

HEALTH AND SAFETY CODE CHAPTER 61. INDIGENT HEALTH CARE AND
TREATMENT ACT

HEALTH AND SAFETY CODE

TITLE 2. HEALTH

SUBTITLE C. PROGRAMS PROVIDING HEALTH CARE BENEFITS AND SERVICES

CHAPTER 61. INDIGENT HEALTH CARE AND TREATMENT ACT

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 61.001. SHORT TITLE. This chapter may be cited as the Indigent Health Care and Treatment Act.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.

Sec. 61.002. DEFINITIONS. In this chapter:

(1) "Department" means the Texas Department of Health.

(2) "Eligible county resident" means an eligible resident of a county who does not reside in the service area of a public hospital or hospital district.

(3) "Eligible resident" means a person who meets the income and resources requirements established by this chapter or by the governmental entity, public hospital, or hospital district in whose jurisdiction the person resides.

(4) "Emergency services" has the meaning assigned by Chapter 773.

(5) "General revenue levy" means:

(A) the property taxes imposed by a county that are not dedicated to the construction and maintenance of farm-to-market roads or to flood control under Article VIII, Section 1-a, of the Texas Constitution or that are not dedicated to the further maintenance of the public roads under Article VIII, Section 9, of the Texas Constitution; and

(B) the sales and use tax revenue to be received by the county during the calendar year in which the state fiscal year begins under Chapter 323, Tax Code, as determined under Section 26.041(d), Tax Code.

(6) "Governmental entity" includes a county, municipality, or other political subdivision of the state, but does not include a hospital district or hospital authority.

(7) "Hospital district" means a hospital district created under the authority of Article IX, Sections 4-11, of the Texas Constitution.

(8) "Mandated provider" means a person who provides health care services, is selected by a county, public hospital, or hospital district, and agrees to provide health care services to eligible residents, including the primary teaching hospital of a state medical school located in a county which does not have a public hospital or hospital district, and the faculty members practicing in both the inpatient and outpatient care facilities affiliated with the teaching hospital.

(9) "Medicaid" means the medical assistance program provided under Chapter 32, Human Resources Code.

(10) "Public hospital" means a hospital owned, operated, or leased by a governmental entity, except as provided by Section 61.051.

(11) "Service area" means the geographic region in which a governmental entity, public hospital, or hospital district has a legal obligation to provide health care services.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 1991, 72nd Leg., ch. 14, Sec. 14, eff. Sept. 1, 1991; Acts 1995, 74th Leg., ch. 76, Sec. 8.119, eff. Sept. 1, 1995; Acts 1999, 76th Leg., ch. 1377, Sec. 1.01, eff. Sept. 1, 1999.

Sec. 61.003. RESIDENCE. (a) For purposes of this chapter, a person is presumed to be a resident of the governmental entity in which the person's home or fixed place of habitation to which the person intends to return after a temporary absence is located. However, if a person's home or fixed place of habitation is located in a hospital district, the person is presumed to be a resident of that hospital district.

(b) If a person does not have a residence, the person is a resident of the governmental entity or hospital district in which the person intends to reside.

(c) Intent to reside may be evidenced by any relevant information, including:

(1) mail addressed to the person or to the person's

spouse or children if the spouse or children live with the person;

(2) voting records;

(3) automobile registration;

(4) Texas driver's license or other official identification;

(5) enrollment of children in a public or private school; or

(6) payment of property tax.

(d) A person is not considered a resident of a governmental entity or hospital district if the person attempted to establish residence solely to obtain health care assistance.

(e) The burden of proving intent to reside is on the person requesting assistance.

(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 Mental Health and Mental Retardation, Texas Youth Commission, Texas School for the Blind, 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.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.

Sec. 61.004. RESIDENCE OR ELIGIBILITY DISPUTE. (a) If a provider of assistance and a governmental entity or hospital district cannot agree on a person's residence or whether a person is eligible for assistance under this chapter, the provider or the governmental entity or hospital district may submit the matter to the department.

(b) The provider of assistance and the governmental entity or hospital district shall submit all relevant information to the department in accordance with the application, documentation, and verification procedures established by the department under Section 61.006.

(c) If the department determines that another governmental entity or hospital district may be involved in the dispute, the

department shall notify the governmental entity or hospital district and allow the governmental entity or hospital district to respond.

(d) From the information submitted, the department shall determine the person's residence or whether the person is eligible for assistance under this chapter, as appropriate, and shall notify each governmental entity or hospital district and the provider of assistance of the decision and the reasons for the decision.

(e) If a governmental entity, hospital district, or provider of assistance does not agree with the department's decision, the governmental entity, hospital district, or provider of assistance may file an appeal with the department. The appeal must be filed not later than the 30th day after the date on which the governmental entity, hospital district, or provider of assistance receives notice of the decision.

(f) The department shall issue a final decision not later than the 45th day after the date on which the appeal is filed.

(g) A governmental entity, hospital district, or provider of assistance may appeal the final order of the department under Chapter 2001, Government Code, using the substantial evidence rule on appeal.

(h) Service may not be denied pending an administrative or judicial review of residence.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 1995, 74th Leg., ch. 76, Sec. 5.95(49), eff. Sept. 1, 1995; Acts 1999, 76th Leg., ch. 1377, Sec. 1.02, eff. Sept. 1, 1999.

Sec. 61.0045. INFORMATION NECESSARY TO DETERMINE ELIGIBILITY. (a) Any provider, including a mandated provider, public hospital, or hospital district, that delivers health care services to a patient who the provider suspects is an eligible resident of the service area of a county, hospital district, or public hospital under this chapter may require the patient to:

(1) provide any information necessary to establish that the patient is an eligible resident of the service area of the county, hospital district, or public hospital; and

(2) authorize the release of any information relating

to the patient, including medical information and information obtained under Subdivision (1), to permit the provider to submit a claim to the county, hospital district, or public hospital that is liable for payment for the services as described by Section 61.033 or 61.060.

(b) A county, hospital district, or public hospital that receives information obtained under Subsection (a) shall use the information to determine whether the patient to whom services were provided is an eligible resident of the service area of the county, hospital district, or public hospital and, if so, shall pay the claim made by the provider in accordance with this chapter.

(c) The application, documentation, and verification procedures established by the department for counties under Section 61.006 may include a standard format for obtaining information under Subsection (a) to facilitate eligibility and residence determinations.

