Task Force on Indigent Health Care

Final Report
December 1984

To: Governor Mark White
Lieutenant Governor William P. Hobby
Speaker "Gib" Lewis
Members of the 69th Legislature

Pursuant to its charge from the Governor, Lieutenant Governor, and Speaker of the House, the Task Force on Indigent Health Care transmits its interim report and recommendations about the needs and problems in the delivery of health care to the poor.

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Vice-Chairperson

Senator Chet Brooks

Representative Jesse Oliver

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Introduction

Indigent health care is an issue which affects all Texans, not just poor individuals in a health crisis. The longer the problem is ignored, the more expensive the consequences become for everyone.

Many individuals have no insurance coverage and therefore lack the ability to pay for necessary and appropriate health care. As both the cost of medical care and our state's population increase, greater numbers of individuals and their families will become medically indigent. A growing indigent health care problem means increased health care costs for everyone, unless steps are taken to finance indigent health care services more equitably and to improve access to necessary and appropriate services.

As a direct consequence of the growing number of persons unable to pay the cost of their care, hospitals and other health care providers must bear an increasing burden for charity care, and that cost must be passed on to others who can pay for their services. Ambiguous state statutes regarding county responsibility and restrictive state and federal programs have resulted in great disparities in the tax burden in different parts of the state. The inequities among health care providers threaten the viability of certain types of hospitals and create disincentives to providing services to the poor and uninsured. Inequities among local governments have generated lawsuits to force certain counties to contribute to the costs of health care for their residents provided in other counties.

For individuals and families, financial and emotional hardships, unnecessary suffering, and even death can result from lack of affordable and accessible health care. Those who, because of financial and other barriers, delay obtaining basic health care until their condition becomes severe create a greater demand for expensive emergency services, the cost of which is passed through to others in the form of higher prices for medical services.

Because of the scope and urgency of this issue, the Task Force on Indigent Health Care was appointed by the Governor, Lieutenant Governor, and Speaker of the House in September, 1983. The Task Force was charged with studying medical indigency in Texas.

Mrs. Helen Farabee is Chairperson, and Representative Gordon Arnold is Vice-Chairperson. The 71 Task Force members include elected officials, physicians, medical school faculty, hospital administrators, other health professionals, community health and mental health center staff, business and labor leaders, individuals from advocacy organizations, consumers, and representatives of state health agencies. (See Appendix for membership list.) The elected officials serve as the Executive Committee, the decision-making body of the Task Force.

The state leadership asked the Task Force to address four main issues regarding any program to provide indigent health care:

- scope of services
- eligibility criteria
- administrative structure
- methods of finance.

As part of its study and deliberations, the Task Force held 11 public hearings and conducted numerous site visits across the state. Individual Task Force members spent many hours talking to community leaders, concerned health professionals and administrators, and indigent patients in their own communities. The Task Force divided into subcommittees on Eligibility, Finance, Services, and Administration. These subcommittees reviewed testimony, questioned staff from state and local agencies, and solicited advice from numerous individuals and organizations. Through this process the subcommittees and the Executive Committee formulated ideas and recommendations about what could and must be done.

This report summarizes the major findings of the Task Force and its recommendations.

Summary of Task Force Findings

Statewide standards for providing indigent health care and statewide programs for financing such care are very limited in Texas. As a result, great disparity exists across the state in access to various types of care and in public and private funding available to support health care for the poor and uninsured. A seemingly haphazard array of public and private, local, regional, and state programs are attempting to cope with increasing demands for indigent care with little or no coordination. Population increases and rising health care costs are transforming these disparities into inequities and even conflicts between types of providers and units of government.

The consequence of these developments for indigent Texans is limited access to necessary health care and often inappropriate utilization of the most costly types of services. At the same time, hospitals and other health care providers are experiencing dramatic changes in how services are financed. The absence of a coherent approach to indigent care threatens the viability of certain sectors of the health care industry which may result in further restrictions in access to care for poor and uninsured Texans.

Inequities in the responsibilities for providing and financing indigent health care ultimately affect all Texas citizens. We may pay more for our hospital care, higher insurance premiums, or higher local, state, and federal taxes. Consequently, all Texans have a stake in seeing that the responsibilities for providing and financing indigent health care are more equitably and efficiently distributed.

The following points summarize the major findings of the Task Force and serve as the focus for the recommendations presented in this report:

- The medically indigent in Texas are primarily those persons without adequate health insurance. Most private insurance is employment-based, leaving many unemployed individuals without coverage. Many persons employed in part-time jobs, with small businesses, or in certain industries (e.g., agriculture), do not have employer-sponsored insurance coverage. Public insurance programs in Texas, particularly the Medicaid program, have been restrictive in both categorical and income eligibility, covering only 25 percent of the poverty population in the state. Survey results suggest that women, children, and minorities, particularly Hispanics, are at greater risk of being without health insurance.

- There is no statewide uniformity in the definition of medical indigency. Great disparity exists between metropolitan and nonmetropolitan counties and between counties with and without public facilities. Hospitals do not have consistent definitions for allocating costs of free care to charity or to bad debt.

- The financing of indigent health care falls disproportionately on certain types of providers and certain types of communities. Large metropolitan public hospitals, particularly teaching hospitals, provide the bulk of indigent health care services with less than full reimbursement from local taxes and other tax-supported programs. Many private nonprofit hospitals, particularly in communities without public hospitals, provide substantial amounts of uncompensated indigent care. Taxpayers in communities with public hospitals which serve as regional tertiary care centers must support the costs of care for indigents who are residents of surrounding counties.

- Geographical access to care for indigent Texans is limited despite underutilization of some private facilities. Many poor and uninsured persons must travel large distances to receive care in major metropolitan public hospitals despite decreasing occupancy rates in private hospitals generally.

- Indigent Texans experience a critical lack of access to maternity care services and primary care services despite the potential for overall cost savings. Preventive care, catastrophic and tertiary care, emergency care, and mental health care are additional types of services to which indigent Texans lack sufficient access. Public testimony highlighted the critical need for prenatal and delivery services for pregnant women in Texas, as well as the need for direct ambulatory primary care services for indigent persons generally. Such care would clearly reduce the current utilization of extremely expensive neonatal intensive care services and the reliance upon costly hospital emergency rooms for basic types of care.

The findings of the Task Force indicate that the problems of providing and financing of indigent care involve issues relating to several additional areas of services. Each has potential

for reducing the overall costs and inequities of financing indigent care.

- The ability of public hospitals and private nonprofit charity hospitals to continue to provide high quality care to indigent Texans is seriously threatened. Private charity hospitals are faced with reducing the amount of indigent care they provide in order to compete more effectively with for-profit and other private hospitals. Competition among hospitals is intensified by efforts on the part of the federal government and private employers to control the costs of health programs. Public hospitals are experiencing greater competition from private facilities attracting away their paying patients and dumping their nonpaying patients, thus establishing a trend toward a separate system of health care for the poor and uninsured.

- There is a serious lack of available information for evaluating the nature and scope of indigent health care needs and for monitoring the efforts of providers and units of government to serve those needs. Ambiguity in state laws regarding indigent care and differing practices across the state have resulted in an absence of consistent efforts to identify the specific health care needs of indigent persons as distinct from the general population. The lack of uniform definitions of medical indigency and charity care has created wide variation in the quality of available information regarding services provided to indigent Texans. Statewide and regional planning and coordination efforts are seriously restricted by the limited information available.

Overview of Task Force Approach to Recommendations

The problem of indigent health care is not unique to Texas. Throughout the country, states are attempting to develop appropriate ways to allocate the responsibilities for providing and financing health care for the poor and uninsured. California relies heavily on its statewide Medicaid program call Medi-Cal. Arizona has replaced its traditional county responsibility approach with a new state-operated system incorporating strong cost-control measures. Colorado provides direct state appropriations to hospitals with a specialized program for maternity services. Some states, like Maryland and New Jersey, have established hospital rate-setting commissions to control prices and require all third-party payors to contribute to indigent care costs.

Unlike these approaches, the recommendations of the Task Force do not represent a major reorganization of the current health care delivery and financing system in Texas. The Task Force's approach attempts to build upon existing programs, providers, and methods of financing while, at the same time, reducing the disparities and inequities in the existing system. The recommendations acknowledge both the historical role of county government in providing medical care for poor county residents and the limitations of a property tax base to respond to rapid increases in health care costs. The traditional roles of the State Departments of Health and Human Resources are retained and expanded respectively. Emphasis is placed on utilization of existing private providers, where possible, in lieu of greatly expanded public facilities and services. And proposals are made to enhance competition in the health care industry rather than to propose new regulatory measures.

A central theme in the Task Force recommendations is the need to spread the burden of providing and financing indigent care more equitably. Much of the cost of providing indigent care is currently financed through increased hospital charges for paying patients. The burden of free care falls disproportionately on those paying patients at hospitals providing the bulk of indigent care, large public hospitals, and many private nonprofit charity hospitals. The burden of financing indigent health care also falls disproportionately on taxpayers in communities which support large public hospitals serving indigent patients from a wide geographical region.

The major recommendations of the Task Force propose including many more individuals in tax-supported programs, which would finance a greater portion of the demand for free care, with additional revenues derived from federal income taxes, state general taxes, as well as local property taxes. At the

same time, the Task Force recommendations acknowledge the limitations of tax-supported government programs to finance all of the costs of indigent care. Further attempts must be made to increase the availability of private insurance coverage.

The Task Force also recommends that the balance of indigent care costs remaining after the expansion of private and tax-supported insurance programs should be more equitably distributed among public and private hospitals.

In addition to more equitably distributing the burden of providing indigent care, the recommendations propose greater uniformity in defining medical indigency, improved geographical access to care, maximum utilization of existing facilities, enhancement of the competitive position of hospitals providing indigent care, and improved information gathering and reporting efforts to facilitate statewide planning and coordination. The Task Force recommendations include a prioritization of the types of services to be provided to indigent persons, giving highest priority to maternity and ambulatory primary care services, followed by preventive, catastrophic and tertiary, emergency, and mental health services.

The following themes reflect the overall approach of the Task Force and the objectives of its specific recommendations:

- Expand health insurance coverage for the medically indigent. The Task Force recommends expansions of federal, state, and local tax-supported health care programs with the greatest potential for reducing unnecessary utilization of high cost health services, i.e., for children and pregnant women. In addition, the Task Force suggests that further efforts should be made to explore ways of increasing the availability of private insurance coverage.
- Improve statewide uniformity in defining eligibility for charity care. The Task Force recommends a minimum standard of eligibility for county-supported indigent health care equal to the income and asset standards used in the state's AFDC-Medicaid program (at approximately 25 percent of the federal poverty income guidelines).
- Provide greater equity in distributing the burden of providing and financing indigent health care. By recommending expansions of the state's Medicaid and Maternal and Child Health programs, a greater portion of the indigent care burden will be borne by federal income taxes (federal Medicaid match) and state general tax revenues. By clarifying county responsibilities for their indigent residents, more counties will participate in sharing the costs of indigent care. By requiring all hospitals to provide some minimum amount of charity care, the balance of uncompensated care (still not covered after expanded tax-supported programs) will not fall as disproportionately on those paying patients at hospitals currently providing the bulk of indigent care services.
- Maximize the utilization of existing health care facilities in order to improve geographical access to care. The expanded state and county financing of indigent care recommended by the Task Force will provide increased funding sources for purchasing health care services from both public and private facilities throughout the state. The requirement that all hospitals provide a minimum amount of indigent care will reduce the need for poor and uninsured citizens to travel great distances to find a hospital obligated to provide charity care. These proposals will help to avoid the creation of a separate system of health care for the poor, while improving geographical access to care for indigent Texans.
- Increase the availability of maternity and primary care services in order to reduce unnecessary utilization of high-cost care. Provide greater access to preventive, catastrophic and tertiary, emergency, and mental health services as resources become available. The Task Force places its highest priority on the provision of prenatal and delivery services for indigent pregnant women in Texas, followed by the provision of ambulatory primary care services. The Task Force recommends funding the perinatal services plan proposed by the Texas Department of Health, which includes contracting with local providers for prenatal care consultations and deliveries. The proposed Medicaid expansions would increase coverage primarily for pregnant women and children as well as providing for a range of health care services for many new eligible individuals. County reponsibilities would include the full range of primary, secondary, and tertiary care services for individuals not categorically eligible for Medicaid. The other priority services recommended by the Task Force emphasize prevention and early intervention efforts in order to reduce overall costs. The service proposals also encourage the use of least restrictive and less costly settings for delivery of care.
- Preserve the ability of public hospitals and

private nonprofit hospitals to provide high quality care to indigent Texans. The Task Force recommendations for expanded state Medicaid and maternity care services, combined with specific county responsibilities, will greatly increase the amount of federal, state, and local tax revenues available to hospitals providing indigent health care. In addition, the Task Force suggestion that all hospitals provide a minimum amount of direct charity care will help to distribute more equitably the amount of uncompensated care still remaining. These proposals will reduce the current disincentives to providing indigent care and will ensure that hospitals serving indigents are not placed at a competitive disadvantage.

- Improve the availability of information on the nature and scope of indigent health care needs and on efforts to meet those needs in order to improve statewide monitoring and coordination. The Task Force recommendations include mandatory uniform reporting requirements for counties and hospitals in Texas. Having specified definitions for eligibility for indigent care, reliable information must be obtained in order to evaluate the efforts of counties and hospitals to meet their obligations to provide such care. Accurate information on indigent health needs and services will greatly facilitate the coordination of efforts by providers and various units of government.

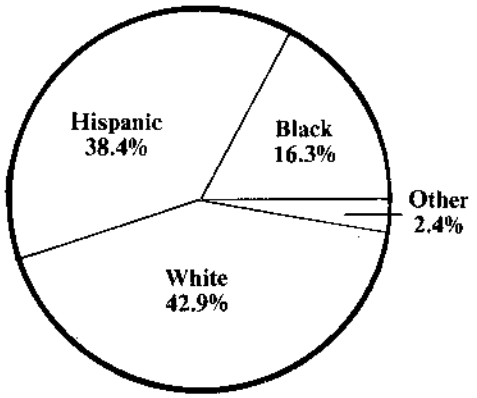
Background & Findings

Who Are the Medically Indigent?

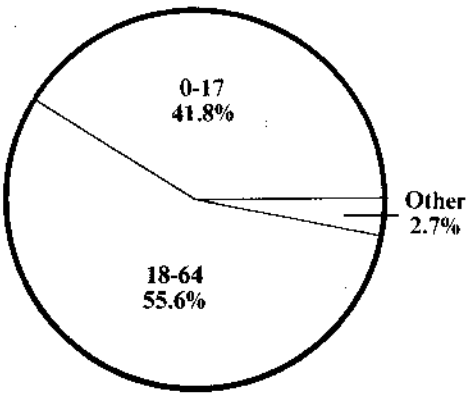
A dominant feature of the health care industry is the use of third-party coverage—insurance—to pay for most health care services. While most Texans have some form of health insurance, including coverage provided through employment, Medicare, Medicaid, or veteran's benefits, many do not.

In 1983 the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research issued its report on access to health care. The commission concluded that "society has an ethical obligation to ensure equitable access to health care for all. Lack of insurance is most pronounced

Total Texas Population
Without Health Insurance
By Race/Ethnic Origin, 1981



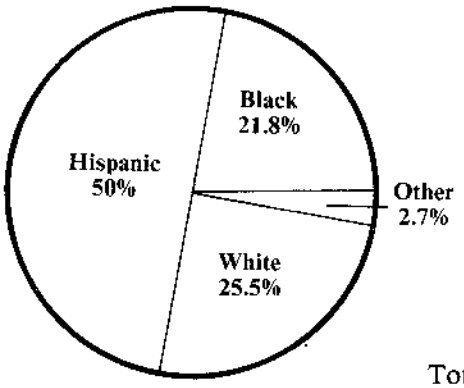
Texas Population
Without Health Insurance
By Age, 1981



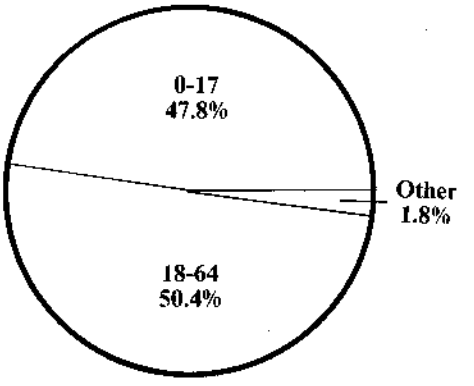
Total Texas Population
Without Health Insurance
1,746,439 persons

Source: Texas Department of Human Resources 1981 Biennial Survey.

Texas Poverty Population
Without Health Insurance
By Race/Ethnic Origin, 1981



Texas Poverty Population
Without Health Insurance
By Age, 1981



Total Uninsured
Texas Poverty Population
726,633 persons

Source: Texas Department of Human Resources 1981 Biennial Survey.

among the very poor, the near-poor, racial and ethnic minorities, and residents of rural areas."

According to a 1981 survey by the Department of Human Resources, about 28 percent of the poverty population in Texas has no public or private health insurance.

The study also revealed that among the poorest of the state's poor, or individuals living below 25 percent of poverty guidelines, almost 46 percent are without any form of health insurance.

Many women living in poverty in Texas are likely to be uninsured. About 60 percent of those below poverty and who have no health insurance are female.

Individuals who are minorities and poor are likely to lack health insurance; 50 percent of the poverty population without insurance are Hispanic and about 22 percent are Black.

Many individuals who are not poor may also lack health insurance. Various national studies have estimated that from 12 to 16 percent of the population at large may lack health insurance.

There is an important link between occupation and insurance coverage. The Texas Poll, a recent public opinion survey conducted by the Public Policy Resources Laboratory of Texas A&M University and Harte-Hanks Communications, found that families headed by persons in professional occupations were most likely to have insurance, while those families where the head of household was unemployed had the lowest levels of insurance coverage. About 26 percent of families where the head of household was unemployed had at least one family member who was uninsured, compared to 19 percent of blue collar families and 10 percent of families headed by an individual in a professional or management occupation.

According to a major national study funded by the Robert Wood Johnson Foundation, "Updated Report on Access to Health Care by the American People," the problems of individuals without health insurance are substantial:

- One in six uninsured families reported increased difficulty in obtaining medical care in the year prior to the survey, compared to one out of 20 families with insurance.
- One million families in the United States have at least one member who needed health care during the year but did not receive it for financial reasons. Uninsured families are three times more likely than insured families to encounter this problem.

According to the Texas Poll conducted in the summer of 1984, a number of individuals have difficulty obtaining medical care. Six percent of those polled reported that they needed medical help sometime during the previous year, but didn't get it. Approximately nine percent of individuals earning less than $10,000 per year and 14 percent of unemployed individuals reported this problem. One-half of those individuals who did not get the medical care that they believed they needed reported costs of medical care as the main reason they did not get it.

Important strides in the provision of health care have been made in the last several decades. The introduction of Medicare and Medicaid in 1965 and the development of employment-related health insurance have been major accomplishments in increasing access to health care. However, the adequacy of health insurance is a growing problem for many, especially the elderly who are concerned about what services are covered by Medicare and whether they can afford the copayments and deductibles required.

Individuals without adequate insurance face difficult choices when seeking medical care. They may:

- defer necessary care, resulting in unnecessary pain and suffering;
- attempt to pay for health care expenses out-of-pocket; or
- rely on a source of "free" or charity care.

Lack of health insurance is a major financial barrier to access to health care.

The Role of Local Government: Ambiguous and Varying Responsibilities For the Medically Indigent

County responsibility for indigents is one of the most difficult and important issues considered by the Task Force.

There are no specific guidelines in Texas law concerning who is considered indigent and what types of medical care must be provided at county expense. As a result, practices vary from county to county and have been the basis for a number of lawsuits and disputes. These lawsuits have included efforts to establish county standards to provide medical care and lawsuits between counties and between counties and hospital districts to recover costs for service provided to nonresidents.

Under Article XII, Section 26 of the Texas Constitution of 1869, counties were directed to provide "a manual labor poor-house for taking care of, managing, employing, and supplying the wants of its indigent and poor inhabitants."

In 1876, when the present constitution was adopted, the legislature made Section 26 permissive and renumbered it as Article XVI, Section 8, thereby only authorizing counties to care for the indigent and poor, rather than mandating such care.

Under century-old Texas statutes, Article 2351, Section 11, "The commissioner's court of each county is required to provide for the support of paupers..., residents of their county, who are unable to support themselves." This has been interpreted by the courts to include medical services. Statutory requirements delineating income and other criteria to be used and establishing the types of services to be provided do not exist.

In addition to the general responsibilities of counties, counties with a county hospital have somewhat different statutory requirements. According to Article 4438, "If there is a regular established public hospital in the county, the commissioners court shall provide for sending the indigent sick of the county to such hospital." And under Article 4487, "whenever a patient has been admitted to said hospital from the county in which the hospital is situated, the superintendent shall cause inquiry to be made as to his circumstances, and of the relatives of such patient legally liable for his support... If the superintendent finds that such patient, or said relatives are not able to pay, either in whole or in part, for his care and treatment in such hospital, the same shall become a charge upon the county."

In many areas of the state, hospital districts have been established by law. These districts are independent, political subdivisions with policy-making authority and budgetary controls set by their own board of directors. Where established, a hospital district assumes the county's responsibility for indigent care. Article 9, Sections 4, 5, and 9 of the Texas Constitution and special legislative action under Articles 4494n and 4494q authorize the creation of hospital districts. While the Constitution states that the hospital district "...shall assume full responsibility for providing medical and hospital care for its needy inhabitants...," some special-act legislation requires only "hospital" care, omitting the word "medical." Terms such as "needy" and "medical care" are not defined.

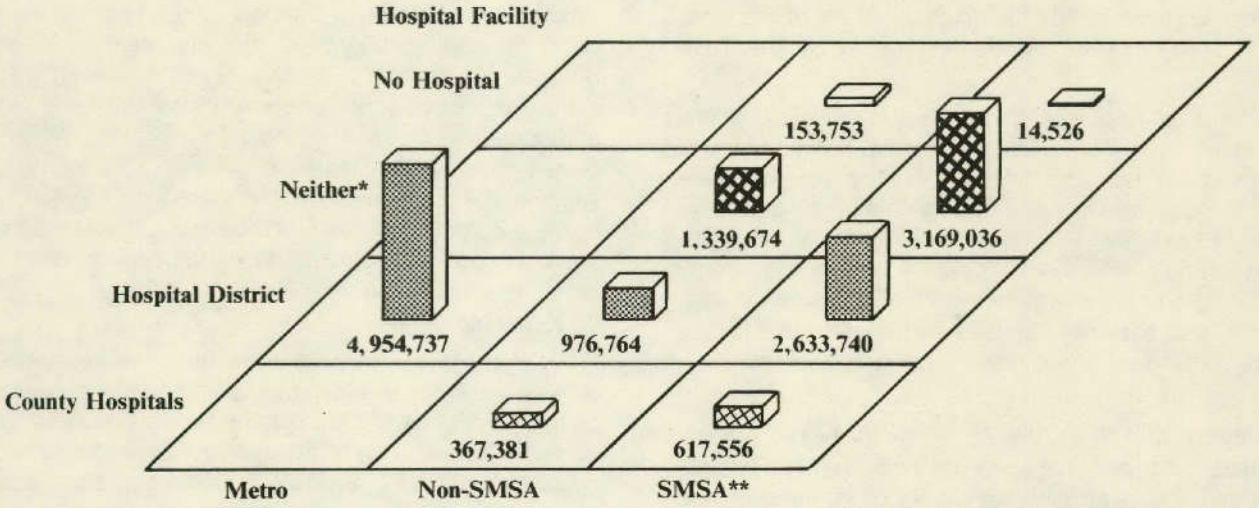
Varying local practices have only compounded the differences in legal requirements to provide services. In counties with hospital districts or county hospitals, there may be formal or informal indigent care programs. In counties without a public hospital, the county commissioners court may determine who is eligible and what services are to be provided. In some cases, these functions have been assigned to a county welfare office or local health department.

Eligibility criteria used in these different programs may include income, family size, and assets; specific criteria vary community by community. The range of income eligibility criteria used is remarkable. For example, the Task Force had reports of urban programs that used 140 percent of federal poverty guidelines and rural programs that required an individual to be completely destitute before any assistance would be provided.

Reliance on local government programs varies across the state, depending on the level of need for services in the community and the existence of other health resources able to serve the needy. In some areas of the state, federally funded Community Health Centers provide comprehensive primary care services. In other places, nonprofit hospitals provide a substantial amount of care to indigents and reduce the demand for local government-funded services. Some areas have postgraduate physician training programs which may provide care to indigents.

To attempt to identify county policies and expenditures for indigent health care, the Task Force surveyed all Texas counties. The Task Force was assisted by the Texas Association of Counties and a number of county judges and commissioners in this effort. The survey sought information regarding characteristics and health care needs of indigents requesting county medical assistance and the relationship between hospitals and counties in Texas. Overall, 65 percent of Texas counties responded to the survey.

Location of Texas Population
By County Census Type and Hospital Facility

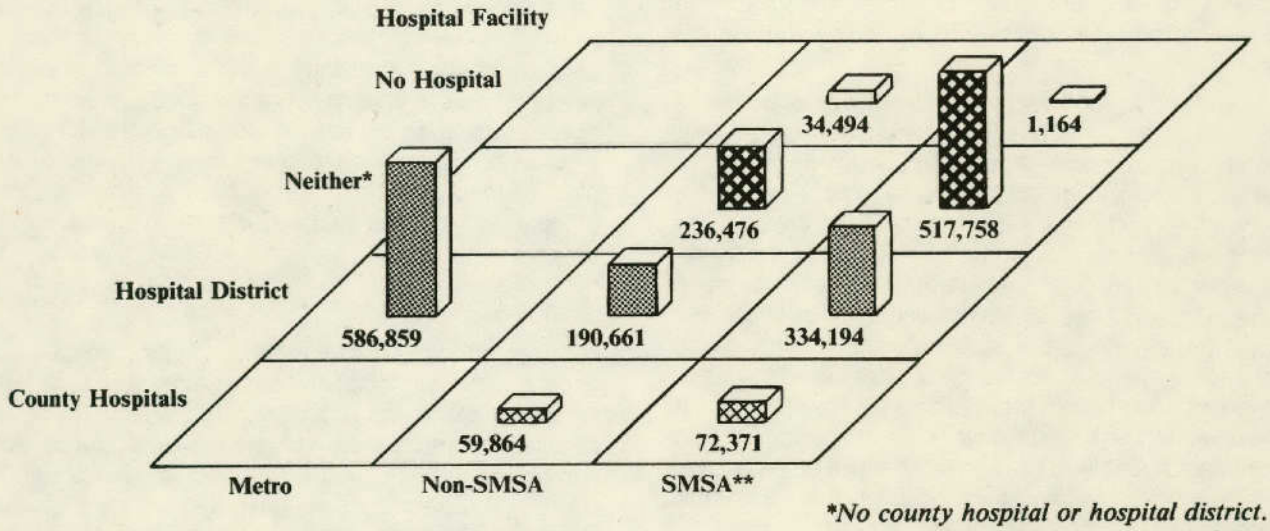


**No county hospital or hospital district.*
***Standard Metropolitan Statistical Area.*

Population 14,229,191

SOURCE: 1980 United States Census.

