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Texas Hospital Districts: Past, Present, and Future

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Texas Hospital Districts: Past, Present, and Future

by

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Report

Presented to the Faculty of the Graduate School of

The University of Texas at Austin

in Partial Fulfillment

of the Requirements

for the Degree of

Master of Public Affairs

The University of Texas at Austin

August 2019

Dedication

To my wife Kimberly and to my children Michael and Lyndon. This work was possible only through their support and love and I am forever grateful for it.

Acknowledgements

I sincerely thank Professor Todd Olmstead for his steadfast and unwavering support of this and many other of my projects. His expertise and knowledge coupled with his striking ability to connect with his students is unparalleled.

I am especially grateful for the perspectives and time of Professor David Warner. This project would not be possible without his enthusiastic support and encyclopedic knowledge of Texas healthcare financing.

To my colleagues who enabled my success by tolerating the tensions between my academic and professional responsibilities, I am very thankful and appreciative.

Abstract

Texas Hospital Districts: Past, Present, and Future

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The University of Texas at Austin, 2019

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Many Texas residents pay taxes into special districts designed to support local healthcare efforts. These hospital districts have their origins enshrined in the Texas Constitution as a means for individual communities to fund their local hospital operations by electing to tax themselves. This report outlines the history of the hospital district in Texas with a review of historical newspaper articles and public records. The report then outlines the legal authorities and responsibilities of these districts through a statutory and legal case review. Hospital districts have a few different means of governing their hospital operations and this report explores those structures with several examples. As these districts are primarily funding mechanisms, a chapter is devoted to cataloging the tax rates, taxing methods, and other funding methods used within the districts. The report concludes with a case study of a prominent hospital district, the Travis County Healthcare District now known as Central Health.

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Chapter 1: Introduction to Hospital Districts

Funding and financing healthcare is complicated. The public funding of healthcare in Texas is no different. Among the multitude of programs and funding mechanisms to pay for healthcare in Texas are legal entities called hospital districts and hospital authorities. With statutory authority, these entities operate in more than 150 Texas communities and are responsible for many aspects of local healthcare governance, management, and funding.

Texas hospital districts make many aspects of healthcare possible for the under- or uninsured population of Texans. The sum of the levies for all of Texas's Hospital districts in 2017 was more than $3 billion.[1] These funds are a significant source of operating dollars for institutions who provide healthcare services. But governance of these monies is highly localized and disparate. As national discussions of healthcare reform persist, and Texas state property tax reform is underway, the operation and financial implications of hospital districts is worth investigation and understanding. This report will consist of cataloging the 142 hospital districts and will describe several of certain districts' governance structures and histories. The report will give special attention to Central Health, the branded name of the Travis County Healthcare District, as it has morphed from one governance category to another, then entered into contracted services and partnerships with not only a non-profit healthcare entity, but also a state-

[1] Hegar, "Special District Rates and Levies 2017." 2017 total $3,009,262,110. Calculations and sorting by author.

affiliated university medical school. Examinations of the district will include information and perspectives from a sampling of stakeholders who helped create or manage those districts and a review of publicly available records.

When the Texas State Constitution was amended on November 2, 1954, the voters of Texas and the Legislature created the state's first hospital districts. A hospital district is a taxing entity that "assumes full responsibility for furnishing medical and hospital care for indigent and needy persons residing in the district."[2] Today, Texas has 142 hospital districts. Each district required the action of the legislature and the consent of the majority of the voters in the proposed district. Hospital districts can provide a community with a recurring funding mechanism for the healthcare of its poorest populations, as the district levies an annual ad valorem tax on real property. These districts created a few different operating methods and governance structures to meet their individual community's demands.