Added by Acts 1999, 76th Leg., ch. 1377, Sec. 1.03, eff. Sept. 1, 1999.

Sec. 61.005. CONTRIBUTION TOWARD COST OF ASSISTANCE.

(a) A county, public hospital, or hospital district may request an eligible resident receiving health care assistance under this chapter to contribute a nominal amount toward the cost of the assistance.

(b) The county, public hospital, or hospital district may not deny or reduce assistance to an eligible resident who cannot or refuses to contribute.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.

Sec. 61.006. STANDARDS AND PROCEDURES. (a) The department shall establish minimum eligibility standards and application, documentation, and verification procedures for counties to use in determining eligibility under this chapter.

(b) The minimum eligibility standards must incorporate a net income eligibility level equal to 21 percent of the federal poverty level based on the federal Office of Management and Budget poverty index.

(b-1) Expired.

(b-2) Repealed by Acts 2001, 77th Leg., ch. 1128, Sec. 7, eff. Sept. 1, 2001.

(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 rules relating to the Temporary Assistance for Needy Families-Medicaid program.

(d) The department shall establish application, documentation, and verification procedures that are consistent with the analogous procedures used to determine eligibility in the Temporary Assistance for Needy Families-Medicaid program. The department may not adopt a standard or procedure that is more restrictive than the Temporary Assistance for Needy Families-Medicaid program or procedures.

(e) The department shall ensure that each person who meets the basic income and resources requirements for Temporary Assistance for Needy Families program payments but who is categorically ineligible for Temporary Assistance for Needy Families will be eligible for assistance under Subchapter B. Except as provided by Section 61.023(b), the department by rule shall also provide that a person who receives or is eligible to receive Temporary Assistance for Needy Families, Supplemental Security Income, or Medicaid benefits is not eligible for assistance under Subchapter B even if the person has exhausted a part or all of that person's benefits.

(f) The department shall notify each county and public hospital of any change to department rules that affect the provision of services under this chapter.

(g) Notwithstanding Subsection (a), (b), or (c) or any other provision of law, the department shall permit payment to a licensed dentist for services provided under Sections 61.028(a)(4) and (6) if the dentist can provide those services within the scope of the dentist's license.

(h) Notwithstanding Subsection (a), (b), or (c), the department shall permit payment to a licensed podiatrist for services provided under Sections 61.028(a)(4) and (6), if the

podiatrist can provide the services within the scope of the podiatrist's license.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 1989, 71st Leg., ch. 1100, Sec. 5.09(a), eff. Sept. 1, 1989; Acts 1991, 72nd Leg., ch. 14, Sec. 15, eff. Sept. 1, 1991; Acts 1995, 74th Leg., ch. 76, Sec. 8.120, eff. Sept. 1, 1995; Acts 1999, 76th Leg., ch. 1377, Sec. 1.04, eff. Sept. 1, 1999; Acts 2001, 77th Leg., ch. 1128, Sec. 1, 7 eff. Sept. 1, 2001.

Sec. 61.007. INFORMATION PROVIDED BY APPLICANT. The department by rule shall require each applicant to provide at least the following information:

- (1) the applicant's full name and address;
- (2) the applicant's social security number, if available;
- (3) the number of persons in the applicant's household, excluding persons receiving Temporary Assistance for Needy Families, Supplemental Security Income, or Medicaid benefits;
- (4) the applicant's county of residence;
- (5) the existence of insurance coverage or other hospital or health care benefits for which the applicant is eligible;
- (6) any transfer of title to real property that the applicant has made in the preceding 24 months;
- (7) the applicant's annual household income, excluding the income of any household member receiving Temporary Assistance for Needy Families, Supplemental Security Income, or Medicaid benefits; and
- (8) the amount of the applicant's liquid assets and the equity value of the applicant's car and real property.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 1999, 76th Leg., ch. 1377, Sec. 1.04, eff. Sept. 1, 1999.

Sec. 61.008. ELIGIBILITY RULES. (a) The department by rule shall provide that in determining eligibility:

- (1) a county may not consider the value of the

applicant's homestead;

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

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

(4) a county must consider as a resource real property other than a homestead and, except as provided by Subsection (b), must count that property in determining eligibility; and

(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.

(b) A county may disregard the applicant's real property if the applicant agrees to an enforceable obligation to reimburse the county for all or part of the benefits received under this chapter. The county and the applicant may negotiate the terms of the obligation.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.

Sec. 61.009. REPORTING REQUIREMENTS. (a) The department shall establish uniform reporting requirements for governmental entities that own, operate, or lease public hospitals providing assistance under this chapter and for counties.

(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.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 1995, 74th Leg., ch. 76, Sec. 8.121, eff. Sept. 1, 1995.

Sec. 61.010. DEDICATED TAX REVENUES. If the governing body

of a governmental entity adopts a property tax rate that exceeds the rate calculated under Section 26.04, Tax Code, by more than eight percent, and if a portion of the tax rate was designated to provide revenue for indigent health care services required by this chapter, the revenue produced by the portion of the tax rate designated for that purpose may be spent only to provide indigent health care services.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.

Sec. 61.011. SERVICES BY STATE HOSPITAL OR CLINIC. A state hospital or clinic shall be entitled to payment for services rendered to an eligible resident under the provisions of this chapter applicable to other providers. The department may adopt rules as necessary to implement this section.

Added by Acts 1999, 76th Leg., ch. 1377, Sec. 1.05, eff. Sept. 1, 1999.

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

Sec. 61.021. APPLICATION OF SUBCHAPTER. This subchapter applies to health care services and assistance provided to a person who does not reside in the service area of a public hospital or hospital district.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.

Sec. 61.022. COUNTY OBLIGATION. (a) A county shall provide health care assistance as prescribed by this subchapter to each of its eligible county residents.

(b) The county is the payor of last resort and shall provide assistance only if other adequate public or private sources of payment are not available.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.

Sec. 61.0221. AUTHORITY RELATING TO OTHER ASSISTANCE PROGRAMS. This subchapter does not affect the authority of the commissioners court of a county to provide eligibility standards or other requirements relating to assistance programs or services that

are not covered by this subchapter.

Added by Acts 1999, 76th Leg., ch. 62, Sec. 13.11(g), eff. Sept. 1, 1999.

Sec. 61.023. GENERAL ELIGIBILITY PROVISIONS. (a) A person is eligible for assistance under this subchapter if:

(1) the person does not reside in the service area of a public hospital or hospital district;

(2) the person meets the basic income and resources requirements established by the department under Sections 61.006 and 61.008 and in effect when the assistance is requested; and

(3) no other adequate source of payment exists.

