states, it has not taken the additional federal match as an opportunity to greatly increase the overall level of service for the same amount of state funding. Instead, the resources have been moved into other spending priorities. In addition, the state has carefully crafted a very large DSH program to maximize federal dollars, while minimizing state contributions by relying heavily on intergovernmental transfers from county hospital districts.

Third-Party Health Coverage for the Low-Income Population

Texas has strict financial eligibility criteria for its health and welfare programs. Largely due to federal requirements, the standards have become somewhat less austere for Medicaid but are still very low compared to those in most other states. The state has an ambitious welfare reform demonstration under way that predates the federal welfare reforms of 1996. The state submitted two proposals to HCFA for research and demonstration waiver programs to expand Medicaid coverage to the uninsured, but neither were approved.

Medicaid Eligibility

Policy on Medicaid eligibility has been driven by the desire to limit state spending while expanding the number of people covered. To that end, the state has sought Medicaid research and demonstration waivers and has followed a middle road regarding federally imposed changes for immigrants.

Trends in Coverage

Although Medicaid eligibility in Texas is quite restrictive, enrollment grew rapidly between 1990 and 1995, at a rate somewhat faster than the national average. Enrollment in Texas grew 14.6 percent per year from 1990 through 1992 and 7.7 percent per year from 1992 through 1995, compared with 11.3 percent and 5.2 percent nationally (table 5). In 1995, approximately 2.9 million Texans were Medicaid beneficiaries; 12.6 percent of the nonelderly population

Table 5 *Medicaid Enrollment by Eligibility Group, Texas and United States (Enrollment in Thousands)*

	Texas					United States				
	Enrollment			Average Annual Growth		Enrollment			Average Annual Growth	
	1990	1992	1995	1990–92	1992–95	1990	1992	1995	1990–92	1992–95
Total	**1,758.9**	**2,309.2**	**2,888.4**	**14.6%**	**7.7%**	**28,856.7**	**35,765.1**	**41,672.0**	**11.3%**	**5.2%**
By Group										
Elderly	246.4	272.9	321.3	5.3%	5.6%	3,412.2	3,771.0	4,116.6	5.1%	3.0%
Cash	167.9	170.3	181.6	0.7%	2.2%	1,713.1	1,739.2	1,789.2	0.8%	1.0%
Noncash	78.5	102.6	139.7	14.4%	10.8%	1,699.1	2,031.8	2,327.3	9.4%	4.6%
Blind and Disabled	169.6	216.1	293.8	12.9%	10.8%	4,040.9	4,875.1	6,405.2	9.8%	9.5%
Cash	155.6	196.8	260.4	12.5%	9.8%	3,236.8	3,853.4	4,973.5	9.1%	8.9%
Noncash	14.0	19.3	33.4	17.4%	20.0%	804.1	1,021.7	1,431.7	12.7%	11.9%
Adults	396.3	497.8	600.9	12.1%	6.5%	6,738.7	8,373.3	9,584.2	11.5%	4.6%
Cash	255.8	303.2	317.5	8.9%	1.5%	4,651.6	5,342.5	5,441.4	7.2%	0.6%
Noncash	140.6	194.5	283.4	17.6%	13.4%	2,087.2	3,030.9	4,142.8	20.5%	11.0%
Children	946.6	1,322.4	1,672.4	18.2%	8.1%	14,664.9	18,745.7	21,566.0	13.1%	4.8%
Cash	578.2	652.2	655.5	6.2%	0.2%	9,946.2	11,281.8	11,314.6	6.5%	0.1%
Noncash	368.4	670.3	1,016.9	34.9%	14.9%	4,718.7	7,463.9	10,251.4	25.8%	11.2%

Source: The Urban Institute, 1997. Based on HCFA 2082 data.

were eligible, about the national average. At the same time, 45.3 percent of the state population below 150 percent of the federal poverty line were eligible for Medicaid, which is significantly below the national rate of 50.3 percent. In 1995, 79 percent of the Medicaid population were children or nondisabled adults, a slightly higher percentage than the national average. While AFDC/TANF caseloads have been dropping, Medicaid enrollment has stayed relatively stable and is projected to remain level through FY 99. Medicaid funds have been returned to the state treasury in recent years because caseloads have been smaller than projected.

Regular Medicaid Eligibility

A large proportion of the Medicaid population is composed of women and children who gain eligibility because they meet AFDC criteria.[9] Texas, like many Southern states, provides a low cash welfare benefit. In 1996, the annual payment for a family of three with no other income was $2,256 (17 percent of the federal poverty line), compared with the national median state payment of $4,668 in 1996 (36 percent of the federal poverty line). There is no interest in increasing cash assistance levels, with the state preferring to focus its attention on moving beneficiaries into the workforce. The state constitution limits total cash welfare expenditures to 1 percent of the state budget, a proportion that it does not come close to reaching. Because of falling AFDC/TANF caseloads, the state has extra state money that it is not required to spend on TANF.[10]

Texas covers only a limited number of optional groups under Medicaid. Although the Texas Medicaid program does cover the "medically needy," the income and asset limits are so low that very few people qualify. Texas does not provide Medicaid eligibility to children whose family incomes are above the federal requirements (133 percent of the federal poverty line up to age 6 and 100 percent of the federal poverty line up to age 14). However, the state does cover (using a presumptive eligibility process) pregnant women and infants up to 185 percent of the federal poverty line without any resource test as part of an effort to reduce infant mortality.

Eligibility Components of "Section 1115" Demonstration Proposals

The state has been pursuing a Medicaid research and demonstration (a so-called "Section 1115") waiver since 1995, with the goals of protecting federal DSH funds, expanding coverage, and drawing down additional federal funds. Particularly motivating the state in 1995 was the fear that federal changes in the Medicaid DSH program would result in a substantial reduction in federal funds. Thus, the waiver proposal was an effort to convert DSH payments to managed care payments for individuals, which might be less vulnerable to reductions at the federal level. Under the initial proposal, eligibility would have been expanded to 133 percent of the federal poverty line for children ages 6 through 18 and 45 percent of the federal poverty line for adults (with a goal of 75 percent of the federal poverty line). In the 1995 proposal, the Medicaid program would

have become a series of per capita payments to so-called "intergovernmental initiatives" (IGIs) at the county level.

Although never formally rejected by HCFA, the waiver proposal was never approved. Ultimately, the proposal ran into problems because of the proposed administrative structure. HCFA was concerned that the IGIs represented a potential conflict of interest since they were dominated by providers and would run the program at the local level. In addition, the proposal never obtained substantial financial or political support from the hospital districts. Local hospital districts, which were expected to put up matching funds for the expansion, were not enthusiastic about the prospect of "their" funds being used to further enrollment in Medicaid managed care and to help fund nonpublic hospitals. While DSH-contributing hospital districts now receive more funds than they contribute in intergovernmental transfers, the demonstration would not have provided the same guarantees. As a result, only one hospital district agreed to put up its money for the waiver program.

In November 1996, the state submitted a revised research and demonstration Medicaid proposal that was less ambitious than the earlier version. The revised plan sought to expand Medicaid eligibility for children ages 6 through 18 with incomes below 133 percent of the federal poverty level, but it did not provide additional coverage for adults. While adding an estimated 384,557 children in 1998, the incremental number of persons covered beyond federal requirements would decline over time as children below the federal poverty line were phased in as mandatory eligibles under current law.[11] By 2002, about 230,599 children would have Medicaid coverage who would not otherwise be covered. The state match would be provided by eight large hospital districts, the city of Austin, and the University of Texas Medical Branch. New state general revenues would not be required.

Under the waiver, "public funding entities" would have assumed responsibility for delivering or arranging care for all newly eligible children. The state would have contracted directly with managed care organizations formed by the funding entities. Newly eligible children would have received their care through these managed care organizations, which had to provide at least the Medicaid benefit package and meet all process and quality requirements of other Medicaid managed care organizations. Waiver beneficiaries would have faced expanded copayment requirements. The state estimated that the total cost of the additional coverage would be $325.7 million, of which $202.5 million would be federal funds in the first year.

In August 1997, HCFA rejected the second Texas waiver proposal on the grounds that the state needed to include more than one managed care organization in each region in order to provide beneficiaries with some choice of health plans. The passage of the children's health insurance initiative as part of the Balanced Budget Act of 1997 may make the waiver request largely moot. Because of its large number of uninsured children, Texas will be entitled to a very substantial amount of federal money under the new State Children's

Health Insurance Program—approximately $560 million in 1998 and $2.5 billion from 1998 to 2002. However, the requirement for a state match in the new program may be problematic for Texas, although the state will likely be able to use intergovernmental transfers to finance the state share.

Issues in Medicaid/Welfare Reform[12]

Historically, Texas's stringent eligibility requirements for AFDC led to low levels of participation in AFDC by the poverty population. The state has been very active in welfare reform and, as a border state with Mexico, will be potentially greatly affected by federal efforts to restrict health and welfare benefits to immigrants.

Texas welfare reform.