Some communities, such as Harris County, formed hospital districts to transfer ownership of their existing general hospitals away from other municipal entities into the health-focused hospital district governing authority.[3] Other hospital districts elect to contract with existing hospital operators to provide services to their community's poorest patients, as evidenced by the 2004 creation of the Travis County Healthcare District, which inherited a partnership with Ascension Seton to provide these services in the central Texas area. Many hospital districts do not provide traditional hospital services at

[2] Health and Safety Code Chapter 281. Hospital Districts in Counties of at least 190,000.
[3] "Harris Health History."

all, as in the Teague Hospital District in a portion of Freestone County, which provides Emergency Medical Services and does not directly support hospital operations.[4] Recently, some hospital districts have chosen to close their hospitals and continue to operate clinics and other health services in their communities. The Chillicothe Hospital District and Hamlin Hospital District are recent examples of reluctant transitions to hospital closures.

Historical and contemporary contextual research informs this discussion of Texas hospital districts. For each of the 142 districts, unique circumstances led to the realization of the entities, but general trends emerge upon examination. Texas law puts the medical care for the indigent and needy population upon the counties. But historically different institutions provided care for these populations in various capacities and qualities. Cities such as Austin, Houston, and Dallas had general hospitals that operated through city budgets. Since 1954, in part motivated by spreading tax obligations to larger area, cities began shifting their hospital operation obligations to healthcare districts with borders largely contiguous with the counties in which they reside.

Counties and municipalities also may create hospital authorities. These entities can acquire, own, or lease hospitals.[5] While these authorities cannot tax citizens or corporations to raise revenue, the hospital authority can borrow money and issue revenue bonds with a tax-exempt status.[6] The governance structure of a hospital authority is often

[4] "Teague Hospital District Emergency Medical Service."
[5] Health and Safety Code Chapter 262. Municipal Hospital Authorities.
[6] Health and Safety Code Chapter 262. Municipal Hospital Authorities. Subchapter D. Bonds

like that of a hospital district, with an appointed, odd number of board of directors comprised of at least seven members. The appointing body is the same as the body that passed the ordinance to create the authority, either a municipal or county governing body.

The hospital district, as a type of special district, exists to fill a community need. Hospitals are essential public institutions. Like other public serving institutions, we see communities demand of them general and specific needs. A hospital district creates a public good with varying degrees of public accountability. Individual districts trade off between direct accountability of elected district board members and the less-political but more publicly distant appointed boards. The districts allow for public input, public accountability, and a manifestation in the public will for healthcare outcomes of their communities. While the budgets vary significantly between health systems, a hospital district allows voters to interface and influence decisions that directly affect their communities. The pull of national healthcare policy and national healthcare economics can cause serious problems to particular communities, especially rural ones. Policies can overlook rural communities; they can underfund their needs; or they can fail to address the economic realities of their communities. The hospital district is a vehicle to capture recurring and reliable funding, establish and maintain community stakeholder buy-in, and participate in those regional and national healthcare practices with more economic agency. This report focuses on hospital districts, but I explore briefly another type of entity, the hospital authority below. The principal difference between the entities is the ability to tax on an ongoing basis with the hospital district, whereas a hospital authority may only borrow money as a tax-exempt public entity.

Hospital authorities are a weaker form of a special district used to provide a community with the benefit of a hospital. Without the authority to levy ongoing taxes, a hospital authority may issue revenue bonds to fund the construction of hospital structures.[7] The 1957 Legislature afforded cities the ability to create hospital authorities. These governing bodies have a board of directors, much like a hospital district, of unpaid managers. Authority boards are appointed by the governing body of the municipality that creates them and serve two-year terms. A single hospital authority may be formed between multiple cities with special provisions for how the cities appoint representative members of the governing board.

The authority to borrow money in the form of issuing revenue bonds is another means of seeking public support for the community's need for hospital services, but with a significant difference. The revenue bonds are a debt that must be repaid. This is an essential difference between hospital authorities and hospital districts. A hospital district imposes a tax on its district residents and provides hospital services, whereas a hospital authority oversees the management of a hospital that is intended to operate profitably enough to pay back the principal and interest to its bond holders. For this reason, hospital authorities tend to exist in metropolitan areas where hospital operations can be expected to maintain revenues that support the debt load incurred by the issuance of revenue bonds. A rural hospital may routinely operate at a loss and would be more likely to fail to realize the revenues sufficient to pay the interests on bonds. Additionally, a rural

[7] Thrombley, "Hospital Districts Chapter V."

hospital may not have the revenue and operational budget to support the bond raising process which can be administratively expensive and cumbersome.

