



John Vachon, 1942

Health Care

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The cost of medical care became a prominent issue in the economic Depression of the 1930s. At that time, the notion of health insurance—that is, periodic prepayment of small contributions by a number of people into a common fund to ensure the availability of money in the event of illness—spread rapidly in the United States. The major shortcoming of voluntary health insurance, however, was insufficient coverage for the elderly and the poor.

In 1965, Congress substantially remedied that shortcoming with the enactment of the Medicare and Medicaid programs, but the escalating costs of medical care continue to be a prominent issue.

Purchased Health Services

Of all the benefits provided to needy Texans by the department, health care may be one of the most significant. The need for health care in Texas is greater now than at any time during the past 50 years. Across the state, nearly 3 million Texans are without health care coverage and must turn to hospital emergency rooms for medical care or do without it because they cannot pay. Unfortunately, that number continues to grow.

Purchased Health Services (PHS) is the only comprehensive, statewide health care program for poor Texans. During the 22 years that the department has administered this program, millions of needy Texans have been served. Last year alone, more than 1.4 million Texans were eligible.

PHS has been designed to meet the health needs of the greatest number of eligible people through the purchase of a wide range of health care services such as physician, hospital, ambulance, nurse mid-wife, maternity clinic, hearing aid, chiropractic, podiatry, home health, optometric, laboratory and X-ray, optical and other services. In administering PHS, the department has acted to ensure that recipients receive the best care possible within the limits of the program, while using the most cost-efficient and cost-effective means possible to achieve that goal.

PHS is under constant change to meet the changing needs of its recipients. During fiscal year 1989, the most dramatic changes were seen in services for children and pregnant women. Requirements were liberalized to make more children and pregnant women eligible for services. Access to health care was increased by making perinatal care in clinic settings available to Medicaid-eligible women. Continuity of hospital care was improved for children up to age 1 by the removal of the 30-day inpatient hospital limitation.

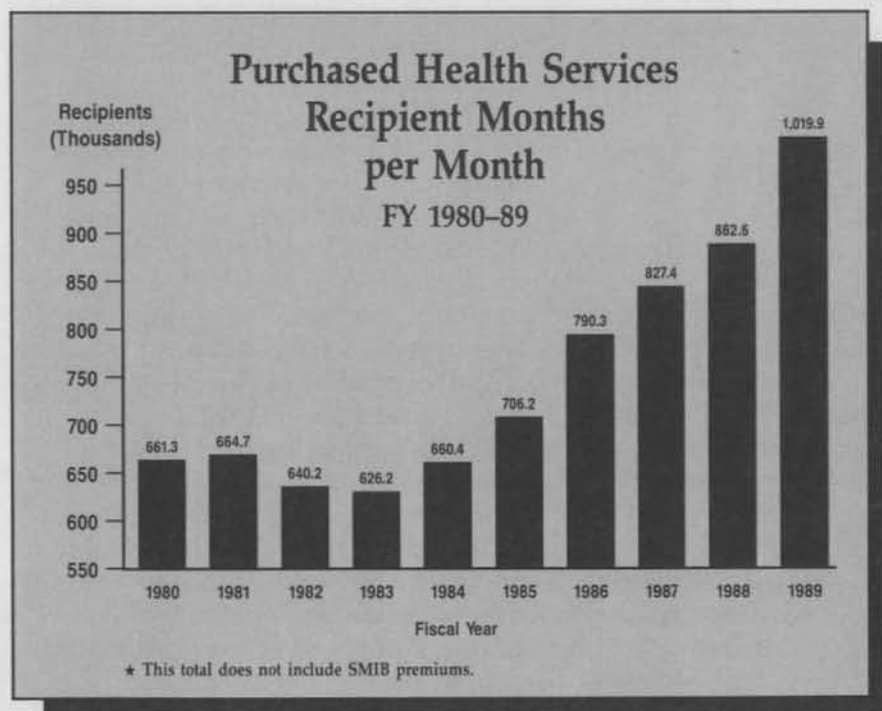
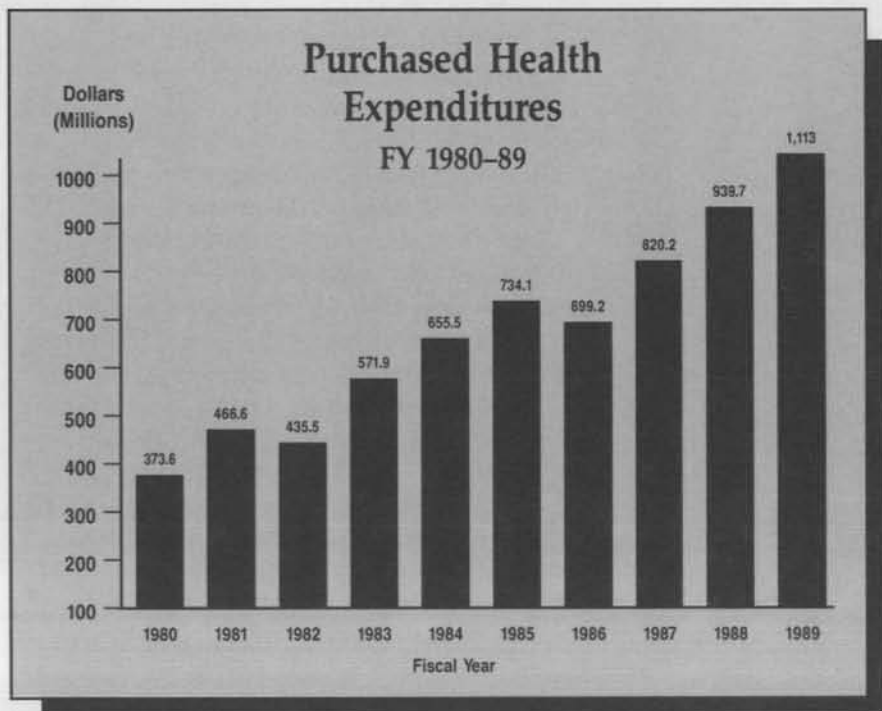
The department joined with the Texas Department of Health (TDH) in working toward comprehensive and coordinated services for poor children and pregnant women. A joint steering committee on maternal and child health, composed of executives from both agencies, was established. Their guidance and direction resulted

