SUBJECT: Indigent health care by counties and public hospitals

COMMITTEE: Public Health — committee substitute recommended

VOTE: 7 ayes — Gray, Coleman, Capelo, Delisi, Glaze, Maxey, McClendon

0 nays

2 absent — Hilderbran, Uresti

WITNESSES: For — Ron Anderson, M.D., Parkland Hospital and Health System, Texas Hospital Association; Celia Davis, Hendrick Health System, Texas Hospital Association; Anne Dunkelberg, Center for Public Policy Priorities; Lee Jackson, Dallas County; Rita Kelley, Bell, Mills, Hamilton County Indigent Health Care Program; Lisa McGiffert, Consumers Union

Against — Gina Oglesbee, Nacogdoches County Hospital District

On — Jim Allison, County Judges and Commissioners Association of Texas; Sue Glover, Texas Association of Counties; Windell M. McCord, Craig Alan Walker, Texas Organization of Rural and Community Hospitals (TORCH); Joseph R. Miller, M.D.; Evan Moore, Comanche Community Hospital, Texas Hospital Association, TORCH

BACKGROUND: The Aid to Families with Dependent Children (AFDC) program, a federal cash assistance program, was replaced by the Temporary Aid to Needy Families (TANF) program in 1996.

Medicaid is a state/federal health-benefit program for low-income and disabled individuals. In fiscal 1999, Texas will pay about 37.5 percent of all costs, with the remainder paid by federal matching funds.

The Indigent Health Care and Treatment Act (Health and Safety Code, chapter 61) defines the indigent health-care responsibilities of counties and public hospitals.

County 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. To be reimbursed for care of indigent residents, health-care providers must follow specified procedures for notifying counties.

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 are not required to report expenditures to the state nor to spend more than 10 percent of the GRTL. If state assistance funding is depleted, counties that exceed the expenditure threshold are not obligated to continue to provide indigent health care. State assistance is budgeted in the Texas Department of Health (TDH) budget at about $8.6 million for fiscal 1998-99.

A person is eligible for county indigent health-care assistance if the person:

- does not reside in the service area of a public hospital or hospital district;
- meets basic income and resources requirements that are consistent with AFDC-Medicaid programs; and
- no other source of payment exists.

Counties may use less restrictive eligibility requirements but may count toward state assistance payment for statutorily mandated services only those provided to residents who meet AFDC income and resource guidelines.

County indigent care programs must provide inpatient and outpatient hospital services, laboratory and x-ray services, family planning services, physician services, payment for up to three prescription drugs per month, and skilled nursing facility services.

Public hospital responsibilities. The act requires public hospitals, such as county- or city-run hospitals, to provide at least the same level of inpatient and outpatient hospital services that counties must provide, along with any other services they provided to indigent residents before January 1, 1985.

Public hospitals must establish eligibility standards that are equal to or less restrictive than those required for county indigent programs, and they cannot receive state assistance in paying for indigent care.

Hospital districts are responsible for medical services to their "needy inhabitants" under the Texas Constitution (art. 9, sec. 4) and may have additional or more specified responsibilities for indigent health care under the statute creating the hospital district. Eligibility standards and the range of services provided vary from district to district.

DIGEST:

CSHB 1398 would amend the Indigent Health Care and Treatment Act to:

- change eligibility standards for public hospitals and counties;
- amend mandated services and authorize the provision of optional services;
- decrease the threshold for state assistance to 8 percent of the GRTL;
- increase state assistance to 90 percent of a county's expenditures over the 8 percent threshold;
- require all counties to report to TDH their indigent health-care provisions, regardless of their intent to seek state assistance; and
- require hospital districts to provide basic services in addition to services required by the Constitution or enabling statutes.

Changes to the act would apply to health services delivered on or after January 1, 2000. TDH would have to study the feasibility of requiring or permitting the issuance of a uniform identification card for eligible residents and report the results to the governor, the lieutenant governor and the House speaker.

