Indigent Health Care Advisory Committee

Report of Recommendations

September 2006

Charge

The 79th Texas Legislature passed Senate Bill 44, which established the Indigent Health Care Advisory Committee, and included the following directives:

(a) The executive commissioner of the Health and Human Services Commission shall establish an advisory committee to advise the commission on rules and policies concerning indigent health care services.

(b) The advisory committee shall consist of 11 members, including four consumers or persons representing consumers and seven other representatives, appointed by the executive commissioner of the Health and Human Services Commission.

(c) The advisory committee shall:

(1) conduct a feasibility study and develop recommendations regarding the implementation of a pilot program for the regionalization of county indigent health care services and assistance and hospital district services and assistance;

(2) review and propose recommendations for legislation updating indigent health care and treatment under Chapter 61, Health & Safety Code, this chapter, including:

- **(A) required the health care services provided under Subchapter B;**
- **(B) the differences in eligibility requirements for and health care services provided by counties, public hospitals and hospital districts:**
  - **(i) a county under Subchapter B;**
  - **(ii) a public hospital under Subchapter C; and**
  - **(iii) a hospital district under Subchapter C;**
- **(C) the allocation method used for distributing state assistance funds; and**
- **(D) county reporting requirements and enforcement by the Department of State Health Services; and**

(3) identify other areas or subjects related to indigent health care that the advisory committee could review or study.

(d) Chapter 2110, Government Code, does not apply to the size or composition of the advisory committee.

(e) Not later than November 1 of each even-numbered year, the Health and Human Services Commission shall submit a report regarding the advisory committee's recommendations to the Governor, Lieutenant Governor, the Speaker of the House of Representatives, and the Legislature.

(f) This section expires September 1, 2007.

SECTION 2. This Act takes effect September 1, 2005.

This report addresses the charges that have been given to this committee.

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EXECUTIVE SUMMARY

S.B. 44, 79th Legislature, Regular Session, 2005, authorized the Executive Commissioner of the Health and Human Services Commission to establish an advisory committee to advise the commission on rules and policies concerning indigent health care services. The Executive Commissioner selected a committee consisting of eleven members, including four consumers or persons representing consumers.

The Committee's work focused on the requirements of Texas Health & Safety Code Chapter 61, which relates to the responsibilities of counties, public hospitals, and hospital districts to provide indigent health services. Topics identified for study in S.B. 44 include:

- feasibility of implementing a pilot program for regionalization of service provision;
- recommended changes to the health care services provided under Chapter 61, Subchapter B;
- differences in eligibility requirements and health care services provided by a county under Subchapter B, and a public hospital and hospital district under Subchapter C;
- the allocation method used for distributing state assistance funds;
- county reporting requirements and enforcement by the Department of State Health Services; and
- recommendations for other areas or subjects related to indigent health care that the advisory committee could review or study.

The committee held six public meetings and individual workgroup meetings that involved several committee members and stakeholders from counties, hospitals, other health care providers, and organizations that represent the indigent health care entities. The workgroups sent written questionnaires to counties conducting indigent health care programs, brainstormed problems, identified issues, and conducted phone interviews with county officials and health care providers.

The committee found inconsistencies in services provided under Chapter 61, differences in eligibility criteria, inequitable and inadequate funding or financing of indigent health care services, and an overall lack of enforcement of reporting requirements and monitoring of Chapter 61 activities and services.

FINDINGS:

Texas' locally-based indigent health care system is made up of more than 300 entities. Across the state, there is great variation in determining who is "indigent," what services are provided and how indigent health care services are funded.

Who is Indigent?

The state does not have a uniform definition of "indigent." Among the different County Indigent Health Care Program (CIHCP) entities, there is an income range of eligibility

from 21 percent to 200 percent of the Federal Poverty Level (FPL). The statutory definition of "indigent" is a net income equal to 21 percent FPL, and most county programs use this minimum eligibility standard of 21 percent. Ultimately, there are many persons that do not qualify for county indigent health care or the current Medicaid system, which contributes to the uncompensated care problem in Texas, and to an increasing burden of care in hospital emergency rooms.

What services must be provided to indigent persons?
Chapter 61 requires county-run programs to provide eligible residents basic health care services and allows them to cover various optional services. The requirement for the hospital districts and public hospitals is that they "shall endeavor" to provide the same basic services. As a result, services provided under Chapter 61 vary from hospital district to hospital district, and public hospital to public hospital. This results in different services for indigent residents depending on where they reside in Texas.

Who is providing services to indigent persons?
The state of Texas does not have a complete picture of the health services provided by entities covered under Chapter 61. Only 37 percent of the entities involved in indigent health care report their indigent spending and client information to the state county indigent program in a uniform reporting method. As a result, there is little data from which to address indigent issues as a whole. Chapter 61 does not address or grant enforcement authority to review county indigent health care programs, nor require reporting of county programs unless a county is requesting state assistance funds. The primary intent of the CIHCP in the 1980s was to ensure care was provided for the population most in need, who are not eligible for Medicaid and secondly, to set reasonable limits on the financial liability of local governments. Without authority to monitor Chapter 61 activities, there is no statewide uniform reporting of eligibility and services provided to indigent residents in Texas. Due to the fragmented information that is reported, it is very difficult to understand the components of indigent systems in Texas and determine the scope of the problem.

