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

COMMITTEE: Public Health — favorably, without amendment

VOTE: 6 ayes — Gray, Capelo, Delisi, Glaze, Maxey, Uresti

0 nays

3 absent — Coleman, Hilderbran, McClendon

SENATE VOTE: On final passage, May 10 — voice vote

WITNESSES: (*On companion bill, HB 3505*):
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 indigent health-care responsibilities of counties. 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. Eligibility standards and services provided vary from district to district. Hospital districts have taxing authority but they 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. In July 1998, Texas finalized the tobacco lawsuit settlement awarding the state a total of $17.3 billion over the next 25 years.

Hospital districts and counties earlier had intervened in the settlement, claiming that it would have barred them from obtaining damages on their own behalf for all of the tobacco-related indigent health care they had provided. A separate settlement agreement between the Attorney General's Office and the intervening counties and hospital districts directed that $2.275 billion would be placed in a permanent trust account from which Texas counties and hospital districts will be reimbursed for costs associated with indigent health care.

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. It also has about 20 beds for tuberculosis treatment. It is the major provider of sub-acute indigent care in its region.

DIGEST:

SB 1615 would authorize two or more counties or hospital districts to create a health services district by adopting a concurrent order. 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 the district to coincide with the boundaries of each county and hospital district.

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.

A health services district would have to provide indigent health care services, manage the funds contributed by each contracting entity, and plan and coordinate with public and private health care providers for the long-term provision of health services to district residents.

The health services district would administer and account for the financial contributions of the contracting entities for the purposes of the district. Creating hospital districts would have to contribute a specified dollar amount or a percentage of their budget and reserves. Creating counties would have to contribute a specified percentage of their budget, not less than their requirement under the Indigent Health Care and Treatment Act. Also, each entity would have to contribute:

- 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.

Each creating county or hospital district would appoint directors to the board of directors of the health services district. Counties or hospital districts that have populations of 125,000 or more would have to appoint one director for every 125,000 people. Counties or hospital districts with populations less than 125,000 could appoint only one director. The number of directors subsequently appointed to the board by each creating county or hospital district would not change with variations in the county or hospital district's population.

The board could contract with a state or federal agency, political subdivision, or other qualified provider to provide services. It also would have to determine the type, number, and location of buildings and type of equipment required to maintain adequate health care. It also could acquire, lease, and transfer by lease, or sell property, facilities, and equipment.

In addition to its other duties specified in the contract, the district would have to provide health-care services to indigent residents. It could adopt a sliding-fee scale for patients who could pay for some, but not all, of their care. It also would have to adopt annually an application procedure to determine eligibility for assistance that complied with the procedures required of public hospitals and hospital districts under the Indigent Health Care and Treatment Act.

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 would have to require reimbursement from counties, municipalities, or public hospitals located outside the boundaries of the district for the care and treatment of their indigent residents. Reimbursement for care to jail inmates would be treated in the same manner as would be done under the Indigent Health Care and Treatment Act.

SB 1615 also would specify:

- qualifications and bond requirements for district directors;
- 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 endowments to be held in trust;
- board authority to sue and liability to be sued on behalf of the district;
- dissolution of the district;
- district budget, audit, and records requirements; and
- district authority and requirements for issuing and using revenue bonds.

The bill would take effect September 1, 1999.

SUPPORTERS SAY:

SB 1615 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 not only indigent health care but addressing diseases common to the border region, such as tuberculosis.

SB 1615 is part of a two-pronged strategy to address South Texas health-care needs. The first prong would involve phasing out the state-funded South Texas Hospital while building an accreditable outpatient facility through the 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 SB 1615. 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 district 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 long-term assurances when contracting.

SB 1615 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 the care 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.

OPPONENTS SAY:

SB 1615 would create a new kind of political subdivision that is not needed. If local governments want to combine their resources to address the area's health-care needs, they can create a hospital district, enter into an interlocal cooperation agreement, or enter into 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 difficult to calculate. This bill would provide increased financial flexibility for a health services district. This potentially could cause the creating counties to expand eligibility for resident participation in the indigent health care program, thereby increasing demand for state assistance once the general revenue tax levy (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.

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:

The companion bill, HB 3505 by Jim Solis, was on the House calendar for April 27 but postponed from consideration. Major differences between this bill and the House bill include:

- the health district would not have the power of eminent domain;
- health district board members would be appointed in proportion to the population of the county or hospital district;
- provisions covering the adoption of an order by hospital districts whose tax rates are set by the county commissioner's court;
- removal of specific authorization for the district to commingle financial contributions of the creating entities;
- making permissive, instead of required, county or hospital district transfer of all land, buildings, and equipment related to health care;
- reimbursement for care to jail inmates would be treated in the same manner as that provided under the Indigent Health Care and Treatment Act;
- contracting with a state or federal agency, political subdivision or other qualified provider to provide services;
- specifying district dissolution by identical concurrent orders of the creating entities;
- providing district audit reports to each state and federal agency that contracts with the district and other entities that contribute substantial funds to the district;

- removing provisions that would have capped administrative expenses to 10 percent of the district's budget; and
- provisions requiring that revenue pledged for bond repayment must be used to repay the principal and interest owed on the bonds before any other obligation of the district, including money owed to physicians.

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 and was reported favorably, as substituted, by the Senate Finance Committee on May 6..

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 reported favorably, as substituted, by the Senate Health Services Committee on May 11.