(b) A county may use a less restrictive standard of eligibility for residents than prescribed by Subsection (a). A county may credit toward eligibility for state assistance under this subchapter the services provided to each person who is an eligible resident under a standard that incorporates a net income eligibility level that is less than 50 percent of the federal poverty level based on the federal Office of Management and Budget poverty index.

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

(d) Not later than the beginning of a state fiscal year, the county shall adopt the eligibility standards it will use during that fiscal year and shall make a reasonable effort to notify the public of the standards. The county may change the eligibility standards to make them more or less restrictive than the preceding standards, but the standards may not be more restrictive than the standards established by the department under Section 61.006.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 1989, 71st Leg., ch. 1100, Sec. 5.10(a), eff. Sept. 1, 1989; Acts 1999, 76th Leg., ch. 1377, Sec. 1.06, eff. Sept. 1, 1999.

Sec. 61.024. COUNTY APPLICATION PROCEDURE. (a) A county shall adopt an application procedure.

(b) The county may use the application, documentation, and verification procedures established by the department under

Sections 61.006 and 61.007 or may use a less restrictive application, documentation, or verification procedure.

(c) Not later than the beginning of a state fiscal year, the county shall specify the procedure it will use during that fiscal year to verify eligibility and the documentation required to support a request for assistance and shall make a reasonable effort to notify the public of the application procedure.

(d) The county shall furnish an applicant with written application forms.

(e) On request of an applicant, the county shall assist the applicant in filling out forms and completing the application process. The county shall inform an applicant of the availability of assistance.

(f) The county shall require an applicant to sign a written statement in which the applicant swears to the truth of the information supplied.

(g) The county shall explain to the applicant that if the application is approved, the applicant must report to the county any change in income or resources that might affect the applicant's eligibility. The report must be made not later than the 14th day after the date on which the change occurs. The county shall explain the possible penalties for failure to report a change.

(h) The county shall review each application and shall accept or deny the application not later than the 14th day after the date on which the county receives the completed application.

(i) The county shall provide a procedure for reviewing applications and for allowing an applicant to appeal a denial of assistance.

(j) The county shall provide an applicant written notification of the county's decision. If the county denies assistance, the written notification shall include the reason for the denial and an explanation of the procedure for appealing the denial.

(k) The county shall maintain the records relating to an application at least until the end of the third complete state fiscal year following the date on which the application is submitted.

(1) If an applicant is denied assistance, the applicant may resubmit an application at any time circumstances justify a redetermination of eligibility.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.

Sec. 61.025. COUNTY AGREEMENT WITH MUNICIPALITY.

(a) This section applies to a municipality that has a population of less than 15,000, that owns, operates, or leases a hospital, and that has made a transfer agreement before August 31, 1989, by the adoption of an ordinance, resolution, or order by the commissioners court and the governing body of the municipality.

(b) The transfer agreement may transfer partial responsibility to the county under which the municipal hospital continues to provide health care services to eligible residents of the municipality, but the county agrees to assume the hospital's responsibility to reimburse other providers who provide:

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

(2) emergency services to eligible residents.

(c) The hospital is a public hospital for the purposes of this chapter, but it does not have a responsibility to provide reimbursement for services it cannot provide or for emergency services provided in another facility.

(d) Expenditures made by the county under Subsection (b) may be credited toward eligibility for state assistance under this subchapter if the person who received the health care services meets the eligibility standards established under Section 61.052 and would have been eligible for assistance under the county program if the person had not resided in a public hospital's service area.

(e) The agreement to transfer partial responsibility to a county under this section must take effect on a September 1 that occurs not later than two years after the date on which the county and municipality agree to the transfer. A county and municipality may not revoke or amend an agreement made under this section, except that the county may revoke or amend the agreement if a hospital district is created after the effective date of the agreement and

the boundaries of the district cover all or part of the county.

(f) The county, the hospital, and any other entity in the county that provides services under this chapter shall adopt coordinated application and eligibility verification procedures. In establishing the coordinated procedures, the county and other entities shall focus on facilitating the efficient and timely referral of residents to the proper entity in the county. In addition, the procedures must comply with the requirements of Sections 61.024 and 61.053. Expenditures made by a county in establishing the coordinated procedures prescribed by this section may not be credited toward eligibility for state assistance under this subchapter.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 1997, 75th Leg., ch. 1103, Sec. 1, eff. Sept. 1, 1997; Acts 1999, 76th Leg., ch. 1377, Sec. 1.07, eff. Sept. 1, 1999.

Sec. 61.026. REVIEW OF ELIGIBILITY. A county shall review at least once every six months the eligibility of a resident for whom an application for assistance has been granted and who has received assistance under this chapter.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.

Sec. 61.027. CHANGE IN ELIGIBILITY STATUS. (a) An eligible resident must report any change in income or resources that might affect the resident's eligibility. The report must be made not later than the 14th day after the date on which the change occurs.

(b) If an eligible resident fails to report a change in income or resources as prescribed by this section and the change has made the resident ineligible for assistance under the standards adopted by the county, the resident is liable for any benefits received while ineligible. This section does not affect a person's criminal liability under any relevant statute.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.

Sec. 61.028. BASIC HEALTH CARE SERVICES. (a) A county shall, in accordance with department rules adopted under Section

61.006, provide the following basic health care services:

(1) primary and preventative services designed to meet the needs of the community, including:

- (A) immunizations;
- (B) medical screening services; and
- (C) annual physical examinations;

(2) inpatient and outpatient hospital services;

(3) rural health clinics;

(4) laboratory and X-ray services;

(5) family planning services;

(6) physician services;

(7) payment for not more than three prescription drugs a month; and

(8) skilled nursing facility services, regardless of the patient's age.

(b) The county may provide additional health care services, but may not credit the assistance toward eligibility for state assistance, except as provided by Section 61.0285.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 1999, 76th Leg., ch. 1377, Sec. 1.08, eff. Sept. 1, 1999.