Different level of expenditures for indigent health care
Over the past several years an average of 20 out of the 142 indigent health program counties have expended over eight percent of their general revenue tax levy and received state assistance funds. Many of the larger metropolitan counties, including Bexar, Dallas, Harris, Tarrant, and Travis, spend much more than eight percent tax levies through separately funded districts and provide health care to individuals well above 21 percent of the FPL. Many counties in Texas spend a significant portion of their revenue on indigent health care services, but possibly in a manner that is not cost-effective for the state as a whole.

Health Care and Uninsured
Texas leads the nation in the percentage of people without health insurance with an estimated 24.6 percent of the state's population identified as being uninsured. Texas is second only to California in the total number of uninsured residents (5.4 million people). The number of uninsured is particularly acute among small employers and the "working poor" – people earning less than 200 percent of the FPL ($18,000 per year for a single

individual, and $40,000 for a family of four). The burden of providing necessary services for uninsured or underinsured persons affects all levels of government, but is particularly acute at the local level.

Other DSHS Safety-Net Programs

The committee had the opportunity to learn about other DSHS programs that support indigent health care services, such as the Federally Qualified Health Center (FQHC) Incubator Grant Program, which provides funding to organizations seeking federal FQHC certification, and the Primary Care Program, which funds direct health services to a population at 150 percent FPL. Both of these programs are part of the safety-net system for the indigent population and the uninsured; however, local and state safety-net programs have limited capacity.

Summary

This report includes the committee's recommendations to improve health care services and attempt to address issues within the current program as identified above.

Many of the recommendations would require an infusion of new state funding into the current system. The committee recognizes that such financial implications may complicate legislative deliberations, but strongly believes it is important to present these issues to state decision-makers.

RECOMMENDATIONS

- Implement pilots for regionalizing health care among counties, hospital districts, and public hospitals as a collaborative approach to leveraging regional resources. The regional pilots should expand coverage above the current eligibility level and focus on providing more preventive and primary care services, beyond the currently required basic services. The regional pilots would be supported through a combination of local and state funds to improve health care delivery, manage costs, and provide efficient access to health care to the indigent population.

- Require all entities (counties, public hospitals, and hospital districts) to provide the same services and be eligible for state assistance funds for unreimbursed basic and optional services under Sections 61.028 and 61.0285 of the Health and Safety Code. The committee also recommends moving some services currently listed as optional into the required basic services category for prevention and cost efficiency.

- Raise the minimum standard for eligibility from 21 percent FPL to 25 percent FPL and increase the maximum individual health care liability for each fiscal year from $30,000 to $35,000.

- Increase the State's match from 90 percent to 100 percent of county expenditures after a county spends eight percent of their General Revenue Tax Levy (GRTL).

- Require all Chapter 61 covered entities to follow reporting requirements currently in place for county-run programs.

- Add compliance review activities for all entities and require an entity found not to be in compliance with Chapter 61 to come into compliance within 90 days.

- Amend Chapter 61 to correct obsolete agency references, clarify terms, and update additional provisions as identified by the committee.

Indigent Health Care Advisory Committee (IHCAC)

Reverend Edouard Atangana (Consumer Representative)
San Juan

David Brown
Citizens Medical Center
Victoria

Lynda Davis (Vice Chair)
Hardin County
Kountze

Hon. Stan Egger
Taylor County
Abilene

Almarie Henderson (Consumer Representative)
Nacogdoches Memorial Hospital
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Concho County Hospital District
Eden

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University of Texas Medical Branch
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Petra Reyna
Rio Grande Health Services District
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Melanie Richburg
Lynn County Hospital District
Family Wellness Clinic
Tahoka

Donald K. Spies (Chair)
Dallas County
Dallas

One Consumer Representative Appointee resigned for personal reasons.

I. Introduction

Indigent health care in Texas is prescribed by the Indigent Health Care and Treatment Act, Chapter 61, under Title 2 of the Texas Health and Safety Code. Under the statute, indigent health care is the responsibility of multiple entities, including 26 public hospitals, 139 hospital districts, and 142 county-run indigent care programs not fully or partially covered by a hospital district or public hospital. There is significant disparity among these 307 entities as to who is eligible for indigent care coverage, and what care is provided. Ceding of indigent care to this many dissimilar entities means that Texas has a "patchwork" system of indigent health care that fails to equitably and consistently meet the health care needs of its most disadvantaged citizens, while, at the same time, failing to adequately address the issue of rising health care costs.

Under the Indigent Health Care and Treatment Act, minimum eligibility standards established by a county must include "a net income eligibility level equal to 21 percent of the federal poverty level" (FPL). The Act also requires counties without hospital districts or public hospitals to establish indigent health care programs. For those counties that spend at least 8 percent of their general revenue tax levy (GRTL) to provide this care, the state may distribute limited "state assistance" funds to assist these counties in providing health care services to their eligible residents.