Location of Poverty Population
By County Census Type and Hospital Facility



**No county hospital or hospital district.*
***Standard Metropolitan Statistical Area.*

Total Poverty Population 2,035,841

Percent of State Population: 14.3%.
SOURCE: 1980 United States Census.

Findings show that about two-thirds of the total state population and about 60 percent of the poverty population reside in counties with public hospitals. In these counties, the local responsibility for indigent care is better defined than in areas without public hospitals. Although there are differences in eligibility standards and services provided, many use income eligibility criteria based on federal poverty guidelines.

About one-third of the total state population and about 40 percent of the poverty population in Texas live in counties without clearly defined responsibilities. This includes 36 counties without any hospital and 97 counties with nonprofit or proprietary hospitals but no county public hospitals. The range of practices in these counties varies enormously. Some counties have no programs at all; in others, local public efforts and charity care by providers are significant.

Local tax support for indigent health care programs varies enormously, with some areas reporting virtually no public spending to other areas reporting $35 to $40 per capita to support a public hospital.

Because of the differences in local programs, the availability of higher levels of service (including specialized tertiary care services) in many public hospitals and the higher income standards often used for eligibility in public hospitals, many individuals seek services in counties which have those facilities. As a result, local taxpayers supporting a public hospital subsidize services provided to residents from other tax jurisdictions.

In public testimony and discussions within the Task Force, county officials acknowledged the need for improved support for indigent health care needs. However, they also pointed out the potential difficulties facing a county attempting to provide care to its own indigents, including:

- the difficulty of predicting and budgeting for indigent health care expenses;
- the potential liability of a county for a catastrophic illness;
- the rising costs of health care which could grow more rapidly than a county's tax base and ability to raise ad valorem taxes; and
- the limits on certain counties' ability to pay for health care services because of widespread poverty and a limited tax base.

Local government programs usually act as "payors of last resort," that is, they pay for services using local tax dollars when there is no other source of reimbursement (such as Medicare, Medicaid, or private health insurance). Therefore, the potential financial liability of local governments for the medically indigent is directly affected by federal and state programs serving the indigent and by the private health insurance coverage provided by local employers. The reliance on local government programs is also affected by the amount of charity care services provided by the private sector, including nonprofit institutions and organizations and other voluntary efforts. Finally, the socioeconomic conditions in an area, including the degree of poverty and unemployment, affects the need for local government support of health programs. Given the diversity of Texas, these factors vary significantly from community to community and affect how local governments might appropriately discharge responsibilities for the medically indigent.

The Problem of Uncompensated Care in Hospitals

Because significant numbers of individuals cannot afford to pay for health care services, the financial burden on hospitals and other providers who care for these individuals has increased. The Task Force recognized early in its study that there is no care that is truly "free" or uncompensated. Ultimately the cost of providing uncompensated care is passed to someone.

Health care providers must increase charges to paying patients (cost-shifting) to finance services to individuals unable to pay. In effect, providers make private tax decisions to support the societal goals of providing health care to the needy. This approach to financing indigent care, which depends on providers subsidizing nonpaying patients with revenues collected from paying patients, has become a major problem.

Uncompensated care affects all types of providers, but hospitals face a particularly difficult situation. Hospital care services are usually the most expensive of health care services, and spending on hospital care is the largest component of health care spending. For many poor individuals, a hospital is the primary point of access to the health care delivery system. However, public funding of programs serving the poor is limited, and many individuals served by hospitals are not fully covered by any public or private program. Little is known about the uncompensated care problem outside of hospitals.

Government and business health benefits programs are becoming increasingly concerned about rising health care costs. To control health care cost increases, Medicare recently implemented a prospective reimbursement system based on diagnostic related

groups (DRGs), and businesses are beginning to use prospective payment systems and negotiate discount rates for services. Because these third-party payors have become less willing to accept and pay for uncompensated care, the ability of hospitals to shift costs has been reduced.

The growing competition among health care providers for paying patients also affects the financing by cost-shifting of indigent health care. Increasing charges to offset uncompensated care can make a hospital's charges for services less than competitive with other providers. Hospitals with a relatively high share of indigent patients and a small paying patient base may be less attractive to third-party payors seeking to negotiate preferred provider rates. Growing competition, coupled with inadequate funding of indigent care, creates incentives for providers to reduce the amount of indigent care provided in order to survive in the marketplace.

There are no standard definitions for uncompensated or undercompensated care and their components, charity care, bad debt, and contractual allowances. Most definitions of uncompensated care include charity care and bad debt. There are disagreements over whether contractual allowances or some portion of contractual allowances should be considered uncompensated care.

Uncompensated and undercompensated care include:

- Charity care. The care provided to individuals who are eligible for free care services or care provided to individuals from whom the hospital does not expect to receive payment because of the individual's inability to pay.
- Bad debt. The care provided to individuals who are not eligible for free care services and who presumably could pay for services, but who either choose not to or are unable to pay.
- Contractual allowances. The difference between the hospital's full charge for services and the rate of payment for those services set by third-party payors and disallowances and denials by third-party payors.

Each of these categories includes care provided to individuals who are medically indigent—they cannot meet their full health care charges. However, uncompensated or undercompensated care charges are not the same as the actual costs of care for indigents. Uncompensated and undercompensated care reflects the price for services established by hospitals as well as the level of service provided.

All general hospitals in Texas are mandated by state law not to "deny emergency services available at the hospital to a person diagnosed by a licensed physician as requiring emergency services, because the person is unable to establish his ability to pay for the service or because of race, religion, or national ancestry." Thus, all hospitals in Texas which provide emergency services have an obligation to provide services to indigents in an emergency.

In addition, many Texas hospitals have some obligation to provide services in return for grants and loans provided through the federal Hill-Burton program. Under the community services obligation of the program, hospitals agreed to refrain from discrimination on the basis of race, religion, sex, or handicaps; take affirmative steps to serve the poor and uninsured; accept Medicaid patients; and not require preadmission deposits from those without cash on hand, if the effect of the deposit requirement is to deny admission.

Under the free care obligation of Hill-Burton, hospitals agreed to provide free or reduced care to the poor in an amount equal to the lesser of three percent of their operating costs or 10 percent of the amount of federal assistance received. Usually, the free care obligation lasts 20 years. Many hospitals in Texas have completed their obligation and many others will do so in the next decade. Only a small portion of uncompensated care provided in Texas hospitals is through this program—approximately $17 million per year, by some state estimates.

There are difficulties in assessing the dimensions of uncompensated care in Texas hospitals because of the lack of standard, adequate definitions and information collection procedures. Every hospital establishes its own definitions, eligibility standards, and accounting procedures to classify individuals unable to pay in full into the categories of charity, bad debt, or contractual allowances.

To assess the magnitude of this problem, the Task Force surveyed all nonfederal, nonpsychiatric, general acute-care hospitals in the state. Two hundred and seventy-seven hospitals provided usable responses to the survey; these responses represent 51.5 percent of the hospitals and 65 percent of the licensed hospital beds in Texas. For 1983 the 277 hospitals received approximately $5.9 billion in total gross revenues, of which $1.4 billion or 24 percent was reported as uncompensated and undercompensated care.

The Role of Public Hospitals

By law, public hospitals are major providers of indigent health care in Texas; hospital districts are responsible for the "needy" of the district and county hospitals are responsible for the "indigent sick." In addition they often provide other community services. For example, public hospitals are required to assist with other public functions, such as providing blood alcohol testing in suspected DWI cases and performing exams to gather evidence in criminal cases, such as rape, child abuse, and drug smuggling.

National studies and analysis of data on public hospitals in Texas have demonstrated the critical role of public hospitals:

- Urban public hospitals in Texas have greater uncompensated care loads than urban public hospitals nationwide. Because state programs are restrictive, more local taxes are required to pay for indigent health care. However, local taxes do not cover the entire amount of uncompensated care provided in public hospitals.
- The cost of caring for the unemployed and uninsured places a significant financial burden on public hospitals and on local taxpayers.
- Public hospitals are sources of care for many recently unemployed individuals who relied on other providers before becoming unemployed.
- Public hospitals have served as "safety net institutions" and have cared for individuals affected by cutbacks in other programs.

The Role of Nonprofit Hospitals

To qualify under Section 11.18 of the Texas Property Tax Code as a charitable organization and to be exempt from taxation, a hospital must be organized to perform a charitable purpose. For hospitals, this generally will be "providing medical care without regard to the beneficiaries' ability to pay."

Many hospitals with religious affiliation in Texas were organized specifically to care for the poor. There are no quantitative standards which specify the amount of charity care nonprofit institutions must provide. In some areas of the state, especially areas where there are no public hospitals, they have provided indigent care at a level similar to that provided by public hospitals.

The Role of Investor-Owned Hospitals

Except for the emergency care requirements which apply to all Texas hospitals, for-profit (investor-owned) hospitals do not have any statutory requirement to provide indigent care. Investor-owned hospitals do pay local property taxes.

Some for-profit hospitals are the only hospitals in an area that provide health care and have made arrangements to provide some charity care. Some for-profit hospital officials believe that the type of services they provide, such as emergency room service, reflects a commitment to indigent care.

According to the 1984 Directory of Investor-Owned Hospitals published by the Federation of American Hospitals, Texas leads all states in the number of investor-owned and managed hospitals. Concerns were expressed to the Task Force that the growth of investor-owned hospitals, with their limited responsibilities to serve indigents, could further restrict access to care. Investor-owned hospitals reported that charity care was less than one percent of their total gross revenues. However, many investor-owned hospitals said that they did not distinguish betweeen charity care and bad debt.

Conclusion

The uneven distribution of uncompensated care among various types of hospitals in the state has potentially serious implications for future access to care by indigents. As noted in the survey findings and from public hearing testimony, the levels of uncompensated care differ significantly among various hospitals. This is a reflection of differences in institutional missions of different types of hospitals to the extent that it is a product of state law.

Public and private insurance programs are growing reluctant to accept higher charges from providers, which jeopardizes indigent care financing accomplished through cost-shifting. The health care industry is being forced to become more competitive in prices, and as a result, there are incentives to limit services to the poor and the resulting cost-shifting to paying patients. This may worsen pressure and financial strain on public hospitals, as well as on other providers willing to serve the poor.

The Role of the State in Indigent Health Care

The principal role of Texas state government in personal and physical health is fourfold. The state and its agencies: (1) educate, train, license, and regulate the health professions; (2) license, certify, survey, and inspect health care facilities; (3) administer programs through which specific health services are delivered or purchased from private providers for particular beneficiary groups; and (4) perform health planning and administer the Certificate of Need program.

For the 1984-1985 biennium, the Texas Department of Human Resources, the Texas Department of Health, and the Texas Department of Mental Health and Mental Retardation received about 95 percent of the state's general revenue appropriations of $3.3 billion for health, welfare, and rehabilitation agencies.

Public health, welfare, and rehabilitation agencies received 18.4 percent of the total state general revenue appropriations for the 1984-1985 biennium. Education received the most state money, 61.2 percent for the 1984-1985 biennium.

The Texas Department of Health operates a number of public health programs and programs directed at specific diseases or conditions (such as kidney health, maternal and child health, and the crippled children's programs) which provide services to indigents. The Department of Human Resources administers Medicaid, the largest state comprehensive health program for the poor. The bulk of the state's financial commitment to indigent care is through institutional care: nursing homes, hospital services, and state schools. (See Appendix for summary of programs.)

In addition to programs operated by state agencies, substantial amounts of state care for indigents are provided through The University of Texas M. D. Anderson Hospital and Tumor Institute and The University of Texas Medical Branch Hospitals.

Problems of Access in a Changing Environment

Continued population growth, the changing distribution of health care providers in the state, rapid change in the health care industry, and economic problems in certain areas of the state contribute to the problems of access to health care by indigents.

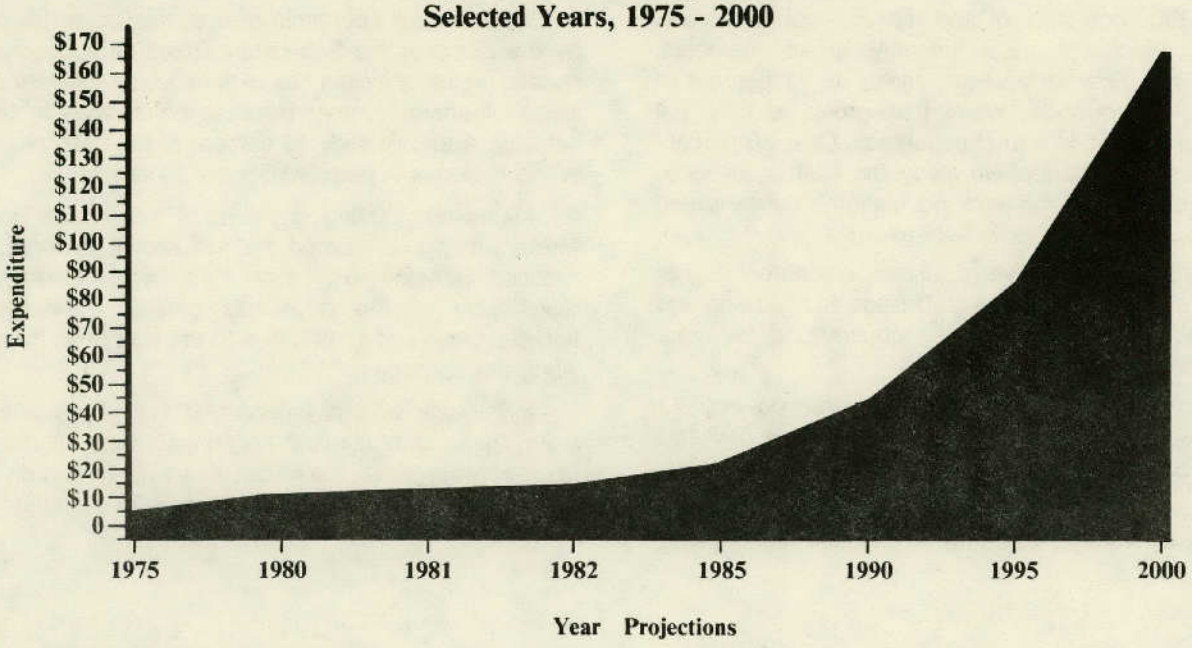
During the last 15 years Texas has had substantial population growth. Between 1970 and 1980, Texas's population increased from 11.2 million to 14.2 million, or 21.1 percent. Texas ranked as the third most populous state in the nation in 1980. Between 1980 and 1982 alone, the U.S. Bureau of the Census estimated that the state added over one million people.

Since 1970, the Texas birth rate has grown faster than the U.S. birth rate. In 1980, Texas had a live birth rate of 19.2 percent, compared to a 15.9 percent rate for the U.S. Substantial immigration continues to add to the state's population.

Despite the overall growth in state population and increases in the number of physicians, there are many areas of the state where physical access to care remains a problem. Physicians remain unlikely to settle and establish a practice in areas that are poor and isolated.

Rural hospitals are in jeopardy of closing in many areas. Generally, rural areas are poorer than other areas of the state, and historically rural hospitals have had low occupancy rates. High fixed costs, continued declines in occupancy, and difficulties in attracting and retaining staff threaten the viability of rural hospitals. Rural hospital

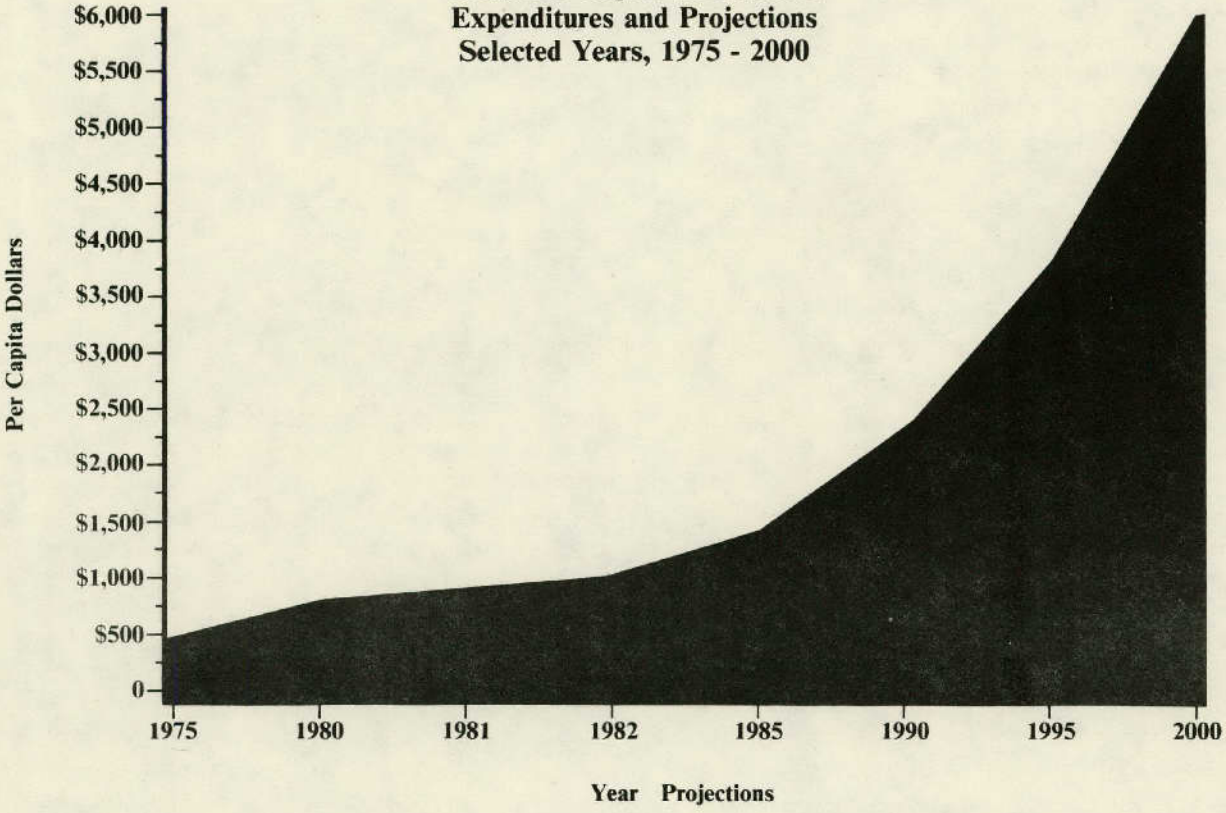
Texas Health Care Expenditures and Projections Selected Years, 1975 - 2000



Trend assumes 15.3% rate of annual growth.

SOURCE: Bureau of State Health Planning and Resource Development, Texas Department of Health, June 1984.

Texas Per Capita Health Care Expenditures and Projections Selected Years, 1975 - 2000



Trend assumes 15.3% rate of annual growth.

SOURCE: Bureau of State Health Planning and Resource Development, Texas Department of Health, June 1984.

closings can reduce access for all individuals who live in or who are travelling through rural areas.

In 1980, one-third of the Texas population was Hispanic, Black, or other minority group members. Individuals of Spanish ancestry make up 21 percent of the state's population, while that group is only 6.4 percent of the nation's total population. Over 50 percent of the state's Hispanics live along the Gulf or in South Central Texas, while the black population is concentrated in the Southeast and North Central areas.

Minority groups have a disproportionately higher share of disease and disability. Despite the growing and changing Texas economy, they continue to be more likely to be uninsured and at risk.

Per capita personal income has increased over 11 percent each year from 1977 to 1982. Texas now has the 17th highest per capita income among the 50 states.

However, there are still large pockets of unemployment along the U.S.-Mexico border. Roughly 30 percent of the regional population along the U.S.-Mexico border still lives in poverty.

While overall economic growth has been hampered by the slump in the $40 billion Texas oil economy, the coastal region of Texas has experienced especially sharp levels of unemployment because of declines in the oil industry. Approximately 40 percent of the unemployment in this region is in petroleum-related industry.

Meanwhile, falling agricultural production in the Plains area, exacerbated by the recent drought, has reduced employment there as well. Finally, the devaluation of the peso has greatly enhanced the financial crisis and contributed to the economic problems along the border.

Individuals who are poor and individuals who are unemployed and have lost health insurance will continue to exert pressure on the health care system and on state and local government for assistance in meeting basic health care needs.

Recommendations

Recommendations

The state leadership which appointed the Task Force members asked them to address four main issues with regard to indigent health care: (1) the scope of services to be provided; (2) the eligibility criteria for receiving care; (3) the administrative structure for providing and financing services; and (4) the actual methods of financing health care for the poor and uninsured. The recommendations which follow were initially proposed by one or more of the four subcommittees of the Task Force assigned to address each of these four main issues. The Task Force Executive Committee took final responsibility for integrating the various subcommittee proposals and establishing priorities for the recommendations set out below.

The recommendations address each of the four main issues included in the Task Force charge. The types of services to be provided to indigent persons are identified, defined, and prioritized. A specific minimum eligibility standard to be used by counties is proposed, as well as a general definition of medical indigency to be used by hospitals in classifying patients' status as charity care. Responsibility for the administration and financing of indigent care is allocated among various levels of government and types of providers. This approach to allocating responsibility among all the major parties involved in the provision of health care in Texas reflects the Task Force's attempt to work within the current system while proposing measures to reduce the inequities in that system.

Certain aspects of the Task Force recommendations involve program expansions which can be implemented at a statewide level, for example, the proposed expansion in Medicaid eligibility and the administration of perinatal services. Most of the proposals provide either a structure for allocating responsibilities or a suggested priority for the types of services to offer. The actual implementation of these proposals will depend upon local and regional initiatives designed to meet the specific needs of each area of the state.

The Task Force recommendations are presented in three sections reflecting the three major issue areas identified by the Executive Committee. The first section includes proposals concerning the allocation of responsibilities for providing and financing indigent health services. The current situation of statutory ambiguities and inequities among providers and units of government must be remedied. More attention can then be directed toward making appropriate services available rather than diverted into litigation.

The second grouping of recommendations reflects the Task Force's attempt to identify priorities for those services which should be included in the responsibilities of governments and providers. Overall types of services (e.g., Maternity Care, Primary Care) are given a priority ordering, as well as the specific activities comprising those overall categories (e.g., prenatal care, labor and delivery). This prioritization acknowledges the limitations of tax-supported programs to provide for the full range of services for all those persons who have inadequate resources to cover the costs of their health care. These priorities are to serve as guidelines for decision makers for including particular services in the responsibilities of governments and providers as funding becomes available.

The final section includes proposals for addressing issues requiring further consideration. These issues have been identified because of their potential for improving the efficiency of delivering health care services to the poor and uninsured. They primarily involve ways of maximizing the utilization and coordination of all available resources.

Section 1. Allocating County, State, Hospital, and Individual Responsibilities for Indigent Health Care

A. County Responsibilities

RECOMMENDATION 1: CLARIFYING LOCAL GOVERNMENT RESPONSIBILITIES FOR INDIGENT HEALTH CARE

THE STATE SHOULD CLARIFY THE RESPONSIBILITIES OF COUNTIES AND HOSPITAL DISTRICTS FOR PROVIDING INDIGENT HEALTH CARE BY ESTABLISHING MINIMUM ELIGIBILITY STANDARDS, PROCEDURES FOR ALLOCATING COSTS FOR NONRESIDENT PATIENTS, TOTAL EXPENDITURE LIMITS FOR COUNTIES, AND STANDARDS FOR MAINTENANCE OF CURRENT EFFORT.

One of the most difficult and politically significant issues surrounding indigent care is county responsibility.

The 254 counties within the state range in population from 93 people to over three million people, and as vastly different as their demographics is their ability to provide care.

A number of factors affect county responsibility for indigent care. Counties which have established hospital districts generally are responsible for providing hospital and medical care for needy inhabitants of that county. Counties with a county hospital have the responsibility for individuals admitted to the hospital who are unable to pay for their own care.

County commissioners are responsible for sending the indigent sick to the county hospital. Counties without a hospital district or a county hospital are responsible for providing "for the support of paupers and such idiots and lunatics as cannot be admitted to the lunatic asylum, residents of their county who are unable to support themselves."

Support has been construed to include the delivery of medical services. However, there are no specific guidelines in Texas law defining "pauper" or "indigent" or the degree of medical care that should be provided. As a result, practices vary from county to county, giving rise to a number of disputes between counties.

The federal courts have determined that the scope and extent of entitlement of resident indigents to medical care is uncertain, and, pending some clarifying interpretation by state courts, abstension by the federal courts is appropriate.

Following is a suggested outline for clarifying the responsibility of local governments to provide indigent health care:

I. Minimum County or Hospital District Responsibility:

Eligibility:

- Counties should, at a minimum, be responsible for persons meeting AFDC-Medicaid financial eligibility standards (e.g., current income standards are $167/month for a mother with two children; $211/month for a two-parent family of four; current AFDC-Medicaid income standards are approximately 25 percent of the federal poverty standard of $850/month for a family of four; AFDC-Medicaid asset requirements in Texas include exemptions for homestead and $1,500 value of auto and limit other resources to $1,000).
- Counties should be payors of last resort, covering persons not otherwise eligible for state, federal, or other health care assistance.
- Counties may choose to have less restrictive eligibility standards.

Services:

- Counties should be responsible for the costs of primary, secondary, and tertiary care for eligible residents not otherwise provided by state, federal, or other health care programs.

Administration:

- Counties and districts are authorized to provide services through county facilities, contracts with private providers or other counties, or through purchase of insurance for county residents.
- Eligibility determinations may be made by TDHR staff for those counties requesting such assistance.
- Counties and districts may affiliate to administer regional programs and may create regional health districts for purposes of administration.

II. Out-of-County Care:

- Liability for residents receiving care in another county should be limited to:

1. persons certified as eligible (using their resident county's income/assets standards),

2. care not available in resident county or inappropriate (emergency), and
3. payment rate limits as specified below.

- A statewide definition of county residency should be established that is consistent with federal court rulings regarding intent to reside.
- Disputes concerning residency should be determined by the Attorney General of Texas.

III. Maximum County Liability Payment Rates:

- Maximum reimbursement rates to be paid by counties should be equal to Medicaid standards.
- Counties contracting for services may negotiate with providers for rates below Medicaid payment standards.

Per case limits:

- County liability should be limited to payment for 30 days of hospitalization per year or $30,000 per year per eligible resident, whichever is reached first.

Total expenditure limits:

- A cap on total county expenditures should be established equal to 10 percent of each county's general revenue tax levy. Capped expenditures would include health care benefits provided to county residents meeting the statewide minimum income/assets eligibility standards. (State funds should be used for the care of eligibles after the county expenditure limit is reached.)
- County expenditures for indigent care should be exempted from the notice and rollback requirements of the "truth-in-taxation" provisions of state law (Chapter 26, Texas Property Code).
- Counties may choose to exceed the limit on total expenditures.