Sec. 61.0285. OPTIONAL HEALTH CARE SERVICES. (a) In addition to basic health care services provided under Section 61.028, a county may, in accordance with department rules adopted under Section 61.006, provide other medically necessary services or supplies that the county determines to be cost-effective, including:

(1) ambulatory surgical center services;

(2) diabetic and colostomy medical supplies and equipment;

(3) durable medical equipment;

(4) home and community health care services;

(5) social work services;

(6) psychological counseling services;

(7) services provided by physician assistants, nurse practitioners, certified nurse midwives, clinical nurse specialists, and certified registered nurse anesthetists;

- (8) dental care;
- (9) vision care, including eyeglasses;
- (10) services provided by federally qualified health centers, as defined by 42 U.S.C. Section 1396d(1)(2)(B);
- (11) emergency medical services; and
- (12) any other appropriate health care service identified by board rule that may be determined to be cost-effective.

(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, the county may credit the services toward eligibility for state assistance under this subchapter.

(c) A county may provide health care services that are not specified in Subsection (a), or may provide the services specified in Subsection (a) without actual or constructive approval of the department, but may not credit the services toward eligibility for state assistance.

Added by Acts 1999, 76th Leg., ch. 1377, Sec. 1.09, eff. Sept. 1, 1999. Amended by Acts 2001, 77th Leg., ch. 874, Sec. 9, eff. Sept. 1, 2001; Acts 2003, 78th Leg., ch. 892, Sec. 24, eff. Sept. 1, 2003.

Sec. 61.029. PROVISION OF HEALTH CARE SERVICES. (a) A county may arrange to provide health care services through a local health department, a publicly owned facility, or a contract with a private provider regardless of the provider's location, or through the purchase of insurance for eligible residents.

(b) The county may affiliate with other governmental entities or with a public hospital or hospital district to provide regional administration and delivery of health care services.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.

Sec. 61.030. MANDATED PROVIDER. A county may select one or more providers of health care services. The county may require

eligible county residents to obtain care from a mandated provider except:

- (1) in an emergency;
- (2) when medically inappropriate; or
- (3) when care is not available.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.

Sec. 61.031. NOTIFICATION OF PROVISION OF NONEMERGENCY SERVICES. (a) A county may require any provider, including a mandated provider, to obtain approval from the county before providing nonemergency health care services to an eligible county resident.

(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 not later than the 72nd hour after the provider determines the patient's county of residence; and

(2) by mail postmarked not later than the fifth working day after the date on which the provider determines the patient's county of residence.

(c) If the provider knows that the patient's county of residence has selected a mandated provider or if, after contacting the patient's county of residence, that county requests that the patient be transferred to a mandated provider, the provider shall transfer the patient to the mandated provider unless it is medically inappropriate to do so.

(d) Not later than the 14th day after the date on which the patient's county of residence receives sufficient information to determine eligibility, the county shall determine if the patient is eligible for assistance from that county. If the county does not determine the patient's eligibility within that period, the patient is considered to be eligible. The county shall notify the provider of its decision.

(e) If a provider delivers nonemergency health care

services to a patient who is eligible for assistance under this subchapter and fails to comply with this section, the provider is not eligible for payment for the services from the patient's county of residence.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 1999, 76th Leg., ch. 1377, Sec. 1.10, eff. Sept. 1, 1999.

Sec. 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 not later than the 72nd hour after the provider determines the patient's county of residence; and

(2) by mail postmarked not later than the fifth working day after the date on which the provider determines the patient's county of residence.

(b) The provider shall attempt to determine the patient's county of residence when the patient first receives services.

(c) The provider, the patient, and the patient's family shall cooperate with the county of which the patient is presumed to be a resident in determining if the patient is an eligible resident of that county.

(d) Not later than the 14th day after the date on which the patient's county of residence receives notification and sufficient information to determine eligibility, the county shall determine if the patient is eligible for assistance from that county. If the county does not determine the patient's eligibility within that period, the patient is considered to be eligible. The county shall notify the provider of its decision.

(e) If the county and the provider disagree on the patient's residence or eligibility, the county or the provider may submit the matter to the department as provided by Section 61.004.

(f) If a provider delivers emergency services to a patient who is eligible for assistance under this subchapter and fails to comply with this section, the provider is not eligible for payment

for the services from the patient's county of residence.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 1999, 76th Leg., ch. 1377, Sec. 1.11, eff. Sept. 1, 1999; Acts 2001, 77th Leg., ch. 1128, Sec. 2, eff. Sept. 1, 2001.

Sec. 61.033. PAYMENT FOR SERVICES. (a) To the extent prescribed by this chapter, a county is liable for health care services provided under this subchapter by any provider, including a public hospital or hospital district, to an eligible county resident. A county is not liable for payment for health care services provided:

(1) by any provider, including a public hospital or hospital district, to a resident of that county who resides in the service area of a public hospital or hospital district; or

(2) to an eligible resident of that county who does not reside within the service area of a public hospital or hospital district by a hospital having a Hill-Burton or state-mandated obligation to provide free services and considered to be in noncompliance with the requirements of the Hill-Burton or state-mandated obligation.

(b) To the extent prescribed by this chapter, if another source of payment does not adequately cover a health care service a county provides to an eligible county resident, the county shall pay for or provide the health care service for which other payment is not available.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.

Sec. 61.034. PAYMENT STANDARDS FOR HEALTH CARE SERVICES.

(a) A county is not liable for the cost of a health care service provided under Section 61.028 or 61.0285 that is in excess of the payment standards for that service established by the department under Section 61.006.

(b) A county may contract with a provider of assistance to provide a health care service at a rate below the payment standard set by the department.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 1999, 76th Leg., ch. 1377, Sec. 1.12, eff. Sept. 1, 1999.

Sec. 61.035. LIMITATION OF COUNTY LIABILITY. The maximum county liability for each state fiscal year for health care services provided by all assistance providers, including a hospital and a skilled nursing facility, to each eligible county resident is:

(1) \$30,000; or

(2) the payment of 30 days of hospitalization or treatment in a skilled nursing facility, or both, or \$30,000, whichever occurs first, if the county provides hospital or skilled nursing facility services to the resident.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.

Sec. 61.036. DETERMINATION OF ELIGIBILITY FOR PURPOSES OF STATE ASSISTANCE. (a) A county may not credit an expenditure made to assist an eligible county resident toward eligibility for state assistance under this subchapter unless the county complies with the department's application, documentation, and verification procedures.

(b) Except as provided by Section 61.023(b), a county may not credit an expenditure for an applicant toward eligibility for state assistance if the applicant does not meet the department's eligibility standards.