Under the Indigent Health Care and Treatment Act, counties that are not fully served by a hospital district or public hospital are required to provide basic health care services to their eligible residents. The services include immunizations, medical screenings, annual physicals, inpatient and outpatient hospital services, rural health clinics, laboratory and x-ray services, family planning services, physician services, three prescription drugs per month, and skilled nursing facility services. Counties may choose to provide twelve other optional services ranging from diabetic supplies and equipment to vision care. The maximum county liability for each state fiscal year for each eligible county resident served is $30,000, or 30 days of hospitalization or skilled nursing facility, whichever occurs first. The statute requires that hospital districts and public hospitals "shall

endeavor" to provide the same health care services required to be provided by the county-run programs.

As part of the charge in Senate Bill 44, the committee held six public meetings. The meetings included health care presentations on the following subjects:

- Department of State Health Services (DSHS) indigent health care program information;
- Center for Health Statistics hospital information;
- Mental health and substance abuse services, federally qualified health centers incubator grant program, and primary health care services;
- Health and Human Services Commission updates on local and regional waiver initiatives and upper payment limit information;
- Indigent Care Collaboration for Travis, Williamson, and Hays Counties;
- Best Practices for Indigent Health Care Delivery Models;
- Best Practices in local county indigent health care programs;
- Galveston County 3-Share Plan
- Access to Health Care in Texas – CODE RED Report.

The committee divided into four workgroups:

- Regionalization;
- Eligibility and Service Differences;
- Allocation, Reporting and Enforcement, and
- Other Issues.

These workgroups consisted of committee members, members from the public and state employees. The workgroups reviewed the original task force report, statutory requirements, conducted surveys, questioned staff from state and local indigent programs, and solicited advice and input from numerous individuals and organizations. Through this process the workgroups and this volunteer advisory committee reviewed numerous issues concerning the current program.

II. Committee Findings

Inconsistencies

The original indigent taskforce, established in 1983, addressed uniformity, financing of indigent health care proportionately for providers and communities, access issues, and improvement to statewide monitoring and coordination. The current advisory committee found that after more than twenty years some of the same issues remain today. The indigent health care system, made up of 307 entities, continues to have inconsistencies in services provided, eligibility criteria, inequitable and inadequate funding or financing, reporting, and monitoring.

Lack of uniformity in definition of "indigent"

One major problem is the state's definition of "indigent". With the different County Indigent Health Care Program (CIHCP) entities, there is an income range of indigent care eligibility from 21 percent to 200 percent of the FPL. The statute's definition of "indigent" is at a net income equal to 21 percent FPL, and most county programs use this minimum eligibility standard of 21 percent. Ultimately, there are many persons that do not qualify for county indigent health care or the current Medicaid system, which contributes to the uncompensated care problem in Texas, and to an increasing burden of care in emergency rooms and hospitals.

Difference in Health Care Services

A major area of inconsistency is with regard to the services provided by the different entities. The statute requires county-run programs to provide eligible residents all the aforementioned basic health care services and allows them to offer additional services. The statute requires that hospital districts and public hospitals "shall endeavor" to provide the same basic services. As a result of that language, the services provided varies from hospital district to hospital district and public hospital to public hospital. This results in different services for indigent residents depending on where they reside in Texas.

Reporting and Monitoring

Among the inconsistencies is the fact that only 37 percent of the entities involved in indigent health care under Chapter 61 actually report their indigent spending and client information to the state county indigent program in a uniform reporting method. As a result, there is little data to address indigent issues as a whole. The original indigent health care taskforce recommended monitoring and recommended language to require reporting. However, the statute does not address or grant enforcement authority to the State to review county indigent care programs, nor require reporting of county programs unless a county is requesting state assistance funds. The primary intent of the CIHCP in the 1980s was to ensure care was provided for the population most in need, who are not eligible for Medicaid, and secondly, to set reasonable limits on the financial liability of local governments. Without authority to monitor Chapter 61 activities, there is no statewide uniform reporting of eligibility and services provided to indigent residents in Texas. Due to the fragmented information that is reported, it is very difficult to understand and capture the components of indigent systems in Texas.

Financing

Over the past several years an average of 20 counties out of the 142 county-run programs have spent over 8 percent of their general revenue and have received state assistance funds. Many of the larger metropolitan counties — including Bexar, Dallas, Harris, Tarrant, and Travis — spend much more than 8 percent of their ad valorem tax levies through separately funded districts and provide health care to individuals well above 21 percent FPL. As a result, residents of surrounding counties that only serve those at 21 percent FPL often travel to these larger counties for health care. According to the ***Code Red*** report from the Task Force on Access to Health Care in Texas,

> "This creates an inequitable and inefficient system where underinsured migrate from their home counties to larger counties to seek medical care, often in already over-crowded emergency rooms, where they are subsidized by the taxpayers of the larger county."

The recommendation of the Access to Health Care in Texas Task Force stated,

"Texas should provide more adequate resources and aggressively seek more efficient and effective methods to support health care to the indigent and uninsured, with the goal of reducing rising health care costs."

