SUBJECT: Creation, powers, and operation of health services districts

COMMITTEE: Public Health — committee substitute recommended

VOTE: 8 ayes — Gray, Capelo, Delisi, Glaze, Hilderbran, Maxey, McClendon, Uresti

0 nays

1 absent — Coleman

WITNESSES: For — Ted Melina Raab, Texas State Employees Union

Against — None

BACKGROUND: The Indigent Health Care and Treatment Act (Health and Safety Code, chapter 61) defines counties' indigent health-care responsibilities. The act requires counties to establish indigent health-care programs that conform to certain minimum standards for eligibility, covered services, and payment responsibilities. Counties are not responsible for the care of indigent residents of an area served by a public hospital or hospital district.

A county is eligible to receive state assistance once it has spent 10 percent of its general revenue tax levy (GRTL) on mandatory indigent health-care services for eligible individuals. Counties do not have to report expenditures to the state nor to spend more than 10 percent of the GRTL. State assistance is budgeted for the Texas Department of Health (TDH) at about $8.6 million for fiscal 1998-99.

Hospital districts are responsible for medical services to their "needy inhabitants" under Art. 9, sec. 4 of the Texas Constitution and may have additional or more specific responsibilities for indigent health care under the statute creating the hospital district. In 1997, Texas' 106 hospital districts reported spending a total of $871 million on charity care. Eligibility standards and services provided vary from district to district. Hospital districts are not eligible for state assistance in meeting indigent health-care demand.

In March 1996, Attorney General Dan Morales filed a lawsuit on behalf of Texas against five major American tobacco companies. The lawsuit sought to recover billions of tax dollars the state had spent to treat Medicaid patients who suffered from tobacco-related illnesses. The suit accused the industry of violating both state and federal laws, including conspiracy, racketeering, wire fraud, mail fraud, consumer protection, and antitrust laws. In July 1998, Texas finalized the lawsuit's settlement, which awarded the state a total of $17.3 billion over the next 25 years.

Hospital districts and counties had intervened in the settlement, claiming that it would have barred them from obtaining damages of their own for all of the tobacco-related indigent health care they had provided. A separate settlement between the Attorney General's Office and the intervening counties and hospital districts directed $2.275 billion to a permanent trust account from which Texas counties and hospital districts will be reimbursed for costs associated with indigent health care. The $2.275 billion is the amount that accrued to Texas because of the "most favored nation" provision in the settlement, which awarded Texas increased payments comparable to Minnesota's subsequent settlement on somewhat more favorable terms.

TDH operates the South Texas Hospital in Harlingen, which was built in the 1950s and is at risk of losing accreditation because of aging and deteriorating facilities. The hospital offers pediatric, women's health, cancer screening, diagnostic, and health education services and about 20 beds for tuberculosis. It is also the major provider of sub-acute indigent care in its region.

DIGEST:

CSHB 3505 would authorize two or more counties or hospital districts to create a health services district by adopting concurrent orders. The concurrent order would have to be approved by the governing body of each creating county or hospital district and would have to define the boundaries of each county and hospital district.

Each creating county or hospital district would have to appoint two directors to the board of directors of the health services district, and the participating entities together would choose one additional board member. The board would administer the district's health-care system, funds, and resources.

The creating counties or hospital districts would have to contract with the health services district to provide all health-care services required by law or by the Constitution. Each entity would have to contribute:

- a specified dollar amount or a percentage of its budget;
- state assistance received for any indigent care;
- federal matching funds received under the Medicaid disproportionate share program; and
- any funds from the state's settlement with the tobacco industry received by the entity on or after the date on which the district was created.

The health services district could commingle the financial contributions of the creating entities for the purposes of the district. In addition to its other duties specified in the contract, the district would have to:

- provide health-care services to indigent residents and provide services to nonindigent residents on a sliding-fee scale;
- annually adopt an application procedure to determine eligibility for assistance for residents who need health-care services but who cannot pay;
- require reimbursement from counties, municipalities, or public hospitals located outside the boundaries of the district for the care and treatment of their indigent residents or jail inmates;
- acquire or build and manage necessary buildings, land, and equipment;
- manage funds contributed to the district by each contracting county or hospital district; and
- ensure the provision of quality health care.

A county that created and contracted with the district could credit a district expenditure for the care and treatment of an eligible county resident to the same extent it could claim the expenditure under the Indigent Health Care and Treatment Act.

The health services district could exercise the power of eminent domain, as authorized by Property Code, chapter 21, to acquire a fee-simple or other interest in property located in the district. The district would not have to deposit trial court money or give bond for the issuance of a temporary restraining order or temporary injunction or for appeal or writ of error costs.

The district would have to bear the costs of relocating or altering railroad or utility facilities.