CSHB 1398 also would impose additional requirements on the Health and Human Services Commission (HHSC) and TDH, establish a mechanism to reimburse tertiary care facilities for certain services, establish a regional health-care system pilot program, and amend the Tax Code.

The bill would take effect September 1, 1999.

Application and eligibility. CSHB 1398 would specify that statutory eligibility requirements are *minimum* standards and would link minimum income eligibility requirements to 25 percent of the federal poverty level instead of to eligibility requirements by the former AFDC program. Minimum standards would have to be at least 22 percent of the federal poverty guidelines for calendar year 2000.

Counties could use a less restrictive eligibility standard and could credit the services provided to their eligible population toward state assistance. People who had received and exhausted their TANF, Supplemental Security Income, or Medicaid benefits could be eligible for county indigent health-care coverage if that county chose to include them in its eligibility standards.

Counties also could treat as eligible for indigent health care inmates of their county jails who were not residents of the county or who resided in an area served by a public hospital or hospital district if the inmate met the county's indigent health-care income and resource-eligibility requirements. Counties that did this would have to waive their rights to any reimbursement from other counties, hospital districts, or public hospitals in which the inmate actually resided.

Services and payment standards. Counties would have to provide basic health-care services and could provide optional health-care services. The basic health-care services would consist of the services currently defined as "mandatory services," with the addition of primary and preventive services, such as immunizations and medical screening services, and health clinics, if appropriate.

Counties also could provide other medically necessary services or supplies that the county determined to be cost-effective, such as ambulatory surgical center services, durable medical equipment, home and community-based services, psychological counseling, and dental or vision care. A county would have to receive TDH approval to provide optional services in order to credit payment of those services toward state assistance. TDH would have to develop rules relating to optional services and would have to meet county requests to provide optional services within 30 days.

Dentists and podiatrists who provide laboratory, x-ray, and physician services could be paid through the indigent care program.

Counties would not be liable for the cost of basic or optional health care services in excess of the payment standards established by TDH.

Any health-care provider would be newly authorized to require patients to provide information demonstrating residency and to authorize the release of necessary information for submitting reimbursement claims to the appropriate

county, hospital district, or public hospital. TDH could develop a standard format for facilitating eligibility and residency determinations.

CSHB 1398 would amend current law to specify that in order to receive reimbursement from counties or public hospitals, health-care providers either would have to contact the responsible entities by telephone within 72 hours, instead of as soon as possible, after the provider determined the patient's county of residence, or contact the entities by mail postmarked not later than the fifth, instead of third, day.

State assistance. To qualify for state assistance, counties would have to have spent at least 8 percent of their GRTL for that year, to report monthly to the department, and to notify the department when the county had reached at least 6 percent of its GRTL.

TDH could provide state assistance at a lower level if the county demonstrated that it could not satisfy the 8 percent expenditure level for reasons including the following:

- the GRTL had increased significantly but expenditures for health care had not increased by the same percentage;
- the county was at the maximum allowable ad valorem tax rate, had a small population, or had insufficient taxable property; and
- the county submitted monthly financial reports for the year for which assistance was sought.

State assistance funds would have to be at least 90 percent — instead of 80 percent, as in current law — of the county's actual payments for health services during the remainder of the state fiscal year after the 8 percent expenditure level was met.

Public hospital responsibilities. Public hospitals and hospital districts would have to provide at least the basic health-care services to residents meeting eligibility standards as newly defined for counties.

Counties that provided health services through a hospital that had a board of managers jointly appointed by the county and a city also could credit services provided to all eligible residents toward state assistance, even if the hospital used less restrictive eligibility standards.

Other provisions. HHSC would have to:

- conduct an analysis of the feasibility of including the indigent health-care programs in the Texas Integrated Eligibility System (TIES);
- continue to pursue a Medicaid waiver to allow for intergovernmental alternatives with the purpose of expanding Medicaid eligibility using managed care; and
- establish a regional health-care delivery system pilot program by January 1, 2000, and by January 1, 2003, report to the governor, the lieutenant governor, and the House speaker with an analysis of the quality of health services and the cost-effectiveness of care, and make recommendations for implementing such a system through legislation.