Health Care Issues

Texas has the third highest obesity rate in the country; has one of the highest death rates from preventable causes; ranks number 46 on expenditures per capita for mental health, and number 32 on state spending for health care as a percent of gross product (Kaiser State Health Facts). The current level of funding for the system at all levels is not sufficient to meet the need. Providers are becoming less willing to accept indigent program recipients due to very low reimbursement rates that at times are less than the cost to provide service.

Texas leads the nation in the percentage of people without health insurance (an estimated 24.6 percent of the state's population) and is second only to California in the total number of uninsured residents (5.4 million people). The number of uninsured is particularly acute among small employers and the "working poor" – people earning less than 200 percent FPL ($18,000 per year for a single individual, and $40,000 for a family of four). The problem is exacerbated by the high cost of health insurance for both employers and employees, including those in the public sector, and the lack of a comprehensive plan to address the high number of individuals in Texas without health insurance.

Other DSHS Safety-Net Programs

The committee had the opportunity to learn about other DSHS state-funded programs that deal with the indigent population such as the *Federally Qualified Health Centers (FQHC) Incubator Grant Program* which provides seed funding to health care entities seeking federal certification as an FQHC or an FQHC Look Alike. The FQHCs and FQHC Look Alikes provide primary care to their service area serving a population up to 200 percent FPL, diverting at least some patients from a hospital emergency room to a more

appropriate setting. The Primary Care Program, under Chapter 31 of the Health and Safety Code, is a DSHS program serving a population up to 150 percent FPL. Both of these programs are part of the safety-net system for the indigent population and the uninsured; however, these safety-net programs are of limited capacity throughout Texas. Once again, an indigent person's residence in Texas can determine their level of access to health care services.

III. Recommendations from the IHCAC

The Indigent Health Care Advisory Committee believes that Texas should study regional, multi-county programs through inter-local cooperation agreements, while ultimately working to increase the State and Federal funding level in order to raise the current 21 percent FPL eligibility level for indigent care responsibility. As stated in the ***Code Red*** report,

> "Action is needed to promote change from county-based indigent care to a regional-based system of indigent care, where appropriate. This would ensure necessary care for all populations, regardless of their county of residence, with more equitable financing"

A collaborative approach across multiple counties offers all counties, both large and small, the opportunity to leverage their resources in a more cost effective manner. For example, through the use of health information technology and disease management and prevention, Texas can lower health care delivery costs while improving the health status of its residents. Delivering the right care, in the right place, at the right time can reduce the burden on emergency rooms and ensure that this valuable resource is available when needed. In addition, regional approaches might enable a combining of general tax revenues in a way that they could be eligible for a federal match through Medicaid 1115 or Health Insurance Flexibility and Accountability (HIFA) waivers resulting in significantly more funds for indigent care.

The burden of addressing the increasing demand for indigent health care is falling both on the counties without the resources to meet their current obligations, and also on the large metropolitan counties that are spending far more than 8 percent of their ad valorem taxes, in order to support their county hospital districts.

Specific recommendations in each of the four areas for which this committee was charged are delineated on the following pages of this report.

A. Pilot Programs for Regional Approach to CIHCP

Recommendation #1

Subject to available resources, DSHS should implement at least three pilot programs designed to test the feasibility of regionalization in different areas of the state, including both rural and urban environments. Each project will operate for a specified period of time and will be subject to a return on investment (ROI) evaluation that will include an evaluation of performance and outcomes. Projects should be selected through a competitive process by DSHS, with evaluation criteria to include the bidder's experience in collaboration with other providers and entities in delivery of health care services. DSHS will require pilot programs to comply with the following elements:

- Implement higher income levels for CIHCP eligibility across the counties participating in the pilot *(All those participating in the pilot will agree to utilize the same indigent income criteria, increasing it from 21 percent up to an agreed upon higher level of FPL).*
- Require participation by county indigent health care programs, public hospitals, and/or hospital districts, and other appropriate providers in the participating counties *(All providers of indigent care services in the selected county collaboration must be eligible to participate in the pilot).*
- Use health information technology infrastructure to improve access, quality of care, and efficiencies in the safety net system *(Pilots will be selected on ability to provide outcome based data showing a return on the time, money and other ROI; also the partners in the project must demonstrate the ability to develop a centralized data base when providing services and when referring patients among the various providers for primary care as well as emergent care, specialty services, etc.)*
- Participate in a health information exchange that includes the uninsured, if available, in the participating counties *(Same as above).*

- Measure Outcomes *(Since the purpose of this endeavor is to prove how collaboration and creativity can produce improved health care delivery, better manage costs, and provide effective and efficient access to health care to the low income uninsured, then there must be criteria in place to measure success. In order to do this, there must be some outcome measures that verify a ROI of all the partners in the pilot. Examples of outcome based criteria/measurement can include but may not be limited to a) improved health status for target diagnostic group(s) such as diabetics; b) decreased expenditures, in-patient days, incidents of ER visits, etc.; c) cost savings for certain services, pooled purchasing, etc.; d) other community based measures for economic, quality of life, etc.).*

In order to increase provider participation, providers may be reimbursed at a rate higher than current Medicaid or CIHCP rates, i.e. Medicaid plus 15 percent, or CIHCP plus 15 percent.