in a statewide, toll-free hotline that provides information about prenatal care. Callers can also find the nearest

location of services. Newspaper and radio public service announcements were prepared to encourage eligible pregnant women to seek early prenatal care. The department is also cooperating with TDH on the Maternal and Infant Care Access Project, a perinatal case-management pilot project serving children and pregnant women in rural West Texas.

In addition to its maternal and child health initiatives, the department advanced its commitment to preventing illness and meeting the specialized needs of some of its recipients. The Texas Board of Human Services approved an expansion of services to include immunizations to prevent pneumonia and influenza, which are permitted under Medicaid. The department estimates that a \$3.50 annual flu shot could save almost \$1,500 and a \$10 one-time pneumonia vaccination approximately \$2,200 in inpatient hospitalization and physician charges. The board also approved the addition of in-home parenteral nutrition (hyperalimentation) for people with medical conditions that prevent them from ingesting food by mouth.

While the needs of clients remain paramount, fairness and equity for those who provide Medicaid services are important as well. Several provider-related changes were made in fiscal year 1989. Reimbursement was restructured for children's hospitals so payments could more accurately reflect the hospitals' costs for high-intensity services to children. The base standard from which hospital reimbursements are calculated was raised from \$1,200 to \$1,600. The maximum limitation for inpatient hospital care was raised from \$50,000 to \$200,000 per recipient per year. Hospitals will now receive full payment for a person's hospital stay even if that



Recollections: Seeing Eye Dogs and the Fall of Rome



Russell Lee, 1952

I remember a few cases where I got a lot of satisfaction in seeing a need answered.

We had an elderly woman who had a Seeing Eye dog. Under the policy, there was no place in the budget for food for the dog. She couldn't keep the dog if she couldn't feed it. And she couldn't continue to live on the ranch she had without the dog.

I suggested she appeal her case with the thought in my mind of trying to get the policy changed, which she did. I thought it was important, not

only for her but for everybody.

I was pleased with the case because I thought it was a policy that needed to be changed. It was not only helpful to that person but to all the clients who were able to have dogs.

There was another woman who told her husband she was younger than she actually was. In fact, she was older than he was, and so had not told him the truth. Now, that's logical. I could understand that. So I asked her to relate her age to other people's ages. She told

me she was two years older to the day than her sister. I said, "Well, where is your sister?"