In 1995, Texas enacted a comprehensive welfare reform package that was approved by the U.S. Department of Health and Human Services in March 1996 as a demonstration program, prior to the passage of the federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA). The Texas welfare reform plan has time-limited benefits of 12, 24, and 36 months based on each person's work experience, education, and literacy; 12 to 18 months of transitional child care and medical assistance for those whose time limits expire; and a requirement that recipients must work, go to school, or participate in a job training program. In some ways, the Texas welfare reform is less restrictive than the federal legislation.[13] One concern of the state regarding the federal legislation is that severing the eligibility link between AFDC/TANF and Medicaid (as required by PRWORA) could add $100 million in administrative costs.

In 1996 Texas proposed the Texas Integrated Enrollment System (TIES), a project to consolidate and streamline eligibility determination for fifteen programs, including AFDC/TANF, Food Stamps, and Medicaid, and to privatize these functions by contracting out to private firms. The value of the contract was estimated to be $2.8 billion over seven years, with savings estimated to be about $120 million annually. In a highly unusual arrangement, public agencies—the Texas Department of Human Services and the Texas Workforce Commission—teamed with different private corporations for purposes of bidding on the contract. In May 1997, the Clinton administration ruled that federal law prevented private employees from determining eligibility for the Food Stamps and Medicaid programs. The state believed that the President was bending to pressure from the public employee unions. Since then, the public agencies have terminated their alliance with the private vendors, and a private company has been awarded a 15-month contract to help the state reengineer eligibility determination and service delivery and secure a new computer system.

As part of welfare reform, the 1996 federal legislation tightened eligibility for Supplemental Security Income (SSI) (and, relatedly, Medicaid) for children. It is estimated that approximately 12,700 children in Texas with Medicaid

expenditures of $52 million will lose SSI. Most will retain Medicaid eligibility through the requirement to cover poverty-level children. However, some children, especially those over age 13, will lose Medicaid eligibility. The 1997 federal budget agreement restored Medicaid eligibility for beneficiaries who lost eligibility as a result of the changes in SSI.

Immigrants.

Changes to immigrants' eligibility for public benefits enacted as part of PRWORA, as modified by the Balanced Budget Act of 1997, will have a significant impact in Texas, although somewhat less than might be imagined because a very high percentage of persons of Hispanic (primarily Mexican) origin are American citizens. Under federal law, almost all legal immigrants who enter the country after August 22, 1996, will be excluded from Medicaid for five years, with the principal exception of refugees. County public hospitals, legally required to serve all medically indigent people, are concerned that the loss of Medicaid eligibility by legal immigrants will increase their levels of uncompensated care.

In addition, the law makes it difficult for states and localities to provide any medical care other than emergency services to undocumented aliens by requiring states to pass a new law making them eligible for state or locally funded benefits. (Undocumented immigrants were, and remain, ineligible for full Medicaid coverage.) For FY 95, roughly 100,000 legal immigrants were eligible for Medicaid at a cost of $440 million. Undocumented aliens who received emergency services accounted for less than 1 percent of total Medicaid recipients and expenditures. (Unlike in California, Texas health care providers have not aggressively sought to obtain Medicaid reimbursement for "emergency" services by identifying undocumented aliens and are philosophically opposed to doing so.)

The political environment is not hostile to immigrants when state budget impacts are minimal. Governor Bush is viewed as moderately pro-immigrant (with a contrast often being drawn with Governor Pete Wilson of California) and lobbied Congress to restore the federal eligibility cuts enacted as part of the 1996 welfare bill. However, for the most part, he has not proposed offsetting the federal cuts with new state programs or using excess state welfare funds to fund services for immigrants, preferring to propose property tax relief instead. In an exception to that general policy, in October 1997, Governor Bush announced that Texas would provide up to $18 million in food assistance to about 28,000 elderly and disabled immigrants who cannot work and whose food stamp benefits have been cut off by the federal government. Perhaps because Texas is a border state, immigrant advocates in the state have traditionally focused on issues involving the Immigration and Naturalization Service and are less familiar with welfare and health issues.

There has been little discussion of or advocacy for providing benefits or services to new immigrants; most of the debate has centered on continuing to pro-

vide for current immigrants. Texas has opted to continue eligibility for Medicaid, TANF, and Title XX/Social Services Block Grant services for qualified aliens in the country as of August 22, 1996. The state has, however, decided to extend the ban on TANF for new immigrants until citizenship, rather than limiting it to the five years after entry into the United States.

In addition to restoring cuts in SSI to certain legal immigrants, the Balanced Budget Act of 1997 guarantees continued Medicaid eligibility for immigrants currently receiving Medicaid on the basis of SSI eligibility. Texas is one of only five states where immigrants losing SSI would not otherwise have retained Medicaid through another existing eligibility category. However, prior to passage of the federal act, the 1997 Texas legislature authorized creation of a new Medicaid category for legal immigrants losing SSI. Because benefits for this group are now restored, the state has not implemented this category. One group whose benefits were not restored by the Balanced Budget Act is legal immigrants already in the United States before August 22, 1996, who are elderly but not disabled. This group is likely to be ineligible for both SSI and Medicaid in Texas, unless the state implements a new Medicaid category authorized by the 1997 state legislature. A relatively small number of legal immigrants falls into this category, and it may be difficult to bring the issue to the attention of state policymakers until more immigrants age into this group.

Other Public Financing Programs

Texas has few programs to provide health insurance for the low-income population, except for Medicaid. For example, Texas does not have a general assistance-medical program for low-income people ineligible for Medicaid. In addition, although Texas has had a high-risk insurance pool since 1989, no funding has ever been approved and it has never become operational. Instead, most uninsured receive care through public hospitals operated by the counties. Counties that do not run public hospitals are eligible for funds through the very small County Indigent Health Care Program. For further discussion of public hospitals and the County Indigent Health Care Program, see the section on "Delivering Health Care to the Uninsured and Low-Income Populations."

During 1996 and 1997, the state debated a variety of initiatives to expand health insurance for children not eligible for Medicaid. Few of the proposals included new state spending or new taxes, limiting the potential impact of planned initiatives. In spring 1997, a law was enacted establishing the Healthy Kids Corporation, which will help insurance companies sell health insurance for children whose parents are not poor enough to qualify for Medicaid. The measure will encourage insurers to cover children through tax breaks and fewer benefit mandates. A major theme of the debate was that providing health insurance to children would save money for employers and Medicaid. Over the next few years, policy initiatives will likely focus on implementation of the Balanced Budget Act's State Children's Health Insurance Program.

Insurance Reforms

Although uninsurance rates are high, a substantial portion of the population below 200 percent of the federal poverty line has private health insurance. Like most other states, Texas has adopted insurance reforms involving rules of issue and rating restrictions for the small-group market (between 3 and 50 employees). However, no individual market reforms have been enacted or are under active consideration.

For the small-group market, the waiting period on preexisting condition exclusions is limited to 12 months for conditions diagnosed 6 months prior to obtaining new health insurance coverage. In addition, a portability provision requires insurers to credit waiting periods if the condition was covered under a previous policy, that is, if there was no gap in coverage longer than 60 days. Moreover, Texas businesses cannot be denied a group health policy because one or more employees suffers from a medical condition. Texas has also established rating bands, with adjustments for age, gender, industry, geographic area, family composition, and group size. Among the nine business classes established, variation across classes is limited to 20 percent and variation within classes is limited to 25 percent. In addition, premium increases at renewal are capped at 15 percent.

In 1993, the Texas Insurance Purchasing Alliance was established to provide health insurance coverage to employers with 3 to 50 workers. Benefits offered through the Texas Insurance Purchasing Alliance were reconfigured in 1996 because relatively few employers had taken advantage of the offerings, claiming that the plans were too expensive or offered too few benefits. Other recent insurance reforms include a 1995 law that authorized a Medical Savings Account pilot program for Medicaid recipients, but it has not been implemented.

Financing and Delivery System

Managed care and the growth of for-profit hospitals is substantially altering health care financing and delivery in Texas. Overall, managed care is growing, and the state is moving steadily to enroll Medicaid beneficiaries into plans. Medicaid hospital reimbursement is fairly generous, especially when combined with DSH payments, but rate setting is increasingly done by the HMOs rather than the state.

The Health Care Market and Access for Low-Income Populations

The health care market is changing rapidly in Texas. Enrollment among preferred provider organizations (PPOs) and HMOs has grown at the expense of indemnity coverage. Simultaneously, for-profit hospitals have made significant inroads in Texas and account for one-third of hospitals in the state. In response, hospitals and physicians have attempted to become more cost competitive and consolidate services. To date, managed care, conversions of nonprofit hospitals to for-profit organizations, and consolidations have not had a discernible impact on access to care for low-income populations.

Managed Care

Growth among PPOs has been rapid, from 80 PPOs in 1995 to 120 in mid-1996. The Texas Department of Insurance estimates that about half of the indemnity market is now in PPOs. HMO enrollment grew from 1.4 million

members in 1991 to 2.2 million in 1995.[14] Of the state's 39 HMOs, only 5 were operated by nonprofit organizations, including one public hospital. There has been considerable competition and consolidation among HMOs. The state reports that net income after taxes per HMO member per month declined by about 60 percent from 1993 to 1995.[15] State officials expect a market shake-out, with mergers and consolidations likely.