TDH would have to study the provision of basic health-care services and develop a threshold to replace the statutory 8-percent-of-GRTL threshold with a formula that reflected a county's fiscal capacity, health-care resources, and population characteristics and would have to report to the governor, the lieutenant governor, and the House speaker by December 1, 2000.

CSHB 1398 would amend the Tax Code to allow counties to make tax-rate adjustments until January 1, 2002, for their enhanced indigent health-care expenditures, which would be the costs associated with providing indigent health care at the increased minimum standards. The rate would be calculated as the relative proportion of the enhanced-expenditures increase to the property value increase.

Tertiary care facilities could seek reimbursement from a new account in the state treasury for any unreimbursed tertiary medical services provided to persons living outside the facilities' service areas. TDH could propose necessary rules and would have to receive necessary information to certify reimbursement amounts to the comptroller. The bill would define a tertiary care facility as any facility that is a primary teaching hospital of a medical school, or a Level 1, 2 or 3 trauma center. Five percent of the account could be used to pay for extraordinary emergencies if the governor issued an executive order or proclamation, if a disaster were declared by the president of the United States, or for a disaster TDH found had resulted in an extraordinary cost.

SUPPORTERS SAY:

CSHB 1398 would take important steps in addressing long-term concerns surrounding the provision of indigent health-care services in Texas. This bill would not establish a new government program but would help resolve problems in an existing program that relies on cooperation between both public and private entities. State liability for financial assistance would be limited to a sum-certain appropriation in the state budget.

The services provided under the Indigent Health Care and Treatment Act are considered the bottom-line safety net for uninsured, low-income sick or injured Texans who are ineligible for any other programs. State efforts to increase health benefits to children through the Texas Healthy Kids Corporation or the CHIP program would do little to help defray counties' indigent care expenses, which are predominantly caused by illnesses and injuries to middle-aged and elderly adults.

The bill primarily would increase incentives, not mandates, for counties to provide indigent health care. Current law gives counties little incentive to do more than the minimum amount required, and those that are doing more than the minimum standards in taking care of their indigent get little reward. As a result, the amount and type of indigent health care being provided in Texas is inconsistent and the burden of care is unevenly distributed, creating conflicts between counties and hospitals and inequities for Texas residents.

Increasing state assistance over previous budgets would mirror the trend also occurring in school finance, in which statewide variations and inconsistencies are ameliorated by the state picking up an increasing proportion of costs. Enhanced state assistance would improve indigent health-care services and reimbursement, a benefit that is shared by counties, hospitals, and the state in terms of the improved health status of Texans and lower health-care costs.

Many of the bill's provisions also would reduce conflicts between counties and hospitals over reimbursement for indigent care by:

- giving hospitals the opportunity to collect information necessary to enroll patients in indigent care programs;
- clarifying notification procedures;
- authorizing TDH to resolve eligibility disputes;
- allowing counties credit for services they provide to indigent, nonresident jail inmates;

- studying the possibility of using a uniform identification card; and
- increasing state financial assistance to counties and public hospitals through a tertiary care account.

Because of these provisions, an officially designated “state mediator” was not considered necessary to resolve payment disputes.

The bill also would require certain studies and a regional health-care system pilot program, which could help the state design a better, more cost-effective way of providing and paying for indigent care in the future.

Eligibility criteria. The AFDC/TANF income limit for a single adult has changed very little since 1985, when lawmakers set county program eligibility standards to conform with state standards to receive cash assistance through the federal AFDC program. Because Texas’ TANF income eligibility standard has not kept pace with general cost-of-living increases, the standard now reflects about 11 percent of the federal poverty level (FPL), a decline from about 25 percent of the FPL in 1985. This has reduced the number of indigent individuals who could receive county coverage for needed health-care services and has increased the number of uninsured individuals whom health-care providers treat without compensation.

Removing the link between welfare and medical assistance is important, because giving medical care to people who are sick or injured is a very different public policy concern from supporting people who do not work.