IV. Maintenance of Effort:

- Counties, hospital districts, or cities (which have assumed the responsibility for indigent health care) must in future years maintain at least their current level of expenditures for indigent health care attributable to their currently eligible residents. Reductions in level of expenditures for currently eligible residents would be appropriate if such persons become covered by expanded state or federal programs. The current maintenance of effort level of expenditures should be adjusted by a medical price index for future years.

RECOMMENDATION 2: IMPROVED LOCAL GOVERNMENT REPORTING AND ACCOUNTING FOR INDIGENT HEALTH CARE EXPENDITURES

THE STATE SHOULD ESTABLISH UNIFORM REPORTING AND ACCOUNTING STANDARDS FOR USE BY COUNTIES IN REPORTING INDIGENT HEALTH CARE EXPENDITURES. REPRESENTATIVES FROM COUNTIES SHOULD PARTICIPATE IN THE DEVELOPMENT OF THESE REQUIREMENTS.

There is great variation in accounting and financial reporting practices within Texas counties. Many county records are incomplete and cannot be compared with those of other counties. For example, ambulance services, medical care for inmates, and mental health/mental retardation services are often included as indigent medical care in some county budgets, while they are not in others. Also, there is no routine collection of information at the state level about county expenditures on indigent health care. As a result, there is no readily accessible source of information for state policy makers about how counties are performing and what they are spending on indigent health care.

The state should require uniform accounting and reporting standards for county expenditures for indigent medical care. County reporting should clearly differentiate sources of revenue for indigent care (i.e., county general revenue funds, hospital district tax levies, and federal general revenue sharing money). The accounting and reporting system should identify the types of expenditures, including information on services provided and individuals receiving service.

A system of reporting and accounting by Texas counties would permit the state to assess the level of need and expenditure effort for indigent care among counties.

The system would have a number of uses for state and local governments, including:

- Assessing levels of need and expenditure efforts by counties;
- Measuring the impact of obligations to provide

indigent health care on county budgets;

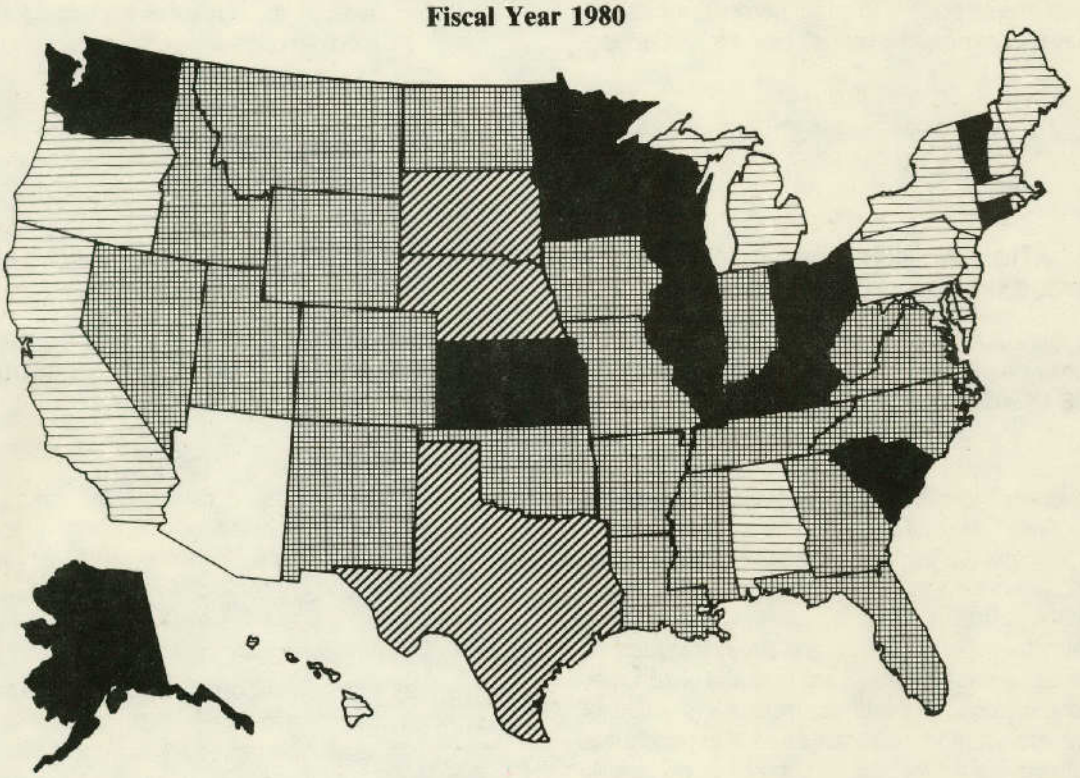
- Evaluating the effects of state policy on county expenditures;
- Identifying areas of financial stress due to indigent health care obligation;
- Monitoring maintenance of effort requirements;
- Determining possible state obligations to pay for indigent health care; and
- Establishing objective information which can be used for future policy development.

B. State Responsibilities

Medicaid

The Medicaid program, authorized under Title XIX of the Social Security Act, is the major health care program for the poor in the United States. Medicaid is financed by state and federal matching funds. The program makes direct vendor reimbursements to participating public and private providers. States administer the program, and each state makes choices within federal guidelines about the eligibility levels and services provided. In Texas the

People Below the Poverty Level Receiving Medicaid Assistance
Fiscal Year 1980



Assistance Levels

- 0 to 25%
- 26% to 41%
- 42% to 60%
- 61% to 100%

Note: Arizona had no federal Medicaid program in 1980.

SOURCE: *Analysis of State Medicaid Program Characteristics 1982*, La Jolla Management Corporation, December 1982.

program is administered by the Department of Human Resources.

States must cover the "categorically needy," which includes individuals receiving assistance from the Aid to Families with Dependent Children (AFDC) program or the federal Supplemental Security Income (SSI) program which serves the aged, blind, and disabled.

States must provide certain required services to the categorically needy, including inpatient and outpatient hospital services, laboratory and X-ray services, early and periodic screening, diagnosis and treatment (EPSDT) for individuals under age 21, family planning services, physician services, skilled nursing facility (SNF) services for individuals over age 21, home health services for individuals entitled to SNF services, rural health clinic services, certified nurse midwife services to the extent allowed under state law, and transportation.

States have options to provide eligibility to other groups described in federal law. States may cover the "medically needy," which includes individuals who are aged, blind, or disabled or families with dependent children whose incomes after deducting incurred medical expenses are below 133 percent of the state's AFDC payment standard. At the minimum, a medically needy program must cover pregnant women and children.

Texas has been one of the most conservative states in the nation in its eligibility for Medicaid. The Texas Medicaid program covers about 25 percent of the state's poverty population, compared to an average of 53 percent of the poverty population for all states participating in Medicaid. Historically the Texas program has not covered major optional coverage groups, including the medically needy, as allowed under federal law.

RECOMMENDATION 3: EXPANSIONS OF MEDICAID PROGRAM ELIGIBILITY

THE LEGISLATURE SHOULD APPROPRIATE FUNDS TO EXPAND MEDICAID IN TEXAS TO NEW GROUPS OF ELIGIBLES, WITH THE GOAL OF BROADENING THE BASE OF COVERAGE AND INCREASING THE INCOME ELIGIBILITY CRITERIA TO 50 PERCENT OF POVERTY BY 1989.

During the course of its deliberations, the Task Force proposed some limited expansions of the Medicaid program to cover more pregnant women and children because of the cost effectiveness of those expansions. In addition, the Task Force made recommendations about the federal funding target system for Medicaid, which unfairly penalized Texas for its historically conservative program.

This year Congress passed and the President signed the Deficit Reduction Act (P.L. 98-369) which mandated expansions of Medicaid eligibility similar to those proposed by the Department of Human Resources and the Task Force on Indigent Health Care. The act eliminated the federal funding target system as well.

These federal changes were influenced by the direction established by the Task Force and were made possible by support from the Texas state leadership and the congressional delegation. The changes are a significant step in addressing some of the problems of medical indigency in Texas. Additional groups covered by the Texas Medicaid program as of October 1, 1984, include:

- Pregnant women who would be eligible for Aid to Families with Dependent Children (AFDC) on the birth of the child, as soon as the pregnancy is medically verified;
- Married pregnant women who meet AFDC financial guidelines;
- Children in two-parent families who meet AFDC financial guidelines (Medicaid has covered primarily single-parent families in the past).

In addition, DHR is assessing the feasibility of extending Medicaid to medically needy pregnant women and children as proposed by the Task Force.

Expansion of Medicaid eligibility has several beneficial effects:

- It covers individuals of the highest need, as identified by the Task Force;
- It increases the number of people who have some form of health insurance coverage and therefore improves access to service;
- It provides comprehensive and cost-effective services, including preventive services for children;
- It decreases the number of individuals who must rely on local health care programs and reduces the burden of funding programs through local ad valorem taxation;
- It reduces the fiscal strain on providers of charity care; and
- It improves the use of federal funds in the state.

An increase in the AFDC payment level raises the maximum income eligibility requirement for AFDC, and,

consequently, for Medicaid eligibility. This results in more poor Texans having Medicaid eligibility.

Additional groups which should be considered for Medicaid eligibility include unemployed parents with incomes below AFDC eligibility levels, medically needy unemployed parents, and individuals who would be eligible for AFDC if the state expanded AFDC as broadly as allowed under federal law.

Despite these proposed expansions of Medicaid, many poor and sick individuals cannot be covered by the program because they do not fit into one of the allowable coverage groups as defined by federal law. The largest groups of ineligibles excluded by federal law are adults ages 21-64 who are not disabled or parents of minor children, non-disabled parents who do not meet the AFDC definition of unemployed, and undocumented aliens.

The Medicaid program should test the use of alternate delivery systems such as HMOs and case management systems in the delivery of health care services to indigents. These alternatives offer the potential for controlling the costs of health care in the long term because of their emphasis on prevention and education and the creation of incentives to reduce the inappropriate use of services.

RECOMMENDATION 4: IMPLEMENTATION OF PERINATAL PLAN FOR TEXAS

THE STATE SHOULD INVEST IN THE WELL-BEING OF INDIGENT PREGNANT WOMEN AND CHILDREN BY IMPLEMENTING A PERINATAL PLAN FOR TEXAS SIMILAR TO THE ONE PROPOSED BY THE DEPARTMENT OF HEALTH.

Under the plan, the state would provide, purchase, or fund critically needed services for pregnant women who are not eligible for Medicaid and who lack the financial resources to pay for needed services. The perinatal plan reflects key elements of the maternity services priorities recommended by the Task Force.

Poor women and children particularly are likely to be uninsured and to face barriers to receiving the care they need. Indigent pregnant women also have substantial health care needs; they have higher rates of low-weight infants at birth than do nonindigents.

When fully implemented and coordinated, the perinatal plan for Texas will improve care for pregnant women and their infants. The plan covers women needing normal care, as well as those with high-risk problems. The plan addresses the following areas:

- Comprehensive prenatal care;
- A well-defined, coordinated, and multilevel network of maternity and infant hospital services;
- Organized perinatal continuing education for health care workers;
- Accessible transportation to and from levels of care for women and infants;
- Coordinated public education and support services for pregnant women; and
- Integrated use of public and private sector providers of maternity and infant care.

The services reflect key elements of the maternity services priorities recommended by the Task Force.

Implementation of the plan should result in major gains within five years, including:

- Reduction of preventable maternal deaths by 50 percent;
- Reduction of neonatal mortality and fetal mortality (stillbirths) by 25 percent;
- Reduction of low-birth-weight infant rate by 20 percent;
- Reduction of repeat pregnancies of adolescents by 35 to 40 percent; and
- Reduction of unchosen out-of-hospital births to less than 5,000 per year.

RECOMMENDATION 5: STATE MONITORING AND TECHNICAL ASSISTANCE

THE STATE SHOULD MONITOR COUNTY EFFORTS TO PROVIDE INDIGENT CARE AND PROVIDE TECHNICAL ASSISTANCE TO COUNTIES.

Monitoring County Efforts:

The Texas Department of Health should be responsible for monitoring county arrangements for meeting minimum requirements for providing indigent care.

Technical Assistance to Counties:

The Texas Department of Human Resources should provide assistance to counties in certifying individuals as eligible for county programs using AFDC-Medicaid standards.

The Texas Department of Health should provide assistance to counties in: (1) determining health care needs and levels of care available by county and region; and (2) identifying regional referral facilities for secondary and tertiary care.

RECOMMENDATION 6: ADDITIONAL STATE FUNDS

THE STATE SHOULD REIMBURSE PROVIDERS FOR ADDITIONAL ELIGIBLE RESIDENTS AFTER A COUNTY HAS MET ITS TOTAL EXPENDITURE LIMIT.

THE STATE SHOULD OFFER FINANCIAL INCENTIVE GRANTS TO COUNTIES TO ENCOURAGE DEVELOPMENT OF COMPREHENSIVE SERVICE DELIVERY SYSTEMS.

Counties Exceeding Total Expenditure Limits:

Recommendation 1 proposes to limit the total liability of any county for indigent care to 10 percent of its general revenue tax levy. To ensure the viability of a minimum statewide definition of eligibility, the state should be prepared to reimburse providers serving eligible residents of counties which have reached their total expenditure limits.

Reimbursement by the state for such persons would be limited to persons meeting the minimum county eligibility standard proposed above (AFDC-Medicaid financial standards). The state would pay the then-current Medicaid payment rates and would have the same per case expenditure limits as proposed for counties (30 days of hospitalization per year or $30,000 per year per eligible, whichever is reached first).

The state's back-up to county responsibilities will guarantee eligibility for all Texans below the AFDC-Medicaid income and asset standards. Those persons not categorically eligible for Medicaid for whom their county of residence has reached its total expenditure limit will be covered by additional state funds.

Incentive Grants for Comprehensive Delivery Systems:

The state should provide additional funds to be used as incentive grants to counties to encourage the development of comprehensive health care service systems for their residents. Only those counties meeting their minimum indigent care responsibilities would be eligible. In addition, the county would have to demonstrate additional expenditures and planning efforts in developing a system of preventive and primary care services with the potential to reduce unnecessary and costly hospital utilization. This system should use both public and private resources to finance and deliver care.

C. Hospital Responsibilities

A substantial amount of uncompensated care (including charity care and bad debt) and undercompensated care (contractual allowances) is provided by hospitals in Texas. However, there is no truly uncompensated care provided. Hospitals shift costs incurred by serving patients unable to pay to those patients who can pay, and some of these costs eventually result in higher insurance premiums. Other costs are covered by local taxpayers.

Currently, the burden of paying for hospital care for the medically indigent falls unevenly on different types of hospitals, their paying patients, and local taxpayers. Public hospitals provide the greatest portion of indigent care, followed by not-for-profit hospitals and by proprietary hospitals. Although public hospitals receive local tax support, it falls far short of the total uncompensated care provided by such hospitals. Among not-for-profit hospitals there is wide variation in the proportion of uncompensated care provided. To some extent, the volume of indigent care depends on the location of the hospital and its accessibility to poor people.

The health care market is becoming increasingly competitive and sensitive to price. Competition strategies have been proposed to hold back the growth rate of health care costs. However, there can be no competition

in the health care system if some providers carry a disproportionately heavy burden for indigent care because of institutional mission or community obligation. Hospitals making a lesser effort to serve indigents can have a price advantage in the health care market.

To remain competitive, providers faced with greater costs because of a willingness to serve the indigent may have to either reduce their commitment to serve or jeopardize the financial viability of their institution. The uneven distribution of the burden of serving the medically indigent and growing public concern about the cost of health care create strong incentives for hospitals to limit access to care by indigents.

James Bole, executive director at St. Elizabeth Hospital in Beaumont, told the panel that the total cost shift, including indigent health care and bad debts, amounted to 14 percent of the hospital's gross revenues in 1982, 19.9 percent in 1983, and will amount to an estimated 21.3 percent in the 1983-84 fiscal year.

Bole noted that this translates into $8.16 million in 1982, $14.12 million in 1983, and an estimated $17.17 million in fiscal year 1984.

Many other hospitals around the state face a similar situation. For example, at John Peter Smith Hospital in Fort Worth, non-county residents ran up hospital bills of more than $2.5 million in 1982. The hospital collected about $700,000 and wrote off the rest as bad debt.

In addition to the statutory responsibilities of county hospitals and hospital district facilities, there is precedent for requiring private hospitals to provide a certain amount of charity care. All general hospitals in the state are prohibited from denying emergency services to an individual who is unable to pay for the services received. Criminal penalties may be imposed for failure to comply with this law. Some private hospitals are obligated to provide charity care in return for federal construction funds pursuant to the Hill-Burton program. Tax-exempt status for nonprofit hospitals in Texas is conditioned upon "providing medical care without regard to the beneficiaries' ability to pay." This latter provision does not specify the amount of free care to be provided.

A recent Texas poll sponsored by Harte-Hanks Communications, Inc., and conducted by the Public Policy Resources Laboratory at Texas A&M University revealed that 79 percent of those asked supported a law to require all hospitals in Texas to give some poor people free medical care or reduced charges on their hospital bills.

RECOMMENDATION 7: RESPONSIBILITIES OF ALL HOSPITALS TO SUPPORT INDIGENT CARE

AS A CONDITION OF LICENSING AND RELICENSING, ALL HOSPITALS IN TEXAS SHOULD PARTICIPATE IN THE PROVISION OF HEALTH CARE TO THE MEDICALLY INDIGENT UNDER A MINIMUM FAIR-SHARE FORMULA. THIS HOSPITAL OBLIGATION SHOULD BE DISCHARGED BY PROVIDING A MINIMUM AMOUNT OF DIRECT SERVICES TO INDIGENTS.

The Task Force recommendations concerning county and state responsibilities would, if implemented, provide substantial new sources of revenue to hospitals in Texas.

However, local and state government is not currently capable of financing the total amount of free care and contractural allowances experienced by hospitals in the state. In order to maintain the competitive position and financial viability of all types of hospitals, the Task Force proposes that the remaining uncompensated care be more equitably shared. This recommendation is also intended to provide greater geographical access to hospital care for indigent Texans. Eligible individuals could receive hospital care closer to their homes rather than travelling great distances to a public hospital or private charity hospital willing to treat them.

The following are suggested characteristics of any fair-share formula:

- The amount of care to be provided should be determined as a percentage of operating budget or gross revenue. The Task Force has not proposed a specific percentage amount in order to permit further input from various sectors of the hospital industry. The formula should be similar to the Hill-Burton obligation, i.e., three percent or less of total operating expenses (less Medicaid and Medicare reimbursements). Hospitals currently meeting their Hill-Burton obligations would be considered already in compliance.
- The formula requirement should be adjusted according to hospital ownership to reflect local property taxes paid by for-profit hospitals.
- Only the costs of direct care to eligible patients should be credited to the service requirement, not the difference between a hospital's price and reimbursement from third-party payors (contractural allowances).
- Costs of care to persons meeting the following income and asset standards may be credited

to the service requirement: (1) family income at or below the federal poverty guidelines (e.g., $850/mo. for a family of four); and (2) limits on assets as specified in the AFDC-Medicaid program in Texas (i.e., exemptions for homestead and $1,500 value of auto and a limit on other resources of $1,000).

- The state should consider requiring hospitals not meeting their minimum obligation to pay a penalty equivalent to the unfulfilled amount (as a percentage of applicable revenues) to a state fund. Such funds could be redistributed to hospitals exceeding their required amount of free care.

RECOMMENDATION 8: USE OF THE CERTIFICATE OF NEED PROCESS

THE CERTIFICATE OF NEED PROCESS SHOULD BE MODIFIED TO REQUIRE A MINIMUM LEVEL OF INDIGENT CARE TO BE PROVIDED. THIS MINIMUM LEVEL SHOULD BE BASED ON COMMUNITY NEED AND SHOULD ENSURE CONTINUED ACCESS TO CARE BY INDIGENTS.

State law (Article 4418h) requires that Certificate of Need reviews performed by the Texas Health Facilities Commission provide consideration of the special requirements of facilities that provide substantial services to indigents, persons residing outside the immediate medical service area of the facility, and rural or sparsely populated areas.

Federal and state certificate of need legislation aims to ensure that a "need" exists for proposed new hospitals, nursing homes or other health care facilities, and any new institutional health services and major capital expenditures. Need is demonstrated through an application review process that examines health care requirements of the local community, the target population served by the proposed project, and economic feasibility of the application. Other application criteria include an analysis of the relation to existing or approved services and facilities, consideration of less costly or more effective alternatives, personnel for staffing the project, and relationship to the state health plan.

A Certificate of Need must be applied for and granted before an obligation by or on behalf of a health care facility of capital expenditures over $600,000 ($400,000 for major medical equipment), the addition of over 10 beds or 10 percent of the facility's total, or the offering of new institutional health services.

Under current law, the Commission does not have the authority to require that a facility offer indigent care. Facility acquisitions (by purchase or lease), which may affect the level of indigent care offered, are in effect exempt from Certificate of Need review. The Texas Health Facilities Commission does have the ability to consider an applicant's "track record" in providing indigent care as the agency makes its review decisions to approve or deny projects.

Under this proposal, the Texas Health Facilities Commission would have a specific basis for denying applications which would adversely affect the provision of indigent care and for approving applications which would improve access to indigent care. This proposal would require that some minimum "acceptable" level of indigent care be established, either statutorily or in the Certificate of Need regulations.

Several states have enacted legislation or established agency regulations that place some responsibility on hospitals and nursing homes to provide indigent care as part of the Certificate of Need process. Examples of these requirements from other states include:

- Georgia requires a three percent gross revenue provision for indigent care for approval of sale of any public hospital sold to private concern;
- New Jersey mandates nursing homes to set aside some beds for indigents;
- Washington, D.C., has Certificate of Need criteria that have the effect of requiring compliance with Hill-Burton free-care and community service obligations for all facilities with an operating budget over $75,000.

Several other states also have begun to consider legislative proposals that involve using the Certificate of Need process to ensure access to care by indigents.

Implementation of a similar approach in Texas would help to ensure that facilities providing indigent health care are recognized and rewarded for their efforts.

RECOMMENDATION 9: IMPROVED REPORTING AND ACCOUNTING FOR UNCOMPENSATED CARE IN HOSPITALS

THE STATE SHOULD ESTABLISH REPORTING AND ACCOUNTING REQUIREMENTS FOR ALL TEXAS HOSPITALS ON UNCOMPENSATED CARE. HOSPITAL REPORTING REQUIREMENTS SHOULD BE MANDATORY. HOSPITAL REPRESENTATIVES SHOULD PARTICIPATE IN THE DEVELOPMENT OF THE REQUIREMENTS.

Currently there is limited information at the state level on the effects on hospitals of serving indigents. State law requires the Department of Health to collect and disseminate data necessary for effective planning of health care services and facilities. Because there are no sanctions for noncompliance with data collection efforts and the cost of collecting information can be significant, the data collected are those that providers have been willing to share.

Texas hospitals are not required to report information on their financial status, which includes the amount, cost, and type of uncompensated care provided. The lack of standard definitions for charity care, bad debt, and uncompensated care for reporting purposes and the lack of information on costs, revenues, indigents served, and services provided makes it difficult to assess the impact of uncompensated care on hospitals.

A system of standardized reporting is necessary to ensure proper accountability for any public funds appropriated for indigent care. Other uses of a standardized reporting and accounting system could include:

- Assessing the impact of indigent care on hospital financial health;
- Determining and monitoring hospital obligations to deliver indigent health care services;
- Evaluating effects of state and local policies and expenditures on hospitals;
- Analysis of morbidity data and costs to develop future policy recommendations; and
- Evaluating costs of hospital care and changes in those costs.

RECOMMENDATION 10: APPROPRIATE TRANSFER OF PATIENTS

THE TEXAS DEPARTMENT OF HEALTH SHOULD BE GIVEN STATUTORY RESPONSIBILITY TO ESTABLISH POLICIES REGULATING INTERHOSPITAL TRANSFERS OF PATIENTS TO ENSURE TRANSFERS ARE MEDICALLY APPROPRIATE. A SYSTEM OF SANCTIONS TO ENFORCE TRANSFER RESPONSIBILITIES SHOULD BE DEVELOPED.

This policy should ensure that patients who enter a hospital on an emergency basis receive appropriate medical attention and care within the capability of the facility before they are transferred to another facility. State policy should define an emergency, stabilization standards, methods of notification of the receiving facility, acceptance and delivery of medical records of patient transfers, and personnel and equipment needed in transit. Transfer policy should be based on what is medically appropriate for the patient and not on the shifting of nonreimbursable services and unprofitable patients to certain institutions.

Currently Texas state law]Art. 4438a, Tex. Rev. Civ. Stat. Ann. (1983)[requires that general hospitals must provide emergency service if available at the hospital, irrespective of a patient's ability to pay. Criminal penalties may be imposed for failure to comply with the law. In some cases it is necessary to transfer a patient from one hospital to another because a hospital does not have the capability to accept and appropriately treat the individual.

The Task Force heard reports of transfers without adequate stabilization, which jeopardized the lives of the individuals transferred. The Task Force also heard of transfers which were not medically necessary but which occurred because of an individual's loss or lack of insurance benefits. The indigent suffer unnecessary health risks because of medically inappropriate transfers. The transferring facility may claim that it does not have

Medical Center Hospital officials charge area hospitals are dumping ailing patients on the Bexar County Hospital District when they find the patients have no money or no other means to pay.

The dumping of needy patients at Medical Center Hospital will cost Bexar County taxpayers about $2 million in 1983.

If the high rate of transfers continues, that figure could soar to $3 million by the end of 1984, Bexar County hospital officials predict.

Bexar County Hospital District officials contend that patients at some hospital emergency rooms are rushed to the county medical facility if they fail to pass a "Wallet Biopsy" in the business office of the first hospital.

Other patients, the officials charge, are kept at the admitting hospital until they run out of Medicare or private funds, and then are transferred.

the proper capability to care for the patient and therefore it must send the patient to another facility.

To enforce transfer policies, there should be a system of sanctions which includes licensing suspension and financial penalties. The policies on transfers should be developed with input from hospitals and other affected providers. Once established, such policies should be added to all hospital bylaws as a requirement of licensure.

D. Individual Responsibility

RECOMMENDATION 11: INDIVIDUAL RESPONSIBILITY FOR THE COST OF CARE

BENEFICIARIES OF ANY INDIGENT HEALTH CARE PROGRAM SHOULD BE EXPECTED TO CONTRIBUTE TO THE COST OF THEIR CARE TO THE EXTENT THEY ARE ABLE TO DO SO.