(c) Regardless of the application, documentation, and verification procedures or eligibility standards established by the department under Subchapter A, a county may credit an expenditure for an eligible resident toward eligibility for state assistance if the eligible resident received the health care services at:

(1) a hospital maintained or operated by a state agency that has a contract with the county to provide health care services; or

(2) a federally qualified health center delivering federally qualified health center services, as those terms are defined in 42 U.S.C. Sections 1396d(1)(2)(A) and (B), that has a contract with the county to provide health care services.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended

by Acts 1989, 71st Leg., ch. 1100, Sec. 5.10(b), eff. Sept. 1, 1989; Acts 1999, 76th Leg., ch. 1377, Sec. 1.13, eff. Sept. 1, 1999.

Amended by:

Acts 2005, 79th Leg., Ch. 1133, Sec. 1, eff. September 1, 2005.

Sec. 61.037. COUNTY ELIGIBILITY FOR STATE ASSISTANCE.

(a) The department may distribute funds as provided by this subchapter to eligible counties to assist the counties in providing health care services under Sections 61.028 and 61.0285 to their eligible county residents.

(b) Except as provided by Subsection (c), (d), (e), or (g), to be eligible for state assistance, a county must:

(1) spend in a state fiscal year at least eight percent of the county general revenue levy for that year to provide health care services described by Subsection (a) to its eligible county residents who qualify for assistance under Section 61.023; and

(2) notify the department, not later than the seventh day after the date on which the county reaches the expenditure level, that the county has spent at least six percent of the applicable county general revenue levy for that year to provide health care services described by Subsection (a) to its eligible county residents who qualify for assistance under Section 61.023.

(c) If a county and a health care provider signed a contract on or before January 1, 1985, under which the provider agrees to furnish a certain level of health care services to indigent persons, the value of services furnished in a state fiscal year under the contract is included as part of the computation of a county expenditure under this section if the value of services does not exceed the payment rate established by the department under Section 61.006.

(d) If a hospital district is located in part but not all of a county, that county's appraisal district shall determine the taxable value of the property located inside the county but outside the hospital district. In determining eligibility for state assistance, that county shall consider only the county general revenue levy resulting from the property located outside the

hospital district. A county is eligible for state assistance if:

(1) the county spends in a state fiscal year at least eight percent of the county general revenue levy for that year resulting from the property located outside the hospital district to provide health care services described by Subsection (a) to its eligible county residents who qualify for assistance under Section 61.023; and

(2) the county complies with the other requirements of this subchapter.

(e) A county that provides health care services described by Subsection (a) to its eligible residents through a hospital established by a board of managers jointly appointed by a county and a municipality under Section 265.011 is eligible for state assistance if:

(1) the county spends in a state fiscal year at least eight percent of the county general revenue levy for the year to provide the health care services to its eligible county residents who qualify for assistance under Section 61.052; and

(2) the county complies with the requirements of this subchapter.

(f) If a county anticipates that it will reach the eight percent expenditure level, the county must notify the department as soon as possible before the anticipated date on which the county will reach the level.

(g) The department may waive the requirement that the county meet the minimum expenditure level imposed by Subsection (b), (d), or (e) and provide state assistance under this chapter at a lower level determined by the department if the county demonstrates, through an appropriate actuarial analysis, that the county is unable to satisfy the eight percent expenditure level:

(1) because, although the county's general revenue tax levy has increased significantly, expenditures for health care services described by Subsection (a) have not increased by the same percentage;

(2) because the county is at the maximum allowable ad valorem tax rate, has a small population, or has insufficient taxable property; or

(3) because of a similar reason.

(h) The department shall adopt rules governing the circumstances under which a waiver may be granted under Subsection (g) and the procedures to be used by a county to apply for the waiver. The procedures must provide that the department shall make a determination with respect to an application for a waiver not later than the 90th day after the date the application is submitted to the department in accordance with the procedures established by the department. To be eligible for state assistance under Subsection (g), a county must submit monthly financial reports, in the form required by the department, covering the 12-month period preceding the date on which the assistance is sought.

(i) The county must give the department all necessary information so that the department can determine if the county meets the requirements of Subsection (b), (d), (e), or (g).

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 1997, 75th Leg., ch. 651, Sec. 1, eff. June 11, 1997; Acts 1999, 76th Leg., ch. 272, Sec. 1, eff. May 28, 1999; Acts 1999, 76th Leg., ch. 1377, Sec. 1.14, eff. Sept. 1, 1999.

Sec. 61.038. DISTRIBUTION OF ASSISTANCE FUNDS. (a) If the department determines that a county is eligible for assistance, the department shall distribute funds appropriated to the department from the indigent health care assistance fund or any other available fund to the county to assist the county in providing health care services under Sections 61.028 and 61.0285 to its eligible county residents who qualify for assistance as described by Section 61.037.

(b) State funds provided under this section to a county must be equal to at least 90 percent of the actual payment for the health care services for the county's eligible residents during the remainder of the state fiscal year after the eight percent expenditure level is reached.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 1999, 76th Leg., ch. 272, Sec. 2, eff. May 28, 1999; Acts 1999, 76th Leg., ch. 1377, Sec. 1.14, eff. Sept. 1, 1999.

Sec. 61.039. FAILURE TO PROVIDE STATE ASSISTANCE. If the department fails to provide assistance to an eligible county as prescribed by Section 61.038, the county is not liable for payments for health care services provided to its eligible county residents after the county reaches the eight percent expenditure level. Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 1999, 76th Leg., ch. 1377, Sec. 1.14, eff. Sept. 1, 1999.

Sec. 61.0395. LIMITED TO APPROPRIATED FUNDS. (a) The total amount of state assistance provided to counties under this chapter for a fiscal year may not exceed the amount appropriated for that purpose for that fiscal year.

(b) The department may adopt rules governing the distribution of state assistance under this chapter that establish a maximum annual allocation for each county eligible for assistance under this chapter in compliance with Subsection (a).

(c) The rules adopted under this section:

(1) may consider the relative populations of the service areas of eligible counties and other appropriate factors; and

(2) notwithstanding Subsection (b), may provide for, at the end of each state fiscal year, the reallocation of all money that is allocated to a county under Subsection (b) but that the county is not eligible to receive and the distribution of that money to other eligible counties.

Added by Acts 1999, 76th Leg., ch. 1377, Sec. 1.15, eff. Sept. 1, 1999. Amended by Acts 2001, 77th Leg., ch. 1128, Sec. 3, eff. Sept. 1, 2001.