CSHB 3505 also would specify:

- district directors' qualifications and bond requirements;
- election and term of board officers and the filling of board vacancies;
- board voting requirements;
- appointment and duties of administrators and administrative staff;
- employment or contracting with nurses, attorneys, and other employees;
- board authority over rulemaking, purchasing, property, and contracting;
- board authority to accept gifts and grants to be held in trust;
- board authority to sue and liability to be sued on behalf of the district;
- dissolution of the board;
- district budget, audit, and records requirements; and
- district authority and requirements for issuing revenue bonds.

The bill would take effect September 1, 1999.

SUPPORTERS SAY:

CSHB 3505 would help many areas in Texas meet the health-care needs of their indigent residents by allowing counties and hospital districts to pool resources. This bill especially would help the Lower Rio Grande Valley in South Texas, which has no hospital district and therefore has limited flexibility in meeting the area's health-care needs, including indigent health care and addressing diseases common to the border region, such as tuberculosis.

CSHB 3505 is part of a two-pronged strategy to address South Texas' health-care needs. The first prong would be phasing out the state-funded South Texas Hospital and building an accreditable outpatient facility through enactment of HB 3504 by Jim Solis. The second prong would be creating a health services district to help finance and provide needed inpatient and outpatient professionals and services, as proposed by CSHB 3505. This bill grew out of an interim study conducted by the Senate Finance Committee on the use of the South Texas Hospital and the Texas Center for Infectious Disease.

The long-range plan for the area would continue state funding at least until 2005 for services formerly provided by the South Texas Hospital through

contracts with the health services district and with local area providers. Combining TDH contracts and financial contributions of the creating entities into the budget of a health services district would make it possible to achieve greater administrative flexibility and cost efficiencies in meeting the demand for indigent health-care services.

Health services districts are needed for counties that want to combine resources to provide indigent care but do not want to establish another taxing entity in their communities. Hospital districts' taxing authority supersedes all other local government taxing authority, and many residents are reluctant to create a new type of governmental unit. Interlocal cooperation agreements, as now authorized in statute, have never been used to provide health-care services, probably because such agreements have to be renewed annually and health-care providers need longer-term assurances when contracting.

CSHB 3505 would specify clear indigent-care responsibilities for health services districts and would require no increase in state spending. Counties could not use health services districts to avoid obligations under the Indigent Health Care and Treatment Act because the creating entities would remain bound by the act's requirements. Counties and hospital districts would have to contract with the health services district for services they are required to provide under state law or the Constitution. Even if the eligibility standards for health services districts were raised to a level above that now provided by the contracting counties, state expenditures would not increase because state assistance is capped by amounts appropriated to TDH for this strategy.

This bill reflects the hard work of legislative officials, staff, and local parties. The support expressed by local providers and government officials ensures the plan's success and warrants legislative approval.

OPPONENTS SAY:

CSHB 3505 would create a new kind of political subdivision unnecessarily. If local governments want to combine their resources to address the area's health-care needs, they can create a hospital district or enter into an interlocal cooperation agreement or a contractual arrangement with providers and administrators.

OTHER OPPONENTS SAY:

The potential impact of this bill on state expenditures for indigent care assistance to counties is hard to calculate. The increased financial flexibility that a health services district would have under the bill could cause the

creating counties to expand eligibility for resident participation in the indigent health care program, thereby increasing demand for state assistance once their GRTL threshold was met.

Many unknown factors still could influence the success of the proposed long-range plan for services now provided by South Texas Hospital. For example, there is no absolute guarantee that the counties would create a health services district for the Valley even if the Legislature should enact this bill. Or, once established, the health services district might not be successful in addressing its indigent-care responsibilities and remaining financially viable over the long term.

NOTES:

Major changes made by the committee substitute to the original bill include:

- limiting the creation of health services districts to counties and hospital districts instead of a combination of political subdivisions, and
- removing the provisions that would have allowed counties that create health services districts to credit toward state assistance residents who do not meet eligibility standards under the Indigent Health Care and Treatment Act.

HB 1161 by Junell et al., which would establish a permanent trust account, outside of the treasury and capitalized by tobacco settlement funds, to reimburse hospitals and counties for uncompensated care, passed the House on April 22, as did:

- HB 1676 by Junell, et al., which would create permanent funds for children and public health, trauma care, rural hospital facility improvements, and tobacco cessation and education programs; and
- HB 1945 by Junell and Cuellar, which would establish permanent funds for health-related higher education activities.

All three bills are scheduled for a public hearing in the Senate Finance Committee on May 4.

HB 3504 by Jim Solis, which would require TDH to contract to build a new facility for health-care services for residents of the Lower Rio Grande Valley, passed the House on April 27 and was referred to the Senate Health Services Committee.