HOMESTEAD AND OTHER EXEMPT PROPERTY SHALL NOT DISQUALIFY A MEDICALLY INDIGENT PERSON FROM RECEIVING NECESSARY MEDICAL CARE, BUT SUCH PROPERTY SHALL REMAIN SUBJECT TO LIEN AND FORECLOSURE FOR AT LEAST PARTIAL REPAYMENT OF MEDICAL CARE COSTS UPON DISPOSITION.

The Task Force believes in the importance of requiring recipients of indigent health care services to share in the cost of their care, preferably by paying a copayment for services rendered.

In public hearing testimony, providers reported that requirements of nominal cash copayments have been more effective than billing for retrieval of some share of the care costs. Many providers—including providers of mental health services—and consumers see cost sharing as a means of maintaining patient dignity and self-esteem.

Studies of varying types of insurance programs have indicated that copayments may reduce unnecessary utilization of health care services. For lowest income groups, cost sharing must be minimal so as not to prevent persons from seeking needed care. Above the lowest incomes, copayments could be determined according to the patient's ability to pay, based on income and family size. If copayments are set sufficiently high, they may be used to encourage insured persons to maintain their private health insurance coverage. Although certain federal programs, such as Medicaid and Maternal and Child Health Services, limit the use of copayments for certain income-eligible persons, waivers to permit copayments could be sought.

There is sentiment on the Task Force that medically indigent persons should not have to liquidate their basic assets, such as a homestead or auto, in order to be eligible to receive assistance with their health care costs. However, some persons may not have sufficient current income, yet may have property of substantial value. Others may potentially have substantial future incomes and may be willing and able to make partial payments over time. Still others may have family members who should be responsible for their relative's care. The Task Force therefore recommends that the state consider legislation to clarify the responsibilities of family members and to specify that a lien may be exercised at the time an individual dies or transfers his property. Persons who transfer valuable property for less than its market value within two years of applying for health care assistance should be denied eligibility for charity services.

E. Federal Responsibilities

RECOMMENDATION 12: RESPONSIVE FEDERAL POLICIES

THE STATE SHOULD ASSUME AN AGGRESSIVE POSTURE RELATIVE TO THE FEDERAL GOVERNMENT BY POINTING OUT THE RAMIFICATIONS OF FEDERAL POLICIES FOR THE PROBLEMS OF MEDICAL INDIGENCY IN TEXAS AND BY PURSUING WAIVERS OR CHANGES TO THOSE POLICIES WHICH ARE NOT RESPONSIVE TO THE NEEDS OF TEXAS.

The federal government has a major role in the health care system in Texas through many activities which directly and indirectly affect the problems of medical indigency. For example, the federal government is a major purchaser of hospital services through the Medicare program, and changes to Medicare

reimbusement systems affect virtually all providers in the state. Medicaid, the largest health program for the poor in the country, is jointly funded by the federal and the state government. States administer the program within guidelines established by federal law and regulation. The federal government funds providers directly, such as Community Health Centers, and it provides block grant funds for programs such as Maternal and Child Health Services. Federal government activities also include setting standards for participation of facilities in programs and health planning functions.

This broad federal role provides substantial support for the care of indigents in Texas. However, there are some federal policies and requirements which do not fully recognize the special needs of Texas. For example, the Task Force opposed the Medicaid-funding target system, which discriminated against Texas for its historically restrictive eligibility and benefits levels in Medicaid. Past cutbacks in federal funding for programs such as Community Health Centers and other block grants have had a profound impact on the indigent of Texas.

The Task Force has identified a number of areas of concern in which federal policy constrains the development of appropriate solutions, including:

- the continued viability of rural hospitals;
- family and individual responsibility for the costs of care;
- categorical restrictions in Medicaid which exclude many indigents from eligibility;
- recognition of federal responsibility and support for Texas-Mexico border health problems.

The Task Force believes the state should make known the special needs of indigent Texans on a consistent and regular basis and should pursue changes to federal policies to meet these needs.

Section 2. Prioritizing the Types of Services to be Provided

A. Health for the Future: Care for Mother and Child

Maternity services has been identified as the top priority health care service for indigents in Texas.

Provision of maternity services can reduce the need for future medical services for both the mother and child.

RECOMMENDATION 13: DEFINITION OF MATERNITY CARE SERVICES

A RANGE OF MATERNITY CARE SERVICES SHOULD BE MADE AVAILABLE TO MEDICALLY INDIGENT PERSONS OF TEXAS.

Maternity services are defined as the following types of services:

1. early pregnancy/diagnosis and prenatal care
2. labor and delivery, newborn care, and neonatology
3. family planning and education for birth and parenting
4. postnatal care
5. health screening
6. transportation
7. access to counseling including genetic counseling
8. dental services

Maternity care services should be defined consistently to facilitate program planning, coordination and evaluation, legislative enactment, regulatory promulgation, reporting, and health care delivery. The result of improved maternity care services would be the reduction of preventable maternal deaths, neonatal and fetal morbidity and mortality, the rate of low-birth-weight infants, the rate of handicapping conditions, the rate of adolescent and repeat adolescent pregnancies, and the number of out-of-hospital births not attended by a licensed and/or certified health professional.

Initially, concentration should be focused on funding, provision of, and access to maternity care services in the order as listed above.

In October of 1984, the Brownsville Community Health Clinic predicted an increase in the number of infant deaths after the federal jobs bill—which funded prenatal care for improverished mothers—expired at the end of September.

Unfortunately, the clinic's fears came true even sooner.

One baby died during childbirth and doctors at the clinic attributed the death to the mother's inability to pay for medical care.

Because she could afford no other treatment, the mother went to an unlicensed partera, or midwife. When the midwife realized the mother needed additional care, she took her to Valley Community Hospital. But by then it was too late, and the baby was dead.

And for those infants who do make it through childbirth, often their parents cannot afford to give them the care they need.

In one case, a baby needed to stay in the hospital for observation for a few extra days after childbirth because of blood sugar problems. But because the parents could not afford the cost of hospital care, which could run $1,000 or more for a normal childbirth, the parents took the baby home.

RECOMMENDATION 14: AVAILABILITY OF PRENATAL CARE

INCREASE THE AVAILABILITY OF PRENATAL CARE TO INCLUDE ALL UNSERVED AND UNDERSERVED AREAS.

Of the estimated 90,000 indigent pregnant women who need services within a given year in Texas, 50,000 are receiving incomplete, inadequate, or no prenatal care.

Study after study has shown that women who receive prenatal care deliver healthier babies than those who do not. An epidemiological study established that without

prenatal care the infant mortality rates were between fourfold and tenfold greater than those for women receiving more than nine prenatal examinations. This held true when poverty, race, birth weight, and geography also were considered.

Furthermore, a number of studies have shown that early and adequate prenatal care, especially for women with high-risk pregnancies, is consistently and strongly associated with improved birth weight (which translates into lower prematurity rate) and survival. One study reported low birth weight to be highest among women who received no prenatal care (21.1 percent), somewhat lower for those who began prenatal care in the third and second trimester (8.6 percent and 8.7 percent respectively), and least among those who started prenatal care in the first trimester (6.6 percent). In addition, the later the mother registered for prenatal care, the higher the incidence of neurologic abnormality found in Caucasian infants at age one.

Therefore, it is in the state's best interest to facilitate development of additional prenatal services. Currently, waiting times are excessive (over four weeks) for prenatal services in several areas of the state. Prenatal services can be provided in a public health setting only with the support and guidance of community physicians. A major obstacle has been the lack of funding for complications of pregnancy and delivery care, which has made many medical communities reluctant to participate in maternity care for indigent women.

Ninety-three of the 254 counties in Texas do not have prenatal clinics. Based on need and density of the population, the Department of Health estimates that 40 new clinics are needed.

RECOMMENDATION 15: SYSTEM FOR CONSULTATION, REFERRAL, AND CARE

EMPHASIS SHOULD BE PLACED ON THE CREATION OF A SYSTEM FOR CONSULTATION, REFERRAL, AND CARE OF ALL HIGH-RISK PRENATAL PATIENTS WHO ARE MEDICALLY INDIGENT.

Many high-risk pregnant women are unable to afford specialized consultation and testing needed during pregnancy. An estimated 50 percent of the 25,000 indigent high-risk pregnancies would require consultation services. Financial access to care is a problem, especially when more sophisticated care is needed than can be provided at the local clinic. Funding a mechanism providing high-risk women the care they need would help prevent the poor outcomes associated with these pregnancies: low birth weight, asphyxia of the newborn, and maternal deaths.

Funds should be used to develop obstetrical consultation services that would be provided to high-risk patients in public health clinics, community health center clinics, and ambulatory/outpatient clinics. This would provide a mechanism of consultation, education, direct patient care, and quality assurance not presently being provided.

RECOMMENDATION 16: PRENATAL AND SELF-CARE DURING PREGNANCY

INCREASE HEALTH PROMOTION ACTIVITIES TARGETED AT INFORMING WOMEN IN THE GENERAL PUBLIC OF THE VALUE OF PRENATAL AND SELF-CARE DURING PREGNANCY.

An increased emphasis on health promotion is needed to inform women in the general public about the value of prenatal and self-care during pregnancy.

Prenatal care is clearly related to positive pregnancy outcome. Many of the risks associated with low birth weight can be identified in the first prenatal visit, and steps can be taken to prevent or correct them. Conversely, late care or no care is associated with low birth weight, increased prematurity rates, increased stillbirths, and increased infant mortality. A pregnant woman who receives no prenatal care is three times as likely as others to have a low-birth-weight baby (one weighing less than 2,500 grams, or about 5.5 pounds). In 1977, neonatal, postneonatal, and infant death rates were four times higher for babies born to women who received no prenatal care than for those receiving at least some care.

Despite the effectiveness of timely prenatal care, fully one-quarter of all pregnant women receive no or only belated care. These figures are significantly higher among poor, black, adolescent, and unmarried women; those in rural areas; and those over 40—the very groups most likely to be at high risk from other causes.

Prenatal care for indigent mothers often is a case of pay now, or pay more later. While prenatal care is expensive, the cost of caring for an infant with diseases or a handicap can be many times greater. Cost can range from the average neonatal

intensive care unit bill of $10,000 to institutionalization of a handicapped individual, which conservatively could cost $25,000 a year.

"Getting the average person to understand what they're getting for money spent on preventive prenatal care is difficult at first," said one hospital official.

"If the government spends money on a road, everybody can see exactly what the money went for, but with prenatal care it is what you don't see that counts—the infants who aren't born sick and handicapped."

RECOMMENDATION 17: TRANSPORTATION OF HIGH-RISK PREGNANT WOMEN AND INFANTS

INCREASE THE AVAILABILITY OF ROUTINE AND EMERGENCY TRANSPORTATION FOR HIGH-RISK PREGNANT WOMEN AND INFANTS TO ALL TYPES OF CARE SITES.

Many high-risk babies are born in hospitals which are unprepared and unequipped to deal with their special problems. Optimal care requires moving the mother to an appropriate facility before the delivery (if possible) when a small or otherwise compromised baby is expected.

Additionally, any transportation program should include the transportation of the high-risk pregnant woman to a hospital where appropriate medical care can be given. This has been proven the most cost-effective way of preventing the premature birth of critically ill newborns.

RECOMMENDATION 18: HIGH-RISK INFANT FOLLOW-UP

DEVELOP A MECHANISM OF HIGH-RISK INFANT FOLLOW-UP IN ORDER TO MONITOR APPROPRIATE DEVELOPMENTAL PROGRESS, DETECT CHILD ABUSE AND NEGLECT, AND PREVENT AVOIDABLE HANDICAPS.

There is no organized, statewide system for follow-up of high-risk infants once they leave the hospital. Many times these babies have been in a neonatal intensive care unit. All infants who have been identified as high-risk during their hospital stay should be systematically followed up through programs that care for developmental and medical needs.

Ideally, an integrated tracking and follow-up system would involve both public and private hospitals and a full range of ambulatory health care providers, including private physicians, community health centers, and public health clinics.

The goals of a high-risk infant program would be to:

- Assure that infants at risk for developmental delays and other handicaps have the maximum opportunity to reach their developmental potential.
- Enhance infant health care for those at risk, through a system of identification and tracking, to assure all high-risk infants remain under child health supervision by a private physician or public health clinic, at least for the first year of life. Appropriate referrals could include such services as the Crippled Children's and Early Childhood Intervention programs.
- Reduce the incidence of child abuse and neglect in this high-risk population.
- Reduce the cost of hospital care by preventing subsequent hospitalizations and unnecessarily long stays for socio-economic reasons.

RECOMMENDATION 19: ADOLESCENT PREGNANCY PREVENTION

EMPHASIS SHOULD BE PLACED ON THE CREATION AND SUPPORT OF PROGRAMS THAT ADDRESS THE NEEDS OF ALL ADOLESCENTS IN THE AREA OF PREGNANCY PREVENTION.

Unemployment, welfare dependency, dropping out of high school, and medical complications for infants are just a few of the problems facing Texas teenagers as a result of unintended teenage parenthood. Resolution of these problems is particularly crucial because Texas ranks fifth in the nation in pregnancy rate for girls ages

15 to 19 and second in the number of pregnancies for girls under age 14.

It is not surprising then that one in nine girls between the ages of 15 and 19 becomes pregnant. In 1982, 49,496 Texans, 15 to 19 years old, became mothers. An additional 1,089 babies were born to females under age 15. Of the 297,683 babies born to Texas residents in 1982, 17 percent were born to mothers under 20 years of age.

Over half of all teen mothers did not receive prenatal care or received care after the second trimester of pregnancy. Over 1,400 of these potentially high-risk deliveries occurred outside the hospital setting. Texas teenagers delivered 4,534 low-birth-weight (less than 5-1/2 pounds) babies or 17 percent of all low-birth-weight babies born in 1982.

B. Primary Care Services

RECOMMENDATION 20: DEFINITION OF PRIMARY CARE SERVICES

A RANGE OF PRIMARY CARE SERVICES SHOULD BE MADE AVAILABLE TO MEDICALLY INDIGENT PERSONS OF TEXAS.

Primary care services are defined as the following types of services:

1. diagnosis and treatment
2. emergency services
3. family planning
4. preventive services and immunizations
5. health education
6. laboratory and X-ray
7. nutrition service
8. health screening
9. home health care
10. dental care
11. transportation
12. prescription drugs and devices and durable supplies
13. environmental health
14. podiatry services
15. social services

The definition of primary care services should be used as a guideline by state and local decision makers to facilitate program planning, coordination and evaluation, legislative enactment, regulatory promulgation, reporting, and health care delivery.

Initially, concentration should be focused on the funding, provisions of, and access to: (1) diagnosis and treatment, (2) emergency services, (3) family planning, (4) preventive services and immunizations, (5) health education, and (6) laboratory and X-ray services. Given the diversity of Texas, individual community needs will vary and should be taken into account in the design of local programs.

The result of improved and available primary care services would be seen in reduction in health care expenditures (particularly for secondary and tertiary care), in mortality and morbidity, and in improvement in individual productivity and economic growth.

RECOMMENDATION 21: PROVISION OF PRIMARY CARE SERVICES BY THE TEXAS DEPARTMENT OF HEALTH

THE MISSION AND SCOPE OF RESPONSIBILITY OF THE TEXAS DEPARTMENT OF HEALTH SHOULD BE MODIFIED TO ALLOW TDH TO PROVIDE PRIMARY CARE SERVICES TO MEDICALLY INDIGENT INDIVIDUALS. THESE RESPONSIBILITIES SHOULD COMPLEMENT THE SERVICES PROVIDED BY LOCAL AGENCIES AND THE PRIVATE SECTOR AND SHOULD BE PROVIDED IN THOSE AREAS OF THE STATE WHERE SERVICES DO NOT EXIST OR WHERE PROVIDERS CHOOSE NOT TO SEE INDIGENT PATIENTS.

The deliberations of the Task Force emphasized the importance of access to appropriate levels of health care, especially primary care. Too often indigents delay seeking health care because of inability to pay for care or the lack of accessible health care providers who are willing to see indigents. Delays in seeking care lead to

increased mortality and morbidity. The reliance on hospital emergency rooms by indigents increases the overall cost of health care. The Task Force made site visits to several local clinic systems serving indigents which have reduced the inappropriate use of hospitals.

A needs assessment of the 254 counties shows that health services are minimal in many areas of the state. Despite the increasing number of physicians in the state, several counties do not have a practicing physician to serve their indigent population. In these instances, individuals have to travel long distances to get health care services. It is difficult for physicians to establish practices in areas that are poor and isolated. More than 49 counties have physician-to-population ratios greater than one to 3,500. The poor distribution of physicians and lack of available health services increases the poor health status of many Texans.

With enabling legislation, the Texas Department of Health could negotiate and contract with state agencies, municipal and county governments, public health districts, hospital districts, community health centers, private organizations and foundations, and physicians and other persons to provide primary health services in areas of need. Under this approach, TDH would act as a prudent buyer of primary care services from the private sector in order to improve and simplify access to care by the medically indigent. TDH could provide more comprehensive services by adding primary care services to its existing responsibilities for preventive services. Thus indigents who rely on the public health system could have their needs more fully and efficiently met in a visit to a clinic.

This effort should be coupled with aggressive efforts to recruit and place private practitioners in underserved areas.

The provision of primary care services by TDH should complement efforts of the private sector and local agencies. TDH should exercise this new responsibility to provide primary care in areas where the private sector is unable or does not desire to provide cost-effective services to indigents. Services delivered through TDH must be designed not to duplicate existing services available in the community.

RECOMMENDATION 22: PRIMARY CARE SERVICE DELIVERY PLANNING

THE HEALTH AND HUMAN SERVICES COORDINATING COUNCIL SHOULD DEVELOP A PLAN TO COORDINATE AND MONITOR STATE INITIATIVES TO INCREASE ACCESS TO PRIMARY CARE SERVICES. PRIMARY CARE SERVICES SHOULD BE AVAILABLE WITHIN A REASONABLE DISTANCE OR TRAVEL TIME FROM AN INDIVIDUAL'S HOME.

Ambulatory primary care services are recognized by the Task Force as a high priority service need. The Task Force has examined several programs providing primary care services which result in lower rates of inpatient hospitalization. Improved access to primary care services can reduce health care costs and improve individual health status by providing less intensive and less expensive forms of care. Individuals with health care needs also can be reached earlier, resulting in less suffering, greater individual productivity, and improved health outcomes.

The Task Force has endorsed a number of strategies to improve access to ambulatory primary care services by indigents, including:

- Expanding Medicaid eligibility;
- Providing primary care services through the Texas Department of Health, when those services are not available in a community;
- Expanding primary care clinical training and residency programs;
- Limiting medical liability to encourage greater participation in voluntary and public programs serving indigents;
- Defining county responsibility to provide primary care; and
- Using alternate delivery systems and reimbursement incentives to encourage use of ambulatory care instead of inpatient services.

These strategies involve a variety of state agencies and organizations as well as local governments. Development of a plan to integrate these activities should ensure the best use of resources devoted to improving access to primary care. The Health and Human Services Coordinating Council should make use of the state health planning agency (TDH), and resources such as the Coordinating Board, Texas College and University System, the Center for Health Policy and Manpower Studies at The University of Texas Health Science Center, School of Public Health, and other state agencies.

RECOMMENDATION 23: HEALTH EDUCATION

HEALTH EDUCATION SHOULD BE AN INTEGRAL COMPONENT OF ALL PRIMARY CARE SERVICES DELIVERED TO THE MEDICALLY INDIGENT POPULATION. PREVENTIVE SERVICES SHOULD BE MARKETED AND MADE READILY AVAILABLE TO REDUCE THE UTILIZATION OF HIGHER COST SERVICES.

Research has shown that health education provides individuals with information and skills that reduce their risk of illness and injury. Health education reduces the incidence of cancer, heart, lung and cerebrovascular diseases, infectious diseases, birth defects, the long-term effects of chronic illness, and fatal and debilitating injuries. Decreasing the risk of illness and injury reduces expenditures for secondary and tertiary care while improving the health status of the population. For example, diabetes education projects in other states have demonstrated reductions in hospitalization and length of stay and have provided a savings of $4 to $5 for each dollar spent on education.

Potential benefits of developing and implementing health education programs are improved general health and well-being and lower health care costs—significant results which cannot be overestimated.

C. Prevention and Promotion

RECOMMENDATION 24: DEVELOPMENT OF HEALTH PROMOTION INITIATIVES

THE STATE SHOULD SUPPORT THE DEVELOPMENT OF LOCAL HEALTH PROMOTION AND HEALTH EDUCATION INITIATIVES UNDERTAKEN BY INSTITUTES OF HIGHER EDUCATION, LOCAL SCHOOL DISTRICTS, VOLUNTARY AND COMMUNITY AGENCIES, AND HEALTH PROFESSIONALS AND PROVIDERS.

Health promotion activities can have a significant impact on health status and utilization of the health care delivery system by specific populations. Through a combination of health education interventions designed to change behavior, health promotion can be a major instrument in the preservation of individual and community health.

Cultural, economic, and language barriers reduce the effectiveness of more global health promotion intervention strategies. In order to inform, motivate, and assist individuals in improving their health status, health promotion activities must occur in supportive environments such as schools, communities, worksites, and clinics/hospitals.

Health promotion may be used to increase the level of public knowledge, to reinforce positive health behaviors, to provide the public with health awareness materials, and to educate the family, community, and public about self-care.

Health promotion services can be provided through community and clinic health service providers to families and individuals to improve and maintain positive health status.

Educating community leaders and participants about the risk factors, symptoms, and prevention of negative health behavior can be targeted to high-risk populations.

Providing comprehensive patient education services in primary, secondary, and tertiary health care sites, which will help the patient become as self-sufficient as possible, should result in an increased quality of life, reduced health care costs, and effective utilization of resources.

Development of relevant health promotion goals and objectives for all preschool and school-age children can reinforce positive health behaviors at an early age.

Providing health education materials may make some people aware of services and programs available to them, encourage people to seek preventive services, and help establish and enhance relationships with health care providers and the community.

RECOMMENDATION 25: DEFINITION OF PREVENTIVE CARE SERVICES

A RANGE OF PREVENTIVE CARE SERVICES SHOULD BE MADE AVAILABLE TO MEDICALLY INDIGENT PERSONS OF TEXAS.

Preventive care services are defined as the following types of services:

1. health screening
2. early detection
3. health education
4. family planning
5. preventive mental health services
6. immunization
7. dental
8. environmental health

This definition of preventive care services should be used as a guideline by state and local decision makers to facilitate program planning, coordination and evaluation, legislative enactment, regulatory promulgation, reporting, and health care delivery. Initially, concentration should be focused on funding, provision of, and access to preventive care services in the order listed above. Individual community needs vary and should be taken into account in the design of local programs.

A very strong case can be made that various types of prevention and health promotion work are effective but are not receiving the emphasis they deserve. Renewed national interest and consensus on this point is reflected in the Surgeon General's Report, Healthy People, which emphasizes that "improvement in health status of our citizens will not be made predominantly through the treatment of disease, but rather through its prevention." The report points out that preventive measures in large part were responsible for major gains in health status in the past—through improvements in sanitation, housing, nutrition, immunization, contraception, and other developments. General agreement is that many of the remaining health problems will not be resolved by our disease-oriented medical care system, however skilled its personnel and sophisticated its technology, but rather by improving the physical and social environments in which we live and by changing individual behavior.

The potential benefits of preventive care and health promotion are especially great for mothers and children. This is due in part because positive influence and the avoidance of hazards at the beginning of the life cycle can lead to long-term benefits and because a disproportionate number of the most effective preventive care measures are directed toward pregnancy, birth, and the early years of life.

Cancer, heart, and cerebrovascular diseases rank as the top three causes of death in Texas and the United States. The incidence rates of these diseases could be significantly reduced with the implementation of a comprehensive preventive health and health education program.

RECOMMENDATION 26: PREVENTIVE MENTAL HEALTH SERVICES

PREVENTIVE MENTAL HEALTH SERVICES SHOULD BE AVAILABLE TO ALL TEXANS IN ORDER TO PROMOTE EARLY DETECTION AND REFERRAL TO APPROPRIATE SERVICES.

At any given time, up to 25 percent of the population is estimated to be suffering from mild to moderate depression, anxiety, or other emotional disorders. Stress can be both positive and negative. Many individuals cope poorly with stress, resulting in increased rates of domestic violence, child abuse, alcoholism, drug abuse, and antisocial behavior.

Poor mental or emotional health also adversely affects physical health, resulting in lower productivity. Many times medical intervention only treats a symptom, not the underlying cause of the illness. Because the nature of asymptomatic physical illness is likely to be nonspecific, often the use of excessive and unnecessary tests and diagnostic procedures will result. This greatly increases the cost of the medical care. Conversely, a legitimate physical illness may adversely affect emotional and mental health. In this situation, maintenance of emotional and mental well-being is the key to physical recovery.

For optimal effectiveness, mental health counseling services should be coordinated with primary care providers and made available at primary care sites.

Other effective preventive mental health services include genetic screening, improvements in maternal and child health care, and reductions of known environmental causes of mental disabilities. Emphasis should also be placed on the prevention of potential mental health problems among "at-risk children" of identified mentally disabled adults.

Development and expansion of preventive mental health services by each of the principal agencies involved

in mental health and mental retardation, the Texas Department of Mental Health and Mental Retardation, the Texas Department of Human Resources, the Texas Rehabilitation Commission, and the Texas Education Agency should reduce the future demand for expensive institutional care.

Preventive mental health services should include programs of early identification of potential alcohol and drug abuse. Early detection and intervention can reduce the need for expensive hospital- or institution-based services. The Task Force recommends that continuing education programs for health providers integrate drug and alcohol abuse assessment techniques into their curricula. In addition, public school personnel should be better trained to identify the symptoms of drug and alcohol abuse and the indicators of serious stresses which may lead to such abuse.

RECOMMENDATION 27: DENTAL SERVICES

PREVENTIVE DENTAL SERVICES SHOULD BE INCREASED AND MADE AVAILABLE TO ADULTS AND CHILDREN.

A MECHANISM SHOULD BE ESTABLISHED TO TREAT MEDICALLY INDIGENT ADULTS AND CHILDREN WITH SEVERE DENTAL PROBLEMS.

Tooth decay affects 95 to 98 percent of the population. By the time they reach 17 years of age, 94 percent of children have an average of nine permanent teeth affected by decay. Periodontal disease in adults creates serious problems which often lead to malnutrition. Dental care is an integral component of an individual's overall health and well-being.

There are few public programs which provide adult dental care services. The Early and Periodic Screening, Diagnosis and Treatment program, a mandatory service of the Medicaid program operated by the Department of Human Resources, provides dental services for children eligible for Medicaid. It is the largest dental program in the state. Expansions of Medicaid eligibility to individuals under age 21 will increase the availability of dental services to indigent children. The Texas Department of Health provides limited funds for basic treatment services for children not covered under EPSDT.

Despite the efforts of both these programs, many individuals are not covered and cannot afford necessary dental services, in particular, indigent adults. Improvements in coordination among programs can help to ensure that the maximum amount of services are provided with limited resources.