Sec. 61.040. TAX INFORMATION. The comptroller shall give the department information relating to:

(1) the taxable value of property taxable by each county and each county's applicable general revenue tax levy for the relevant period; and

(2) the amount of sales and use tax revenue received by each county for the relevant period.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended

by Acts 1991, 72nd Leg., 2nd C.S., ch. 6, Sec. 64, eff. Sept. 1, 1991.

Sec. 61.041. COUNTY REPORTING. (a) The department shall establish monthly reporting requirements for a county seeking state assistance and establish procedures necessary to determine if the county is eligible for state assistance.

(b) The department shall establish requirements relating to:

(1) documentation required to verify the eligibility of residents to whom the county provides assistance; and

(2) county expenditures for health care services under Sections 61.028 and 61.0285.

(c) The department may audit county records to determine if the county is eligible for state assistance.

(d) The department shall establish annual reporting requirements for each county that is required to provide indigent health care under this chapter but that is not required to report under Subsection (a). A county satisfies the annual reporting requirement of this subsection if the county submits information to the department as required by law to obtain an annual distribution under the Agreement Regarding Disposition of Settlement Proceeds filed on July 24, 1998, in the United States District Court, Eastern District of Texas, in the case styled The State of Texas v. The American Tobacco Co., et al., No. 5-96CV-91.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 1999, 76th Leg., ch. 1377, Sec. 1.16, eff. Sept. 1, 1999.

Sec. 61.042. EMPLOYMENT SERVICES PROGRAM. (a) A county may establish procedures consistent with those used by the Texas Department of Human Services 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.

(b) The county shall notify all persons with pending applications and eligible residents of the employment service program requirements not less than 30 days before the program is

established.

Added by Acts 1993, 73rd Leg., ch. 880, Sec. 1, eff. Sept. 1, 1993.

Amended by Acts 1995, 74th Leg., ch. 76, Sec. 8.122, eff. Sept. 1, 1995.

Sec. 61.043. PREVENTION AND DETECTION OF FRAUD. (a) The county 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 county for administrative hearings conducted under this section shall provide for appropriate due process, including procedures for appeals.

Added by Acts 1993, 73rd Leg., ch. 880, Sec. 1, eff. Sept. 1, 1993.

Sec. 61.044. SUBROGATION. (a) The filing of an application for or receipt of services constitutes an assignment of the applicant's or recipient's right of recovery from:

- (1) personal insurance;
- (2) other sources; or
- (3) another person for personal injury caused by the other person's negligence or wrong.

(b) A person who applies for or receives services shall inform the county, at the time of application or at any time during eligibility, of any unsettled tort claim that may affect medical needs and of any private accident or sickness insurance coverage that is or may become available. An applicant or eligible resident shall inform the county of any injury that is caused by the act or failure to act of some other person. An applicant or eligible resident shall inform the county as required by this subsection within 10 days of the date the person learns of the person's insurance coverage, tort claim, or potential cause of action.

(c) A claim for damages for personal injury does not constitute grounds for denying or discontinuing services under this chapter.

(d) A separate and distinct cause of action in favor of the

county is hereby created, and the county may, without written consent, take direct civil action in any court of competent jurisdiction. A suit brought under this section need not be ancillary to or dependent on any other action.

(e) The county's right of recovery is limited to the amount of the cost of services paid by the county. Other subrogation rights granted under this section are limited to the cost of the services provided.

(f) An applicant or eligible resident who knowingly and intentionally fails to disclose the information required by Subsection (b) commits a Class C misdemeanor.

(g) An applicant or eligible resident is subject to denial of services under this chapter following an administrative hearing. Added by Acts 1993, 73rd Leg., ch. 880, Sec. 1, eff. Sept. 1, 1993.

SUBCHAPTER C. PERSONS WHO RESIDE IN AN AREA SERVED BY A PUBLIC
HOSPITAL OR HOSPITAL DISTRICT

Sec. 61.051. APPLICATION OF SUBCHAPTER. (a) This subchapter applies to health care services and assistance provided to a person who resides in the service area of a public hospital or hospital district.

(b) For the purposes of this subchapter, a hospital is not considered to be a public hospital and is not responsible for providing care under this subchapter if the hospital:

(1) is owned, operated, or leased by a municipality with a population of less than 5,500;

(2) was leased before January 1, 1981, by a municipality that at the time of the lease did not have a legal obligation to provide indigent health care; or

(3) was established under Section 265.031.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 1991, 72nd Leg., ch. 14, Sec. 16, eff. Sept. 1, 1991.

Sec. 61.052. GENERAL ELIGIBILITY PROVISIONS. (a) A public hospital or hospital district shall provide health care assistance to each eligible resident in its service area who meets:

(1) the basic income and resources requirements

established by the department under Sections 61.006 and 61.008 and in effect when the assistance is requested; or

(2) a less restrictive income and resources standard adopted by the hospital or hospital district serving the area in which the person resides.

(b) If a public hospital used an income and resources standard during the operating year that ended before January 1, 1985, that was less restrictive than the income and resources requirements established by the department under Section 61.006, the hospital shall adopt that standard to determine eligibility under this subchapter.

(c) If a public hospital did not use an income and resources standard during the operating year that ended before January 1, 1985, but had a Hill-Burton obligation during part of that year, the hospital shall adopt the standard the hospital used to meet the Hill-Burton obligation to determine eligibility under this subchapter.

(d) A public hospital established after September 1, 1985, shall provide health care services to each resident who meets the income and resources requirements established by the department under Sections 61.006 and 61.008, or the hospital may adopt a less restrictive income and resources standard. The hospital may adopt a less restrictive income and resources standard at any time.

(e) If because of a change in the income and resources requirements established by the department under Sections 61.006 and 61.008 the standard adopted by a public hospital or hospital district becomes stricter than the requirements established by the department, the hospital or hospital district shall change its standard to at least comply with the requirements established by the department.

(f) A public hospital or hospital district may contract with the department to perform eligibility determination services.

(g) A county that provides health care services to its eligible residents through a hospital established by a board of managers jointly appointed by a county and a municipality under Section 265.011 and that establishes an income and resources standard in accordance with Subsection (a)(2) may credit the

services provided to all persons who are eligible under that standard toward eligibility for state assistance as described by Section 61.037(e).

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 1999, 76th Leg., ch. 1377, Sec. 1.17, eff. Sept. 1, 1999.