In addition to providing or arranging for the basic services listed in Chapter 61, pilot projects should also offer two or more of the following services through a collaborative approach across the regional system of care:

- 24-Hour Call Center *(Operators take both emergency and non-emergency requests, schedule appointments, and direct clients to the most appropriate health care services, thus avoiding non-emergent Emergency Room (ER) visits. Trained operators can make important differences in the type and location of care a client receives thus allowing the indigent care system to operate in the most efficient and effective manner).*
- Care Coordination *(Coordination of medical care increases the ability to maximize available medical resources in the most appropriate manner, decreases duplication of services, and provides a more efficient system of access and care for patients).*

- Non-Emergency Transportation *(Many who live at or below the FPL do not have reliable transportation to access even the most basic needs, which includes medical appointments. Some who delay accessing medical services find themselves in emergency situations that may be life threatening as well as more costly than the expense of providing non-emergency transportation).*
- Patient Education (*Also referred to as "information therapy" – defined as "the prescription of condition-specific medical information to a specific patient in a healthcare setting." Patient education offers an opportunity for cost savings, especially through reduction in unnecessary clinical visits and services. Using health information to engage patients in management of their own health is essential to achieving effective clinical goals in chronic-care management).*
- Access to more than three prescription drugs or other alternative prescription programs *(CIHCP is currently limited to three prescriptions per month. Often recipients, especially those with multiple medical conditions, take more than three prescriptions per month, but do not have adequate resources to purchase the remaining prescriptions. Expanding the prescription drug benefit increases the opportunity for better health outcomes that decrease the incidents of higher cost services such as ER, hospitalization, etc.).*

State funding and/or financial incentives for participation in a regional pilot should include one or more of the following, provided that no reductions shall be made to existing funding programs:

a) Include additional pilot services in the services counted towards a county's 8 percent requirement under Chapter 61.

b) Provide matching dollars for additional services provided and/or increase in eligibility.

c) Provide funding for health information technology infrastructure, including infrastructure for participation in health information exchange.

d) Provide funding for additional capacity for primary and specialty care services.

Applications should be developed and requested in a manner that does not cause harm or jeopardy to existing funding (i.e. Disproportionate Share Hospital (DSH) or Upper Payment Limit (UPL) funds). It would be counterproductive to develop any new projects that would reduce the current level of funding available to the local community via participating partners.

Rationale: Regionalizing health care where surrounding counties collaborate their resources, both tangible and intangible, addressing the health care needs particular to their region of the state, will provide a more efficient delivery of services, less duplication, and a decrease in expensive hospitalizations, and increase the opportunity for less costly preventive care for both individuals and providers. The regional pilots should be diverse, flexible and target the specific needs of the region.

B. Legislation Updating Indigent Health Care Eligibility and Differences Under Chapter 61

Recommendation #1

Require public hospitals and hospital districts to provide the same services as the county programs and be eligible for state assistance funds for unreimbursed basic and optional services under Sections 61.028 and 61.0285 of the Health & Safety Code. Set the same limitations for all entities as established by Section 61.035.

Rationale: *Currently, Chapter 61 of the Health & Safety Code makes a distinction between responsibilities for counties not covered by a public hospital or a hospital district and those that are covered. The law requires non-covered counties to provide a range of basic services, but directs public hospitals and hospital districts to "endeavor to provide" the same services. This lack of consistency in services contributes to the state's "patchwork" system of care across the counties, hospitals districts, and public hospitals in Texas. Setting the same limitations for all services adds to the consistency of the program standards.*

Recommendation #2

Change Advanced Practice Nurses, Colostomy Supplies, and Diabetic Supplies from optional services to basic services required under Chapter 61.

Rationale: *Currently the counties have the option to provide additional services as defined in Section 61.0285. The committee believes the focus should be on preventive services and services that may be provided by other medical professionals in a more cost effective manner.*

Recommendation #3

Add Case Management services to the list of optional services that can be provided under Chapter 61.

Rationale: *Case management services can help ensure clients are following their medical recommendations and thus avoid emergency room visits for non-emergent conditions.*

Recommendation #4

Raise minimum income standard for eligibility from 21 percent FPL to 25 percent and increase the maximum healthcare liability for each fiscal year for health care services to each eligible resident from $30,000 to $35,000. (Refer to Chapter 61, Section 61.035).

Rationale: *The $30,000 maximum has been in effect since 1986, and there have been small incremental changes in the income standards throughout the program's existence. Texas indigent care programs need to recognize that policies limiting support to persons living at 21 percent FPL or below provide inadequate support for indigent care to residents of this state. Ultimately regional solutions combined with raising the program's eligibility levels statewide will reduce unfair subsidies and create a more efficient and equitable system.*

Recommendation #5

Include a requirement for all eligible clients to comply with physician orders.