RECOMMENDATION 28: ENVIRONMENTAL HEALTH

ENVIRONMENTAL HEALTH SERVICES SHOULD BE INTEGRATED WITH PUBLIC HEALTH PREVENTIVE CARE SERVICES IN A COMPREHENSIVE APPROACH TO SERVICES.

Evidence is increasing that the onset of illness is strongly linked to influences in one's physical environment. Over the last 100 years we have drastically altered our physical environment to one which hosts thousands of potentially hazardous chemicals and by-products of manufacturing, transportation, energy, and agricultural production processes. Some estimates hold that 20 percent of all premature deaths and a majority of disease and disabilities could be eliminated if people were protected from environmental hazards.

RECOMMENDATION 29: HEALTH SCREENING AND EARLY DETECTION

INCREASE THE PROVISION OF HEALTH SCREENING AND EARLY DETECTION TO ADULTS AND CHILDREN TO REDUCE UTILIZATION OF HIGHER COST SERVICES.

A MECHANISM SHOULD BE ESTABLISHED TO REFER ALL MEDICALLY INDIGENT PERSONS TO TREATMENT IF HEALTH SCREENING AND EARLY DETECTION DETERMINES THAT ABNORMALITIES EXIST.

Health screening and early detection and intervention reduce the long-term cost of health care, decrease the utilization of secondary and tertiary services, increase individual and economic productivity, and improve the quality of life of the population. Health screening and early detection reduce the incidence and long-term effects of catastrophic and chronic disease.

D. Catastrophic and Tertiary Care

Medical care can be expensive. Most individuals can afford the normal costs of living, such as food, clothing, and shelter, but they may not be able to afford necessary medical care. Many individuals have health insurance, although a substantial number do not. Some individuals with health insurance may not have adequate coverage, or they may exhaust their coverage because of a high-cost medical problem.

The Texas Poll conducted for the Task Force in the summer of 1984 found that only 41 percent of the individuals surveyed were very confident of their ability to meet the cost of a major illness. About 20 percent were not very or not at all confident. Almost 36 percent of individuals in households with income less than $10,000 and about 26 percent of individuals in households with incomes between $10,000 and $30,000 were not very or not at all confident in their ability to meet the costs of a major illness.

High-cost or catastrophic medical expenses can cause severe emotional and financial strain on families. Catastrophic expenses also affect public and private health care providers who try to meet the needs of these families.

Catastrophic medical expenses include problems which affect children and young adults, such as congenital birth defects, low birth weight, and accidents. They also include problems which affect the middle-aged and elderly, such as cancer, heart disease, and stroke.

Recently there has been growing concern and public awareness about the devastating effects of catastrophic illnesses and the difficulty of relying on one or two specialized facilities to provide charity care. With adequate funding, many problems can be handled in the local community, resulting in positive medical outcomes, greater continuity of care, and improved family support for the patient.

RECOMMENDATION 30: DEFINITION OF CATASTROPHIC AND TERTIARY CARE SERVICES

A RANGE OF CATASTROPHIC AND TERTIARY CARE SERVICES SHOULD BE MADE AVAILABLE TO MEDICALLY INDIGENT PERSONS OF TEXAS.

Catastrophic and tertiary care services are defined in broad categories of services:

Acute traumatic medical and surgical services. Services in this category may include, but are not limited to, those for trauma, burns, cancer, serious infection, stroke, or intensive care for a variety of types of patients, medical conditions, or surgical events. Intensive care may be provided in, but not necessarily confined to, a specialized unit. Intensive care services may include, but are not limited to, those for neonates, cardiac patients, neurological patients, or neurosurgical patients.

Long-term maintenance and rehabilitation services. Services in this category may include, but are not limited to, occupational therapy, physical therapy, speech therapy, kidney dialysis, transplantation, chronic pulmonary services, social services, and other services designed to maintain or restore a person to his best possible functional level.

This definition of catastrophic and tertiary care services should be used as guidelines by state and local decision makers to facilitate program planning, coordination and evaluation, legislative enactment, regulatory promulgation, reporting, and health care delivery.

Initially, concentration should be focused on funding, provision of, delivery of, and access to acute traumatic medical and surgical services for the medically indigent. The focus on this type of service will reduce mortality and morbidity rates among high-risk pregnant women, high-risk newborns, trauma victims, and others suffering from catastrophic diseases. Intervention in the disease process of cancer not only reduces pain and suffering, but decreases the future need of long-term care and rehabilitation.

The leading six causes of death in Texas are: heart disease, cancer, cerebrovascular disease, motor vehicle accidents, other accidents, and chronic obstructive pulmonary diseases. The mortality and morbidity rates for the diseases and for injuries resulting from accidents could be reduced with better access to and delivery of catastrophic and tertiary care services.

Long-term maintenance and rehabilitation services should be delivered, when appropriate, as community-based services (e.g., home health care services) rather than as institutionally based services. Community-based services can be more cost effective than institutionalization and healthier for individuals who are able to remain in familiar surroundings with their personal and family support systems in place.

RECOMMENDATION 31: STATE CATASTROPHIC ILLNESS OR INJURY COVERAGE PROGRAM

A STATE CATASTROPHIC COVERAGE PROGRAM SHOULD BE INITIATED TO HELP OFFSET THE HIGH COST OF SERIOUS TRAUMATIC INJURIES, ILLNESS, CONDITIONS, AND SURGICAL PROCEDURES WHICH ARE NOT COVERED BY MEDICARE, MEDICAID, OTHER FEDERAL, STATE, OR LOCAL PROGRAMS OR PRIVATE HEALTH INSURANCE.

A catastrophic injury or illness may cause medical indigency for people normally able to pay for routine medical services. Also, one large hospital bill, due to a catastrophic injury or illness, incurred by an indigent citizen may cause that citizen's county a severe financial hardship. One indigent patient with catastrophic expenses may create substantial financial difficulties for a hospital.

Catastrophic programs operating in other states are structured with many basic similarities. State-financed catastrophic programs are designed to be "payors of last resort"; the programs pay medical bills only after all other sources of third-party coverage have been exhausted. State-financed catastrophic programs are intended to be secondary to all other public and private programs in paying for health expenses.

The existing programs are structured in the following manner:

- Eligibility - determined by two criteria, residency and amount of uninsured medical bills;
- Covered services - includes basic hospital and medical benefits similar to those under a comprehensive insurance policy. Services covered may be limited to control the costs of the program and to exclude services of unknown or unproven value; and
- Administration - through existing state agencies.

All of the states determine eligibility under the programs on the basis of deductibles. Options for establishing eligibility criteria include:

- a proportion of family income,
- combination of proportion of family income plus assets,
- high minimum deductible plus a proportion of family income and assets, and
- proportion of family income, adjusted for insurance coverage.

All of the catastrophic programs cover basic hospital and medical services. State programs differ in their coverage of psychiatric and nursing home care. Limits on these types of coverage have been important for cost control.

Texas has some programs in place that do provide for catastrophic expenses. For example, the Kidney Health program and provisions within the Crippled Children's program make important contributions. Also, some services which are catastrophic in cost are provided directly by state institutions such as M. D. Anderson and John Sealy Hospital.

Some type of catastrophic program should be devised to ensure that the medically indigent in need of high-cost services to sustain and rehabilitate life are not denied services because of a lack of funds. To ensure optimal care, the assurance of financial assistance to the providers of the care should be made at the outset. A catastrophic program would provide some protection to the working poor and middle class who are not eligible for other public programs. A catastrophic program could be used to support the regional delivery of some types of care, instead of requiring individuals who cannot afford needed high-cost services to travel long distances to use a state institution.

E. Emergency Care Services

RECOMMENDATION 32: DEFINITION OF EMERGENCY CARE SERVICES

A RANGE OF EMERGENCY CARE SERVICES SHOULD BE MADE AVAILABLE TO MEDICALLY INDIGENT PERSONS OF TEXAS.

Emergency care services are defined as the following types of services:

1. stabilization
2. diagnosis and treatment
3. diagnostic technology
4. laboratory and X-ray
5. education for emergency recognition
6. transportation/transfer/referral
7. communication

The definition of emergency care services should be

used as a guideline by state and local decision makers to facilitate program planning, coordination and evaluation, legislative enactment, regulatory promulgation, reporting, and health care delivery. Improved and available emergency care services can preserve life and diminish temporary and permanent disability.

In addition, priority should be given to funding, provision of, and access to the diagnosis and treatment of emergency conditions for the medically indigent. This entails two elements: (1) that all citizens are not more than a reasonable distance from an emergency care facility; and (2) that medically indigent patients are assured diagnosis and treatment, regardless of their ability to pay, once they arrive at a facility which offers emergency care services.

The Medicare program defines emergency care as "services provided in a hospital emergency room after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in:

- placing the patient's health in serious jeopardy;
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part."

RECOMMENDATION 33: INCREASE IN LIFE SUPPORT UNITS

THE NUMBER OF ADVANCED LIFE SUPPORT UNITS AND BASIC LIFE SUPPORT UNITS IN THE STATE SHOULD BE INCREASED WHERE NEEDED.

Ambulance services are the key to transporting victims of accidents and acute illnesses quickly and safely to the appropriate emergency care facility, as well as rendering on-site first aid. Traumatic injuries are among the leading causes of death in the productive age groups, and accidents are among the leading causes of death in children.

Prompt and efficient transportation of the ill and injured cannot occur if there are insufficient and inadequately distributed life support units throughout the state. Currently, the Texas Department of Health is conducting a needs assessment to determine underserved areas in the state. Based on the findings from that study, the state should develop strategies to ensure that advanced and basic life support units are available in all areas of the state. The state should explore the use of volume purchasing to obtain equipment at a discount price on behalf of local communities.

RECOMMENDATION 34: 911 COMMUNICATION SYSTEM

THE STATE SHOULD ASSESS THE FEASIBILITY OF IMPLEMENTING A STATEWIDE 911 EMERGENCY COMMUNICATION SYSTEM.

The success of an emergency medical services system is dependent upon a series of communication links. Somebody must find the ill or injured person and call for help; the communications center that receives the call for help must quickly dispatch the nearest appropriate vehicle and personnel; and the patient must be moved from the point of discovery to a medical facility that can stabilize and diagnose the condition.

An easily remembered telephone number for a statewide communication system would improve the response time to emergencies in many areas, thereby reducing mortality and disabling injuries.

Several states have mandated the creation of statewide emergency number systems with varying results. These systems have been financed by several methods, including telephone companies, state subsidies, local governments, and telephone rate increases to consumers. In Florida, where the 911 system was mandated in 1974, Bell Telephone Company absorbed the costs of equipment adjustments to accommodate the mandated system, and the state allocated $1.5 million for the system's operation.

One problem of a statewide system is the difficulty of implementation in remote, rural areas because of lack of financing and cooperation among emergency services. Illinois mandated a state system requiring counties to design and finance their own systems and ensure that law enforcement, fire, and emergency medical services were all included. The mandate was later rescinded in counties with populations under 100,000.

The state should assess the feasibility of a statewide 911 emergency number system and promote the implementation of such a system. Innovative methods of designing and administering the system could address and remedy problems encountered by other states.

RECOMMENDATION 35: TRAINING AND EDUCATION FOR EMERGENCY MEDICAL SERVICES

TRAINING AND EDUCATION PROGRAMS RELATED TO EMERGENCY MEDICAL SERVICES SHOULD BE EXPANDED AND IMPROVED, INCLUDING INCREASES IN PUBLIC EDUCATION PROGRAMS FOR IDENTIFYING AND INTERVENING IN EMERGENCY CONDITIONS AND COMMUNITY-BASED EDUCATION PROGRAMS FOR PROVIDERS OF EMERGENCY CARE.

Very often the first person at the scene of an emergency situation is not an emergency care professional, but a citizen who just happened to be there. The first few minutes after an emergency situation occurs can be the difference between life and death or minor injury and permanent disability. Because heart disease, cancer, cerebrovascular disease, motor vehicle accidents, and other accidents are the five leading causes of death in Texas—and each has the potential to present emergency situations—greater public awareness of how to deal with emergencies will reduce the death rate. Encouragement should be maintained and support increased for CPR programs as well as for education on how to handle burns and injuries to the head and neck. Programs can be targeted at high-risk groups such as families with a member suffering from heart disease or individuals working in occupations with high risk of injury.

Information on public education programs for identification of and intervention in emergency conditions can be disseminated to a mass audience through media, such as television, radio, billboards, and publications.

The need for more instructors for public emergency care programs is particularly critical in rural areas where emergency care facilities and resources are insufficient.

The Texas Emergency Medical Services Act (S.B. 385, 68th Texas Legislature) authorizes the Texas Department of Health to implement statewide standards for EMS training programs. Currently there is no statewide standardization of the training programs, so the instructional quality of programs varies. TDH should complete the evaluation and accreditation of EMS training programs. Based on community needs, high quality training programs for emergency care service providers should be made available throughout the state.

F. Mental Health Care Services

RECOMMENDATION 36: DEFINITION OF MENTAL HEALTH CARE SERVICES

A RANGE OF MENTAL HEALTH CARE SERVICES SHOULD BE MADE AVAILABLE TO MEDICALLY INDIGENT PERSONS OF TEXAS.

Priorities for mental health care services include the following:

1. diagnosis and treatment
2. emergency services
3. preventive services
4. alcohol and drug abuse education
5. psychological counseling

Initially, concentration should be focused on funding, provision of, and access to mental health care services in the order as listed above.

The definition of mental health care services should be used as guidelines by state and local decision makers to facilitate program planning, coordination and evaluation, legislative enactment, regulatory promulgation, reporting, and health care delivery.

Improved and available mental health care services can help reduce rates of domestic violence, child abuse, suicide, alcoholism, drug abuse, crime, and antisocial behavior and thus increase individual productivity and improve physical health.

The first two priority mental health services, diagnosis and treatment and emergency services, can be defined using the following categories:

I. Direct Mental Health Care Services

A. Early Identification Services - including case finding, diagnosis and evaluation, and screening and referral

B. Emergency Intervention Programs - including crisis telephone services and emergency treatment

C. Active Psychiatric Treatment Programs (Voluntary and Involuntary) - including hospital-based inpatient, community-based inpatient, community-based partial hospital, and community-based outpatient services, and discharge planning

D. Habilitation/Rehabilitation Programs - including evaluation and planning for social and vocational skills and patient therapeutic education programs

E. Case Management Services

F. Family and Community Support Programs - including family education and respite services, police and court education and assistance, and education aimed at employers and providers

II. Sustaining Services - including basic medical care, dental care, speech and physical therapy, housing and food, job training and placement, and legal aid services

Severe mental disabilities cause patients and clients to be at high risk for other physical illnesses and create additional barriers to housing, employment, and other self-sustaining needs. Sustaining services are, therefore, no less important than direct mental health services for mentally disabled persons served outside state institutions to enable them to function effectively in the community.

The remaining priority mental health care services are discussed in Recommendation 26: Preventive Mental Health Services above.

RECOMMENDATION 37: DEVELOPMENT OF ALTERNATIVES TO INSTITUTIONALIZATION IN STATE HOSPITALS AND STATE SCHOOLS

A RANGE OF OUTPATIENT RESIDENTIAL CARE AND COMMUNITY-BASED ALTERNATIVES TO INSTITUTIONALIZATION IN STATE HOSPITALS AND STATE SCHOOLS SHOULD BE CREATED. THIS EFFORT SHOULD INCLUDE INCREASING THE AVAILABILITY OF MEDICAID OUTPATIENT PSYCHIATRIC SERVICES, RESIDENTIAL CARE FOR INDIVIDUALS UNDER AGE 21, OUTPATIENT SERVICES FOR THE ELDERLY RESIDING AT HOME, AND HALFWAY AND QUARTERWAY HOUSES FOR THE CHRONICALLY MENTALLY IMPAIRED.

Not enough community residential facilities presently are available in Texas. The funds, community acceptance, the need for a central location, and transportation services are all factors which impede expansion of these services.

Research has shown that recidivism, or repeat hospitalization, can be substantially reduced for the chronic, severely mentally disabled through the development and implementation of comprehensive and individualized community-based services. A 1982 study conducted by TDMHMR found that if community residential facilities were available, 1,194 state hospital clients would require minimal supervision. The need for community placement is much greater than this limited study of state hospital clients indicates.

As more community residential and intervention programs are developed, clients who require short-term treatment can be cared for more often in their home communities. The cost per client in institutional settings is increasing proportionately to the number of severely handicapped clients who need higher staff-to-client ratios and more intensive medical, education, and habilitative services. Expensive institutional care should be reserved for those clients who need such care, and alternatives for those clients who require less intensive care could be cost efficient and more effective. Institutional care, when unnecessary, can render semi-independent clients unnecessarily dependent.

Troubled children and adolescents frequently are placed in foster homes, special schools, and mental and correctional institutions without adequate evaluation and follow-up. Residential facilities specializing in the treatment of the special problems of children and adolescents are virtually nonexistent in rural areas and in insufficient numbers in urban areas.

When appropriate and possible, children and youth should be placed in the least restrictive environment which provides nurturing appropriate care and support systems of friends and family. Helping some youth to cope with the world as it is may be more successful in the community, rather than in the artificial environment of an institution.

Outpatient services for the maintenance of the elderly in their homes or in group living homes are lacking or underfunded. Up to 25 percent of older persons (over age 65) are estimated to have significant mental health problems.

In addition to a higher incidence of mental illness and emotional distress, the elderly are frequently isolated in their homes and generally are less ambulatory due to their age. There are almost no outreach efforts or in-home services in the mental health system. Services which were provided in the home or in group living situations could provide the necessary support for the elderly to remain in the community and give them a sense of community involvement.

TDHR and TDMHMR have applied for a Home and Community-Based Services Waiver under Title XIX in order to maximize the funds available for the home and community-based services for persons with developmental disabilities.

While a number of psychiatric patients will need the services of a good inpatient hospital, the majority of patients can be dealt with on an outpatient basis. Texas needs to increase the number of halfway and quarterway houses and other outpatient alternatives to institutional care so that patients are not unnecessarily institutionalized in hospitals. The effort to reduce hospitalization should include expansions of Medicaid services for outpatient psychiatric services.

RECOMMENDATION 38: EMERGENCY CRISIS INTERVENTION SERVICES

THE STATE SHOULD INCREASE THE AVAILABILITY OF 24-HOUR EMERGENCY CRISIS INTERVENTION SERVICES ON A STATEWIDE BASIS.

There is a severe shortage of 24-hour crisis intervention services for individuals with mental health and mental retardation problems, particularly in rural areas of the state. This shortage results in the commitment of individuals to state mental hospitals, temporary confinement in jails, or other inappropriate treatment.

Community mental health and mental retardation centers provide free services to indigents within their service areas. Other areas of the state are served by outreach clinics of state hospitals and state schools. Nevertheless, many centers and clinics do not have 24-hour emergency services with inpatient facilities. Emergency services could be made available through adequate funding to centers and clinics with the development of agreements with local hospitals to accept mentally ill persons in crises.

Twenty-four-hour-a-day crisis intervention and stabilization services should be supplemented by a telephone hotline number.

RECOMMENDATION 39: INHALANT ABUSE

EMPHASIS SHOULD BE PLACED ON THE CREATION OF EDUCATIONAL PROGRAMS AND TREATMENT SERVICES FOR INHALANT ABUSE FOR CHILDREN.

Currently the Drug Abuse Prevention Division of the Texas Department of Community Affairs (TDCA/DAPD) and a state Task Force on Inhalant Abuse are studying the life-threatening practice of inhalant abuse among Texas youth. Their findings indicate the need for increased educational programs and treatment services for inhalant abuse.

The organic brain disorders which may result from inhalant abuse will have a substantial impact on the state's health care and educational systems. A new population of organic brain-disabled persons is being created which will be dependent on the state for custodial care and treatment for possibly their entire lives.

Since 1975, 74 deaths in Texas have been attributed to the abuse of inhalants. In the same period of time, 6,072 state residents were admitted to treatment programs for inhalant abuse. Those receiving treatment are predominately male, Hispanic, and age 19 or under.

In 1980, 980 persons were admitted to inhalant abuse programs. This number decreased to 663 in 1981 and subsequently dropped to 486 in 1983. This decrease is thought to be due to the establishment of prevention programs more appropriately serving young clients than did efforts of the past. In order to prolong this trend, additional measures must be taken.

Full funding of the R. B. McAllister Drug Treatment Program Act (S.B. 1209, 66th Texas Legislature) would allow education and treatment programs for inhalant abuse to be created. This Act encompasses all areas of drug abuse and mandates the TDCA/DAPD to establish and supervise a comprehensive system of services, including prevention, treatment, diversion, and administration. Funding of $19 million is needed for the Act for the biennium. This is compared to TDCA's current funding of $6.3 million in federal money and $547,000 in state money.

In addition, state law (S.B. 108, 66th Texas Legislature) regulating the sale to minors of abusable products should be strictly enforced.

Section 3. Issues for Further Consideration

RECOMMENDATION 40: IMPROVED USE OF PRIVATE HEALTH INSURANCE

THE STATE SHOULD DEVELOP STRATEGIES TO ENHANCE THE AVAILABILITY OF PRIVATE HEALTH INSURANCE.

The Task Force has found that medical indigency can be defined to a considerable degree by lack of adequate health insurance, either public or private. About 28 percent of the poverty population and up to 16 percent of the population at large lack any type of public or private health insurance coverage. Individuals without insurance may defer needed care resulting in greater suffering, more difficult medical problems, and increased costs. These individuals may rely on a source of "free" care, if available, such as a public or nonprofit hospital, which increases the fiscal strain on many of these providers.

The Task Force has proposed a number of strategies to extend the coverage of public programs to certain targeted groups, including Medicaid expansions for pregnant women and children and county programs for indigents.

Increased private insurance coverage can reduce the demand for public programs because public programs operate as payors of last resort. Increased private insurance coverage will decrease the number of persons who are medically indigent because of inability to pay medical bills.

The Task Force has heard reports of increases in private insurance premiums which have resulted in individuals dropping optional coverage of family dependents to reduce family insurance premium expenditures. Other individuals may lose insurance because of unemployment. Also, health insurance is not provided as a benefit in some occupations. The Texas Poll done in the summer of 1984 by the Texas A&M Public Policy Resources Laboratory found that over 10 percent of families in Texas had a member who lost or dropped health insurance during the year.

The state should explore its options in areas such as regulation of insurance and incentives to employers to improve the availability of private health insurance.

RECOMMENDATION 41: RESPONSIBILITIES OF MEDICAL AND DENTAL SCHOOLS AND THEIR STUDENTS

MEDICAL AND DENTAL SCHOOLS RECEIVING FINANCIAL SUPPORT FROM THE STATE SHOULD PROVIDE GREATER ACCESS TO CARE FOR THE MEDICALLY INDIGENT BY EXPANDING PRIMARY CARE CLINICAL TRAINING AND BY EXTENDING THOSE PROGRAMS INTO UNDERSERVED AREAS OF THE STATE.

THE STATE SHOULD INCREASE THE AVAILABILITY OF LOANS AND SCHOLARSHIPS, ESPECIALLY FOR LOW-INCOME AND EDUCATIONALLY DISADVANTAGED STUDENTS. SCHOLARSHIP AND LOAN FORGIVENESS PROGRAMS SHOULD BE CONTINGENT UPON THE PROVISION OF SERVICES TO INDIGENT PATIENTS IN UNDERSERVED AREAS OF THE STATE FOR A SPECIFIED PERIOD OF TIME FOLLOWING COMPLETION OF A STUDENT'S TRAINING.

The Task Force heard considerable testimony about the lack of available physician primary care services for the medically indigent. Although the number of physicians per population statewide is approaching optimum levels, shortages of available physicians continue to increase in family practice and other primary care specialties. In addition, the current geographic distribution of physicians still leaves many rural areas and certain pockets of urban areas with few available physicians.

The level of state support for medical education in Texas is one of the highest in the country in terms of amount appropriated per student, per state population, and per personal income of state residents.

The Rural Medical Education Program established by the Texas Legislature to provide support for medical education in exchange for rural practice has limited funding available.

The National Health Service Corps (NHSC) provides financial assistance to medical students in exchange for services provided after graduation in designated medically underserved areas. The NHSC program has been jeopardized by planned federal budget cutbacks. It cannot meet the demand for physician placements nationwide.

The Task Force discussed making better use of students and graduates of Texas medical and dental schools in providing services to indigents. The Task Force also reviewed family practice residency sites which benefit indigents and the community at large through

low-cost, accessible services and by bringing primary care physicians into the community. Expanded primary care clinical training and residency programs can be used to increase access to care in the many areas of the state which continue to be underserved. An expanded scholarship or loan forgiveness program administered by the state should be designed to be more responsive to the special needs in Texas.

The Task Force acknowledges that medical schools have three primary functions: education, research, and patient care. These three functions must be kept in balance so that research and patient care stimulate continuing excellence in medical education. The Task Force proposals to extend physician training into underserved areas of the state should not be at the expense of maintaining quality education.

RECOMMENDATION 42: POST-GRADUATE PHYSICIAN TRAINING

THE STATE SHOULD INCREASE ITS SUPPORT FOR POST-GRADUATE TRAINING OF PHYSICIANS IN PRIMARY CARE RESIDENCY PROGRAMS IN MAJOR TEACHING HOSPITALS.

Primary teaching hospitals provide a disproportionate share of indigent care provided in hospitals. They are likely to continue to provide a disproportionate share of indigent care, including care to individuals from other jurisdictions, even after the implementation of other Task Force recommendations.

State law allows for Texas state medical schools to receive appropriated funds to pay the stipend (up to $15,000 per year) of resident physicians in the primary teaching hospitals. During the previous biennium, $54 million was requested, but only $6 million was appropriated for residency training stipends.

Primary teaching hospitals are responsible for compensating residents to the extent the state does not fully fund resident physicians. Parkland Hospital estimates that the state pays for less than 10 percent of the direct cost of post-graduate medical education in that facility.

Consistent with the Task Force services priorities, state support should be increased for primary care residency programs.

RECOMMENDATION 43: COMPREHENSIVE SERVICE DELIVERY BY THE TEXAS DEPARTMENT OF HEALTH

THE TEXAS DEPARTMENT OF HEALTH SHOULD HAVE LIMITED AUTHORITY TO TRANSFER FUNDS AMONG APPROPRIATION LINE ITEMS FOR THE SPECIFIC PURPOSE OF PROVIDING COMPREHENSIVE SERVICE DELIVERY.

The programs of the Texas Department of Health are funded by the state on a categorical basis. Categorical funding has the advantage of keeping simple the tracking of program dollars, especially comparisons of program activities from year to year. However, categorical program funding makes difficult a comprehensive approach to public health service delivery, since employee salaries, travel and related expenses paid from categorical funds can be used only for specific categorical purposes.

Under a comprehensive approach allowing greater budget flexibility, the Health Department could make more efficient use of staff resources. For example, services could be provided to children and adults in a comprehensive clinic instead of needing separate clinic operations to serve children and adults. Also, staff now funded under separate categories can work more closely together for greater overall efficiency.