HMOs have been affected by several trends in Texas, some of which would tend to hinder and others that would tend to promote HMOs. Trends that might promote further entry of HMOs include the expansion of Medicaid managed care, increases in HMO enrollment within self-insured plans, and relatively high Medicare payment rates in some parts of Texas. However, negative publicity about the quality of care in HMOs—combined with the relatively low political clout by managed care organizations with state legislators—has translated into stricter regulation of managed care in Texas compared with other states. Physicians in Texas are strongly opposed to managed care and have fought for rules to make operating an HMO in the state less attractive. Although a "patient protection act" promoted by the state medical society was vetoed by Governor Bush in 1995, the governor did order that many patient and provider protections be instituted by regulation. These regulations address emergency room services, continuity of care, out-of-network referrals, balance billing, and member information. Additional legislation required the state to collect extensive patient care and quality data from HMOs. In 1997, Texas became the first state to enact a law allowing patients to sue HMOs for malpractice. Aetna is suing the state over this legislation.

Further hindering the development of HMOs is a legal provision that bars the "corporate practice of medicine." Under this ban, nonphysicians may not own physician groups. In response, entities have emerged called 501(a) nonprofit medical corporations, with physician-only boards of directors.[16] The 501(a) entity is the only organization in Texas that can contract directly with an HMO for both physician and hospital services on a capitated basis. Otherwise, risk-bearing entities are subject to full HMO licensure and regulation. Consequently, hospitals, physician management companies, and other medical groups have formed 501(a) organizations in order to contract with HMOs.

Physicians and Hospitals

Both physicians and hospitals have been affected by the growth in managed care that has resulted in pressure on provider rates and competition for patients. Although Texas has a strong tradition of solo physician practice, managed care has changed the face of physician practice. According to a 1996 survey of Texas physicians, HMO and PPO patients accounted for 31 percent of all patients seen in physician practices, up from 20 percent in 1994 and 15 percent in 1992.[17] Forty-two percent of surveyed physicians were members of physician-hospital organizations, 41 percent were members of independent practice associations, 11 percent were members of 501(a)'s, and 10 percent were members of physician practice management organizations. Group practice is

viewed as necessary in the face of HMOs and employer purchasing groups. From 1990 to 1996 the proportion of solo practitioners has dropped from 50 percent to 40 percent.[18] Network formation is uneven geographically and generally follows managed care trends.

Hospitals are also undergoing change. Texas has roughly one-third each nonprofit, public, and for-profit hospitals. Its share of public and for-profit hospitals is greater than the national average. Two national for-profit chains, Columbia/HCA and Tenet, have a strong presence in Texas. Columbia/HCA has acquired 71 hospitals, some of which were formerly nonprofit hospitals; at least 3 were subsequently closed. (It is unclear what effect the criminal investigation of Columbia/HCA and the subsequent management changes ultimately will have on the company's Texas operations.) Recent high-profile mergers among nonprofits have been proposed between Harris Methodist and Presbyterian Healthcare Resources in North Texas and Hermann Hospital and Memorial Healthcare System in Houston. Blue Cross and Blue Shield of Texas has merged with Blue Cross and Blue Shield of Illinois. Some officials complain that the state receives only "paper boy" notification (i.e., they read about it in the newspaper) of these mergers and conversions. Texas does not require that the acquiring hospital maintain the level of charity care previously provided.

Like physicians, hospitals are responding to managed care pressure in a variety of ways. Specific activity depends on whether an area has excess hospital capacity and on the extent of pressure from for-profit hospitals. Cutting costs, laying off staff, developing integrated networks, shifting care to outpatient settings, creating partnerships with HMOs, or even pursuing HMO licensure are common hospital responses. Consolidations and for-profit conversions are other responses. In some cases, a chain such as Columbia/HCA will build a new specialty hospital rather than acquire an existing one. Columbia/HCA was planning a children's hospital of its own in Houston to compete with the existing facility but has recently decided against the project.

Medicaid Managed Care

Texas began its move into Medicaid managed care in 1992 with two modest pilot programs. Through these pilots the state was able to work out some implementation issues, such as plan selection and contracting criteria, beneficiary enrollment, plan capacity, and payment. In May 1995 the state passed legislation to vastly expand mandatory managed care as part of a larger Medicaid reform initiative that also would have expanded eligibility. This legislation, Senate Bill 10, was adopted at a time of great uncertainty over Medicaid block grants and federal DSH policy.

While block grants faded from the national policy discussion, the state continues to phase in mandatory managed care enrollment, one geographic area at a time. In 1996, mandatory managed care was expanded to three additional geographic areas, and two more are planned for 1997. Most of the state will be phased in by 2000. State officials emphasized the potential of managed care to

improve access and provide a "medical home" to Medicaid beneficiaries. However, in the view of many, the state's emphasis has increasingly been on cost containment and the desire to "privatize" the Medicaid program.

In 1995, the prospect of expanded Medicaid eligibility through the demonstration waiver assuaged concerns among consumer advocates and providers about the state's managed care plans. However, their support quickly waned when the state proceeded to implement mandatory managed care through a freedom-of-choice waiver without eligibility expansions. In fact, two hospital districts, Tarrant County and Lubbock, and an HMO formed by community health centers, sued—unsuccessfully—to stop the mandatory managed care program.

Under its managed care program, Texas enrolls AFDC and related populations (pregnant women and children) in managed care on a mandatory basis. Persons with disabilities may enroll in managed care voluntarily, but dually eligible (Medicaid-Medicare) beneficiaries are barred due to the administrative complexity of coordinating between the two programs. In 1997 the state began developing a separate program combining acute and long-term care coverage for dually eligible beneficiaries in Houston. (See the section on "Long-Term Care for the Elderly and Younger Persons with Disabilities.")

Managed care plans must cover most Medicaid-defined services, including special services for children, but not dental services or long-term care. Plans that offer benefits beyond those normally covered by the state are favored during the selection process. In particular, plans receive extra points for innovative coverage of behavioral health services. Beneficiaries enrolled in HMOs have coverage for unlimited prescriptions, whereas fee-for-service Medicaid has a three-per-month prescription limit for adults. In addition, HMOs must cover a wellness exam and may not limit inpatient coverage to 30 days per spell of illness, as is the case under Medicaid fee-for-service. HMOs are permitted to use their capitation payment to pay for services not covered by Medicaid, for example, home modifications needed because of disabilities. However, these services are not factored into the payment rates. The original pilot program included a provision to extend HMO coverage for six months, even if a beneficiary lost Medicaid eligibility. Because the cost must be borne by the state without any federal Medicaid contribution, this provision was dropped.[19] Managed care organizations must contract with traditional safety net providers (e.g., public hospitals and community health centers) for three years.

The original managed care pilot programs used a freedom-of-choice waiver to implement mandatory enrollment in Travis County (around Austin) and in three contiguous eastern counties, Jefferson, Chambers, and Galveston. In Travis County the state contracted with an HMO and a prepaid health plan that was partially capitated. In the tricounty pilot, the state tested a primary care case management (PCCM) model, in which beneficiaries are linked to a primary care provider who must provide most care and approve referrals to specialists. The state chose a PCCM model in the tricounty area because it is largely

rural and beneficiaries were considered to have high, potentially inappropriate, emergency room use.

For a number of administrative reasons and political pressure from providers and advocates, the schedule for the implementation of managed care throughout most of the state has slipped somewhat. The next phase involves mandatory enrollment around Houston, the largest urban area in Texas. Dallas will follow in 1998.

Plan Selection and Payment Rates

Since the Medicaid pilot programs in 1992, commercial managed care has expanded greatly in Texas, allowing the state to contract with more plans in each area. In addition to Austin and the eastern counties, mandatory enrollment has been implemented in and around Tarrant County (Fort Worth), Bexar County (San Antonio), and Lubbock County (Lubbock). Although Texas continues to operate a PCCM program in the eastern counties, it prefers to contract with commercial HMOs. However, the state was forced, due to political pressure from physician groups, to implement a PCCM program in Bexar and Lubbock counties, giving beneficiaries the choice between an HMO and a primary care physician network.

Except for PCCM programs, the state will only contract with state-licensed HMOs. While the state does not completely rule out Medicaid-only plans, it has a strong preference for commercial HMOs as a way of mainstreaming Medicaid beneficiaries. The state has not lacked bidders, who see Medicaid contracts as a way of increasing their market share.

The selection of plans to participate in Medicaid managed care has been controversial in Texas. Some public hospitals and clinics formed HMOs, motivated by a desire to retain Medicaid enrollees. However, these plans have not been very successful in winning contracts. One HMO formed by a network of community health centers bid unsuccessfully for contracts in three areas in 1996. Although the state selected an HMO formed by the hospital district in San Antonio, it did not award a contract to the HMO formed by the Harris County (Houston) hospital district because it did not score well on the selection criteria. The failure of the principal Medicaid provider in Houston to obtain a managed care contract could be financially crippling to the hospital district.[20] This decision precipitated state legislation in 1997 requiring the Medicaid program to contract with hospital district–sponsored HMOs. The downside of this contracting guarantee is that the state may lack leverage in requiring improvements in these public HMOs.