"She is dead," she said. Then she added, "She's buried out here in the cemetery."

So, without telling her, I went to the cemetery and found her sister's grave. There was the date of her sister's birth, exactly as she had said it was.

I remember one of the cutest old women I ever had for a client. You could see that she was as old as a tree. She was old, and there was no question about it.

At one time, we were allowed to take the information clients gave us and

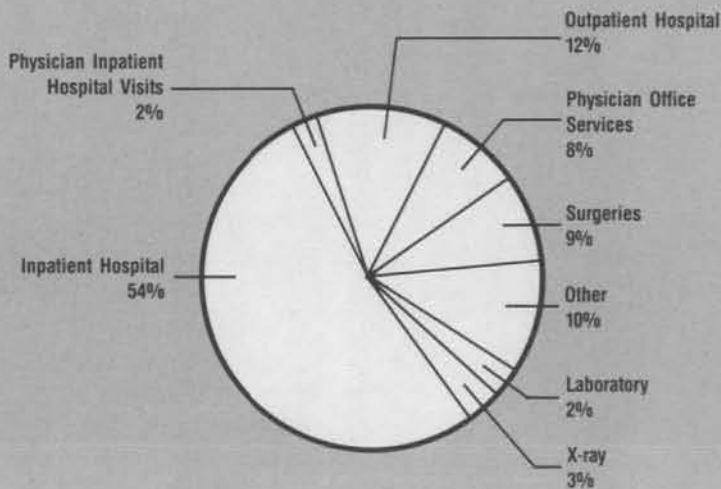
decide if they were eligible even if they didn't have papers to prove it.

I was talking to her and asking about things way back to see if she remembered. I mentioned the Galveston flood, and she remembered that. She was well aware of things, and I was certain she was old enough. So I said, "Well, do you remember the fall of Rome?"

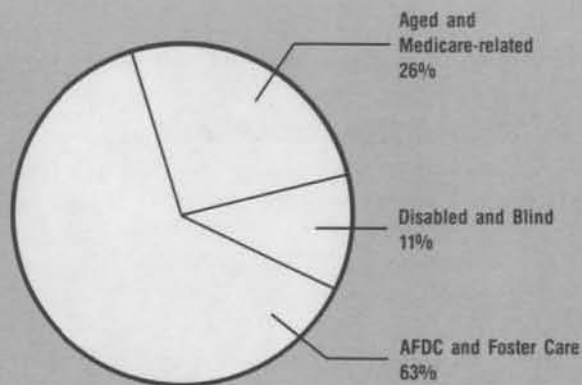
She said, "That's what that noise was I heard! That was when I was a little girl." ■

Baylor Durham, Waco

Purchased Health Benefit Payments FY 1989



Payments by Recipient Group FY 1989



person exhausts benefits before leaving the hospital. Finally, the 30-day spell-of-illness limitation for physician services to people in inpatient hospital settings was eliminated.

Texas is somewhat unique in that its PHS program is partially administered through contract under an insured

arrangement. In fiscal year 1989, proposals were accepted for the insured arrangement contract. Following an extensive review and evaluation process, the contract was awarded for a four-year period, with provision for two two-year extensions, to the National Heritage Insurance Company (NHIC), which has held the contract since January 1977. Under the contract, which goes into effect Sept. 1, 1989, NHIC will receive an average administrative fee of about \$2 per recipient month for processing claims, a 17.1 percent drop from the previous contract charge. Further, NHIC is limited to a profit of 5 percent of the audited cost of administration, down from the 10 percent formerly allowed.

The department maintained its commitment to efficient administration of the PHS program. Utilization review continued its aggressive policy of assuring that submitted bills are appropriate and that any available third-party resource, such as Medicare or private insurance, was used before any Medicaid payment was made. By requiring third parties to pay first, the department avoided costs of more than \$660.7 million.

