SUBJECT: Statewide system and funding for tertiary medical care

COMMITTEE: Public Health — favorable, without amendment

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

0 nays

2 absent — Hilderbran, Uresti

WITNESSES: For — David Keith; Lee Jackson, Dallas County

Against — None

BACKGROUND: The Texas Department of Health designates hospitals according to the level of care they provide in trauma services:

- Eight Level 1 trauma facilities in Texas provide comprehensive care to critical trauma patients, conduct trauma-related research, and provide health professional educational opportunities;
- Five Level 2 trauma facilities provide similar services as Level 1, but without the availability of some medical specialties and research;
- 11 Level 3 trauma facilities provide resuscitation, stabilization, and assessment of injury victims and either can provide treatment or arrange for appropriate transfer to a higher level trauma facility; and
- 108 Level 4 trauma facilities provide resuscitation, stabilization, and arrangement for transfer of all critical trauma patients to a higher level trauma facility.

The indigent health care responsibilities of counties and public hospitals are defined under the Indigent Health Care and Treatment Act (Health and Safety Code, chpt. 61). The act requires counties to establish indigent health care programs that conform to certain minimum standards for eligibility, covered services, and payment responsibilities. Counties and public hospitals are not responsible for the care of indigent residents of an area served by another county, public hospital, or hospital district.

A county is eligible to receive state assistance once it has spent 10 percent of its general revenue tax levy on mandatory indigent health care services for eligible individuals.

The act requires public hospitals, such as county or city-run hospitals, to provide at a minimum the same level of inpatient and outpatient hospital services that counties are required to provide, along with any other services they provided to indigent residents prior to January 1, 1985. Public hospitals must establish eligibility standards that are equal to or less restrictive than those required for county indigent programs, and they cannot receive state assistance in paying for indigent care

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

The Disproportionate Share Hospital Program, also called Dispro or DSH, makes special payments through the Medicaid program to hospitals that serve a large number of indigent patients. The federal government subsidizes DSH at the same matching rate as health care services (62 percent federal funds, 38 percent state funds). Texas uses local public hospital and hospital district tax dollars and state-appropriated funds to state hospitals to fund the state's Medicaid share, thus using dollars already being spent in order to obtain matching federal funds.

DIGEST:

HB 2573 would establish an account in the state treasury to reimburse tertiary care facilities for any unreimbursed tertiary medical services provided to persons living outside their service areas. The bill would require the Texas Department of Health to increase the availability of tertiary care, to encourage hospitals to provide tertiary care, and to designate various hospitals as tertiary care facilities.

A tertiary care facility would be defined as any facility that is a primary teaching hospital of a medical school, a Level 1 or Level 2 trauma center, or a Level 3 trauma center that is more than 100 miles from a Level 1 or 2 trauma center. Tertiary medical services would include pediatric and trauma surgery, organ transplants, neurosurgery, services related to high risk pregnancies or cancer, or services provided by burn centers and neonatology Level III units.

**TDH responsibilities.** The bill would require TDH to propose rules relating to minimum standards and objectives to implement a tertiary medical services

system and to certify reimbursement amounts to the comptroller.

TDH rules would have to provide for:

- tertiary care services for all areas of the state, taking into account time and distance to get to a tertiary care facility;
- coordination among health care facilities in the delivery area;
- pre-hospital care guidelines for triage and transfer of patients;
- minimum requirements for resources and equipment and standards for health care personnel, and;
- assurances that designated tertiary care facilities would not refuse to accept transfer patients solely based on inability to pay.

Each designated facility would have to submit to TDH information on unreimbursed tertiary services for persons residing outside service areas. If total costs of unreimbursed tertiary care certified by TDH to the comptroller exceeded the amount in the treasury's tertiary care account, TDH would have to allocate the account money. Allocation would be based on each designated facility's relative percentage of unreimbursed tertiary care.

TDH could deny, suspend or revoke a tertiary care designation, and appeals of that action would be governed by the Administrative Procedures and Practice Act.

**Tertiary Care Facility Account**. Money in the account could consist of gifts, grants, donations, and state funds only appropriated to TDH for tertiary care facilities. Not more than 5 percent could be used for administrative costs. Five percent would be held in reserve for unpaid care resulting from extraordinary emergencies, such as disasters declared by the president or by proclamation of the governor. TDH also could declare that a disaster has resulted in an extraordinary cost to a particular facility.

HB 2573 would take effect September 1, 1999.