Also, the TANF-based eligibility determination procedures are too cumbersome and time-consuming for most county resources. This bill would streamline

eligibility determination by linking eligibility to a specific percentage of the FPL.

Services offered or required. By setting *minimum* eligibility and service standards instead of requiring cross-county uniform standards, this bill would allow counties to tailor their programs to meet the demand for indigent health services in a more cost-effective manner. The current list of mandatory services does not include many preventive and primary care services that can prevent more complicated and more expensive health-care problems from

arising and can reduce county expenditures in the long term. Many counties provide preventive and primary care services but they cannot credit those expenditures toward state assistance. The authorization to include optional services also would help the counties meet specific community priorities with available funding.

State assistance and reporting. CSHB 1398 would provide counties an opportunity for more relief and would help compensate them for the bill's requirements to increase eligibility standards and add new services.

By lowering the expenditure threshold to 8 percent of GRTL and increasing the reimbursement amount to 90 percent of all additional costs, the state would rightfully assume more responsibility in paying for indigent care, since the relative poverty, insurance coverage, or health status of any county's population is a matter of circumstance and not something that the local government can control. These changes also would encourage counties to meet the needs of their medically indigent population better.

Also, the required study by TDH on basic services and expenditure thresholds and its authorization to waive the 8 percent threshold for state assistance would help Texas further fine-tune its level of assistance. Any threshold amount, whether 10 percent or 8 percent, does not take into account an individual county's ability to meet its indigent care needs due to varying fiscal capacities, health-care resources, and population characteristics. An across-the-board threshold unfairly burdens counties with large percentages of uninsured individuals and relatively low tax revenues.

CSHB 1398 also would help the state measure the provision of indigent health care by Texas counties by requiring all counties with indigent care responsibilities to report in some fashion to TDH. Many counties now do not bother reporting to TDH for credit for state assistance, believing that they never will cross the 10 percent threshold. Without reliable and consistent information from counties, the state has no way of identifying the demand for and costs of indigent health care provided statewide, nor of assessing whether and to what degree indigent health-care needs are being met.

State assistance would not be provided to hospital districts because, unlike counties, they are established for the sole purpose of providing health care and reflect an area's choice to provide health care for their indigent. Hospital

districts and public hospitals alike, however, would see improved levels of reimbursement for uncompensated services now rendered because of the provisions in the bill that would increase payment opportunities and through the creation of a tertiary care account.

Tertiary care. The bill's provisions for tertiary care would help provide taxpayer relief in areas supporting a public tertiary care facility and would sustain the operations of hospitals that carry the regional burden of providing unreimbursed tertiary care. Also, a state account would reduce many of the reimbursement conflicts between hospitals who have provided complex and expensive medical care to indigent residents of another county or public hospital.

Including Level 4 facilities in the distribution of funds from the tertiary care account would dilute the effectiveness of the account. Level 4 facilities provide an important function, but they simply resuscitate and stabilize and do not have the facilities to provide advanced levels of care. National studies have shown that when given increased reimbursement, some Level 4 facilities actually experience greater death rates because they tend to treat traumatized patients instead of transferring them to a tertiary care facility.

In addition, small and rural health-care facilities likely will receive substantial financial support this session through the enactment of bills regarding the use of tobacco settlement receipts that would help them build facilities, improve trauma response, and meet indigent care costs.

Medicaid study and regional health system pilot. Both of these provisions would help local governments and public hospitals maximize existing resources and expenditures. The Medicaid waiver directive could help increase Medicaid eligibility standards by matching funds now being spent by local governments and hospital districts on indigent care with federal funding from Medicaid. Increasing the number of people on Medicaid would reduce the burden borne by local governments for care to those same people, since the state matching rate for Medicaid services is only about 37 percent.

The pilot project would be a voluntary endeavor for public entities to pool resources, making current expenditures more cost-efficient and avoiding unnecessary spending on capital resources.