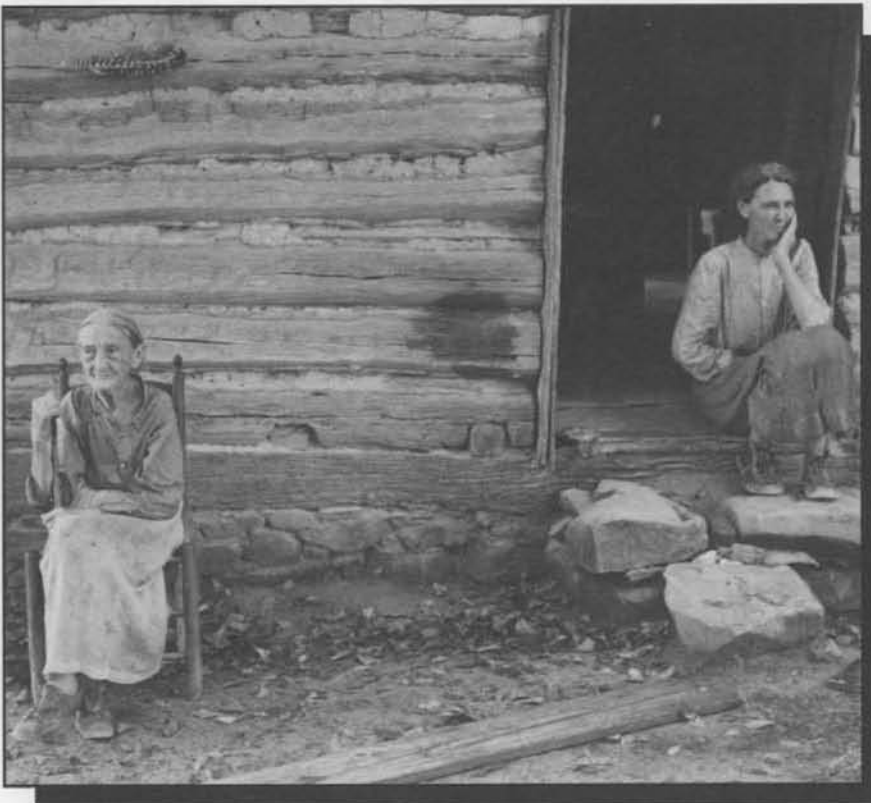
During fiscal year 1989, 1 million eligible recipients were covered with medical care at a cost of \$1.113 billion. This represents an increase over the previous year when 944,875 people received health care services at a cost of \$878 million.

Indigent Health Care

In 1985, the 69th Legislature passed major indigent health care legislation to provide health care services to medically needy people who do not qualify for Medicaid. One component of the legislation, the County Indigent

Health Care Program (CIHCP) provides health care benefits to the poorest of the poor. DHS is legally responsible for establishing CIHCP guidelines.

CIHCP covers the 141 counties not fully served by public hospitals or hospital districts. According to the law, if an indigent patient is a resident of a county area not served by a public hospital or hospital district, the county is financially responsible for the patient's health care. Legislation enacted in 1987 and 1989 increased the number of counties liable for health care by eliminating the indigent health care responsibilities of certain public hospitals.



Marion Post Wolcott, 1939

A county is legally liable for spending up to 10 percent of its general revenue tax levy for hospital and medical services for county residents who meet AFDC income and resource

limits but are categorically ineligible for Medicaid. These people are primarily men, non-pregnant women, women without dependent children, married couples and illegal entrants to the United States. Their incomes are below 25 percent of the federal poverty level.