Rationale: *Indigent health care is only as effective as the partners who contribute to the program. To be successful all components of the system – including the client – need to be involved. Lack of compliance on the part of the clients potentially worsens their health status and requires higher cost and more complicated services in the future.*

C. Allocation, Reporting and Enforcement

Recommendation #1

Maintain current method of allocation, but increase the State's match from 90 percent to 100 percent of county expenditures after a county spends 8 percent of its General Revenue Tax Levy on payment for health care services to eligible county residents.

Rationale: *According to Fiscal Year 2005 county spending reports, 112 counties (out of 142) reported spending $63 million on indigent health care, while the State spent around $5 million on reimbursements to counties for state assistance. The ability to reimburse counties at a higher percentage level would benefit those counties that spend above 8 percent GRTL and would allow some of the counties that have less money available to participate in the state reimbursement process. Some counties do not have the funds to continue serving their eligible indigent residents and are forced to close their programs prior to the end of the fiscal year.*

Recommendation #2

a) Require public hospitals and hospital districts to follow reporting requirements currently in place for county-run programs.

Rationale: *For consistency in reporting and in an effort to better understand the existing program, the same reported information should be required from all entities. Eligibility levels and services provided by each entity may differ and an annual report would assist in program identification.*

b) Develop targeted education and policy clarifications of any new reporting and/or enforcement activity for county officials and hospital administrators.

Rationale: *With current program delivery, some of the individuals who make administrative and funding decisions are not aware of program specifics according to statute; therefore, the eligibility decisions may conflict with those making administrative decisions.*

Recommendation #3

Propose legislation to add language in Chapter 61 to provide compliance review activities for all indigent health care entities (counties, public hospitals, and hospital districts), and require an entity found not to be in compliance with Chapter 61 to come into compliance within 90 days. The State should implement a system of sanctions for noncompliant entities.

Rationale*: For consistency and equal administration of Chapter 61, compliance reviews are being recommended for all entities. Indigent persons in Texas, regardless of their residence, should be able to access identical health care from any entity. After twenty years of program mandates, some entities are complying with Chapter 61 mandates and others are making decisions to comply with portions or none of the statute. Many reasons may factor in the evolution of the CIHCP. Some of the changes range from programmatic, health care costs, staff changes at the local and state levels, local funding issues, and program responsibilities. Some of these factors have affected local administration of the program and services provided to the indigent population. Since fiscal year 2004, budget cuts have resulted in staff reductions from 18 to 8 full time employees. The ability to provide regional and one-on-one training, quality assurance reviews to all state assistance counties, and technical assistance has been affected. Any significant change to the statute would need to include very thorough training with specific written policies for compliance procedures.*

D. Other Areas or Subjects

Recommendation #1

Amend Chapter 61 of the Health and Safety Code to reflect agency name changes, consistency with Temporary Assistance to Needy Families (TANF) policy, and clarification of services (see Appendix A).

Rationale: *Consistency and accuracy. Throughout the statute there are references to procedures and standards not being more restrictive than TANF, therefore changes are being made to align policies with TANF. There are several references to update agency names. Other changes reflect clarifications to services and reporting.*

Recommendation #2

Add non-emergency medically necessary transportation services to the optional health care services.

Rationale: *Lack of transportation is a major factor in non-compliance on the part of clients and impedes early diagnosis and primary and preventative care.*

Recommendation #3

Participating entities that provide basic or optional services to otherwise eligible clients from other counties, housed in county jails, should be allowed a credit toward state assistance for the costs they have incurred.

Rationale*: Counties are required to provide health care to incarcerated individuals in their counties. Many incarcerated individuals are not residents of the county in which they are incarcerated and the housing county is often unable to get another responsible county to reimburse the required health costs. This statutory change would allow the housing eligible county to credit their expenditures toward state assistance regardless of inmates' residence.*

Recommendation #4

Clarify redetermination of eligibility in Chapter 61 to be consistent with TANF.

Rationale: *The current language leaves the possibility for applications to be left open indefinitely, and for the counties to be responsible for an indefinite period of time. This issue may be resolved by placing a timeframe in the statute or by adding rules to define justifiable circumstances to which an application can be redetermined eligible.*

Recommendation #5

Propose legislation that provides state funded options for counties, hospital districts, and public hospitals that are providing preventive health care services to their indigent population at or below 100 percent FPL. Preventive health care services may include the following services:

- Screenings for health conditions such as diabetes, hypertension, obesity-related illnesses, and others;
- Influenza and pneumonia immunizations;
- Use of Promotoras or Community Health Workers to educate the indigent population and the county either as resources or employees

Rationale: *Currently, counties report that 57.76 percent of their indigent health care expenses are for inpatient and outpatient hospital expenses. According to the Centers for Disease Control and Prevention only 20 percent of ER visits are for emergent conditions, and at least one-third of all visits in America are for non-urgent health problems. In order to change the culture of treating health care as a crisis, the recommendation is to promote preventive health care for the indigent population as a long-term solution.*

Recommendation #6

Investigate the implementation of statewide or regional pharmaceuticals purchasing, such as 340B pricing, through a regional or statewide consortium.