Plans must bid on individual service areas and are selected using a quasi-competitive process. First, applications are assessed with regard to minimum requirements set out in the application request; they also must meet the regulatory requirements of the Department of Insurance and the Department of Health, which apply to all HMOs operating in the state. Medicaid-contracting

plans must respond to required time and distance limits between patients and their designated physicians, emergency care definitions, case management and specialty care for people with chronic conditions, requirements with respect to family planning providers, and a requirement that plans make reasonable efforts to contract with community health centers. The state has established a point system by which plans' applications are scored. Plans are given points for increasing quality, timeliness, and scope of services and specific behavioral health initiatives.[21]

In the application request the state also sets maximum capitation rates for AFDC adults, AFDC children, pregnant women, newborns, and two categories of non-AFDC children. Plans must bid at or below the maximum. Maximum capitation rates for a given area are determined using fee-for-service data and data from the pilot programs and typically are set at 90 percent of estimated fee-for-service costs. The fee-for-service costs include costs of graduate medical education but not DSH. Rates are not equal across plans because of differences in proposed coverage. There also is a profit-sharing arrangement between the state and the HMOs. HMOs may keep a percentage of the profits, but the remainder must be shared equally with the state. On the other hand, there are no Medicaid-specific stop-loss or other financial protections for plans; reinsurance is not offered. Limits on risk-sharing within the plan are set by laws and regulations that apply to all plans. In addition to the capitation payments, plans can receive up to $2 per member per month if the plans achieve certain performance targets established in the contract. The performance objectives address EPSDT screens, immunizations, adult annual visits, pregnancy visits, and health education. For enrollees who are blind or disabled, plans are reimbursed on a fee-for-service basis, plus a $14 per month case management fee.

In the PCCM program, primary care providers are paid the state's Medicaid fee-for-service rates plus a $3 per month case management fee. In the future Texas hopes to conduct more aggressive referral management in order to lower costs and perhaps develop a specialty provider network. In addition, the PCCM program is used as an opportunity to renegotiate hospital reimbursement rates. The state negotiates rates with hospitals in the PCCM area on a facility-by-facility basis, rather than paying the state's usual diagnosis-related group (DRG)-based rates (which are discounted through selective contracting in some areas).

Enrollment and Implementation Issues

In some areas the state has experienced start-up difficulties because many beneficiaries did not select an HMO or PCCM provider as required. If beneficiaries do not select a plan, they are automatically assigned to one. The auto-assignment procedure takes into account a client's claims history and makes an assignment based on prior primary care provider, geographic location, the health plans of other family members, and special needs. Auto-enrollment is on the order of 40 to 50 percent in some areas, including Austin (despite the area's experience with Medicaid managed care). This raised concern in the state that some beneficiaries are not sufficiently aware of their rights and obligations under the mandatory managed care program.

To protect beneficiaries from aggressive marketing pressure, HMOs may not conduct "direct contact" marketing, although they may distribute approved written materials.[22] Instead, the state has contracted with a broker to conduct education and enrollment. Both state officials and advocates alike felt that the education and enrollment materials were inadequate.

Oversight of HMOs occurs through the departments of health and insurance. Overall quality oversight conducted by the health department was transferred in 1996 to the insurance department, which is also responsible for licensure. Only a small staff is assigned the numerous tasks of overseeing a Medicaid managed care program, for example, quality monitoring, contract monitoring, and patient satisfaction surveys. The state feels pressure to build up its managed care administrative capacity, but it faces very tight administrative budgets. In some cases, particularly capable state staff have been hired away by managed care organizations. Recognizing this problem, the state is considering contracting with an outside organization, possibly an accreditation agency, to monitor quality of care.

Medicaid Provider Payment and Disproportionate Share Hospital Policy

Medicaid is a relatively generous payer of hospital care; physician care is less well reimbursed. For hospital care, Medicaid is thought to be a better payer than many managed care organizations. In addition, the state has very aggressively maximized Medicaid DSH payments by using intergovernmental transfers from local hospital districts. Thus, safety net providers are reimbursed quite well.

Medicaid Hospital and Physician Reimbursement

In 1991 the Texas Hospital Association sued the state Medicaid program under the federal Boren amendment, arguing that Medicaid reimbursement rates were too low.[23] After a settlement in 1993, payment rates improved. According to data from the American Hospital Association, Medicaid paid hospitals (including DSH payments) 76 percent of costs in 1991 and 117 percent in 1993.[24] Medicaid rates, in fact, are considered quite favorable by hospitals compared to private payers, where competition and managed care is growing. In many local areas, competition for Medicaid patients, particularly in obstetrics and pediatrics, is intense. Protection of hospitals through the Boren amendment is viewed as less and less relevant because of Medicaid managed care, hospital selective contracting, and DSH.[25] In contrast to the repeal of the Boren amendment, federal policy changes that might eliminate or reduce DSH funds were considered potentially very destabilizing to the hospital industry.

Most hospitals, except children's specialty hospitals and psychiatric hospitals, are paid by Texas Medicaid on the basis of DRGs. The state makes a flat payment based on a patient's diagnosis category, regardless of the actual length

of a patient's stay in the hospital. In an effort to save funds under Medicaid, the state in 1995 introduced selective contracting in 24 metropolitan areas for nonspecialty hospitals that were not state owned. Under selective contracting, hospitals were asked to offer the state a discount on their standard payment rates. The state intended to contract with the lowest-bidding hospitals (i.e., those offering the greatest discounts) and exclude the others from participating in Medicaid. In fact, the state was very lenient in its contracting, selecting 220, or all but 20, Medicaid-participating hospitals. Ironically, hospitals that offered substantial discounts in anticipation of gaining additional Medicaid volume were disadvantaged because those hospitals did not see more patients.

Physician payment is not as favorable as hospital payment in Texas, and rates have been frozen since 1993. Physicians were paid 88 percent of Medicare payment rates, based on an index of 28 services, in 1993.[26]

Disproportionate Share Hospital Payments

Beginning as a small program in 1986, the Medicaid DSH payment program in Texas is now very large, totaling $1.5 billion, or 17 percent of program expenditures in 1995. In 1996, 25 public hospitals contributed DSH funds through intergovernmental transfers for the state share of the Medicaid match, while approximately 160 hospitals qualified for DSH payments. The contributors include 10 local public hospitals (9 hospital districts and 1 city hospital) and 15 state-owned institutions (10 mental health/mental retardation facilities, 2 hospitals operated by the health department, and 3 university hospitals). Hospital districts are looked upon by the state as a favored source of funds to expand Medicaid.

Unlike some DSH programs in other states, where federal funds have been diverted to the state treasury, the DSH program in Texas has been used to provide financial support to local hospitals serving a large number of Medicaid and uninsured patients. All hospitals receiving DSH funds must formulate a local health needs assessment and address how DSH funds will be used to meet those needs. About two-thirds of the hospitals receiving funds are located in rural areas. Changes in federal law in 1993 that limit DSH payments to any individual hospital to what it spends on uncompensated care have shifted the distribution of funds away from state-owned hospitals toward other institutions. Consequently, the amount that the state facilities can contribute for federal matching funds has declined. Some contributing hospital districts believe it is unfair that "their" money—money that they have imposed taxes to raise—is used to fund hospitals in other areas of the state and, in some cases, competing private hospitals.

Delivering Health Care to the Uninsured and Low-Income Populations

Efforts to provide health care to the uninsured and low-income populations in Texas face enormous difficulties. Because the Medicaid program covers a relatively small proportion of the low-income population and private insurance coverage rates are low, uninsured rates are high. Moreover, aside from having many uninsured persons, some parts of the state lack even basic public health services. The state health department plays a minimal role in health care for low-income populations outside of the Medicaid program. To fill this void, Texas depends largely on local health departments and hospital districts to provide health care for the uninsured. Houston and El Paso provide examples of how local communities cope with this responsibility and how changing market conditions threaten traditional arrangements.

State and Local Health Departments

Outside of administering the acute care portion of Medicaid, the state health department does not see its role as funding additional service delivery programs for low-income people. The state appropriates few funds outside of matching funds required in order to receive specific federal grants. Non-Medicaid health programs—including disease prevention and control, environmental health, vital statistics, family planning, services for children with special needs, and maternal and child health services, but excluding the

Supplemental Food Program for Women, Infants, and Children (WIC)—are allocated about one-tenth the funds that Medicaid receives.

Efforts were made over the past few years to maximize Medicaid funds and obtain federal matching payments for health care that otherwise would be entirely state funded. However, frequently the additional federal match is used to reduce the state budget rather than to expand existing programs. As a result, over the past few years, funding for non-Medicaid programs has been flat or reduced. Moreover, most of the public health initiatives, such as increasing the number of children receiving health screens, involve Medicaid rather than traditional state-only funding.

The state health department operates through eight regional offices or through contracts with local health departments. Regional offices provide clinical and regulatory services only in areas that choose not to have local health departments, mostly sparsely populated areas. In some areas the regional office complements services provided by local health departments. The state estimates that approximately four-fifths of clients receive state-supported services through local health departments, one-fifth through state regional offices.

County commitment to public health varies greatly. Only counties receiving funds from the state are subject to state requirements. Others elect not to pursue state funding, and the state has very little information and policy control over them. Only 69 local health departments receive funding from the state and are termed "participating local health departments." Local entities enter into program contracts with the Department of Health to provide various services, for example, maternity care, WIC, and screening for sexually transmitted diseases. Populations served with these funds must be low income; immigration status is not used as an eligibility criterion and is rarely checked. In order to receive primary care and now maternal and child health funds, local health departments and other agencies must compete for grants. Awardees must offer 24-hour services and a regular provider for patients—a requirement that most local health departments cannot currently meet. Previously, local health departments were allotted funds on a population basis. The change has caused great concern among health departments providing important, albeit minimal, services such as immunizations and health screens. Many local health departments worry that they will no longer qualify for state grants to continue those services.