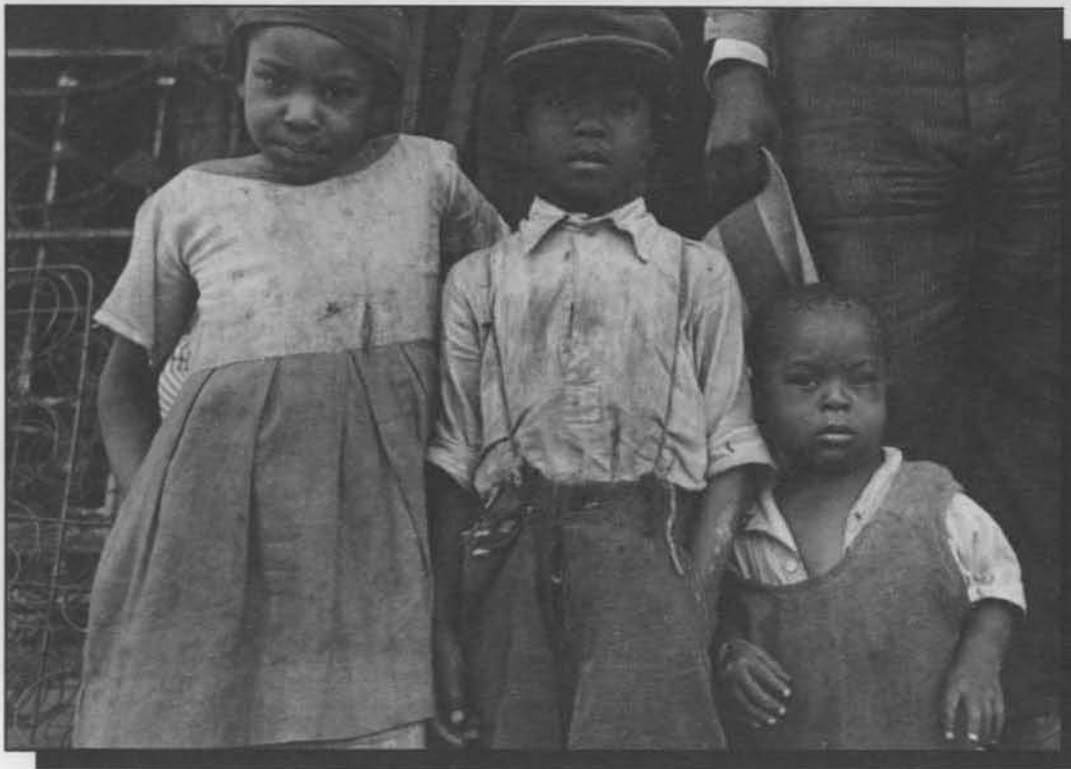
Once a county reaches the 10 percent limit, the department reimburses 80 percent of additional county expenditures. While total county liability is unlimited as long as state assistance funds are available, liability for each eligible resident is limited to \$30,000 or 30 days of hospital or skilled nursing facility care per year.

Eligible county residents receive inpatient and outpatient hospital care, physician services, laboratory services, X-rays, family planning services, skilled nursing care and up to three prescribed drugs per month.

The department develops rules used by counties that operate the program and provides technical assistance and support. Service definitions and payment rates are based on the Medicaid program. The department is also responsible for resolving residency disputes between governmental entities and providers but has no program enforcement authority. A health care coordinator in each DHS region serves as liaison between the department and local health care programs.

The 1985 legislation also requires public hospitals to provide inpatient and outpatient services to eligible residents who live within their service areas. Currently, public hospitals and hospital districts are responsible for providing indigent health care in 113 counties.

Public hospital eligibility requirements cannot be more restrictive than those the department developed for counties. The 70th Legislature



Russell Lee, 1938

exempted hospital authorities from the responsibilities mandated for public hospitals. The 71st Legislature exempted certain leased, city-owned and city and county-owned hospitals from public hospital responsibilities.

Hospital districts are required to provide indigent residents with the health care services specified by the state constitution and enabling legislation. The 71st Legislature enacted legislation which may make it easier to create hospital districts.

During fiscal year 1989, counties spent more than \$19 million in local funds for mandatory services for eligible residents, up from \$18.6 million in fiscal year 1988, and approved more than 10,480 households for health care services, as compared to more than 11,715 households approved last year. While only 12 counties received state assistance last year, 11 counties received about \$2 million in state

matching funds in fiscal year 1989, less than the \$3.2 million in state matching funds distributed in fiscal year 1988.

Distribution of federal State Legalization Impact Assistance Grant (SLIAG) program funds to CIHCP counties is also the department's responsibility. SLIAG was established under the Immigration and Reform Act of 1986 to partially defray the financial impact on state and local governments from providing health, public assistance and educational services to eligible legalized aliens.

Counties providing health care services to legalized aliens under the act are eligible for 100 percent federal reimbursement for service costs through the SLIAG program. Counties spent about \$5 million to cover services for legalized aliens in fiscal year 1989. A recent federal Medicaid expansion reduced county caseloads and expenditures by enabling certain illegal entrants and eligible legalized aliens to qualify for Medicaid.

The 1985 indigent health care legislation required the department and TDH to implement a computerized Integrated Eligibility process for a more coordinated intake and referral process for the various health care programs.