Rationale: *The 340B Drug Pricing Program provides access to reduced price prescription drugs to "covered entities" that serve the most vulnerable patient populations. There may be as many as 664 covered entities in Texas as of January 1, 2006, but no statewide plan, other than a program for correctional populations (SB347). This deprives some of the least knowledgeable and smaller indigent care facilities and counties from receiving the most favorable pharmaceutical pricing that can be as much as a 50 percent discount from retail prices for drugs covered under Medicaid. Several other states, including California, Maine, Maryland, New Mexico, and Vermont are investigating state bulk purchasing programs.*

Recommendation #7

Continue to support innovative initiatives such as the Galveston County 3-Share Plan.

Rationale: *The State has submitted a waiver to the Centers for Medicare and Medicaid Services (CMS) for approval of a 3-share plan for Galveston County that would provide benefits for those people working for small employers whose income is less than 200 percent FPL that has an estimated cost of $180 per member per month ($60 employee, $60 employer, $60 public funds). It is anticipated that 3,525 people will participate in the program. Children's Health Insurance Program (CHIP) dollars fund the public share of the program. Eligible employers are small businesses that have not provided health insurance to their employees in the past 12 months.*

Recommendation #8

Create a statewide Client Data Depository to enhance communications between providers and avoid duplication of services funded by the state.

Rationale: *The Indigent health care program is not linked to any client data depository and may result in duplication of services. A benefit from a client depository system*

would be the ability to access client information, client services, and health care data in a much more efficient manner. The depository could link the indigent health care programs into existing healthcare systems.

Recommendation #9

Explore the potential and development of mechanisms in which county funds could become eligible for federal match.

Rationale: *Local governments and the State should continue to explore Medicaid or CHIP waiver opportunities that leverage local tax dollars to gain matching federal funds. Counties are interested in establishing good business partnerships that provide better services for taxpayers.*

Recommendation #10

Establish an ongoing indigent health care advisory committee with broad representation.

Rationale: *An advisory committee with public meetings sets an arena for good public policy making and a format for continued discussion on indigent health care issues in Texas. Broad representation on the committee allows for voices from the different stakeholders.*

IV. Summary

This advisory committee recognizes the challenge to provide medical care to the uninsured and indigent population, and that sufficient funding for indigent care is a long-term goal. In the meantime, however, we believe that there are measures that can be taken now, to move to a more equitable and cost effective system – one that recognizes the effectiveness of multi-county programs (regionalization of certain geographic areas), Medicaid or CHIP waivers, better reporting systems for health care data, and best practices programs that provide all indigent residents access to health care in the most appropriate setting.

The 80th session of the Texas Legislature can be a watershed opportunity for indigent health care in Texas. If implemented, the initiatives outlined in this report can create a more equitable and affordable indigent health care system that delivers better outcomes for Texas.

Appendix A – Recommended Changes to Chapter 61

The following language is recommended for updating or amending Chapter 61 for agency name changes, policy to be analogous with TANF, and clarification of services.

SUBCHAPTER A. GENERAL PROVISIONS

§ 61.002. Definitions

(1) "Department" means the ~~Texas Department of Health~~ **Department of State Health Services**

Rationale: *Name change*

§ 61.003. Residence

(f) For purposes of this chapter, a person who is an inmate or resident of a state school or institution operated by the ~~Texas Department of Corrections~~ **Texas Department of Criminal Justice**; ~~Texas Department of Mental Health and Mental Retardation~~ **Department of Aging and Disability Services, Department of State Health Services,** Texas Youth Commission, Texas School for the Blind **and Visually Impaired**, Texas School for the Deaf, or any other state agency or who is an inmate, patient, or resident of a school or institution operated by a federal agency is not considered a resident of a hospital district or of any governmental entity except the state or federal government.

Rationale*: Agency name changes.*

§ 61.004 ~~Residence or~~ Eligibility Dispute

Rationale: *Eligibility Dispute includes determination of residence.*

§ 61.006. Standards and Procedures

(c) The department shall also define the services and establish the payment standards for the categories of services listed in Sections 61.028(a) and 61.0285 in accordance with ~~Texas Department of Human Services~~ **Health and Human Services Commission** rules relating to the Temporary Assistance for Needy Families-Medicaid program.

Rationale: *Agency name change.*

61.007. Information Provided by Applicant

(6) any transfer of title to real property ~~that the applicant has made in the preceding 24 months~~;

(8) the amount of the applicant's liquid ~~assets and the equity value of the applicant's car and real property.~~ **resources, vehicles and real property.**

Rationale: *Make more general to remain no more restrictive than TANF. TANF uses the term "vehicle."*

61.008. Eligibility Rules

(2) a county must consider the ~~equity~~ **value** of a ~~car~~ **vehicle** that is in excess of the amount exempted under department guidelines as a resource;

Rationale: *Consistency with TANF, which uses the terms "value" and "vehicle."*

(3) a county must subtract the work-related and ~~child care~~ **dependent care** expense ~~allowance~~ allowed under department guidelines;

Rationale: *Stay analogous with TANF, which applies a deduction for dependent care, not just childcare.*

~~(5) if an applicant transferred title to real property for less than market value to become eligible for assistance under this chapter, the county may not credit toward eligibility for state assistance an expenditure for that applicant made~~

~~during a two-year period beginning on the date on which the property is transferred.~~

(5) transferal of countable resources may be no more restrictive than the resource requirements for Temporary Assistance for Needy Families program.