Hospital authorities may also enter into management agreements with hospital operators and they may sell part of or an entire hospital owned by the authority, so long as certain conditions are met. Those conditions include taking the issue to voters who live within the authority. Under certain circumstances, a hospital authority may also exercise eminent domain powers to support hospital projects.

Another distinction between hospital authorities and hospital districts is that authorities have no obligation to provide ongoing indigent health care services.[8], [9] While federal Emergency Medical Treatment & Labor Act (EMPTALA) provisions ensure public access to emergency medical care regardless of a patient's ability to pay, a hospital authority is the not responsible entity for sustained healthcare for indigent persons.[10] These obligations fall upon the county that the hospital authority resides in or a nearby hospital district.

This report exists in the context of constant change and tumult in the realm of healthcare financing reforms and struggles. Property tax reform measures in Texas were enacted when Governor Greg Abbot signed the 86th Legislature's SB2 relating to ad valorem taxation.[11] The statute grants hospital districts special status, allowing these taxing entities to increase taxes at higher rates than other entities.[12] While the effect of

[8] "Chapter 262. Municipal Hospital Authorities."
[9] "Chapter 264. County Hospital Authorities."
[10] Centers for Medicare & Medicaid Services, "Emergency Medical Treatment & Labor Act (EMTALA)."
[11] Najmabadi, "Gov. Greg Abbott Signs Bill Designed to Limit Property Tax Growth."
[12] "SB2 An Act Relating to Ad Valorem Taxation; Authorizing Fees."

this law is yet to be seen, it is reasonable to suspect that counties and municipalities may find the creation of a hospital district an effective way to continue to raise tax revenues commensurate with community health needs. A discussion on some possible outcomes of the tax reform measures also forms a component of this report. The report will demonstrate a fundamental issue within Texas's approach to ad valorem taxation: that farm, ranch, and wildlife management land are valued according to productivity, rather than market value. Open-space designation can even result in no property tax paid at all. These approaches to valuation have real impact on the entities that derive their funding from property taxes. Tax law reform, especially property tax reforms, are not often perceived as connected to healthcare and community health programs, but hospital districts with perpetual taxing power and hospital authorities with bond-measure borrowing all depend on ad valorem taxation.

For better understanding of their development, a brief history of hospital districts in Texas follows, including an account of the state's constitutional and legal changes that allowed the creation of the special districts. Then an account of the governance structures and district design is explored. One chapter is devoted to how particular districts are operated, who manages them, and how their borders are determined. This report details hospital district responsibilities, and their scopes of service as outlined per Texas statute. The report also contains a discussion of finances and elements of ad valorem taxation in Texas as they pertain to hospital district operations and budgeting. This report concludes with an examination of a particularly

complicated and unique hospital district, the Travis County Healthcare District, doing business as Central Health.

Chapter 2: History of Hospital Districts in Texas

Hospital districts are a subcategory of taxing entities called special districts. The United States Census Bureau states “special district governments are independent,

special-purpose governmental units that exist as separate entities with substantial administrative and fiscal independence from general-purpose local governments."[13] These special districts provide specific services, such as the administration of electric power, libraries, ports, healthcare, and even cemetery management. The distinction of a special district from a general-purpose government, like a city council or a county commissioner's court, is the specific scope of the entities' responsibility. A hospital district is responsible for the hospital services in the district and another entity may not tax for those same services. According to statute, later discussed, a hospital district must provide essential services to the district's poorest residents.