SUPPORTERS SAY:

HB 2573 would create a coordinated and viable system to help Texans in need of tertiary care throughout the state. The measure would provide taxpayer relief in areas already supporting public tertiary care facilities. It would sustain the operations of hospitals carrying the regional burden of unreimbursed tertiary care, and help increase availability of such services by encouraging more hospitals to provide them.

Tertiary care is what makes the U.S. medical system outstanding. However, the state currently relies on a few large hospitals and medical schools to provide this care to victims of car wrecks and other accidents, brain injury patients, and others in need of trauma surgery, organ transplants, or services related to high-risk pregnancy or cancer cases.

Today's tertiary care facilities treat a large number of indigent or uninsured patients from areas adjacent to their actual service territory. Parkland Hospital in Dallas is perhaps the biggest provider in Texas of tertiary care services to patients from surrounding areas. It provided about $14.8 million last year in uncompensated tertiary care to such individuals.

This measure would build on the state's investments in medical schools and local hospital resources by establishing a coordinated care system. Not all areas of the state have tertiary care services readily available. HB 2573 would be a key component in the development of a statewide trauma system.

The bill would provide a health-care safety net supporting other actions taken by the House this legislative session. These include improvements for EMS/trauma systems; measures supporting indigent health care in provisions in the general appropriations act; amendments to the TDH sunset bill; and passage of bills that would establish permanent health-related funds with tobacco settlement funds.

By creating a specially dedicated account for tertiary hospital reimbursement, HB 2573 would prompt the state to help hospitals that receive severely injured and ill indigent patients in the same way it helps the counties that send these patients to them. However, the Legislature would not be obligated to appropriate funds to this account. The establishment of this account also could be used to solicit and accept funds from outside sources.

State tertiary care assistance is needed because responsibilities under the Indigent Health Care Act are not always met by counties and public hospitals, and because eligibility standards under the act usually are too low and do not cover all of the uninsured residents. Also, federal cutbacks in the Medicare and disproportionate share program, plus growing medical costs, have reduced the funding cushion used by tertiary care hospitals to support their legally required policy to serve all who need care.

HB 2573 would establish an account and certification mechanism similar to that proposed in HB 1161 by Junell et al. for indigent health care reimbursement to hospitals and counties with tobacco settlement receipts.

Including Level 4 facilities in the distribution of funds from the tertiary care account would dilute the effectiveness of the account and the tertiary care system. By definition, these facilities are not tertiary care providers. Level 4 facilities perform an important function, but they simply resuscitate and stabilize. They do not have the facilities to provide advanced levels of care. Small and rural health care facilities likely will receive substantial financial support this session through the enactment of legislation earmarking use of tobacco settlement receipts to help them build facilities, improve trauma response, and meet indigent care costs.

OPPONENTS SAY:

HB 2573 would increase the state's responsibility in paying for indigent care. This issue should be worked out among hospital districts, public hospitals, and counties through the Indigent Health Care and Treatment Act. There are other intergovernmental means of coordinating care and resources that should be used instead.

Large public and private nonprofit hospitals, comprising most of the hospitals designated as Level 1, 2 and 3 trauma facilities, already receive special compensation through the Medicaid disproportionate share program. Many of these facilities will receive reimbursement for indigent care through permanent health funds established this session with tobacco settlement receipts.

OTHER OPPONENTS SAY:

This bill falls short the truly comprehensive, statewide tertiary care system that is needed in Texas because it fails to include the 108 Level 4 trauma facilities, predominately small and rural facilities, that often provide the first response in trauma care.

HB 2573 would merely end up directing more money to 24 large facilities that, in general, have far greater access to financial resources and bigger tax bases than the small and rural hospitals.

Level 4 trauma facilities may not provide the lion's share of the uncompensated tertiary care, but they are important players in early response to trauma. They write off comparable proportions of their patient revenues due

to uncompensated care. Including Level 4 facilities in the system would provide some additional reimbursement needed by these hospitals, without taking that much money away from the larger facilities.

NOTES:

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

HB 1676 by Junell et al., which would establish a permanent fund for EMS/trauma care, also passed the House on April 22.

The House-passed version of HB 1 by Junell, the general appropriations act for fiscal 2000-01, contains provisions in the Article 11 wish list to appropriate $20 million to $30 million for reimbursing tertiary care.

HB 1398 by Coleman, which includes similar provisions regarding tertiary care, was reported favorably, as substituted, by the Public Health Committee on April 21.