Rationale: *Stay analogous with TANF requirements.*

§ 61.009. Reporting Requirements

(a) The department shall establish and maintain current uniform reporting requirements for governmental entities that own, operate, or lease public hospitals providing assistance under this chapter and for counties **and hospital districts**.

(b) The reports must include information relating to:

(1) expenditures for and nature of hospital and health care provided to eligible residents;

(2) eligibility standards and procedures established by counties and governmental entities that own, operate, or lease public hospitals; and

(3) relevant characteristics of eligible residents.

(c) The reports must be sent to the department at least annually;

Rationale: *Provide uniformity in the reporting of indigent health care data.*

SUBCHAPTER B. COUNTY RESPONSIBILITY FOR PERSONS NOT RESIDING IN AN AREA SERVED BY A PUBLIC HOSPITAL OR HOSPITAL DISTRICT

61.023. General Eligibility Provisions

~~(c) A county may contract with the department to perform eligibility determination services.~~

Rationale: Delete, as department is not able to provide this service.

61.025. County Agreement with Municipality

(1) ~~mandatory~~ **basic** inpatient or outpatient services to eligible residents that the municipal hospital cannot provide; or

Rationale: *Word change only, to be consistent with terminology elsewhere in statute (61.028 – required services are called "basic" health care services.*

§ 61.0285. Optional Health Care Services

(1) **freestanding** ambulatory surgical center services;

Rationale*: Add word for accuracy/clarification. Ambulatory surgical center currently falls in the basic (required) services of an outpatient hospital service.*

(b) A county must notify the department of the county's intent to provide services specified by Subsection (a)~~. If the services are approved by the department under Section 61.006, or if the department fails to notify the county of the department's disapproval before the 31st day after the date the county notifies the department of its intent to provide the services,~~ and ~~the~~ county may credit these services toward eligibility for state assistance under this subchapter.

Rationale: *Modify provision related to optional services, dropping requirement that counties get State approval. State approval appears unnecessary if counties have made decision to provide optional care services, as allowed by the statute.*

§ 61.031. Notification of Provision of Nonemergency Services

(b) If the county does not require prior approval and a provider delivers or will

deliver nonemergency health care services to a patient who the provider suspects may be eligible for assistance under this subchapter, the provider shall notify the patient's county of residence that health care services have been or will be provided to the patient. The notice shall be made:

(1) by telephone **or fax** not later than the 72nd hour after the provider determines the patient's county of residence; and

§ 61.032. Notification of Provision of Emergency Services

(a) If a nonmandated provider delivers emergency services to a patient who the provider suspects might be eligible for assistance under this subchapter, the provider shall notify the patient's county of residence that emergency services have been or will be provided to the patient. The notice shall be made:

(1) by telephone **or fax** not later than the 72nd hour after the provider determines the patient's county of residence; and

Rationale: *The notification policies need updating to add other ways to communicate information. Allowing providers to fax information is beneficial if entities are closed on the weekends or holidays.*

§ 61.042 – Employment Services Program

(a) A county may establish procedures consistent with those used by the ~~Texas Department of Human Services~~ **Health and Human Services Commission** under Chapter 31, Human Resources Code, for administering an employment services program and requiring an applicant or eligible resident to register for work with the ~~Texas Employment Commission~~ **Texas Workforce Commission.**

Rationale: *Agency name change.*

§61.066. Prevention and Detection of Fraud.

(a) A hospital district **and public hospital** shall adopt reasonable procedures for minimizing the opportunity for fraud, for establishing and maintaining methods for detecting and identifying situations in which a question of fraud may exist, and for administrative hearings to be conducted on disqualifying persons in cases where fraud appears to exist.

(b) Procedures established by a hospital district **and public hospital** for administrative hearings conducted under this section shall provide for appropriate due process, including procedures for appeals.

Rationale: *Language to include public hospitals and to include the same word "shall" for all entities.*

Appendix B - Participants

The Committee extends its appreciation to the following persons who assisted committee members by participating in workgroups:

Ann Kitchen – Austin ICC
Rita Kelley – Bell County and Texas Indigent Health Care Association
Rick Thompson – Texas Association of Counties
Marilyn Manford – Comal County
Scott Hermstien – UTMB
Mark Yates – Cameron County
Mike Chapa – Zapata County
Rebecca Currington – Hockley County Public Hospital
Frank Salinas – Webb County
Janeane Hester – Atascosa County
Karl Lavine – Fort Bend County
Teresa Munoz – Mitchell County Hospital District
Claudia Sanchez - Mitchell County Hospital District
Lena Saenz – Guadalupe County
Margaret Salaika – Brazoria County
Gilbert Andrade – Brooks County Public Hospital
Karl Lavine- Ft. Bend County
Tom Foegelle- Dewitt County and Hospital District
Rudy De La Vina – Hidalgo County
Lynette Schatte – Lee County
Joyce Hafford – Jefferson County
Susan Webb – Hardin County
Donna Burt – Liberty County