Sec. 61.053. APPLICATION PROCEDURE. (a) A public hospital or hospital district shall adopt an application procedure.

(b) Not later than the beginning of a public hospital's or hospital district's operating year, the hospital or district shall specify the procedure it will use during the operating year to determine eligibility and the documentation required to support a request for assistance and shall make a reasonable effort to notify the public of the procedure.

(c) The public hospital or hospital district shall furnish an applicant with written application forms.

(d) On request of an applicant, the public hospital or hospital district shall assist an applicant in filling out forms and completing the application process. The hospital or district shall inform an applicant of the availability of assistance.

(e) The public hospital or hospital district shall require an applicant to sign a written statement in which the applicant swears to the truth of the information supplied.

(f) The public hospital or hospital district shall explain to the applicant that if the application is approved, the applicant must report to the hospital or district any change in income or resources that might affect the applicant's eligibility. The report must be made not later than the 14th day after the date on which the change occurs. The hospital or district shall explain the possible penalties for failure to report a change.

(g) The public hospital or hospital district shall review each application and shall accept or deny the application not later than the 14th day after the date on which the hospital or district receives the completed application.

(h) The public hospital or hospital district shall provide a procedure for reviewing applications and for allowing an applicant to appeal a denial of assistance.

(i) The public hospital or hospital district shall provide an applicant written notification of the hospital's or district's decision. If the hospital or district denies assistance, the written notification shall include the reason for the denial and an explanation of the procedure for appealing the denial.

(j) The public hospital or hospital district shall maintain the records relating to an application for at least three years after the date on which the application is submitted.

(k) If an applicant is denied assistance, the applicant may resubmit an application at any time circumstances justify a redetermination of eligibility.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.

Sec. 61.054. BASIC HEALTH CARE SERVICES PROVIDED BY A PUBLIC HOSPITAL. (a) Except as provided by Subsection (c), a public hospital shall endeavor to provide the basic health care services a county is required to provide under Section 61.028.

(b) If a public hospital provided additional health care services to eligible residents during the operating year that ended before January 1, 1985, the hospital shall continue to provide those services.

(c) A public hospital shall coordinate the delivery of basic health care services to eligible residents and may provide any basic health care services the hospital was not providing on January 1, 1999, but only to the extent the hospital is financially able to do so.

(d) A public hospital may provide health care services in addition to basic health care services.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 1999, 76th Leg., ch. 1377, Sec. 1.18, eff. Sept. 1, 1999.

Sec. 61.055. BASIC HEALTH CARE SERVICES PROVIDED BY HOSPITAL DISTRICTS. (a) Except as provided by Subsection (b), a hospital district shall endeavor to provide the basic health care services a county is required to provide under Section 61.028, together with any other services required under the Texas Constitution and the statute creating the district.

(b) A hospital district shall coordinate the delivery of basic health care services to eligible residents and may provide any basic health care services the district was not providing on January 1, 1999, but only to the extent the district is financially able to do so.

(c) This section may not be construed to discharge a hospital district from its obligation to provide the health care services required under the Texas Constitution and the statute creating the district.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 1999, 76th Leg., ch. 1377, Sec. 1.19, eff. Sept. 1, 1999.

Sec. 61.056. PROVISION OF HEALTH CARE SERVICES. (a) A public hospital or hospital district may arrange to provide health care services through a local health department, a publicly owned facility, or a contract with a private provider regardless of the provider's location, or through the purchase of insurance for eligible residents.

(b) The public hospital or hospital district may affiliate with other public hospitals or hospital districts or with a governmental entity to provide regional administration and delivery of health care services.

(c) A hospital district created in a county with a population of more than 800,000 that was not included in the boundaries of a hospital district before September 1, 2003, may affiliate with any public or private entity to provide regional administration and delivery of health care services. The regional affiliation, in accordance with the affiliation agreement, shall use money contributed by an affiliated governmental entity to provide health care services to an eligible resident of that governmental entity.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 164, Sec. 3, eff. September 1, 2007.

Sec. 61.057. MANDATED PROVIDER. A public hospital may

select one or more providers of health care services. A public hospital may require eligible residents to obtain care from a mandated provider except:

- (1) in an emergency;
- (2) when medically inappropriate; or
- (3) when care is not available.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.

Sec. 61.058. NOTIFICATION OF PROVISION OF NONEMERGENCY SERVICES. (a) A public hospital may require any provider, including a mandated provider, to obtain approval from the hospital before providing nonemergency health care services to an eligible resident in the hospital's service area.

(b) If the public hospital does not require prior approval and a provider delivers or will deliver nonemergency health care services to a patient who the provider suspects might be eligible for assistance under this subchapter, the provider shall notify the hospital that health care services have been or will be provided to the patient. The notice shall be made:

(1) by telephone not later than the 72nd hour after the provider determines that the patient resides in the hospital's service area; and

(2) by mail postmarked not later than the fifth working day after the date on which the provider determines that the patient resides in the hospital's service area.

(c) If the provider knows that the public hospital serving the area in which the patient resides has selected a mandated provider or if, after contacting the hospital, the hospital requests that the patient be transferred to a mandated provider, the provider shall transfer the patient to the mandated provider unless it is medically inappropriate to do so.

(d) Not later than the 14th day after the date on which the public hospital receives sufficient information to determine eligibility, the hospital shall determine if the patient is eligible for assistance from the hospital. If the hospital does not determine the patient's eligibility within that period, the patient is considered to be eligible. The hospital shall notify the

provider of its decision.

(e) If a provider delivers nonemergency health care services to a patient who is eligible for assistance under this subchapter and fails to comply with this section, the provider is not eligible for payment for the services from the public hospital serving the area in which the patient resides.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 1999, 76th Leg., ch. 1377, Sec. 1.20, eff. Sept. 1, 1999.

Sec. 61.059. 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 hospital that emergency services have been or will be provided to the patient. The notice shall be made:

(1) by telephone not later than the 72nd hour after the provider determines that the patient resides in the hospital's service area; and

(2) by mail postmarked not later than the fifth working day after the date on which the provider determines that the patient resides in the hospital's service area.

(b) The provider shall attempt to determine if the patient resides in a public hospital's service area when the patient first receives services.

(c) The provider, the patient, and the patient's family shall cooperate with the public hospital in determining if the patient is an eligible resident of the hospital's service area.