Local health departments also are expected to undergo change as a result of Medicaid's shift to managed care. Most health departments had become Medicaid providers during relatively recent efforts to maximize Medicaid reimbursement. Now health departments are expected to move away from direct service delivery and Medicaid dependence and perform system planning and coordination functions. Some may form relationships with managed care organizations. In Austin, for example, the city health department is a subcontractor to a commercial HMO. In Galveston the health department is a PCCM provider. Others may withdraw from patient services and focus only on community and environmental health.

Hospital Districts

Counties must have a program to serve the medically indigent. Most counties fulfill this requirement by forming hospital districts, which have property taxing authority and use the funds they collect to operate public hospitals and, in some cases, clinics. In 1995 there were 102 hospital districts in Texas. Counties without hospital districts are eligible for funds through the County Indigent Health Care Program.[27] However, the program is very small—less than $6 million is budgeted for 1998—and operates in only 17 counties. In addition, the state operates a few university-based hospitals, which serve significant numbers of Medicaid and uninsured patients. Of particular note is the University of Texas Medical Branch in Galveston, which is viewed as the absolute provider of last resort and which draws patients from all over the state.

Most public hospitals are at a distinct competitive disadvantage. In fact, their ability to serve commercial patients is restricted, and many county officials believe that the public sector should not compete with private organizations. More recently, some counties have sought to limit their role in supporting indigent care through public hospitals. Three hospitals have been shifted to private management (in Austin, Corpus Christi, and Amarillo), one hospital district facility was contemplating a merger with a nonprofit hospital (in Fort Worth), and another public hospital was "for sale" (in Lubbock).

State government does not have an explicit policy to shore up these safety net hospitals, aside from Medicaid DSH funds. State officials see their major responsibility as being the Medicaid program and its beneficiaries, even when it is at the expense of public hospitals. For example, although Medicaid-contracting HMOs are required to enter into agreements with traditional safety net providers for three years, enrollment of Medicaid beneficiaries in these plans is likely to reduce utilization of these hospitals, both because HMOs seek to reduce hospital utilization and because patients are channeled to other facilities because of lower payment rates. Public hospitals tend to have higher costs because they are teaching institutions, may see sicker patients, serve the uninsured, and may be inefficient because of constraints imposed by public management. If public hospitals see fewer Medicaid patients, that will significantly lower third-party revenue to these institutions. With the exception of state-operated hospitals, the burden of lost revenues is then shifted to counties. Counties may have to raise taxes, which is difficult, or reduce services.

Impact of Government Policies and Market Changes on Safety Net Providers: Houston and El Paso

In order to assess the impact of government policies and market changes on safety net providers, public hospitals, teaching hospitals, community health centers, and other providers were interviewed in Houston and El Paso. Houston, located in Harris County, is the fourth-largest city in the country, with

substantial black, Hispanic, and immigrant (both Hispanic and non-Hispanic) populations. Although there is a large low-income population, Houston/Harris County is generally prosperous. In contrast, El Paso is a medium-size, very poor city with high unemployment. Situated on the border, it is overwhelmingly Hispanic and is dominated by its relationship with Mexico. While Houston is very much at the center of state concerns, El Paso is distant geographically and very marginal politically to Austin.

In both areas, the hospital district plays a central role in delivering care to Medicaid and low-income populations, but other hospitals also have large uncompensated care loads. Competition has increased for the Medicaid population, and more Medicaid patients are being seen in the private hospitals. In both cities, safety net providers expect managed care to dramatically alter the system of care.

Health care in Houston is characterized by a large number of tertiary teaching hospitals (including three private academic medical centers, a large tertiary-care public hospital system, a children's hospital, and a state-owned cancer institute), with an oversupply of hospital beds and physicians. Many of these institutions are located adjacent to one another in the center of the city. They are all affiliated with two medical schools, Baylor College of Medicine and the University of Texas at Houston, and are committed to the three-fold mission of patient care, education, and research. Houston has a high proportion of for-profit hospitals, including 19 owned by Columbia/HCA, which have a reputation for being tightly managed and aggressively competing on price. Managed care came rapidly to Houston and, by 1996, reached 16 percent of the population.[28] Access to care is generally considered good in Houston; however, access in certain low-income pockets of the city and to basic preventive care is poor.[29]

In contrast, El Paso has poor or limited access to care in many areas, the most extreme of which are the *colonias,* which have limited or no access to potable water, waste water disposal, and paved roads, and minimally acceptable housing. Managed care has not reached El Paso to any significant degree, although it was anticipated to enter the market in the near future. For-profit hospitals are extremely important in El Paso; as a result of recent mergers, El Paso has one public hospital and four for-profit hospitals. Two national chains, Columbia/HCA and Tenet, each operate two hospitals.

Hospitals and clinics in Houston and El Paso demonstrated great diversity in financial status, in competitive position and bargaining power, and in the sophistication of their responses to market changes. Medicaid is viewed as a desirable payer in both areas, and increased competition for Medicaid patients has drawn these patients away from public and traditional safety net providers to other hospitals.

Both areas anticipated changes due to Medicaid managed care, although Houston will be affected earlier. Hospitals emphasized the importance of cap-

turing Medicaid managed care enrollment early on, to avoid losing existing patient bases and facing barriers to entry later. Hospitals in Houston were especially active, applying for HMO licenses, forming networks with other hospitals and physician groups, expanding primary care capacity and clinics, cutting costs, and preparing to accept risk-based contracts.

Although currently in relatively good financial shape, the public hospital system in Houston is vulnerable in regard to Medicaid managed care. Although it has expanded its clinic network and obtained an HMO license, it has no commercial managed care contracts and is heavily dependent on Medicaid for its revenue. In 1997, the public hospital HMO failed to win a Medicaid contract, the financial consequences of which could have been catastrophic for the institution. In response, the state passed a law requiring Medicaid to contract with licensed HMOs formed by hospital districts.

In El Paso, the hospital district has benefited from large DSH payments. However, it is even less well prepared for managed care than Houston's hospital district. El Paso's public hospital has almost no outpatient capacity and has strained relationships with Texas Tech Medical School, which provides almost all physician services, and with the county commissioners, who approve tax revenues. In contrast, private hospitals in El Paso have made concerted efforts to form integrated care systems and cooperative relationships with local physicians.

Adding to the uncertainty in the health care environment of El Paso and Houston is that Columbia/HCA is the target of a nationally publicized federal criminal investigation, which began in El Paso. Although the investigation is very wide-ranging, the principal focus has been on possible fraudulent Medicare billing and on the financial relationship of physicians with Columbia/HCA. As a result, several top managers at Columbia/HCA have resigned and others have been indicted.

In Houston, the local hospital district operates a very large network of clinics, leaving a smaller role in personal health services for private health centers and the city and county health departments, the latter which have focused on preventive services, maternal and child health, dental services, sexually transmitted diseases, and AIDS. A relatively small proportion of revenues for the county and city health departments is derived from Medicaid. The local health departments are grappling with their new role in a managed care environment and are investigating the possibility of subcontracts with the local hospital district and commercial HMOs.

In contrast, private community health centers play a more important role in El Paso. Clinics at the medical school have long waiting lists for appointments, and the public hospital has little outpatient capacity. At this point, the community health centers have no experience with managed care and are concerned about the potential "culture clash" between bottom line–oriented, for-profit HMOs and the "serve-people-in-need" philosophy of the health centers.

The combined city and county health department has sustained major budget cuts in recent years that have forced clinic closures. The department cannot meet some of the state's requirements for funding, such as providing 24-hour care. With so few resources available, the potential loss of state funds to the El Paso public health department was viewed as of more immediate concern than changes that might ensue due to Medicaid managed care.

Long-Term Care for the Elderly and Younger Persons with Disabilities

Long-term care for the elderly and younger people with disabilities is a critical component of the state's involvement in health care and plays a major role in the Medicaid program. While delivery has historically been dominated by a large number of relatively low-cost institutions, Texas is attempting to alter the balance between institutional and noninstitutional services. Quality of care has been a consistent concern.

Supply, Utilization, and Expenditures

Given its large population and huge territory, it is not surprising that Texas has a very large number of long-term care providers and spends a lot, at least in absolute terms, on long-term care. As shown in table 6, Texas spent $2.2 billion on Medicaid long-term care for the elderly and younger persons with disabilities in 1995. The vast majority of expenditures are for institutional care, although expenditure growth in recent years has been much faster for home and community-based services.

The state has a large supply of nursing homes and home health agencies and a slowly shrinking supply of institutional mental health and mental retardation beds. In 1995, Texas had approximately 130,000 nursing facility beds (68 beds per 1,000 elderly compared with the national average of 53 beds per 1,000 elderly), which is the second largest nominal number of beds of any state in the country. In 1995, the state had 2,399 licensed home health care agencies.