But what explains the proliferation of this kind of special district? Given the eventual legislative and constitutional changes of the 1950s, there was clearly a public demand for the role these special districts could play in a community. Newspaper articles from the early 1950s show examples of communities trying to solve a basic problem: how to fund the construction and operation of a hospital that would serve their localities. Healthcare was more and more dependent on the hospital as an institution, as opposed to the informal network of private and unaffiliated physicians that served a community's health needs. Hospitals require infrastructure, physical plant investment, and significant ongoing operational costs that many communities were unequipped to accommodate. Moreover, hospitals require physicians to practice in them, and communities recognized the need to attract them. With federal funding possible from the Hospital Survey and

[13] "Individual State Descriptions: 2017," 5.

Construction Act of 1946, commonly called the Hill-Burton program, communities required vetted plans to build hospitals and maintain them to access the federal support. The bill "built a state-federal partnership to survey the need for acute-care hospitals and subsidize their construction, mostly as voluntary, nonprofit institutions."[14] The bill focused on rural areas and was built on a requirement for both state and local community institutional support to access the funds. These were the incentives that steered many communities to invest in a hospital district

The Moulton Eagle, a newspaper serving Lavaca County, Texas, described a novel approach to rural healthcare in Ennis, Montana, in a column entitled "Small Town Ingenuity Improving Health Condition in Farm Areas" in January 1950. The article recounts the efforts of retired Admiral, W. H. P. Blandy who helped solve the problems many rural communities faced: a lack of doctors and an inability to attract them. *The Moulton Eagle* editorial board agreed with Blandy's solution for their community. They supported a limited taxing district to fund the support of a hospital building and an institution that would attract physicians to their small community. Hospital authorities, though not named as such, also are posited as a viable solution, with examples given of other "forward-thinking" communities in Washington County, Kansas and in Okarche, Oklahoma. These communities raised funds by voter-approved bond measures to fund their hospital construction. Given the context of the Hill-Burton funds, this is an early example of the community campaigns that would soon lead to the proliferation of the

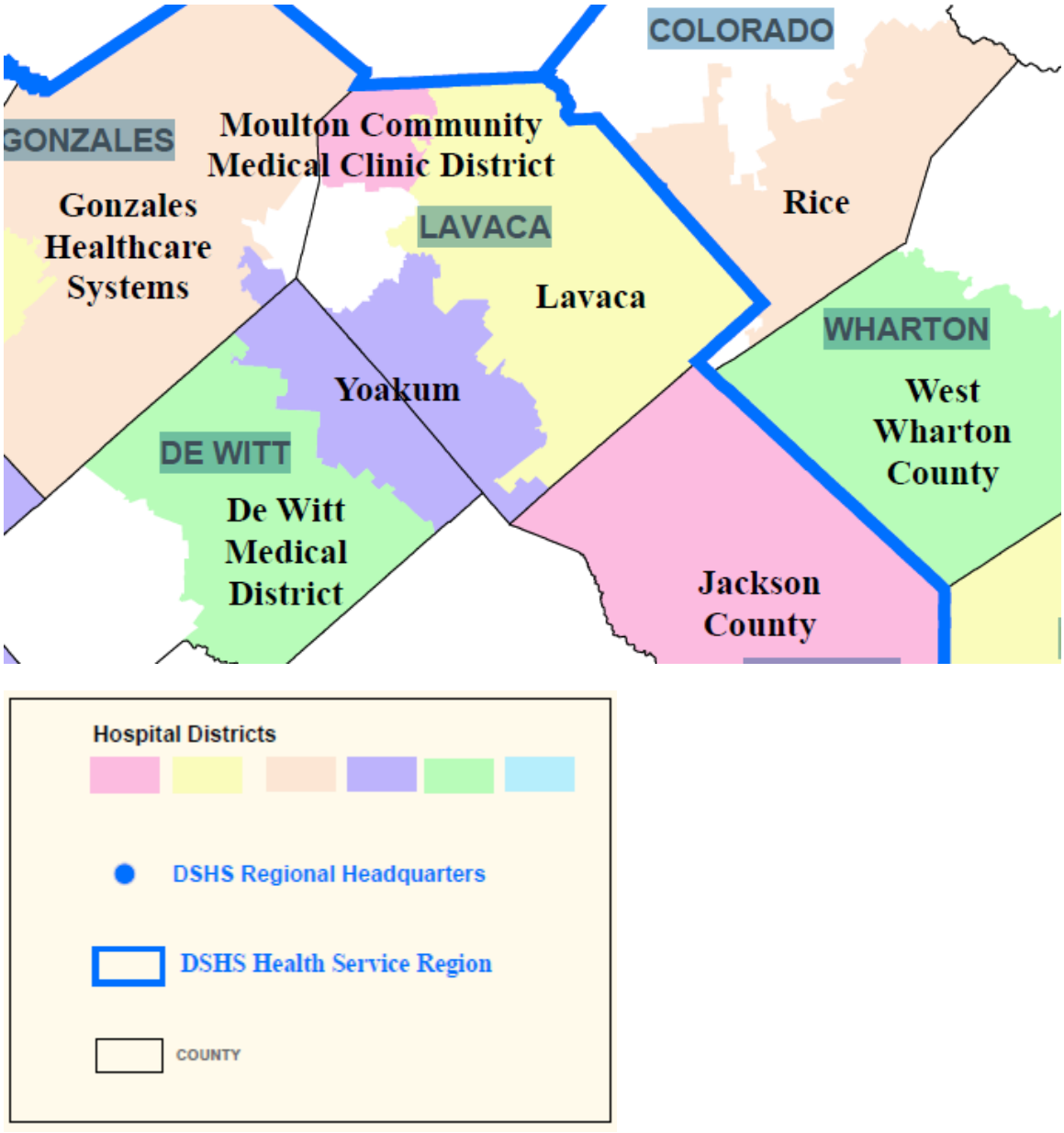
[14] Melhado, "Health Planning in the United States and the Decline of Public-Interest Policymaking."

