SUBJECT: Health care districts in Bexar, Hidalgo, Montgomery, and Webb counties

COMMITTEE: County Affairs — committee substitute recommended

VOTE: 6 ayes — R. Allen, W. Smith, Casteel, Coleman, Farabee, Laney

0 nays

3 absent — Naishtat, Olivo, Otto

WITNESSES: For — Patricia Kolodzey, Texas Hospital Association; Vicki Perkins, Christus Santa Rosa Health Care; Richard Peters, Texas Association of Public and Non Profit Hospitals; Leilah Powell, Bexar County Commissioners Court; Todd Ramberg, Kingwood Medical Center; Jim Gjerset; Shauna Lorenz

Against — None

BACKGROUND: Medicaid, the state-federal health care program for low-income families, children, elderly, and the disabled, is governed by both federal and state laws. The program is administered by the Centers for Medicare and Medicaid Services (CMS) at the federal level and by the Health and Human Services Commission (HHSC) in Texas.

The total budget for Medicaid is a mixture of federal, state, and local funding. The federal government pays about 60 cents for every 40 cents expended by the state in the Medicaid program. Local funds may be counted in lieu of some state funds, in the form of intergovernmental transfers, and still draw down the federal match.

One way the state draws down additional federal funding for Medicaid is through the Upper Payment Limit (UPL), a way for the state to pay certain hospitals the Medicare rate, usually higher, rather than the Medicaid rate for services. Texas' UPL program uses intergovernmental transfers to pay the difference between the Medicaid and Medicare rates.

DIGEST: CSHB 2463 would permit four counties to establish a health care funding district to levy a tax on hospitals, which would be used to draw down additional UPL funds through the Medicaid program.

The counties would be:

- each county located on the Texas- Mexico border that has a population of 500,000 or more and is adjacent to two or more counties with populations of 50,000 or more (Hidalgo County);
- each county with a population of over 270,000 with no municipality with a population of over 60,000 and that is adjacent to a county with a population of over 3.3 million (Montgomery County);
- each county with a population of less than 200,000 with a municipality with a population over 100,000 (Webb County); and
- each county with a population of 1.4 million or less in which a municipality with a population of over 1.1 million was predominantly located (Bexar County).

The tax on hospitals in Hidalgo and Webb counties would be based on outpatient hospital visits, updated biennially. It would apply to all hospitals within a district, without any held harmless except hospitals that primarily treat mental illness. The maximum rate of $100 per outpatient hospital visit would be set. The tax could not be charged to a patient.

In Montgomery and Bexar counties, the charge would be based on emergency room visits, updated biennially. It would be applied to all hospitals within a district, without any held harmless except hospitals that primarily treat mental illness. The maximum rate of $150 per emergency room visit would be set for Montgomery county and $100 for Bexar County. The tax could not be charged to a patient.

Disbursements of the funds would be used to pay the non-federal share of Medicaid and indigent health services. Administrative costs could not exceed 4 percent of total revenue or $20,000, whichever was less.

Hospitals would submit to the district copies of the hospital financial and utilization data required under current statute by the Department of State Health Services. The district could inspect hospital records to ensure compliance. The tax could be collected by the county tax assessor-collector and could be subject to usual and customary fees for collection or could be contracted out.

For each fiscal year (September 1 to August 31), the commission governing the district would prepare a budget that would include proposed

tax rates, collections, and disbursements. It would hold a public hearing with notice 10 days before in a local newspaper.

Each district would be governed by a five-member commission, appointed by each member of the county commissioners court and the county judge to serve two-year terms, first appointed by October 1, 2005. Candidates would have to be over 18 years old and U.S. citizens who had resided in the state for 12 months and in the county for six months prior and were knowledgeable in health care. They also could not have been convicted of a felony or determined mentally incompetent. Vacancies would be filled by the commissioners court within 30 days or by vote of the commission. Members would elect a chairperson and secretary. No member could be compensated, but they could receive reimbursement for expenses. The commission could employ the services of an attorney, financial advisor, or bookkeeper.

Any action to impose a tax, spend money, or other business would require a majority vote. A district could not spend money unless it received the approval of 95 percent of the district taxpaying hospitals. The commission could prescribe the manner for making purchases and expenditures by the district and could adopt rules governing the operation and administration of the tax. All minutes and records would be maintained at the district office and open for public viewing during reasonable hours. The commission would designate a bank as a depository.

The districts could sue and be sued. They also would have a financial audit each fiscal year. The districts would expire September 1, 2007, and remaining funds would be used to pay outstanding administrative expenses or returned to hospitals, unless the districts were continued by the Legislature.

The bill would take immediate effect if finally passed by a two-thirds record vote of the membership of each house. Otherwise, it would take effect September 1, 2005.

SUPPORTERS SAY:

CSHB 2463 would allow hospitals in these four counties to leverage their funding to draw down additional federal funds through UPL. By paying a tax on emergency room and other outpatient visits, the hospitals would receive back the amount they paid, plus additional federal funds. The level of uncompensated care combined with dwindling Medicaid reimbursement

rates has pushed most hospitals' emergency care budgets into the red. This is a way to bring some of that money back.

All of the hospitals in these counties have agreed to the tax and do not anticipate it placing a burden on hospitals with small Medicaid populations because those hospitals have healthy balance sheets. Uncompensated care and low-reimbursement rates are significant problems only for hospitals with large indigent and Medicaid patients.

OPPONENTS SAY:

This bill would be another way for the state to continue to shift the burden of health care costs to the local level. The hospitals that would pay the tax are funded through a variety of mechanisms, but the proportion of local contribution continues to rise. Instead of shifting the burden to local governments for paying for Medicaid, the state should improve provider rates and access to the program.

This tax would be an unfair burden on hospitals with small Medicaid populations. They would have to pay the tax but would receive little benefit from the UPL payments because they see few Medicaid clients.

NOTES:

The committee substitute tailored some provisions, such as the amount of the tax and the basis for it, to each county.