Table 6 *Medicaid Long-Term Care Expenditures by Eligibility Group, Texas and United States ($ in Millions)*

	Texas					United States				
	Long-Term Care Expenditures			Average Annual Growth		Long-Term Care Expenditures			Average Annual Growth	
	1990	1992	1995	1990–92	1992–95	1990	1992	1995	1990–92	1992–95
Total	$1,226.1	$1,638.6	$2,180.4	15.6%	10.0%	$32,264.2	$42,542.5	$53,996.1	14.8%	8.3%
Elderly	$715.1	$1,042.4	$1,400.5	20.7%	10.3%	$18,408.9	$24,846.4	$30,413.7	16.2%	7.0%
Nursing Home Care	598.8	874.8	1,068.4	20.9%	6.9%	15,131.3	20,542.9	25,571.5	16.5%	7.6%
ICFs/MR[a]	21.3	26.9	34.6	12.4%	8.7%	348.9	452.0	615.8	13.8%	10.9%
Mental Health	0.0	0.0	0.0	n/a	n/a	973.0	1,286.0	1,107.3	15.0%	–4.9%
Home Care	95.1	140.6	297.5	21.6%	28.4%	1,955.7	2,565.6	3,119.1	14.5%	6.7%
Blind and Disabled	$509.5	$593.9	$776.8	8.0%	9.4%	$12,842.4	$16,201.0	$21,618.7	12.3%	10.1%
Nursing Home Care	77.9	105.2	128.0	16.2%	6.8%	3,161.3	3,968.0	4,813.3	12.0%	6.6%
ICFs/MR[a]	400.8	441.6	524.1	5.0%	5.9%	7,241.3	8,380.4	9,321.1	7.6%	3.6%
Mental Health	0.0	0.0	0.0	n/a	n/a	457.9	682.1	881.3	22.1%	8.9%
Home Care	30.8	47.1	124.6	23.6%	38.4%	1,982.0	3,170.5	6,603.0	26.5%	27.7%
Adults and Children	$1.4	$2.3	$3.2	26.8%	11.7%	$1,012.9	$1,495.1	$1,963.7	21.5%	9.5%

Source: The Urban Institute, 1997. Based on HCFA 2082 and HCFA 64 data.
a. Intermediate care facilities for the mentally retarded.

The state runs 9 state mental hospitals, 12 state schools for persons with mental retardation/developmental disabilities, 5 state centers (two serve only persons with mental retardation; three also serve persons with mental illnesses), and 36 community mental health and mental retardation centers.

Long-Term Care for Older People in Texas

Long-term care for the elderly in Texas has been dominated historically by institutional care. In an effort to alter this, the state's policy initiatives center on financing and delivery system reform that would increase the supply of home and community-based services. It is also planning a major demonstration that will integrate acute and long-term care services through managed care. At the same time, it has relied heavily on traditional methods of controlling long-term care expenditures: a moratorium on new construction of nursing homes and low nursing home reimbursement rates. Partly as a result, quality of care in nursing facilities is a major issue that has recently been addressed in the legislature.

Medicare Maximization and Private-Sector Initiatives

Unlike some states, such as New York, Texas does not have major initiatives to reduce Medicaid spending by maximizing Medicare nursing home and home care revenues or by promoting private-sector initiatives. For example, there are no major initiatives to encourage the purchase of private long-term care insurance. Despite the requirement of the Omnibus Budget Reconciliation Act of 1993 that the state operate an estate recovery program, the state does not, because to do so would mean certain "political death." (Earlier proposals by one state legislator to establish estate recovery led to his electoral defeat.) The state believes that the transfer of assets in order to qualify for Medicaid nursing home benefits is a problem, but there are no major efforts under way to prevent it.

Home and Community-Based Services

Although not nationally known as a model for its provision of noninstitutional services, Texas, in fact, finances a substantial amount of home and community-based services. Texas Medicaid covers personal care, has a large home and community-based care waiver, and is one of the few states to participate in the Medicaid "frail elderly" option. A majority of long-term care beneficiaries receive home and community-based care rather than institutional care. In a recent study by Ladd et al., Texas ranked eighth among the states in 1992 in "commitment" to home and community-based services.[30] While officially supportive of widening the continuum of care, the nursing home industry contends that home and community-based services are not cost effective.

Demand for Medicaid home and community-based care waiver services far exceeds the number of funded slots, and there are long waiting lists. The num-

ber of persons budgeted to receive services is considerably below the number of slots approved by HCFA. Given excess demand, the state wants to ensure that persons receiving services are at high risk of institutionalization, a strategy which has been controversial among consumer and home care advocacy groups.

Managed Care and Long-Term Care

In the Medicaid managed care waivers that have been implemented in Texas to date, the elderly population needing long-term care has been excluded. However, the state is developing a model program—known as the STAR+Plus Integrated Care Project—that will enroll 50,000 aged and disabled Medicaid beneficiaries in Houston in managed care plans that are responsible for both acute and long-term care. While the state cannot require dually eligible (Medicare-Medicaid) beneficiaries to receive their Medicare benefits through the HMOs, the state is seeking to provide incentives for the aged and disabled to enroll. Specifically, building on the fact that many Medicare HMOs in Texas offer extra benefits with no additional premium, Medicaid beneficiaries enrolling in the program will obtain additional prescription drug and eyeglass benefits beyond what is currently covered under Medicaid. HMOs appear to be interested in enrolling dual eligibles in the pilot project, according to some observers, because long-term care clients are typically more middle-class than other Medicaid beneficiaries. The high costs of long-term care necessitate that many middle-class elderly rely on Medicaid to finance their nursing home care. Given the lack of managed care organizations' experience with long-term care, long-term care providers are "nervous" about the reimbursement rates that HMOs will pay, particularly for nursing home care.

Nursing Home Care

While the state has kept Medicaid nursing home rates fairly low and has a moratorium on new construction, it has not tried to restrict eligibility. Quality-of-care deficiencies, according to some, are a significant problem. Politically, the nursing home industry is a major force in the state, especially on Medicaid issues, and its views must be taken into account when policies are proposed.

Nursing home eligibility.

The state has not attempted to tighten admission criteria for nursing homes as a way to control nursing home costs, despite home care advocates' contention that approximately 25,000 nursing homes residents have low levels of disability and do not need to be institutionalized. In response, the nursing home industry argues that lower-disability nursing facility residents still need care, and savings are not possible by shifting to home-based services. In 1994, the state tried to implement preadmission screening for nursing homes, but it was an administrative failure because no additional funds were allocated for staff.

Nursing home reimbursement and the Boren amendment.

Texas nursing homes are reimbursed by Medicaid on a case-mix adjusted, flat-rate basis. Each resident is classified into one of 11 categories, each with a separate statewide rate. In 1995, the average reimbursement rate was $56.17, well below the national average of $85.05. Indeed, the state has the third-lowest average rates in the country, although one expert contended that the average rates were depressed by the large number of low-disability (and, therefore, low-cost) nursing home residents.

A key issue is that facilities make profits in flat-rate reimbursement systems by spending less than they receive in reimbursements. This creates an incentive for low levels of service, which may result in poorer quality of care. The position of the Texas nursing home industry is that the state gets what it pays for: Facilities have low staffing ratios because the state is not willing to pay for higher staffing levels. At the same time, the state asserts that nursing homes do not always use the money properly when Medicaid rates are increased to improve staffing.

The state has been sued twice under the Boren amendment, and there has been one major threat of an additional suit. Most recently, in November 1996, the Texas Health Care Association sued the state over its nursing home reimbursement system, claiming that rates were inadequate to cover the federally mandated increase in the minimum wage. In February 1997 a settlement was reached that provided Texas nursing homes with about half of their requested rate increase.

According to state officials interviewed before the most recent lawsuit, federal nursing home reimbursement rules put the burden on the state to prove the adequacy of the rates, and the state cannot win in court. (In addition, the limited resources of the attorney general's office are no match for the law firms hired by the nursing home industry.) As a result, the threat of a lawsuit is just as effective as an actual lawsuit. Many state respondents felt that it is inequitable that nursing homes receive special protection whereas other providers do not. Speculating about what might happen if the Boren amendment were repealed (as it has been by the Balanced Budget Act of 1997), the nursing home industry believed that there are some general provisions in state law requiring adequate payment that it could use to prevent rate reductions.

Controlling the nursing home supply.

Nursing homes in Texas are significantly overbuilt, resulting in very low occupancy rates (only 76 percent in 1995); this situation has existed for many years. The state has had a moratorium on nursing home construction since 1985, but no certificate-of-need requirement. The nursing home industry, which supports the moratorium, would like to see the moratorium broadened to include hospitals that are trying to convert empty beds to nursing home beds.

Quality of care in nursing homes.

Quality of care in nursing homes has been a major focus of legislative activity in the last two years. Passed in the closing hours of the 1995 legislative session without much public scrutiny, HB 2644 prohibited the state from establishing nursing home standards that are different from those of the federal government for purposes of certifying facilities to participate in Medicare and Medicaid. The nursing home industry, which proposed the bill, contends that the state rules do not add much to meaningful quality-of-care regulation and state rules never figure into the federal certification decisions. Opponents say that it repeals a host of quality standards and makes adding onto the requirements much more difficult.

In September 1996, a committee of the Texas Board of Nursing Facility Administrators developed new, much stronger draft regulations. These rules were proposed after it was reported that the board had failed to discipline any nursing home administrators since 1993, including the 23 administrators working at homes where conditions were so bad that they were put under state control. However, opposition to the proposed regulations by nursing home administrators caused them to be scrapped.

