

Indigent Health Care Policy Issues

Lack of administrative infrastructure. Many programs do not have a sufficient administrative structure (including trained staff, written policies, physical locations, etc.) in place to administer an indigent health care program and consequently spend little or nothing on providing services. Access is an issue, particularly in counties and hospital districts without an administrative infrastructure for the indigent health care program. A surprising number of programs could not provide information about where and when to apply for services, what application to use, or what guidelines are used to determine eligibility.

One area of the state is consolidating administrative functions. The Brazos Valley Council of Governments administers eight indigent health care programs for surrounding counties. While they must still follow the varying policies in each of the programs they administer, there is more likely to be uniform application of the policies and perhaps some administrative savings for each of the programs with which they have contracts.

Expenditure gaps. A total of 52 programs report expenditures that are less than one percent of tax revenue. There is a total of \$24.3 million in tax revenue that is not being spent by these 52 indigent health care programs; there are 545,000 people that live in the areas served by these programs.

If 8 percent of GRTL is a target for expenditures for counties, there is a gap of \$66 million between reported expenditures and 8 percent of county GRTL. Adding this expenditure gap for counties to the \$16.3 million in taxes collected in hospital districts spending less than 1 percent of their tax revenue, there is more than \$82 million in tax revenue that is not being spent on indigent health care.

Diagnoses. The top diagnoses reported by indigent health care programs point to the lack of public health and primary care services to address chronic conditions. The top diagnosis is diabetes, followed by hypertension, heart failure, back disorders, and respiratory diseases. Some program policies have stricter limitations on outpatient care than on inpatient care, including less restrictive income eligibility guidelines for inpatient care. Some policies restrict services to hospital-based services only.

Public hospital designation. There are 20 counties with hospitals that are designated by the Department of State Health Services (DSHS) as public hospitals and 13 counties with hospitals that are designated as counties. Counties designated as public hospitals are exempt from the requirements of Chapter 61. There is no known reason for the difference between a county designated as a public hospital and a county designated as a county program and no known procedure for changing the designation of these counties.

Resource disparities. There will always be disparities in service delivery when services are dependent on property taxes. There are many ways of evaluating spending: spending per client, spending per capita or per person in poverty, or spending as a percent of tax collections. Determining how much local property tax should be used for health care is subjective, and deciding what spending level is appropriate for 300 local programs is challenging. The interplay between tax rates and taxable property value complicates comparisons of spending as a percent of tax collections from county to county.

Reimbursement to out-of-county providers. One of the issues for counties with health care facilities is that residents of surrounding counties come to the facilities to receive health care services.

Limitations on payments to providers makes it difficult for other counties to collect payment for indigent clients who travel across county lines for health care. Many policies limit out-of-county provider reimbursement, place caps on out-of-county health care, or limit reimbursement of services only to providers within the county of residence.

Data collection. Better data about the 300 programs providing indigent health care is needed on an ongoing basis. Counties are required to submit Form 300 to DSHS annually, but less than half do. Form 300 can be an effective tool for data collection, but the following changes are needed:

- Form 300 should be automated to allow data entry via the DSHS website.
- Administrative costs should be requested.
- Information on reimbursements should be requested.
- Instructions on how to determine “top” diagnostic codes should be specified: by total charges, costs, frequency, etc. Also, the form should specify whether inpatient and outpatient diagnostic codes be combined or reported separately.
- “Expenditures” should be defined and clarified. Programs with hospitals often report indigent health care expenses as a cost of write-offs for charity care programs. Form 300 currently does not accommodate the difference between costs and expenditures.

In addition, there is no known source of data for determining the population by county living at 21 percent of FPL or below or for determining how many of those individuals have no other source of funding for health care and may be eligible for services through a local indigent health care program.

Conclusions

The sheer number of programs, the lack of uniformity among the programs, the disparity in resources committed to indigent health care, and the variations in eligibility criteria and service delivery indicate a lack of a cohesive “program” for providing indigent health care in Texas. The application of indigent health care is dependent upon the ability to fund the program through property taxes or hospital operating revenue as well as the attitudes and beliefs of local program administrators.

While county programs are required to operate their indigent health care programs according to statutory guidelines, there are no provisions for monitoring or enforcing compliance. The programs operated by hospital districts and public hospitals are not even required to meet minimum program guidelines. However, even if state law were changed to require all 300 indigent health care programs to adhere to the same minimum requirements, the administrative burden of overseeing compliance would be significant.

Half of the population in Texas lives in the large, urban counties that have the least restrictive eligibility requirements and the broadest array of services. In these counties, the indigent health care programs far exceed state requirements. However, one-third of the population lives in areas served by programs that meet minimum eligibility requirements. Many of these programs are spending very little or nothing for indigent health care.

More resources would likely be spent on indigent health care if all programs were statutorily required to meet minimum guidelines and if compliance could be monitored. Requiring less restrictive eligibility requirements will have only a marginal impact until programs have a viable infrastructure in place for administering the program that is currently required.