For a family seeking public health services, one visit to a clinic could replace several encounters for immunization, screening for diabetes, or a blood pressure check. The traditional concept of providing one clinic service for one type of program for a few hours or on one day of the week inconveniences and discourages persons seeking services. Comprehensive clinic services have demonstrated a reduction in the number of no-show appointments.

TDH currently uses a comprehensive approach in some areas of the state. These comprehensive public health clinics provide most services needed by a patient during a single clinic site visit. Clinical personnel are cross-trained in health programs offered by the clinics and are able to meet the needs of the patient more efficiently and at a lower unit cost of service delivered.

The limited and specific ability to transfer funds among line items would improve the ability of TDH to implement comprehensive delivery systems, while minimizing administrative costs. Appropriate management systems and controls should be used to support the delivery of comprehensive services. The use of transfer authority for the purpose of providing comprehensive services and effectively meeting emerging public health needs must not reduce accountability for public funds or contravene the intent of the legislature.

RECOMMENDATION 44: ACCESS TO HEALTH CARE SERVICES

STATE AND LOCAL HEALTH POLICY INITIATIVES SHOULD BE DESIGNED TO PROVIDE EQUAL ACCESS AND QUALITY HEALTH CARE FOR THE INDIGENT. PUBLICLY FUNDED PROGRAMS WHICH PURCHASE HEALTH CARE SERVICES IN THE MARKET PLACE SHOULD ACT AS "PRUDENT BUYERS," CONSISTENT WITH THE MAINTENANCE OF STANDARDS OF QUALITY AND ACCESS.

Several public hospital administrators around the state have said that their hospitals appear likely to become "indigent hospitals" because their hospitals render the bulk of services to indigent patients. A number of nonprofit hospital administrators, especially those whose hospitals have religious sponsorship, have stated that their hospitals have also assumed increasing indigent care loads.

The stigma of becoming an "indigent hospital" may lead to the loss of paying patients. These paying patients may feel that they will not receive quality care in hospitals that serve primarily indigent people.

Some hospital administrators from financially strapped public hospitals have noted their hospital's inability to attract needed physicians and other hospital personnel because of revenue shortages, resulting partly from increasing indigent costs. Other hospital administrators have stated that serving a high volume of indigent patients causes current hospital staff to be overworked and underpaid. Other areas that also have been affected by increased uncompensated costs include replacing obsolete equipment, keeping abreast of new technology, and providing proper building maintenance.

Delivering health care services to the poor and uninsured in a separate system may lead to higher overall health care costs because of the need to have duplicate services and facilities to serve all types of patients. It may also lead to a reduction in the quality of care provided to the poor and uninsured.

Publicly funded programs have the obligation to make the best possible use of tax dollars. Under a "prudent buyer" concept, state and local programs would purchase the most cost-effective services available in the health care market. The "prudent buyer" concept encourages efficiency in the health care industry and uses cost-effective modes of service delivery, thus rewarding efficient providers. Examples of "prudent buyer" approaches which may be used to provide services to indigents include:

- the purchase of services under a competitive bidding system or through negotiation; for example, by using a preferred provider organization (PPO) which provides services at a discounted rate;
- the use of prospective price systems instead of retrospective, cost-based reimbursement systems to encourage the use of less expensive forms of care; and
- case management systems and primary care networks, in which a primary care provider is responsible for authorizing referrals for services and shares in the risks and rewards for the appropriate use of services.

Under a "prudent buyer" concept, some providers may be excluded from providing indigent health care on the basis of the price of services. However, the use of price alone to select providers may work against other important public policy objectives. For example, a provider may have comparatively high prices for services because of the costs of serving charity patients or delivering other essential community services. If that provider is excluded from serving individuals reimbursed by public programs or is not paid adequately, an overall reduction in the amount of care provided to indigents could occur. Prudent buyer approaches should consider overall effects on access by indigents and not simply the control of costs in a single program.

Many indigent Texans find themselves in a Catch-22 situation, too proud to ask for assistance but unable to pay for the services they so desperately need.

One woman gave just such a testimony to the Task Force in Lubbock. "It's not that I'm getting free service or nothing. We pay a little bit, you know, what we can afford," the woman said.

"But there's a lot of patients that really don't have the money to pay (the hospitals), and because a lot of them don't pay them, there's a lot of (hospitals) that won't see other patients because of some that don't pay.

"I feel responsible, because I know that I haven't paid some of my hospital bills, and for that reason they won't see other patients that might need the attention."

The woman testified that she has a brain tumor and needed a brain scan, for which she would have to pay cash, but was unable to do so.

Finally, she was sent to Galveston for the brain scan. "The Catholic welfare has been helping me go all the way (from Lubbock to Galveston). It's so expensive to go over there (to Galveston). But really the (biggest) problem is my family, my kids. If there was somewhere I could go, where my family could be, it would be so much easier."

RECOMMENDATION 45: COORDINATION OF STATE GOVERNMENT ACTIVITIES RELATED TO INDIGENT HEALTH CARE

THE HEALTH AND HUMAN SERVICES COORDINATING COUNCIL SHOULD MONITOR, EVALUATE, AND REPORT ON IMPLEMENTATION OF THE RECOMMENDATIONS OF THE TASK FORCE ON INDIGENT HEALTH CARE. FURTHER, THE SCOPE OF RESPONSIBILITY OF THE HHSCC SHOULD BE BROADENED TO EVALUATE ACTIVITIES OF ALL PARTIES INVOLVED IN INDIGENT HEALTH CARE.

The current delivery system for health care services is fragmented and complex, often reflecting multiple sources of administration and funding. The Task Force received testimony about duplication of services in some areas of the state, while it is known that significant gaps exist in many other areas. In some cases, state agency policies have worked against local public and private sector initiatives to serve the indigent. In other cases, state agency health programs appear to be operating independently of other similar state agency programs. A comprehensive coordinated planning and evaluation process is essential to improve efficient, effective delivery of health care services to the medically indigent in Texas. Recommendations by the Task Force on Indigent Health Care should be the basis for incremental changes in the health care delivery system in Texas.

The Health and Human Services Coordinating Council (HHSCC) was created to serve as the primary state resource to coordinate and plan for health and human services, to establish and maintain comprehensive data, to conduct and contract for studies of significant issues, and to review and analyze policies and make recommendations to the Governor and legislature. Because the issues considered by the Task Force on Indigent Health Care affect many state agencies and levels of government and because the changes recommended will occur over an extended period of time, it is appropriate to designate the HHSCC to monitor and report on implementation progress.

Currently, the scope of responsibilities of the HHSCC for health services is limited to federal, state, and local governments, other political subdivisions, and private sector services provided by voluntary health agencies. Testimony in public hearings and study by the Task Force revealed that the private sector plays a major role in the financing and delivery of health services to indigents:

- The availability of health insurance (both public and private) to a large extent defines who is medically indigent;
- Much indigent care is financed by cost-shifting, especially in hospitals, and activities of the private sector providers have a major impact on activities and responsibilities of public providers;
- Individual, private, voluntary activities to serve indigents are significant and should be recognized and encouraged.

Because the health care delivery system is complex, highly interrelated, and continues to undergo rapid change and because Task Force recommendations will be implemented over a period of years, HHSCC functions should be strengthened and reinforced.

RECOMMENDATION 46: TEXAS-MEXICO HEALTH CARE ISSUES

A COMPREHENSIVE EFFORT TO RESOLVE HEALTH CARE ISSUES AND PROBLEMS AFFECTING TEXAS AND MEXICO SHOULD BE INITIATED. THIS EFFORT SHOULD FOSTER COLLABORATION ON HEALTH PROBLEMS, HELP DEVELOP STATE AND LOCAL POLICIES, AND CREATE AN AGENDA FOR FEDERAL ACTION.

The effort should include a thorough assessment of health conditions, frameworks, and relationships that affect health care consumers and institutions in both Texas and Mexico. The effort should build on information gathered by the Task Force on Indigent Health Care and on the efforts of the U.S.-Mexico Border Health Association. It should also include support for innovative local projects on the border addressing common public health concerns, including the development of systems to exchange records and information and joint training of public health personnel. The effort should examine and develop policies and practices which can be implemented by state government to improve the situation. Further, it should develop recommendations for federal action which can be supported by the state leadership and the congressional delegation.

Texas's relationship with Mexico in most areas, including health care, is long-standing and complex. People from Mexico have migrated in and out of Texas for centuries, and similarly, people from Texas have traveled throughout Mexico. The economies of Mexico and Texas border cities have strong interdependencies that have developed as a result of the continual migration and travel of people from both sides.

Several factors have contributed to deteriorating

health conditions along the border. Both Texas and Mexico have experienced unprecedented population growth in the last decade. Almost all Texas-Mexico border cities have grown substantially. Some cities on both sides have even doubled their populations.

The Texas-Mexico border area economy has suffered dramatically because of Mexico's oil revenue loss and large debt payments. These events have led Mexico to devalue its currency several times. Generally, more people who have less financial resources to take care of their health are now in the border area.

Several studies have found that the health conditions of Texas residents who live along the border vary substantially from the state's general population. Many border area counties have higher ratios of population per physician, fewer, if any, hospital facilities, and higher mortality and morbidity rates than the rest of the state. Health conditions in Mexico's border areas pose even greater problems than in Texas's border areas.

Hospital administrators and city and county officials have testified in Task Force meetings and public hearings that their hospitals are providing substantial health care, especially for undocumented indigent persons. This indigent care often is placing an extra financial burden on the affected hospitals.

Social workers and health care providers also have testified that many United States citizens who live along the Texas border, now more than in the past, use medical services provided in Mexico. The increased use of Mexican medical services is occurring because these people cannot afford to pay the higher costs charged by health care providers in Texas. While many people express satisfaction with the treatment they receive in Mexico, these witnesses also testified that a number of problems are created by Texas citizens seeking care in Mexico. For example, when these people finally receive treatment in the United States, they often do so when their condition has worsened. This means that the hospital facility must spend more to treat them. Additionally, doctors who treat these patients often do so without the benefit of any medical records.

Mercy Hospital in Laredo, located in an area of the state with one of the highest unemployment rates, wrote off a total of $9.5 million in 1983 in uncompensated care.

That figure represents 30 percent of the hospital's revenue, said Ernesto "Buddy" Flores, Mercy Hospital administrator.

"Typically, most hospitals, especially if operating in the black, write off 10 to 15 percent of their revenue. Ours is pretty high," Flores said.

Of the $9 million, $2.5 million was for known charity care. Another $2 million was for bad debt in which an attempt was made to collect from previously unidentified charity care. Discounts to Medicare and Medicaid accounted for $5 million.

For indigent care, Mercy received $129,000 from Webb County and $79,000 from the City of Laredo. The Sisters of Mercy provided $70,000 for free charity care.

"Without those contributions, our net charity care would have been $2.7 million instead of $2.5 million," Flores said.

The Texas Advisory Commission on Intergovernmental Relations could assume a leading role in undertaking the work of the proposed study that will examine Texas-Mexico health care issues. The State of Texas should ensure that Texas-Mexico health care issues receive constant, consistent review and that state agencies, local governments, and health care institutions and practitioners obtain reliable information on developments involving this important area.

Agreement exists among Texas health organizations and the Task Force that Texas should seek ways to increase its cooperation with Mexico on this problem.

RECOMMENDATION 47: LIMITATIONS ON MEDICAL LIABILITY/INDEMNIFICATION OF PROVIDERS

THE STATE SHOULD DEVELOP OPTIONS FOR LIMITING THE LIABILITY OR INDEMNIFYING HEALTH PROFESSIONALS AND INSTITUTIONS FOR SERVICES PROVIDED TO THE INDIGENT ON A VOLUNTARY BASIS AND FOR SERVICES PURCHASED BY STATE OR LOCAL GOVERNMENTS FOR INDIGENTS.

Health care providers and practitioners have said that the potential or threat of a lawsuit discourages many health professionals and providers from participating in programs that serve the indigent. For example, providing several hours of service per week in a clinic may result in a sharp increase in malpractice insurance rates.

The practice of defensive medicine because of the fear of malpractice suits also increases the overall costs of health care. Sustained health professional and provider participation is crucial to the success of state and local health care programs. Private voluntary efforts by providers can affect the need for public programs and can complement them by serving some individuals not covered by public programs or by reducing the need for individuals to use publicly funded programs.

Actions by the state to limit liability or to indemnify

providers should provide incentives to health professionals and institutions to voluntarily participate in indigent health care programs.

However, a voluntary effort or government payment should not be a defense for careless action or omission by a provider. The duty of providing quality care should be maintained, despite the source or amount of payment, so that a dual system of care is not created. Similarly, any action by the state to reduce the liability of health professionals and institutions should not create a lesser system of justice for the indigent.

The state has a variety of options for limiting liability of health professionals and institutions. The reasons for increases in malpractice insurance rates and policy options should be examined and a comprehensive program which is fair to providers and to indigent patients should be developed. For example, the state could broaden the Tort Claims Act to include services rendered by private practitioners and by public or private facilities, either government-compensated or charity.

The state may also want to purchase insurance for health professionals and institutions. The state could establish a no-fault insurance program similar to the one that exists for motorists. The statute of limitations period could be reduced. Upper limits also could be established for judgments for pain and suffering. The state also might want to modify the contingent-fee system for lawyers or stiffen medical profession regulations.

RECOMMENDATION 48: USE OF NONPHYSICIAN HEALTH CARE PROFESSIONALS

IMPROVEMENTS IN ACCESS TO CARE AND GREATER EFFICIENCY IN THE DELIVERY OF SERVICES CAN BE MADE BY THE OPTIMAL USE OF NONPHYSICIAN HEALTH CARE PROFESSIONALS. THE STATE SHOULD APPOINT AN INTERIM STUDY COMMITTEE TO CONDUCT A COMPREHENSIVE EVALUATION OF THE POTENTIAL USE OF NONPHYSICIAN HEALTH CARE PROFESSIONALS AND TO RECOMMEND NECESSARY LEGISLATIVE CHANGES TO MAKE BETTER USE OF NONPHYSICIAN HEALTH CARE PROFESSIONALS.

Certified and licensed nonphysician health care professionals can be highly effective in providing services. The effective utilization of these nonphysician health care professionals can allow the physician to apply his knowledge and skills to the more serious health and medical problems.

The Task Force heard considerable testimony about the potential use of nonphysician health care professionals, in particular, nurse midwives.

Testimony was heard that nurse midwives can safely manage normal pregnancies at low cost and with high patient satisfaction. Testimony was also heard that nurse midwife services are being provided successfully in several programs in the state.

Nurse midwife services, where legally authorized, are mandatory for state Medicaid programs. Although the practice of midwifery has been recognized as legally permitted in Texas, nurse midwife services are not reimbursed directly by the Medicaid program because of ambiguity about the precise scope of services which may be legally provided.

In addition, the Task Force heard testimony about the need for educational programs to provide training of nonphysician health care professionals. Training for nonphysician health care professionals in different regions across the state may improve the cultural and language congruence between patient and provider and improve access and use of the health care system.

The Task Force's charge asked that the Task Force not attempt to address issues related to the use of nurses and other nonphysician health care professionals. However, issues of access to health care are highly interdependent, and it is difficult to exclude substantial areas from consideration.

It would be appropriate for the state to systematically assess issues related to the use of nonphysician health care professionals and to develop necessary legislative changes to make better use of all licensed and certified professionals and to improve access and appropriate use of health care resources.

RECOMMENDATION 49: OPTIONAL MEDICAID SERVICES

THE DEPARTMENT OF HUMAN RESOURCES SHOULD CONDUCT A STUDY TO ASSESS THE COST AND EFFECT OF ADDING OPTIONAL SERVICES NOT CURRENTLY INCLUDED IN THE STATE MEDICAID PLAN. THE RESULTS OF THE STUDY SHOULD BE REPORTED TO THE 1987 REGULAR SESSION OF THE LEGISLATURE. DHR SHOULD DEVELOP A PLAN TO PHASE IN ADDITIONAL MEDICAID SERVICES WHICH ARE COST EFFECTIVE, CONFORM TO THE PRIORITY SERVICE CATEGORIES ESTABLISHED BY THE TASK FORCE, AND MAY REDUCE THE COSTS OF OTHER STATE OR LOCALLY FUNDED HEALTH PROGRAMS.

Texas does not cover many services which are options under federal guidelines. These include:

1. clinic services
2. other practitioners' services
3. dental services
4. screening services
5. preventive services
6. dentures
7. diagnostic services
8. physical therapy
9. occupational therapy
10. speech, hearing, and language disorder therapy
11. Skilled Nursing Facility (SNF) services for persons 65 or older in TB institutions
12. Intermediate Care Facility (ICF) services for persons 65 or older in TB institutions
13. SNF services for persons under age 21
14. home health physical and occupational therapy, speech pathology, and audiology
15. inpatient psychiatric services for individuals under age 21
16. mental disease inpatient hospital services for individuals 65 and older
17. mental disease SNF service for individuals 65 and older
18. mental disease ICF services for individuals 65 and older

Some of these services may be provided through other state or local programs, and a Medicaid service expansion may reduce the need for state or local funds. Other services may be cost effective for the state to cover and may reduce long-term costs.

The costs and benefits of adding new services must be compared to the costs and benefits of using public funds to increase the number of individuals eligible for Medicaid. Care must be taken to avoid creating a benefit package under Medicaid which would not be available through employment-based health insurance and would reduce incentives to seek employment.

RECOMMENDATION 50: COST CONTAINMENT

THE STATE SHOULD UNDERTAKE A COMPREHENSIVE EFFORT TO DEVELOP COST-CONTAINMENT STRATEGIES TO ENSURE THAT MEDICAL INDIGENCY DOES NOT INCREASE BECAUSE OF RAPIDLY ESCALATING HEALTH CARE COSTS.

Although health care cost containment is relevant to the interest of the Task Force, the charge from the state leadership asked that the Task Force not attempt to address cost containment in order to develop recommendations in other areas. However, the continuing escalation of health care costs makes cost-containment initiatives critical to the long-term success of indigent health care programs. In fact, the availability of affordable health care to many Texans who are not indigent may be jeopardized by continuing increases in health care costs.

Health care costs increase for a number of reasons, including changes in demographics, general inflation, changes in medical technology and treatment modalities, and the use of financing and reimbursement systems which are not cost sensitive. There is little agreement about the solutions to increasing health care costs. Any cost-containment initiatives should consider both regulatory and competitive strategies for controlling costs and should be system-wide in approach. Cost-containment initiatives should attempt to improve the efficiency and effectiveness of the health care delivery system rather than limiting costs by reducing program services or shifting costs to other programs.

Appendix

TASK FORCE ON INDIGENT HEALTH CARE

MEMBERS

Dr. Ron Anderson, Dallas
Ken Argo, DDS, Carrollton
Philip Armour, PhD, Dallas
Rep. Gordon "Doc" Arnold, Terrell
Judge Tom Bacus, Wichita Falls
Pat Bailey, New Braunfels
Morris "Snake" Bailey, Amarillo
Steve Bickerstaff, Austin
Joseph Boro, Fort Worth
David Briones, MD, El Paso
Sen. Chet Brooks, Pasadena
Judge Les Brown, Andrews
Zen Camacho, PhD, Houston
Jamie Clements, Temple
Jud Cramer, Fort Worth
Judge "Doc" Lester Cranek, Columbus
Rafael De La Cruz, MD, Brownsville
Elaine Darden, Houston
Mayor Pro Tem Irma Dickey, Trinidad
Tom Dunning, Dallas
Dick Durbin, Houston
Joseph A. Ethridge, Austin
Scott Evans, Round Rock
Helen Farabee, Wichita Falls
J. Jerdy Gary, Denison
Dr. Charles E. Gibbs, San Antonio
Dr. Bob Glaze, Gilmer
Frances Goff, Houston
Paula Gomez, Harlingen
Francisco Gonzales, Harlingen
B. D. Griffin, Fort Worth
Lauro G. Guerra, MD, McAllen
Rev. John D. Hardin, Jasper
Douglas Hawthorne, Dallas
Mary Haynes, El Paso
Bobby Henson, Happy
Christine Hernandez, San Antonio
Don Horn, Houston
Harry Hubbard, Austin
W. R. Jenkins, DO, Fort Worth
Billy Jewell, Arlington
Ron Jordan, Fort Worth
Rep. Don Lee, Harlingen
Dorothy Lee, Tyler
Bill Levin, MD, Galveston
Dr. Cervando Martinez, San Antonio
Dora McDonald, Dripping Springs
Vernon McGee, Austin
Stephen McIntyre, Lubbock
Mort Myerson, Dallas
Robert Moreton, MD,FACR, Houston
Mayor Ron Mullen, Austin
Rep. Jesse Oliver, Dallas
Belinda Pillow, Waco
Roger Pricer, Sour Lake
Mayor Cy Rone, Azle
Bill Ross, MD, Dallas
Norberto "Beto" Salinas, Mission
Sister Mary Sapp, San Antonio
Marina Sifuentes, Austin
Dr. James Simpson, Corpus Christi
Jim Smith, Clifton
Ron Smith, Fort Worth
John Stevens, PhD, Abilene
Albert Tate, DDS, Austin
Lin Team, Austin
Sen. John Traeger, Seguin
Jim Tyson, Dallas
Barvo Walker, DDS, Dallas
Dr. Mary Walker, RN, Austin
Dr. Lowell Wilder, Falfurrias

September 29, 1983

Because of the scope and urgency of this issue, we have decided to jointly appoint a Task Force on Indigent Health Care. This group reflects the diversity of interests and concerns about health care for indigents. The Task Force includes: elected officials, health care providers and administrators and citizen-consumers. The elected officials will serve as the executive committee of the Task Force. Mrs. Helen Farabee will be the Chairperson of the Task Force.

The Task Force should explore and collect information about needs and problems in the delivery of health care to indigents and should develop proposed solutions to those problems. The Task Force is charged with presenting a package of findings and recommendations to the 69th Texas Legislature. This package should propose a pilot program approach to implement and test the Task Force's recommended methods of delivering health care to indigents. Findings from pilot activities should be reported to the 70th Texas Legislature for consideration of statewide application.

In the course of its work the Task Force should address four subjects: who is at risk and what eligibility criteria should be applied to those individuals; the scope of services to be provided; administrative structure to operate a program; and methods of finance.

The Task Force will meet from October 1983 through November 1984 and will require a commitment of your time and effort to achieve its purposes during that period. Your knowledge and experience will be most useful in assisting the Governor's Office and the Texas Legislature with creative strategies to resolve problems in the current system of providing health care for indigents. We have an opportunity now to make significant strides in meeting the health care needs and improving the quality of life for the people of this state.

We look forward to you participation and assistance on the Task Force on Indigent Health Care.

Yours truly,

Mark White
Governor
State of Texas

William P. Hobby
Lt. Governor
State of Texas

Gib Lewis
Speaker, House
of Representatives
State of Texas

Pilot Program Concept

The Task Force was asked to recommend a pilot program approach to implement and test the adequacy of its recommended method of providing health care service for indigents.

During the course of its study, the Task Force found that:

- The medically indigent primarily are those persons without adequate health insurance.
- Financing health care for indigents falls disproportionately on certain types of providers and certain communities.
- Geographical access to care for indigent Texans is limited, despite underutilization of some private facilities.
- Public and private nonprofit hospitals' ability to continue providing quality care to indigent Texans is seriously threatened.
- Indigent Texans experience a critical lack of access to certain services, such as maternity and primary care services, which in the long run could reduce overall health care costs.

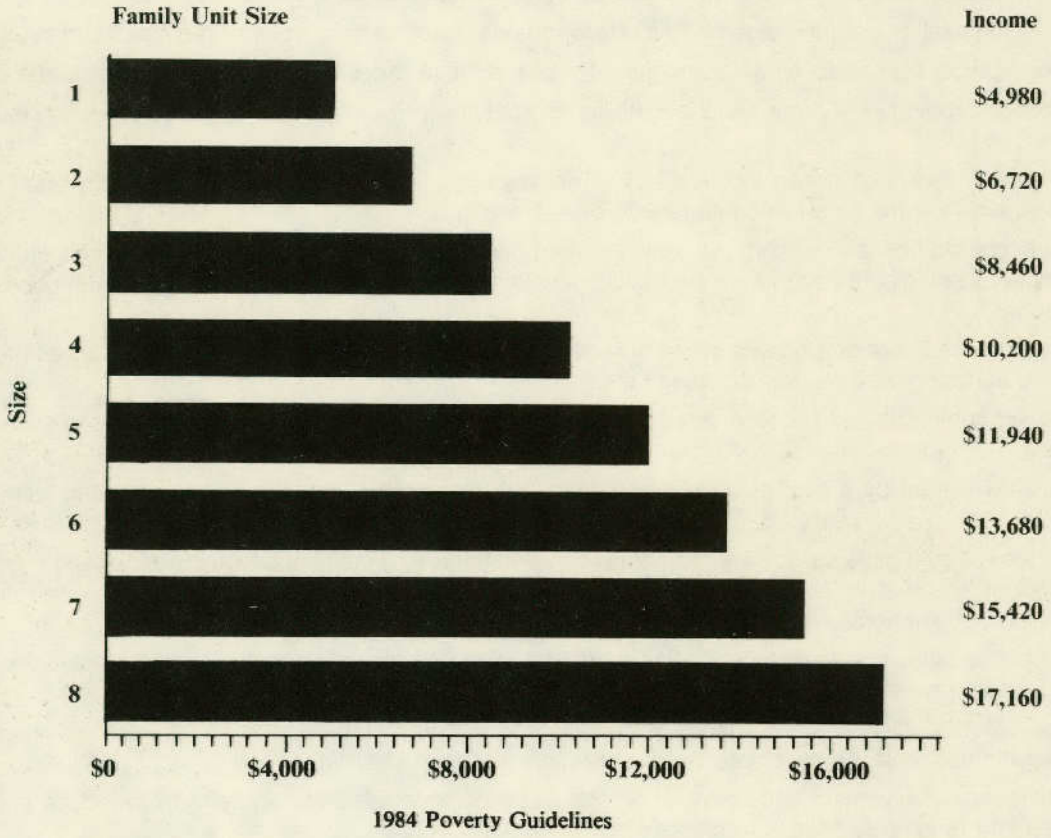
The Task Force did not recommend one exclusive method to provide health care services for indigents for several reasons. The problems of indigent health care are multidimensional; the state is diverse; and local health needs and resources vary considerably.

However, the Task Force proposed a series of recommendations, which together will improve access to care and more equitably distribute responsibilities for providing care.