Reacting to the controversy over HB 2644 and the publicity concerning the Texas Board of Nursing Facility Administrators, the legislature passed several new laws in 1997 that strengthened nursing home regulation. The prohibition against state standards being more stringent than federal law for certification for participation in Medicare and Medicaid was repealed, and many new standards were imposed, including a detailed listing of patients' rights. To aid consumers, a nursing home consumers' guide is to be created. Soon after these bills were signed by the governor, the state auditor released a report sharply criticizing the state's enforcement of nursing home quality standards.

Younger People with Disabilities

As with the rest of its health and welfare programs, Texas, historically, has not spent very much for mental health and mental retardation services. For example, in 1994, Texas ranked 48th in the nation in state mental health agency expenditures per capita, even after substantial expenditure increases between 1990 and 1993. State initiatives concerning long-term care for the younger population with disabilities reflect developments on four policy issues—fragmentation of responsibilities for services, the relationship between institutional and noninstitutional services, Medicaid maximization, and managed care.

Fragmentation of Services

Coordination among agencies responsible for serving younger persons with disabilities is difficult. Long-term care for younger persons with disabilities in Texas is funded by a variety of state agencies, including the Department of Human Services, the Department of Mental Health and Mental Retardation,

the Department of Health, and the Texas Rehabilitation Commission. Each operates different home and community-based waiver programs for younger disabled persons. Moreover, because Texas is a big state, there is a lot of intrastate variation in how state policies are implemented. Advocates and some in state government believe that the Health and Human Services Commission is not providing the coordination that is needed. Although the Health and Human Services Commission is supposed to have policymaking authority, the line between policy and operations is often difficult to establish, and a great deal of authority remains in the operating departments.

Institutional and Noninstitutional Services

Like virtually all states, Texas is moving away from institutional care for its mental health and mental retardation/developmental disabilities (MR/DD) populations and toward more community-based options. A major impetus for this movement was two lawsuits, a class-action suit involving the state psychiatric hospitals (*RAJ v. Jones*) and a second class-action suit requiring improvements in services to individuals with mental retardation (*Lelsz v. Kavanagh*).

Community-based service funding as a percentage of total program funding of both mental health and mental retardation has increased steadily.[31] In 1983, just under 30 percent of mental health funding was for community programs; this will approach 62 percent in 1997. For mental retardation programs, community funding was slightly more than 10 percent of expenditures in 1983; in 1995, community funding represented about 50 percent of spending, which will continue to rise, reaching nearly 68 percent by 1997. Medicaid home and community-based waivers figure heavily in providing funds for services for persons with mental retardation. While services have expanded, there were 30,000 people on waiting lists for community-based MR/DD and mental health services. First priority is given to people who are or were in institutions, making access very limited for those people who have always received services in the community.

The census of state schools (which serve those with mental retardation or developmental disabilities) is down compared with historical figures, as is the number of persons in psychiatric facilities. In 1995, there were 6,156 individuals in state schools, which is projected to decline to around 5,300 by 1999; but remaining residents of the state schools are much more disabled and costly to serve. Although the trend is toward less institutionalization, there are vocal parent groups that are very strongly opposed to closing the state schools. Moreover, the state has more than 8,100 persons in community-based intermediate care facilities for the mentally retarded (ICFs/MR), utilization of which is not projected to decline. The number of persons in state psychiatric facilities is also projected to stay virtually flat in the coming years. Compared with the rest of the country, Texas residents are much more likely to reside in large facilities.

Despite Texas's movement toward community care, the state lags behind other states. For example, the state ranked 30th in Medicaid home and community-

based care waiver outlays per participant in 1994. In terms of fiscal effort, which is spending compared with state wealth, Texas ranked 36th overall.

Medicaid Maximization

The state has a very conscious policy of maximizing Medicaid revenue for mental health and mental retardation services. In FY 95, Medicaid accounted for about 27 percent of the operating budget for TDMHMR. About half of the funds for MR/DD services come from Medicaid and other federal sources, while less than 10 percent of mental health spending is Medicaid or otherwise federal. TDMHMR's FY 95 Annual Report states that the legislature "expects TDMHMR to earn more Medicaid dollars, and it reduced the agency's FY 1996–97 general revenue appropriations accordingly."[32] Expansion funds are expected to come from billing Medicaid more aggressively.

Managed Care

There is a great deal of interest in managed care for people with disabilities. Beyond just capitation, the state is interested in learning from the private sector about utilization review, quality management, uniform assessment systems, and focusing on outcomes. Four new pilot programs are being implemented to provide mental health care for those on Medicaid. Under these pilots, a seriously mentally ill person will receive acute behavioral services from an HMO and long-term rehabilitation from the local mental health authority. Advocates are concerned that managed care plans will be unable and unwilling to adequately treat persons with chronic mental illness. Younger people with disabilities will also be enrolled in the STAR+Plus Integrated Care Project.

Continuity and Change in Texas's Health Care Policy for Low-Income Groups

Texas is a large, high-poverty state with a substantial number of foreign-born residents that has traditionally provided relatively minimal health and welfare benefits beyond what is required to receive federal funds. Texas culture values independence and private-market solutions to problems. Compared with those of other states, cash welfare payment levels are especially low. From the state's perspective, its modest benefit structure makes it unconcerned about becoming a "welfare magnet." Politically, there is no interest in raising state taxes to fund a richer set of services for the low-income population. Instead, in 1997 the governor and legislature agreed to increase state funds for education in order to reduce property taxes at the local level.

To partly compensate for the lack of health coverage at the state level, Texas has a large number of public hospitals and clinics funded at the local level by the property tax. Counties are constitutionally responsible for providing health care for the indigent. Unlike localities in California and New York, however, the counties are not involved in running the Medicaid or cash welfare programs. Texas hospital districts are major providers of health care for the indigent and Medicaid populations. As a result, access to care is better than one might imagine from looking solely at Texas's Medicaid eligibility levels.

This duality between the state and local governments creates a number of health policy dilemmas. For example, providing health care to the low-income population is viewed more favorably than cash welfare benefits, and the state is

pursuing initiatives that would increase Medicaid eligibility. However, while the state is interested in raising Medicaid eligibility levels, it is unwilling to pay any more in state funds. As a result, Texas's strategy depends entirely on using intergovernmental transfers from local entities to draw down additional federal Medicaid dollars. For their part, local hospital districts are concerned about losing control of their funds and having the state use their money to pay providers not supported by the hospital district. Thus, in some cases they have been reluctant to provide the funds necessary to obtain the additional federal Medicaid match. Some at the federal level may be concerned that these initiatives may result in merely a substitution of federal for local funds and little actual expansion of access to or improvement in quality of care. This is especially true if newly entitled beneficiaries are required to use mostly hospital district providers that they previously used.

A second, closely related dilemma involves the relationship between Medicaid managed care and the public hospitals. Expansion of managed care is the centerpiece of the state's Medicaid strategy to control costs and improve quality and access. Texas is moving steadily to enroll all of its Medicaid beneficiaries into managed care organizations and is contracting almost exclusively with commercial HMOs, an approach that is viewed as a way to mainstream Medicaid beneficiaries. Competition among HMOs is intense and the state has had little difficulty obtaining bidders. Although these HMOs are required to contract with traditional safety net providers for three years, enrollment of Medicaid beneficiaries in these plans is likely to reduce utilization of these hospitals, both because HMOs seek to reduce hospital utilization and because patients are channeled to other facilities with lower payment rates. Although from the perspective of the Medicaid program this reduction in the use of public facilities may result in reduced costs, more consumer choice, and better quality of care, the loss of Medicaid patients would financially strain these safety net hospitals because there would be fewer paying patients over which to spread the cost of providing care to indigent patients. Without Medicaid patients, public hospitals would require far larger local contributions, which is not likely given the current political environment. As a result, facilities could close or reduce services, endangering access to care by the uninsured population.

The recent failure by the Harris County Hospital District HMO to obtain a Medicaid managed care contract and the efforts of the legislature to ensure that public hospitals will obtain contracts is indicative of this problem. Without the contract, the Harris County Hospital District will face financial disaster. However, guaranteeing any provider a contract, as the legislature did for public HMOs, could limit the leverage of the state in requiring that standards be met.

The state faces at least two other major policy challenges. One involves the relationship between welfare reform and Medicaid. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 separated eligibility for cash assistance and Medicaid. As people lose welfare benefits because they

have reached the time limits or are sanctioned for failure to meet work and other requirements, Texas will have to develop the systems to make sure that people understand that they may still be eligible for Medicaid. Even more daunting is that Texas must educate people to understand that they may be eligible for Medicaid even if they are unwilling to accept the various requirements of cash assistance. In any event, given the low levels of employer health insurance coverage in Texas, people working their way off welfare may find themselves without health insurance coverage, raising the number of uninsured and placing additional strains on public hospitals. Although the Balanced Budget Act of 1997 restored some Medicaid and cash benefits to legal immigrants that were to be ended as a result of changes enacted in 1996, most new legal immigrants will not be able to obtain Medicaid for five years, again possibly placing additional strains on the public hospital system.