OPPONENTS SAY:

The state should not be assuming more responsibility for paying for indigent care, nor should it be placing more requirements on counties and public hospitals. Health care is best provided through the private market and not through government programs, which end up distorting the market and increasing health costs for all.

Also, more state involvement in indigent health care is not needed. The 76th Legislature already has considered legislation to improve the availability of health-benefit coverage or health services, such as coverage for children through the new CHIP program (SB 445 by Moncrief) and establishing endowment funds that could help provide indigent care through medical schools and other programs (HB 1161, HB 1676, HB 1945 by Junell).

Increases in services and eligibility standards should be optional, not mandatory. The state should not be telling local governments and hospitals how to take care of the residents of their service areas.

OTHER OPPONENTS SAY:

Mandatory services and eligibility standards. Mandatory services and eligibility standards should be made uniform across the state and be required for hospital districts as well as for counties and public hospitals. For example, hospital districts are not required by the Constitution or by statute to provide minimum indigent care eligibility, and hospital district eligibility standards vary widely, ranging from a low of 11 percent to 200 percent of the FPL.

Also, hospital district responsibilities are not specified as clearly under the Constitution as are public hospital and county responsibilities by law. As a result, some hospital districts reduce their indigent care load by providing fewer services than do counties and public hospitals and by paying for fewer services for indigent residents, who must travel outside the district for care.

A person’s access to needed health care should not depend on where that person lives. Uniformity of services and eligibility standards also would insure that every county, public hospital, and hospital district upheld the same responsibility for indigent care. Inconsistencies and variances in indigent health care programs create a hodgepodge of a program intended to be the state’s safety net for the uninsured, and they exacerbate reimbursement problems between local entities.

State assistance. Hospital districts and public hospitals also should be able to receive state assistance. The current law unfairly helps counties that did little to assist their indigent residents in the past, and it does nothing for those communities that created hospital districts or public hospitals and now face additional expenditures through state mandates to provide care.

Specified mediator. No state entity is authorized to mediate payment disputes or to hold counties, public hospitals, and hospital districts accountable for meeting statutory minimum requirements. Such an authority is needed.

Tertiary care. Level 4 trauma facilities also should be reimbursed through the tertiary account. Although they may not provide the lion's share of the uncompensated tertiary care, they are important players in first response to trauma and end up writing off a comparable proportion of their patient revenues as uncompensated care.

NOTES:

Rep. Coleman plans to offer a floor amendment that would remove the requirement that hospital districts and public hospitals provide basic services, yet would ensure that indigent patients needing services would be directed to the appropriate providers.

Provisions added by the committee substitute to the original bill include:

- authorization for providers to receive necessary eligibility information from an indigent patient;
- requiring income eligibility to equal 25 percent of the federal poverty guidelines;
- authorizing counties to credit toward state assistance inmates of county jails;
- adding dental care to the list of optional services;
- authorization for TDH to waive the 8 percent expenditure threshold for state assistance;
- public hospital responsibilities to provide basic health services; and
- tax-rate adjustments.

Provisions removed by the substitute from the original bill include:

- linking eligibility to TANF;

- removing dental care from the list of basic services;
- authorization for counties to credit health-benefit plan premium payments for state assistance and for hospital districts to buy health-benefit plan coverage for indigent residents;
- using state assistance for unreimbursed out-of-county or out-of-service-area tertiary care;
- relating to performance standards; and
- establishing a regional health-care delivery system trust account.

CSHB 1398 contains provisions similar to those in HB 2573 by Wolens concerning reimbursement of tertiary care facilities. HB 2573 passed the House on April 27 and has been referred to the Senate Health Services Committee.

CSHB 1398 also contains a provision, with a similar impact to those of provisions in HB 2866 by Kuempel, that would allow counties that provide indigent care services through a public hospital run by a joint city-county board to receive state assistance for residents who are eligible under less restrictive standards than the minimum standards. HB 2866 passed the House on the Local, Consent, and Resolutions Calendar on April 16 and is scheduled for a public hearing in the Senate Human Services Committee on May 5.