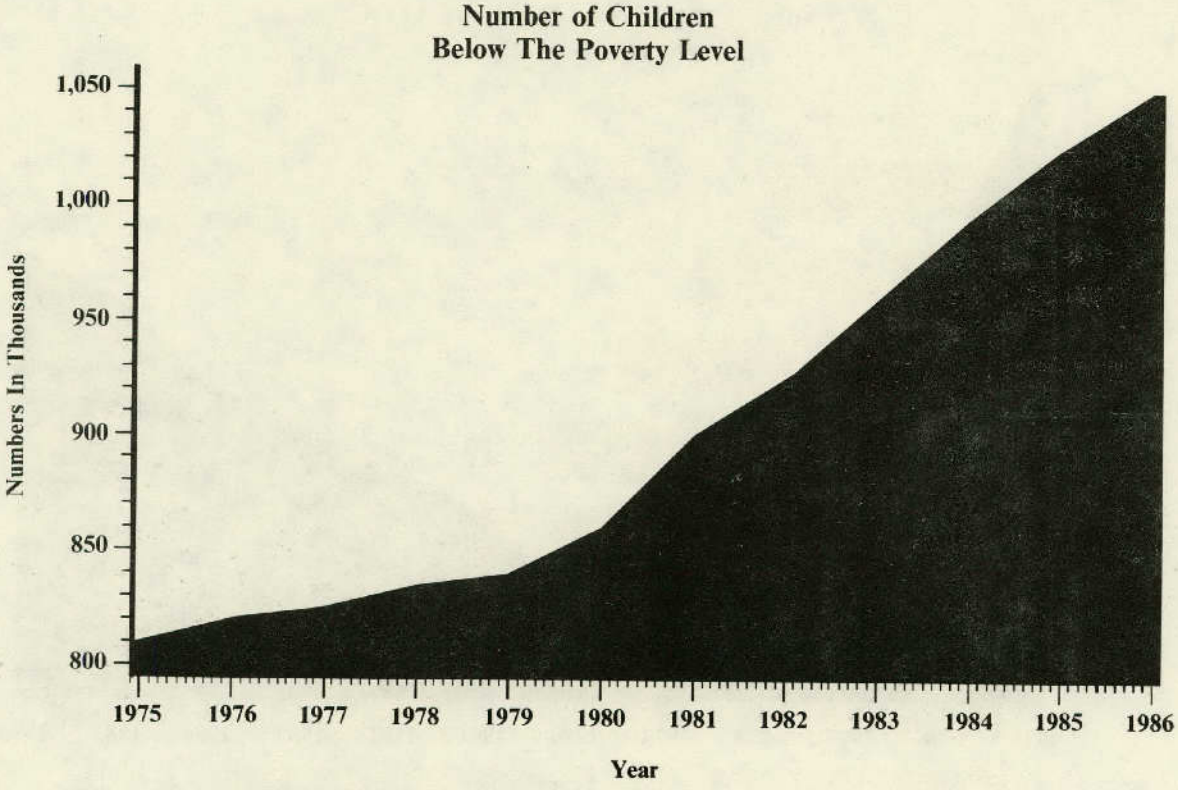
The following criteria should be considered to select, develop, and implement pilot programs in several areas of the state:

- The area served by a pilot project should have high rates of poverty, unemployment, and lack of health insurance.
- The area should have substantial problems in access to care by indigents, high morbidity and mortality rates, lack of public hospitals or abundance of fiscally stressed hospitals, waiting lists for care or significant delays in arranging appointments.
- Multiple counties and local jurisdictions should be involved, and a regional approach to planning, administering, and delivering services should be used.
- Local elected officials, state agency staff, local community members, and health care providers should be involved in the project's development, organization, and management.
- Multiagency involvement and cooperation should be demonstrated through efforts to reduce duplication of services and to simplify access to care.
- The project should demonstrate collaboration and full use of public and private financial resources, including:
  - — participation of local governments in meeting minimum requirements for serving indigents, as established by the Task Force;
  - — charity care commitments and voluntary efforts by local private providers; and
  - — participation of programs funded by the state and federal governments.
- Service priorities established by the Task Force and local needs should be reflected.
- Monitoring and evaluation should be a component of the project.

Federal Poverty Income Guidelines For All States

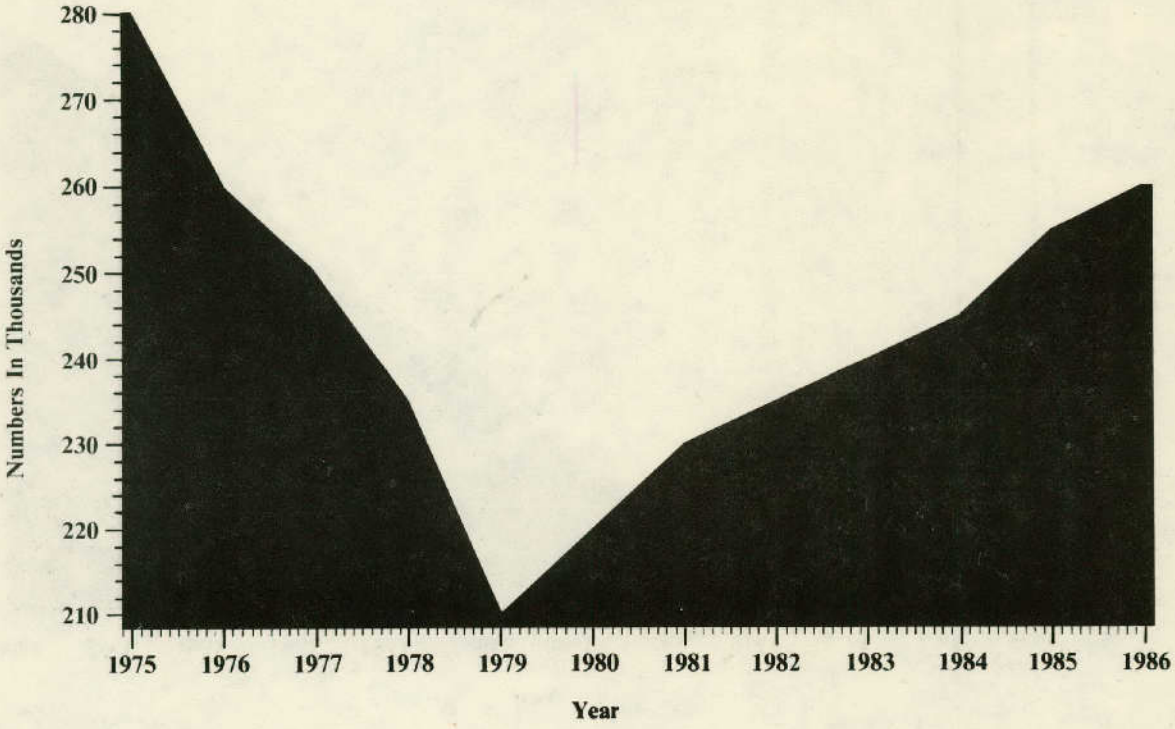


SOURCE: Federal Register; Vol. 49, No. 39; February 27, 1984.



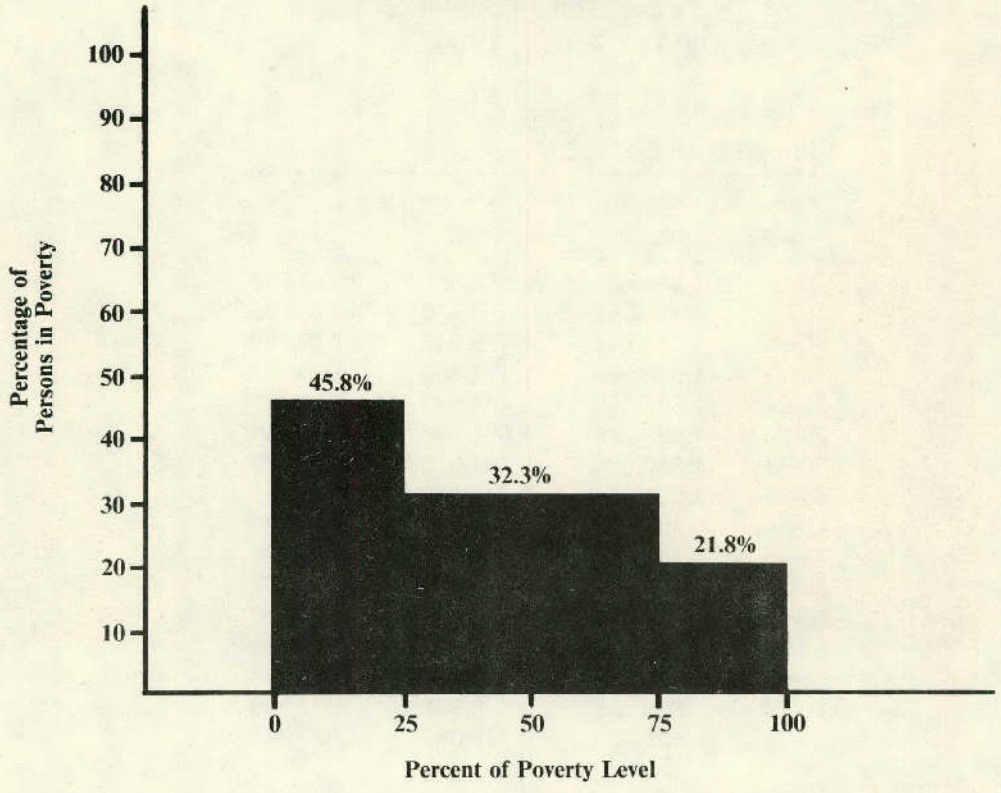
SOURCE: Texas Department of Human Resources.

Number of Children Receiving AFDC
Average Per Month



SOURCE: Texas Department of Human Resources.

Persons Below the Poverty Level Who Have No Insurance



SOURCE: Texas Department of Human Resources, 1981 Biennial Survey.

Actual and Projected Total Texas State Population By Age Group, 1984-2000

All Race/Ethnic Groups

Age Group	Actual	Projected	
	1984	1990	2000
0- 4	1,314,426	1,588,055	2,128,712
5- 9	1,315,553	1,589,525	2,126,348
10-14	1,264,941	1,429,947	2,018,882
15-19	1,363,962	1,415,880	1,996,187
20-24	1,397,150	1,404,637	1,761,673
25-29	1,423,786	1,655,999	1,811,447
30-34	1,340,965	1,781,913	1,871,077
35-39	1,096,659	1,549,843	2,026,747
40-44	908,373	1,308,596	2,095,835
45-49	784,824	997,581	1,789,708
50-54	713,784	785,504	1,472,807
55-59	667,441	718,875	1,098,463
60-64	579,568	672,832	804,464
65-69	520,855	607,217	695,654
70-74	398,726	450,991	579,389
75	609,535	770,067	1,039,474

SOURCE: State Health Planning and Resource Development, Texas Department of Health, December 1984.

Total Number of Hospitals and Hospital Beds By Type of Ownership

Type of Ownership Group	Number of Hospitals	Number of Beds	Percent of Total Beds
Public			
Hospital District	91	8,382	12.0
County	40	3,333	4.8
City	9	771	1.1
City/County	4	399	0.6
Hospital Authority	39	3,498	5.0
Total	183	16,383	23,5
Private/Investor-Owned			
Corporation	170	20,185	29.0
Partnership	11	280	0.4
Individual	2	42	0.1
Total	183	20,507	29.5
Private/Non-Profit			
Church	43	13,050	18.8
Non-Profit Corporation	119	17,704	25.4
Other Non-Profit	14	1,938	2.8
Total	176	32,692	47.0

SOURCE: Texas Department of Health, February 1984.

APPENDIX A

SUMMARY OF INDIGENT HEALTH CARE PROGRAMS

TITLE	Description	Who is Served	How is Eligibility Determined	What Services are Provided	How is the Program Financed	How is the Program Administered
MEDICARE	Title 18 of the Social Security Act is a federally funded program which provides hospital and physician services.	. The aged (65+) . Persons under 65 who have been receiving cash Social Security benefits due to a disability for two consecutive years. . Certain chronic disease patients. . 1.5 million eligible in Texas in 1982.	. Based on age, disability or disease. . Determined by federal Social Security offices.	Hospital services (HI) are provided under Part A; voluntary supplementary medical insurance (SMI) provided under Part B include physician, outpatient and home health services.	Funded from payroll contributions from individuals presently working and monthly premiums by Part B enrollees. . $2.5 billion spent in Texas in 1983.	Federally administered; uses carriers and intermediaries to pay claims.
MEDICAID	Title 19 of the Social Security Act is a state and federal program to provide services to certain groups of low income individuals.	. The aged, blind or disabled (about 270,000 per month are eligible). . Families receiving AFDC (about 250,000 children per month are eligible). . Other categorically related individuals with low incomes unable to pay for medical care.	. Eligibility is based on income, family size, resources, and in some cases disability or medical expenses. . The state administers AFDC and nursing home eligibility. . The federal government determines eligibility for the aged, blind, and disabled.	Inpatient and outpatient hospital, physician, pharmacy, lab and X-ray, SNF, ICF, ICF-MR, EPSDT, transportation, home health and other.	Federal funds match state and local government funds at approximately 50-50 rate. $1.812 billion budgeted for health care services in FY85.	DHR is single state agency responsible for the program; some functions contracted.
COMMUNITY AND MIGRANT HEALTH CENTERS	Provide primary care services in medically underserved areas.	Medically and economically disadvantaged individuals in target areas. Approximately 200,000 served in Texas annually, 69% below 100% of poverty level.	Based on income and family size; sliding fee scales are used. Administered by the center.	Physician, PA and nurse clinician services, lab and X-ray; preventive dental, pharmaceutical, emergency and preventive services.	In 1982, about $25 million in federal funds were provided to 28 community health centers. Some funding from patient fees and third party resources.	Each center has board including clinic users and community leaders which establishes policy.

SUMMARY OF INDIGENT HEALTH CARE PROGRAMS (Continued)

TITLE	Description	Who is Served	How is Eligibility Determined	What Services are Provided	How is the Program Financed	How is the Program Administered
MATERNAL AND CHILD HEALTH PROGRAMS	Provides access to maternal, child health and family planning services	Low income families. In 1983, the program served 60,136 maternity service patients, 309,264 family planning patients (Title X included), 127,000 child health patients. WIC served about 140,000 individuals.	Eligibility is based on federal poverty guidelines. Pregnant and lactating women are eligible for WIC.	. Screening, physical exams and lab services for women and children . Vision, hearing, and speech screening of children. . Nutritional assessment and supplemental foods for women.	For 1984, clinic program budget of $23.3 million, WIC budget of $84,067,795 million; vision, speech and hearing budget of $1 million.	For MCH, local health departments contract with state health department or through regional public health systems. For WIC state TDH contracts with 56 local agencies.
CRIPPLED CHILDREN'S SERVICES	Program locates and provides specialized medical services, hospital care and follow up services for eligible children.	78,000 on case register; about 25% served per year. Most have specific health needs caused by bone, joint, muscle, or ossicular chain (ear) defects or deformities, neurological conditions including neurofibromatosis, congenital heart defects, childhood cancer and cystic fibrosis.	Parents unable to pay for necessary care for child under 21 years of age. No age limit for persons with cystic fibrosis.	Specialized medical and hospital care and follow up services to correct handicapping conditions.	$35.3 million budgeted for FY84; includes $3.5 million federal.	. State Department of Health. . Regional/local level provide follow up activities.
DENTAL HEALTH	Dental treatment.	Individuals under age 19 who are not eligible for other dental programs. 19,740 to be served FY84	. Dental care: guidelines adopted by the Bureau of Dental Health (same as those applicable to full free lunch guidelines used by Texas public schools. Persons eligible cannot be recipients of other local/state programs.	Basic dental services for the relief of pain and infection.	- 2.3 million is the budget and this includes federal funds for flouridation - The amount budgeted for dental care/dental health education in FY84 is 1.9 million (state general revenues) - The amount for indigent dental care in FY84 is approximately $1.5 million.	Public health regions with support from central office.

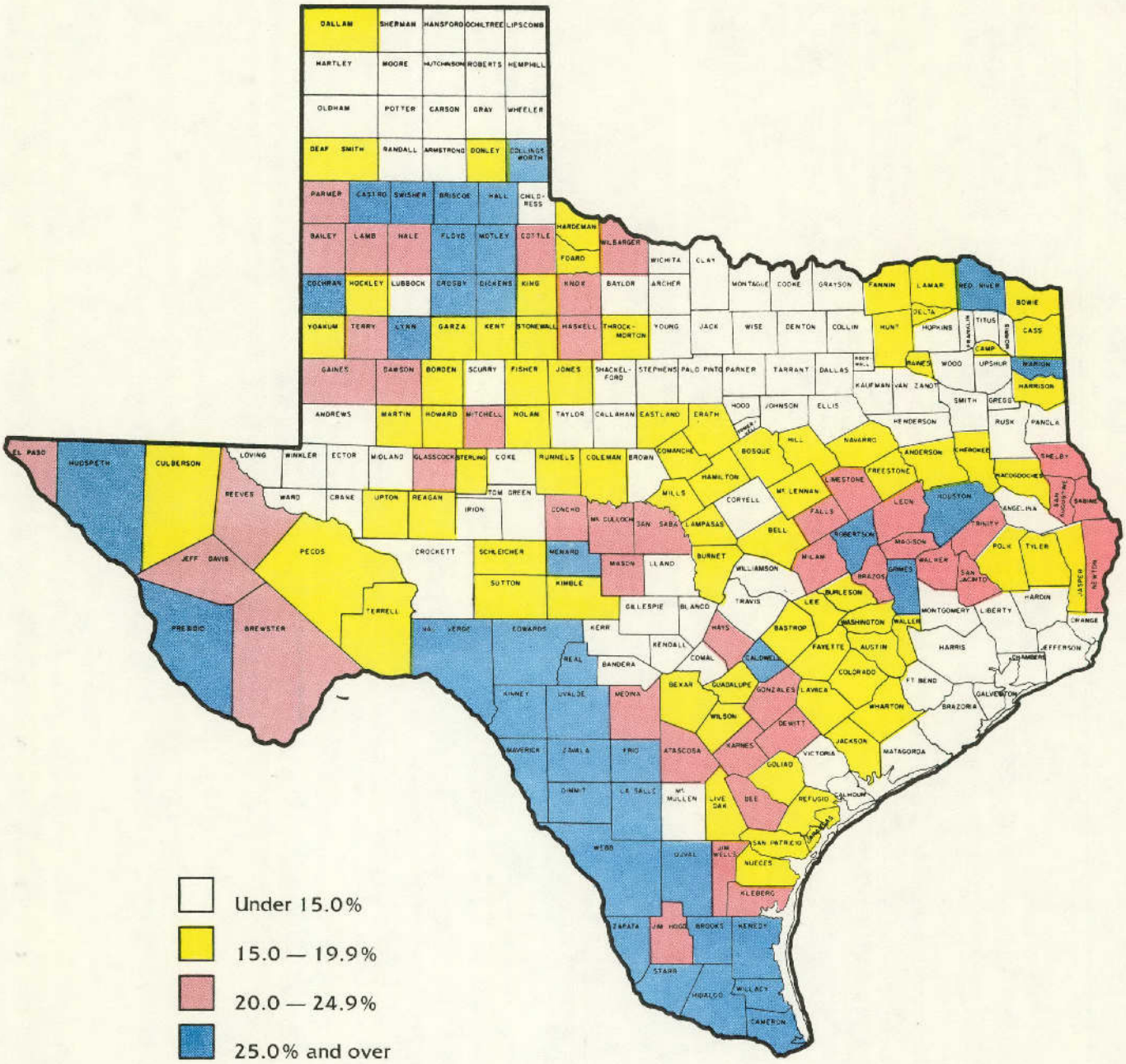
SUMMARY OF INDIGENT HEALTH CARE PROGRAMS (Continued)

TITLE	Description	Who is Served	How is Eligibility Determined	What Services are Provided	How is the Program Financed	How is the Program Administered
KIDNEY HEALTH PROGRAM	Services extend the life expectancy and improve the quality of life of persons with end-stage renal disease and to prevent their being pauperized by cost of treatment.	End-stage renal disease patients.	- Medical diagnosis of end-stage renal disease - Texas resident - Enroll through a program approved dialysis facility, a Medicare approved hospital, or a V.A. hospital located in Texas	Benefits provided for: - dialysis treatment - hospitalization and laboratory charges - physician's charges - home dialysis supplies - medications - transportation	State Legislature appropriation FY84 $12.0 million FY85 $15.7 million	State Department of Health through dialysis center contractors.
ADULT HEALTH PROGRAM (CHRONIC DISEASE SCREENING)	Three distinct services: .Diabetes screening. .Multiphasic screening. .Hypertension services.	- Diabetes Screening: 16+ year old Texas residents meeting high risk criteria - Multiphasic screening: 16+ year old Texas residents in need of services for selected chronic diseases - Hypertension services: 16+ Texas residents in need of screening, detection, referral, and follow-up on compliance with treatment for hypertension.	Based on age and risk criteria.	. Diabetes screening: screening/educational services. . Multiphasic screening: comprehensive screening and follow up for selected chronic diseases in 5 public health regions (2, 4, 5, 6, 9) and one metropolitan health district. . Hypertension services: preventive services for screening, detection, referral, and follow up on compliance with treatment for hypertension.	- Diabetes screening: state ($120,000 FY84) - Multiphasic screening: state ($424,479 FY84) - Hypertension services: Federal ($408,045 FY84)	Central office direction with services delivered by public health nurses in regional and local health departments and several migrant health clinics.

SUMMARY OF INDIGENT HEALTH CARE PROGRAMS (Continued)

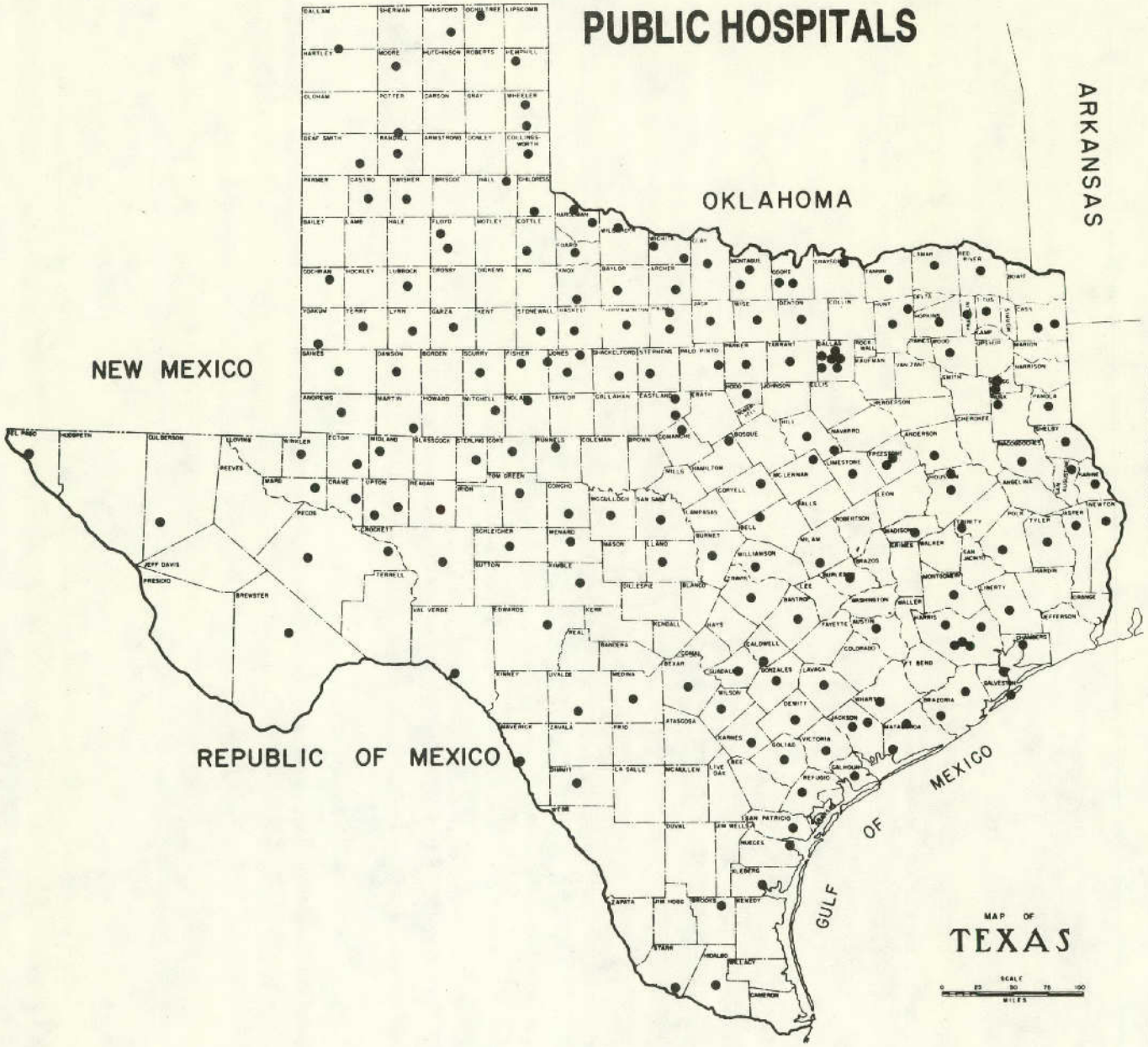
TITLE	Description	Who is Served	How is Eligibility Determined	What Services are Provided	How is the Program Financed	How is the Program Administered
PUBLIC HOSPITALS	In Texas there were 189 state and local community hospitals in 1981. (Note: hospital statistics from 1981 AHA Survey)	Serve many uninsured, unemployed as well as others. 639,000 admissions total in 1981. Provide most of charity care provided through hospitals	Determined by providers. Generally use poverty income guidelines or some variation.	Major services provided by public hospitals: . outpatient and emergency care. . community services (ie., acute mental illness, alcoholism, drug dependency). . In urban areas, specialized tertiary care (life-threatening trauma, neonatal intensive care) and specialty training for physicians and other health professionals.	Local tax dollars and third-party coverage including public and private insurance programs.	Hospital Boards, County Commissioners, Hospital District Boards, County Judges.
NOT-FOR-PROFIT HOSPITALS	In Texas there were 159 not-for-profit hospitals in 1981. Not for profits must provide charity care for tax exemption.	1,206,000 admissions in 1981.	Determined by provider. Institutions that received loan assistance from the federal government under Hill-Burton must provide a specified volume of uncompensated care for as long as the loan remains unpaid or for a period of up to 20 years.	Inpatient, outpatient services vary by facility.	Medicare, Medicaid, and other third-party coverage.	May be administered and operated locally or as part of a larger chain or system.
INVESTOR-OWNED HOSPITALS	In Texas there were 150 investor owned hospitals in 1981.	667,000 admissions in 1981.	By provider. Texas hospitals may not deny emergency care to individuals if available at the hospital	Inpatient, outpatient services vary by facility.	Medicare, Medicaid, and other third-party coverage.	May be administered and operated locally or as part of a larger chain or system.