The other challenge relates to long-term care for the elderly and disabled. Like the rest of the country, the elderly and disabled populations in need of long-term care are increasing. The state is pursuing a strategy of changing the balance of care in the direction of additional home and community-based services; but institutions still dominate funding, and the nursing home industry is particularly influential in determining state policy. From the state's perspective, it would like to extend managed care to include both acute and long-term care services, but it recognizes that there are formidable practical, political, policy, and legal barriers in pursuing this policy objective.

In sum, Texas is a big, bustling state with enormous contrasts of wealth and poverty. Its system of restrictive state benefits combined with an extensive locally funded health care safety net is both a strength and a problem for the state as it tries to expand coverage and move toward managed care.

Notes

1. This research is based largely on interviews conducted in Austin and Houston, Texas, in July 1996 and in El Paso, Texas, in February 1997.
2. The "disproportionate share hospital" portion of the Medicaid program requires states to make additional Medicaid payments to hospitals that serve a "disproportionate share" of Medicaid and uninsured patients.
3. ReliaStar, *The ReliaStar State Health Rankings, 1996 Edition* (St. Paul, MN: ReliaStar Financial Corporation, 1996).
4. Texas Department of Health and Texas Higher Education Coordinating Board, *Physician Work Force Strategy for Texas: A Report to the Subcommittee on Health and Human Services and Education of the House Appropriations Committee* (Austin: Texas Department of Health, 1995).
5. General Appropriations Act, Texas 75th Legislature, 1997–98 Biennium, House Bill 1, June 1997.
6. General Appropriations Act, Texas 75th Legislature, 1997–98 Biennium, House Bill 1, June 1997.
7. General Appropriations Act, Texas 75th Legislature, 1997–98 Biennium, House Bill 1, June 1997.
8. Texas's Federal Medical Assistance Percentage was 64.44 in 1996 and 64.18 in 1997.
9. AFDC has been replaced by Temporary Assistance to Needy Families, but the old AFDC criteria are used to determine eligibility for Medicaid.
10. Because the welfare block grant was based on spending in FY 94 (when AFDC caseloads were higher), Texas, along with most other states, received more federal money than it would have under the previous program. Thus, even after meeting the maintenance-of-effort requirement specified in the federal law, the state has funds left over from what it was spending previously.
11. Current federal law requires state Medicaid programs to phase in, one year at a time, coverage of all children younger than age 19 who have incomes below 100 percent of the federal poverty line.
12. For a more detailed discussion of welfare reform issues, see: Nancy Pindus et al., *Income Support and Social Services for Low-Income People in Texas* (Washington, D.C.: The Urban Institute, forthcoming, 1997).
13. Only the adults would lose eligibility, not children (as in the federal law). Extensions are available in counties with high unemployment. Recipients are exempt from this provision until the youngest child at home is four years old. Time limits (12, 24, and 36 months) apply only after employment services begin for the client.
14. Texas Department of Insurance, data as of December 31, 1995.
15. Texas Department of Insurance, "Basic Service Industry: Financial Data Graphs as of December 31, 1995" (Austin: Texas Department of Insurance, no date).
16. David W. Hilgers and Joe H. Cunningham, "Integrated Delivery Systems: What Does it Mean?" (materials for the 2nd Annual Rural Health Conference, "Community Oriented Care: Community Survival in the New Environment"), Texas Tech University Health Sciences Center, Lubbock, Texas, April 19–20, 1996.
17. Texas Medical Association and MTI Research, Inc., *1996 Survey of Texas Physicians: Research Summary Report* (Austin: Texas Medical Association, April 1996).
18. Ibid.
19. The Balanced Budget Act of 1997 now provides for a federal match when a state guarantees Medicaid eligibility for six months to beneficiaries who enroll in managed care organizations.

20. "Hospital District Not Selected by State as Medicaid Provider," *Houston Chronicle*, May 13, 1997, 1A, 8A.
21. Texas Register, "Texas Department of Health, Medicaid Managed Care, Standards for the State of Texas Access Reform (STAR)," Proposed Rule, 21 TexReg 7324, August 6, 1996.
22. Ibid.
23. This provision in the Medicaid law requires states to pay hospitals and nursing homes enough to cover the costs of "economically and efficiently" operated facilities that meet the quality standards. Congress repealed that requirement as part of the Balanced Budget Act of 1997.
24. Prospective Payment Assessment Commission, "Medicare and the American Health Care System: Report to Congress" (Washington, D.C.: ProPAC, June 1995).
25. The Health Care Financing Administration contends that the Boren amendment does not apply to rates negotiated between hospitals and HMOs.
26. Stephen Norton, "Medicaid Fees and the Medicare Fee Schedule: An Update," *Health Care Financing Review* (fall 1995), vol. 17, 167–181.
27. Counties seeking funding under this state program must first spend 10 percent of "general revenue tax levy" on indigent care. State funds are then available for subsequent services with a 20 percent county match.
28. Hardy Loe et al., "The Houston-Galveston-Brazoria Consolidated Metropolitan Statistical Area Health Needs Assessment" (Houston: University of Texas, School of Public Health, 1994).
29. InterStudy, The Competitive Edge 6.2, Part III: Regional Market Analysis (St. Paul, MN: InterStudy, December 1996).
30. Richard C. Ladd, Robert L. Kane, Rosalie A. Kane, and Wendy J. Nielsen, "State LTC Profiles Report" (Minneapolis: University of Minnesota, 1995).
31. These figures must be viewed with caution because the state defines as "community" any service that is not located on the grounds of state institutions.
32. Texas Department of Mental Health and Mental Retardation, "Setting the Stage for Change," FY 95 Annual Report, p. 15.

APPENDIX

List of People Interviewed

Most of the information in this report was collected through interviews conducted in Austin and Houston during July 1996 and in El Paso during February 1997. People interviewed included the following:

State Government Officials

Office of the Governor
Ronald Lindsey

Health and Human Services Commission
Michael D. McKinney
Cathy Rossberg
Linda Wertz

Department of Health
Lynn Hudson
Demetria Montgomery
Pattie Patterson
Debra Stabeno
Steve Svadlenak

Department of Human Services
Anita Anderson
Ron Borg
Dee Church
Amy Orum
Kay Priest
Susan Syler

Department of Mental Health and Mental Retardation
Nancy Gravley
Rose Ann Rossman
Sam Shore
James Williamson

Department of Insurance
Tyrette Hamilton
Leah Rummel

Department on Aging
Mary Sapp
Peggy Seely
Karl Urban
John F. Willis

Attorney General's Office
Jan Soifer
Mark Tobey

Texas Comptroller of Public Accounts
Bee Moorhead

Legislative Staff

Offices of State Legislators

Marianne Dwight	Senate Health and Human Services Committee
Erin Florence	Speaker's Office
Laura Lawlor	House Public Health Committee
Kathy Spurgin	Rep. Harvey Hildebran
Chris Taylor	Rep. Harvey Hildebran

Legislative Budget Board
Maureen McCormack
Anita Zinnecker

Provider Associations

Texas Association for Home Care, Inc.
Anita Bradberry
Heather Vasek

Texas Association of Homes and Services for the Aging
David Latimer
Sandy Derrow

Texas Health Care Association
Tim Graves
Tom Seuhs

Texas Hospital Association
James Houdek
Joe Dasilva
Richard Shirmer
Camille Miller

Texas Medical Association
Connie Barron
Helen Davis

Other Provider Associations

Jose Camacho	Texas Association of Community Health Centers
Brian Sperry	Children's Hospital Association of Texas
Geoffrey Wurzel	Texas HMO Association

Consumer Advocacy Groups

Robert Almanzan	Mexican American Legal Defense and Education Fund
Candice Carter	American Association of Retired Persons
Lynne Coyle	Lawyers Commission on Civil Rights
Ann Dunkelberg	Center for Public Policy Priorities
Beth Ferris	Texas Advocates for Nursing Home Residents
Penny Kendall	Disability Policy Consortium
Suzan Kern	Border Rights Coalition
Lisa McGiffert	Consumers' Union
Maureen O'Connell	Advocacy, Inc.

Experts

Paso Del Norte Health Foundation

W. Blake Fry
Geri Kaugh
Ann G. Pauli

University of Texas at El Paso

Fernando Galan	Social Work Program
Amy K. Liebman	Center for Environmental Resource Management
Dennis Soden	Public Policy Research Center

Others

Charles Begley	School of Public Health, University of Texas at Houston
Cliff Dasco	Baylor College of Medicine
DeAnn Friedholm	Independent Consultant
Richard Ladd	Ladd & Associates

Local Health Departments and Government Officials

City of El Paso

Raymond Telles	Mayor Pro-Tempore and City Councilman

El Paso City-County Health and Environmental District

Jorge Magaña
Raul V. Muñoz, Jr.

Harris County/City of Houston

M. des Vignes-Kendrick
Thomas Hyslop
Carol Pierson
Antonia Stewart

Providers—El Paso

Thomasson Hospital
Pete Duarte
Kent Giles

Others

Salvador Balcorta	Centro De Salud Familiar La Fe
Cindy Hague	Maternidad La Luz
Amy Lacera	Project Vida
Randall H. Rolfe	Columbia West Texas Division
Mario Sanchez	Centro Medico de Valle

Providers—Houston

Mel Bishop	Columbia North Houston and Columbia Doctors
Jeannie Fraser	Hermann Hospital
Lois Moore	Harris County Hospital District
Mark Wallace	Texas Children's Hospital

About the Authors

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