Integrated Eligibility is designed to ease client access to health and human service programs by bringing a number of programs together at a single entry point. Using the process, staff in health care settings can quickly assess a client's situation, channel the

client into the appropriate program and assist the client through the application process to expedite the eligibility determination. Integrated Eligibility ensures that the appropriate funding source pays for the service, thereby maximizing use of federal funds and reserving local and state money.

By the end of the fiscal year, seven new Integrated Eligibility sites were operational, bringing the total to 18 throughout the state. More than 185 other sites, ranging from county eligibility programs to public hospitals, reported using Integrated Eligibility screening tools to help refer clients to the programs that can most effectively meet their needs.

Coordination of services and program eligibility continues to be the major accomplishment of the Integrated Eligibility process. Health and social service providers at the state and local levels are working together

to reduce overlaps and gaps in services, establish single points of entry when possible and explore more prudent funding possibilities. As a result, client access to services and program eligibility has been eased, duplication of efforts among agencies has been reduced and appropriate use of state and local funds has been ensured.

As health care programs continue to expand, the Integrated Eligibility program continues to generate interest among health and human service providers throughout the state. The Legislature appropriated \$923,542 for the program in fiscal year 1989.

Pharmacy Services

The Texas Vendor Drug program was implemented Sept. 1, 1971. Throughout the 1970s and the early years of this decade, state funding was available to cover expanding Medicaid caseloads and increased costs of drug products and pharmacy dispensing fees. Early problems with the claims payment system were ironed out by the mid-1970s, and the Texas program was hailed as a national model of economy and efficiency.

In the 1986-87 biennium, however, appropriation levels were frozen, amounting to a 10 percent to 12 percent reduction in funds due to inflation factors. To deal with funding constraints and maintain a modest level of drug



Austin History Center

coverage, the agency adopted several policy changes. The Estimated Acquisition Cost policy was changed Sept. 1, 1985, to include consideration of purchase discounts routinely received by pharmacies from drug suppliers. Reimbursement policies were changed to require the use of therapeutically equivalent generic drug products when possible. And a sliding-scale dispensing fee was implemented to stem the steadily increasing costs in this area while still encouraging contracted pharmacies to continue participation in the program.

As a result of these efforts, the program has saved more than \$105 million in state and federal funds during fiscal years 1986 through 1988. These savings allowed the program to continue providing up to three prescription medications per month for Medicaid recipients and add the expensive drug AZT to the Medicaid formulary for Medicaid victims of AIDS. The program also now has more pharmacy contractors participating than at any other point in its history, a total of 3,520 this fiscal year.

With the expansion of Medicaid coverage, the Vendor Drug program served an additional 22,000 children and pregnant women. About 120 Medicaid AIDS patients per month received the drug AZT through a cooperative agreement with the Texas Department of Health. TDH supplied AZT to low-income recipients under a special federal grant. DHS identified and paid for Medicaid eligibles through the Vendor Drug program.

The average prescription price increased from \$16.83 in fiscal year 1988 to \$18.46 in fiscal year 1989. Total expenditures increased from \$139 million to \$160.6 million during the same period, and the number of prescriptions increased from 8.2 million to 8.7 million.

Medical Transportation

The Medical Transportation program began in 1974 as a result of a court order to provide transportation for eligible Medicaid recipients to access Title 19 services.

Appropriations for the medical transportation program have remained fairly level since the beginning of the program. In fact, until fiscal year 1986, riders to the department's appropriation prohibited transferring lapsed funds to the transportation program.

As a result, many program initiatives over the years have been aimed at stretching available dollars. In the past two bienniums, the program expanded services by negotiating more reasonable unit rate contracts and monitoring to ensure services are provided only to eligible recipients. Increased uniformity of contract administration has resulted in greater program efficiency. Regional transportation staff received automation training this year to further increase program efficiency.

To help Medicaid clients make use of medically necessary services, the department furnished non-emergency transportation through contracts with metropolitan transit authorities, local taxi companies, independent school districts, community agencies, private corporations and other organizations. More than 475 volunteers also provided transportation and were reimbursed for mileage.

The department spent \$4.9 million to pay for 589,516 one-way trips in fiscal year 1989 as compared to 590,981 one-way trips purchased for \$4.7 million last year. The average cost per trip increased when additional services were provided in rural areas where greater distances increased costs. ■