(d) Not later than the 14th day after the date on which the public hospital receives sufficient information to determine eligibility, the hospital shall determine if the patient is eligible for assistance from the hospital. If the hospital does not determine the patient's eligibility within that period, the patient is considered to be eligible. The hospital shall notify the provider of its decision.

(e) If the public hospital and the provider disagree on the patient's residence or eligibility, the hospital or the provider may submit the matter to the department as provided by Section

61.004.

(f) If a provider delivers emergency services to a patient who is eligible for assistance under this subchapter and fails to comply with this section, the provider is not eligible for payment for the services from the public hospital serving the area in which the patient resides.

(g) If emergency services are customarily available at a facility operated by a public hospital, that hospital is not liable for emergency services furnished to an eligible resident by another provider in the area the hospital has a legal obligation to serve.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 1999, 76th Leg., ch. 1377, Sec. 1.21, eff. Sept. 1, 1999; Acts 2001, 77th Leg., ch. 1128, Sec. 4, eff. Sept. 1, 2001.

Sec. 61.060. PAYMENT FOR SERVICES. (a) To the extent prescribed by this chapter, a public hospital is liable for health care services provided under this subchapter by any provider, including another public hospital, to an eligible resident in the hospital's service area. A public hospital is not liable for payment for health care services provided to:

(1) a person who does not reside in the hospital's service area; or

(2) an eligible resident of the hospital's service area by a hospital having a Hill-Burton or state-mandated obligation to provide free services and considered to be in noncompliance with the requirements of the Hill-Burton or state-mandated obligation.

(b) A hospital district is liable for health care services as provided by the Texas Constitution and the statute creating the district.

(c) A public hospital is the payor of last resort under this subchapter and is not liable for payment or assistance to an eligible resident in the hospital's service area if any other public or private source of payment is available.

(d) If another source of payment does not adequately cover a health care service a public hospital provides to an eligible resident of the hospital's service area, the hospital shall pay for

or provide the health care service for which other payment is not available.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.

Sec. 61.061. PAYMENT RATES AND LIMITS. The payment rates and limits prescribed by Sections 61.034 and 61.035 that relate to county services apply to inpatient and outpatient hospital services a public hospital is required to provide if:

(1) the hospital cannot provide the services or emergency services that are required; and

(2) the services are provided by an entity other than the hospital.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.

Sec. 61.062. RESPONSIBILITY OF GOVERNMENTAL ENTITY. A governmental entity that owns, operates, or leases a public hospital shall provide sufficient funding to the hospital to provide basic health care services.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 1999, 76th Leg., ch. 1377, Sec. 1.22, eff. Sept. 1, 1999.

Sec. 61.063. PROCEDURE TO CHANGE ELIGIBILITY STANDARDS OR SERVICES PROVIDED. (a) A public hospital may not change its eligibility standards to make the standards more restrictive and may not reduce the health care services it offers unless it complies with the requirements of this section.

(b) Not later than the 90th day before the date on which a change would take effect, the public hospital must publish notice of the proposed change in a newspaper of general circulation in the hospital's service area and set a date for a public hearing on the change. The published notice must include the date, time, and place of the public meeting. The notice is in addition to the notice required by Chapter 551, Government Code.

(c) Not later than the 30th day before the date on which the change would take effect, the public hospital must conduct a public meeting to discuss the change. The meeting must be held at a convenient time in a convenient location in the hospital's service

area. Members of the public may testify at the meeting.

(d) If, based on the public testimony and on other relevant information, the governing body of the hospital finds that the change would not have a detrimental effect on access to health care for the residents the hospital serves, the hospital may adopt the change. That finding must be formally adopted.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 1995, 74th Leg., ch. 76, Sec. 5.95(82), eff. Sept. 1, 1995.

Sec. 61.064. TRANSFER OF A PUBLIC HOSPITAL. (a) A governmental entity that owns, operates, or leases a public hospital and that closes, sells, or leases the hospital:

(1) has the obligation to provide basic health care services under this chapter;

(2) shall adopt the eligibility standards that the hospital was or would have been required to adopt; and

(3) shall provide the same services the hospital was or would have been required to provide under this chapter on the date of the closing, sale, or lease.

(b) If the governmental entity owned, operated, or leased the public hospital before January 1, 1985, and sold or leased the hospital on or after that date but before September 1, 1986, the obligation retained is the obligation the hospital would have had on September 1, 1986.

(c) Notwithstanding Subsections (a) and (b), if a hospital district that owns, operates, or leases a public hospital dissolves, the district has no responsibility under this chapter. If on or before dissolution the district sold or transferred its hospital to another governmental entity, that governmental entity assumes the district's responsibility to provide health care services in accordance with this subchapter. If the district did not sell or transfer the hospital to another governmental entity, the county shall provide health care services to the residents of the district's service area in accordance with Subchapter B.

(d) This section does not apply to a governmental entity that sold or leased a public hospital to a hospital district or a hospital authority on or after January 1, 1985, but before

September 1, 1986. If a governmental entity sold or leased a hospital as provided by this subsection, the hospital ceased being a public hospital for the purposes of this chapter on the date it was sold or leased, and neither the governmental entity nor the hospital district or hospital authority has any responsibility under this chapter.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 1999, 76th Leg., ch. 1377, Sec. 1.23, eff. Sept. 1, 1999.

Sec. 61.065. COUNTY RESPONSIBILITY FOR HOSPITAL SOLD ON OR AFTER JANUARY 1, 1988. (a) This section applies to a county that, on or after January 1, 1988, sells to a purchaser that is not a governmental entity a county hospital that was leased at the time of the sale to a person who is not a governmental entity.

(b) On the date the hospital is sold, the hospital ceases being a public hospital for the purposes of this chapter, and the county shall provide health care services to county residents in accordance with Subchapter B.

(c) If the contract for the sale of the hospital provides for the provision by the hospital of health care services to county residents, the value of the health care services credited or paid in a state fiscal year under the contract is included as part of the computation of a county expenditure under Section 61.037 to the extent that the value of the services does not exceed the payment standard established by the department for allowed inpatient and outpatient services.

Added by Acts 1989, 71st Leg., ch. 1100, Sec. 5.10(c), eff. Sept. 1, 1989.

Sec. 61.066. PREVENTION AND DETECTION OF FRAUD. (a) A hospital district may 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 for administrative hearings conducted under this section shall provide

for appropriate due process, including procedures for appeals.

Added by Acts 2001, 77th Leg., ch. 563, Sec. 1, eff. Aug. 27, 2001.