PERCENT OF POPULATION BELOW POVERTY
TEXAS COUNTIES 1979



Source: 1980 Census of the Population
Bureau of the Census

PUBLIC HOSPITALS



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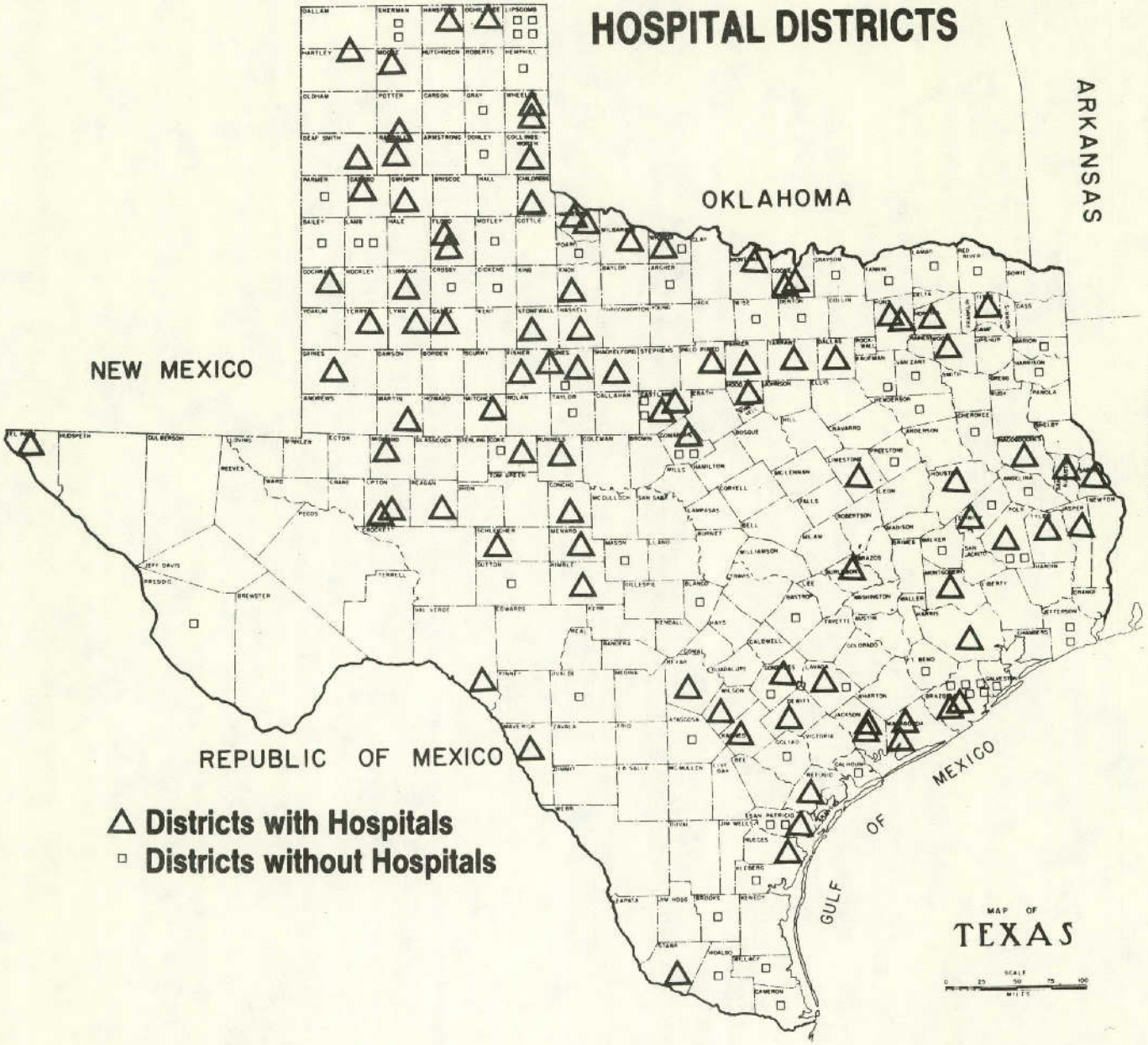
HOSPITAL DISTRICTS



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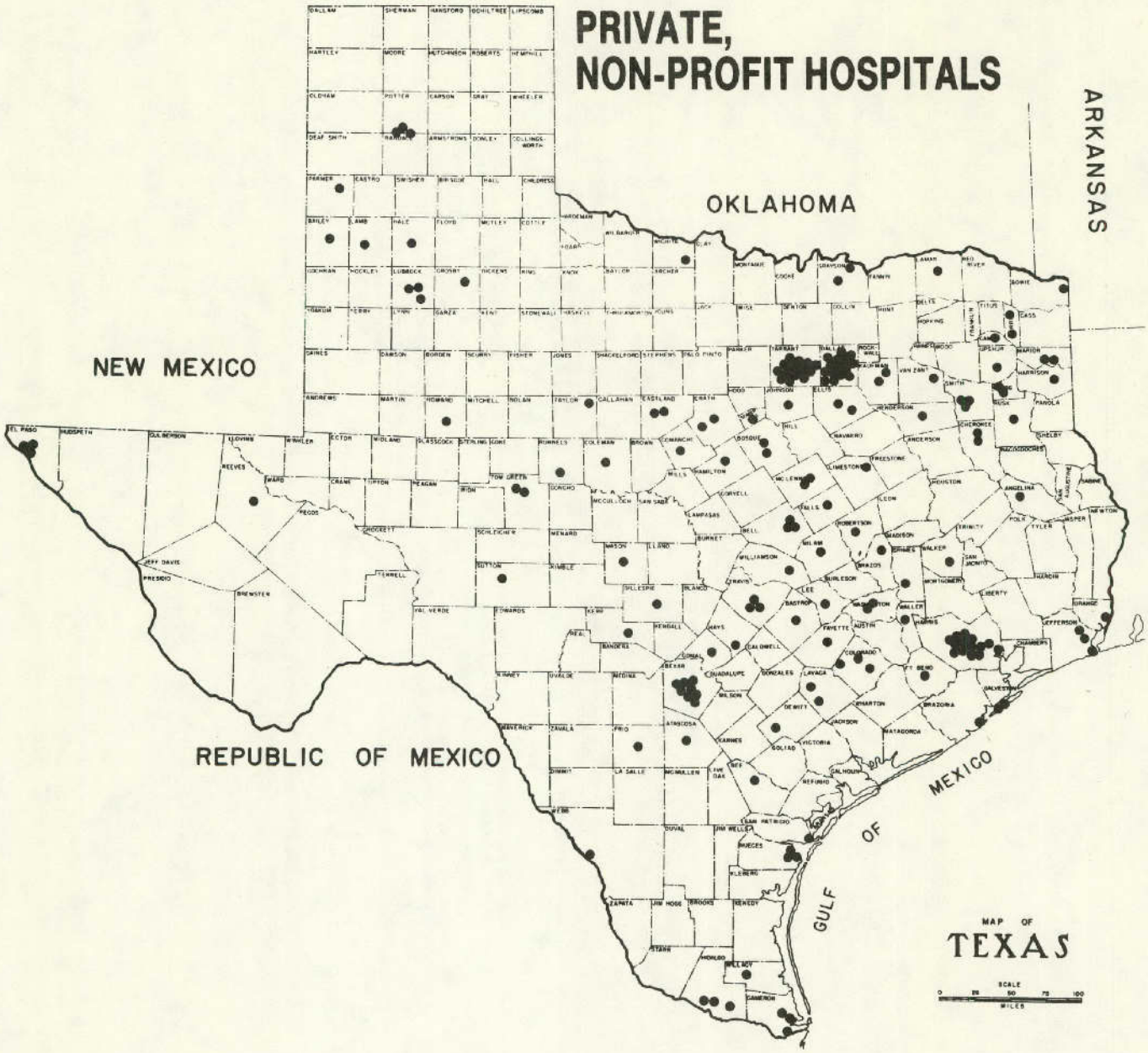
PRIVATE, NON-PROFIT HOSPITALS



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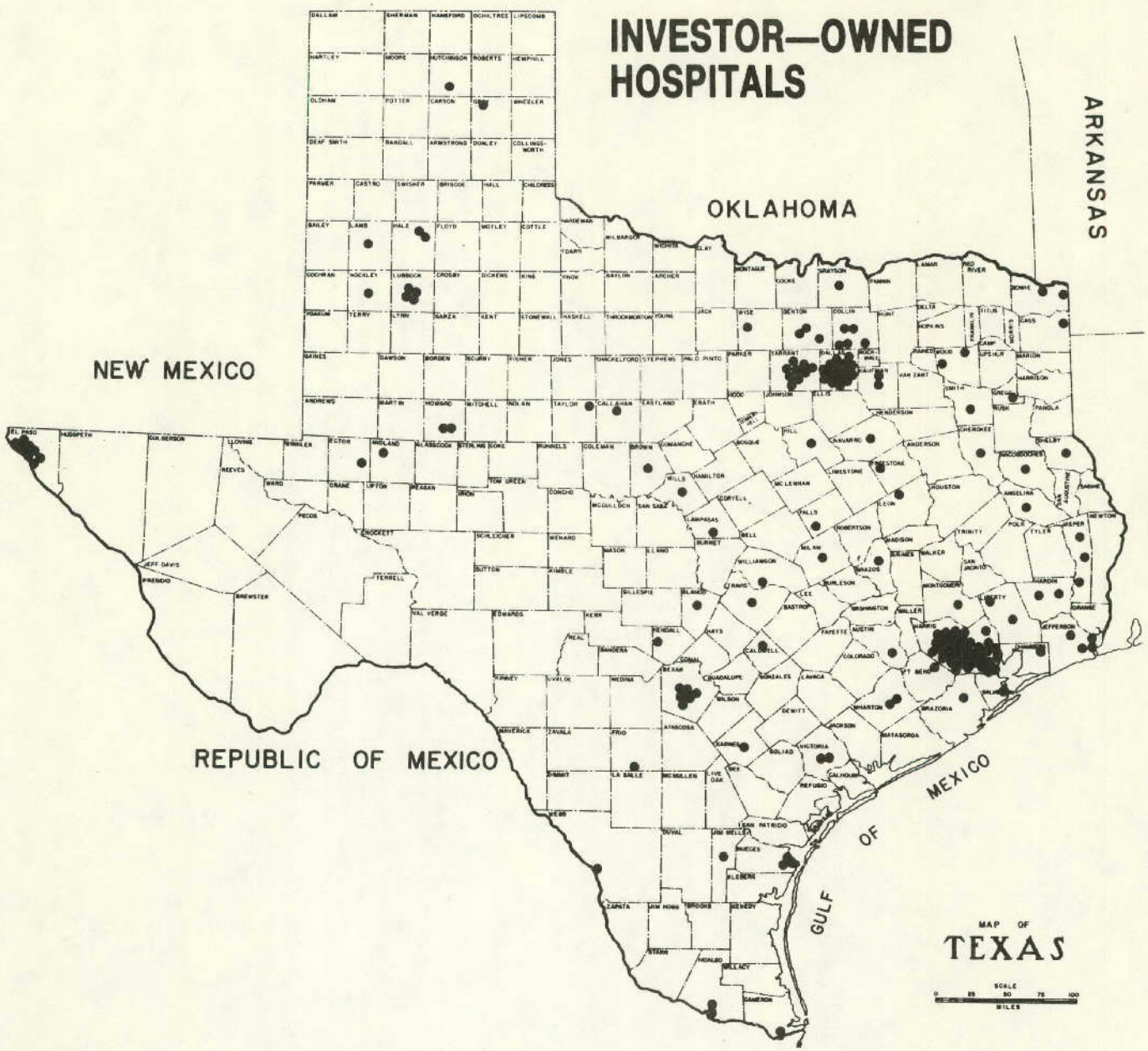

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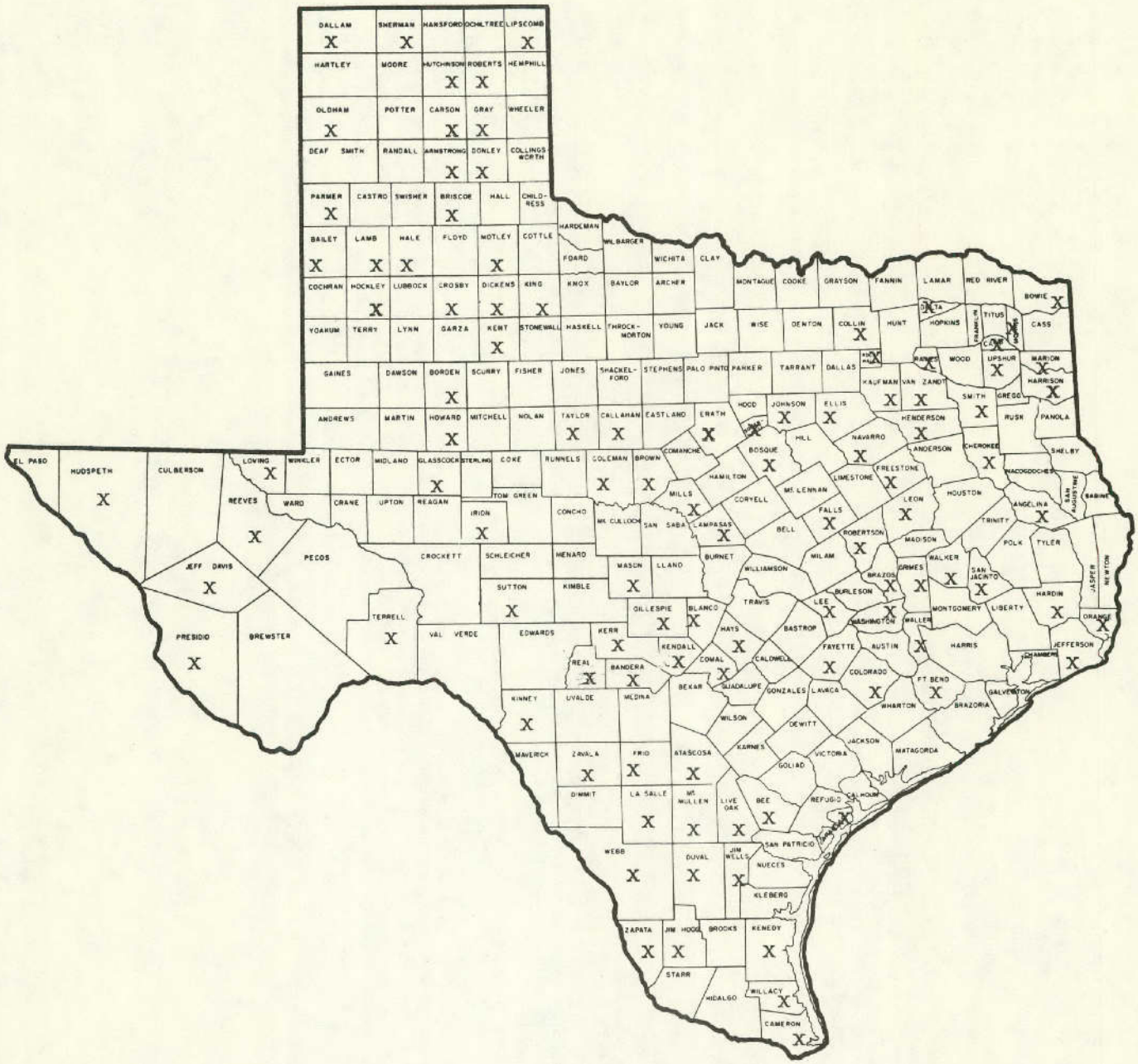
TEXAS COUNTIES WITHOUT PUBLIC HOSPITALS



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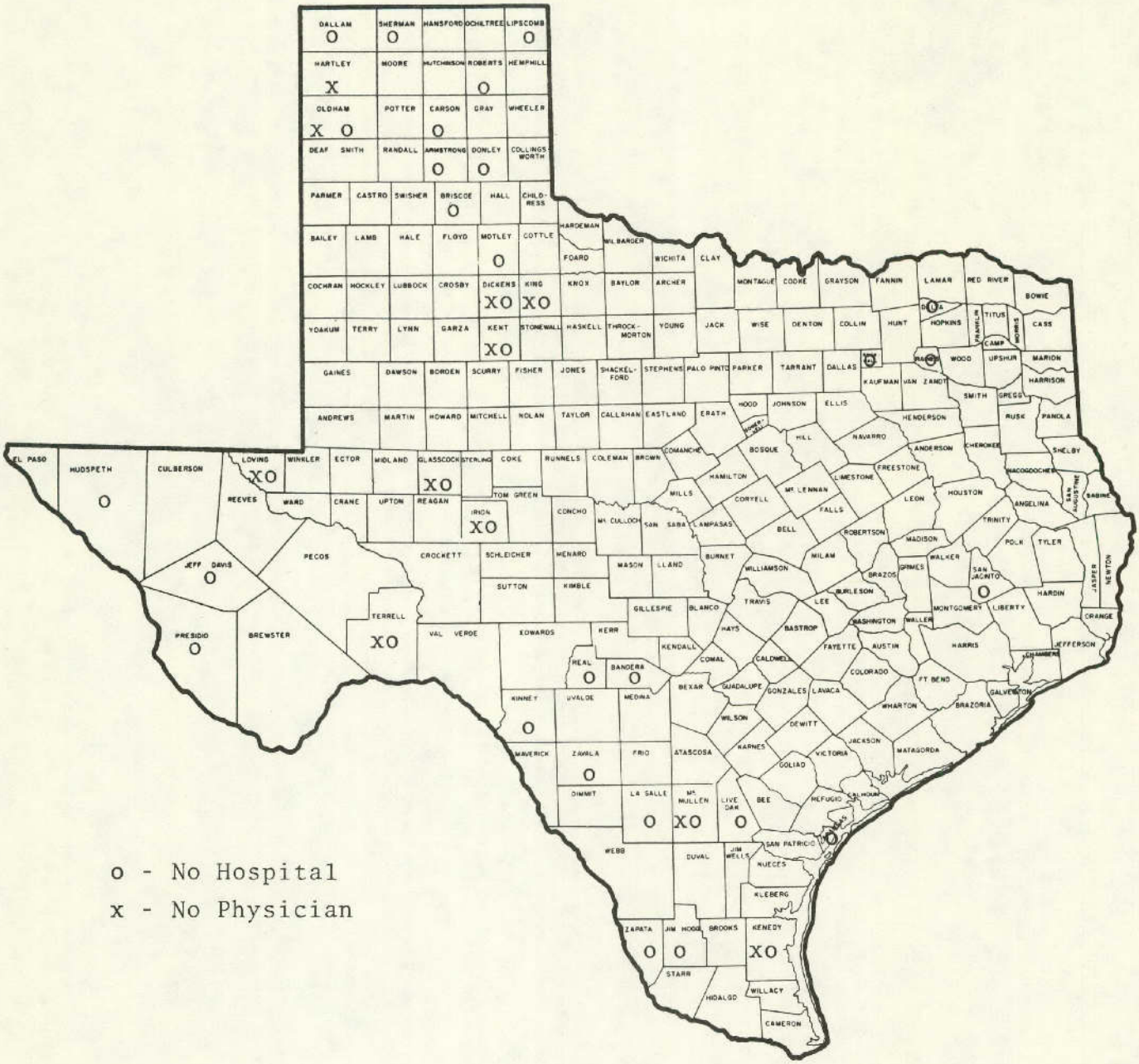
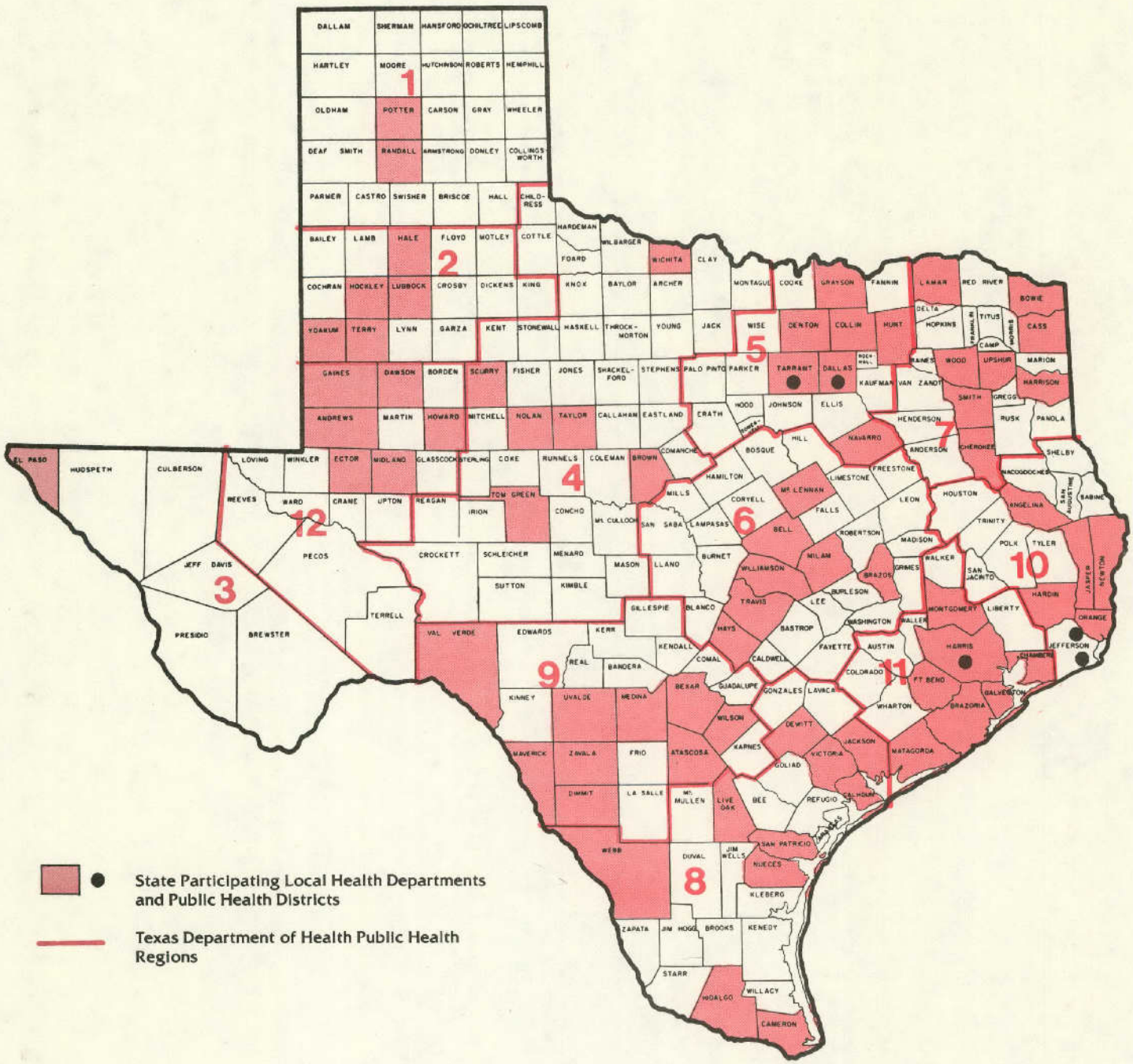
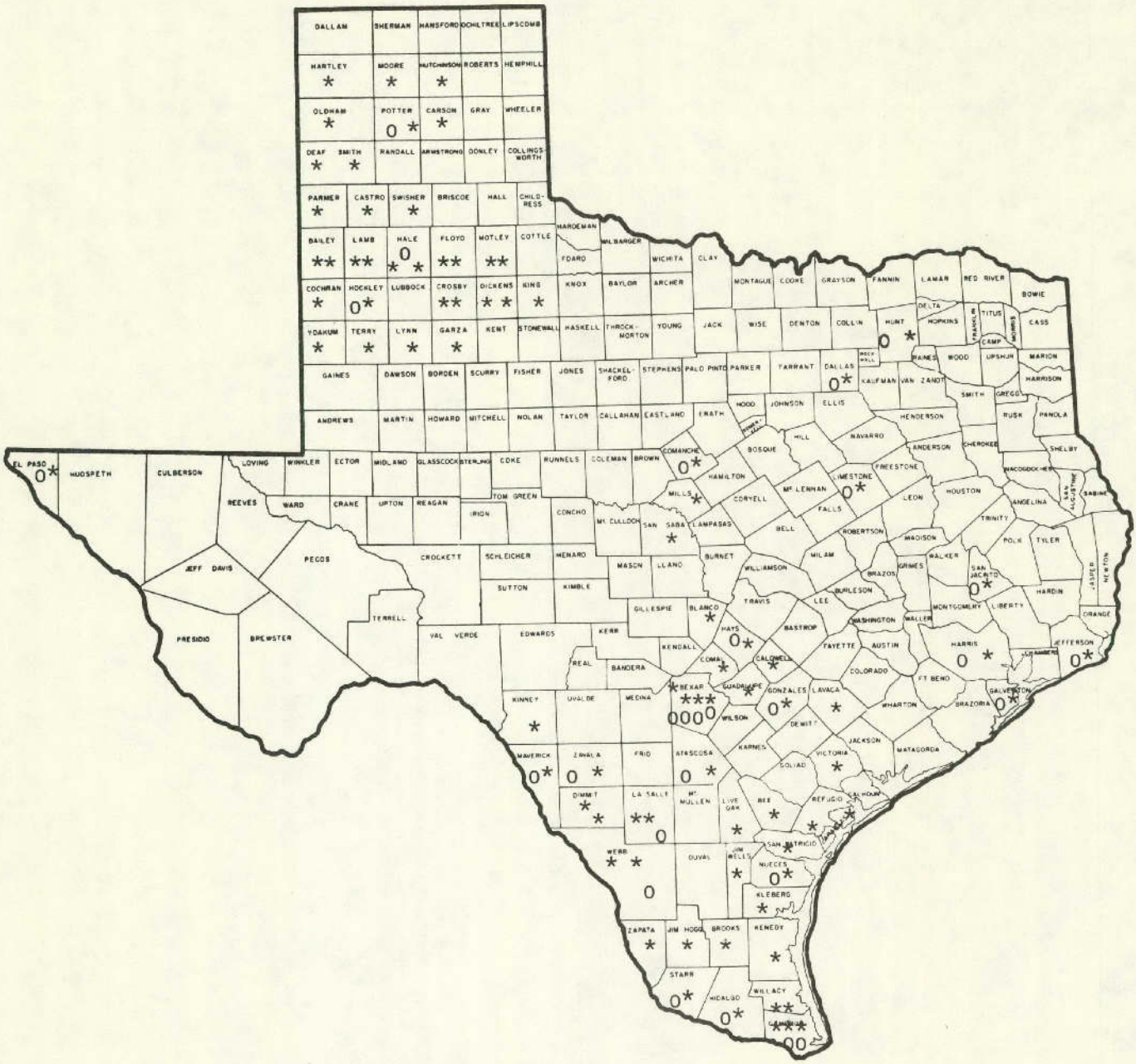


SOURCE: TEXAS HOSPITAL DIRECTORY, Hospital Licensing Division, Texas Department of Health, 1983.

Texas Department of Health



TEXAS MIGRANT AND COMMUNITY HEALTH CENTERS



LEGEND

o Texas Health Centers

* Satellite Centers

Community and Rural Health 1984

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