hospital district as a means of contributing to the public health of communities all over Texas.[15]

While it would be difficult to correlate this early campaigning for a hospital district in *The Moulton Eagle's* readership area, today it represents a particularly concentrated number of hospital districts in that area of Texas. The map below illustrates this concentration, where each color represents an individual hospital district. These communities chose segments of their counties for their district boundaries. The graphic is an inset of Map B., later discussed.

Map A:
Inset of Lavaca County and Surrounding Hospital Districts

[15] The Moulton Eagle Editorial Board, "Rural Health: Small Town Ingenuity Improving Health Condition in Farm Areas."



Sources:
Health Service Regions - Department of State Health Services (DSHS)
Hospital Districts and Hospital District Boundaries - County Central Appraisal Districts

The *Port Neches Chronicle* outlined the results of an informal election of a group of citizens calling themselves "the hospital group" in 1952. E. L. Gish, the

temporary chairman of the group explained the options they were considering when building

a hospital to serve the Midcounty areas.

> There are three possibilities for the operation of the proposed hospital. The first is that the St. Franciscan sister, a Catholic organization with headquarters in Ohio and operating some 36 hospitals throughout the U. S., might be induced to take over the project…secondly, the Methodist denomination might be interested in the operation of a hospital of some 40-50 rooms, which is being proposed in the Midcounty area. Thirdly, a hospital district could be created in the Midcounty area to take care of establishment and operations of the hospital."[16]

The options available to that community in need of a hospital were not entirely different from today. Faith-based healthcare institutions are still major operators of Texas hospitals and hospital networks. The demand for a reliable public taxing mechanism to contribute to better health conditions and improved community health resources was growing in Texas communities. This culminated in a series of state-wide constitutional amendments to allow for these special districts to exercise the state's taxing authority in voter-approved communities to support local healthcare infrastructure and operations.

On November 2, 1954, the State of Texas amended its constitution to include the following provision for the creation and powers of hospital districts:

> Texas Constitution Article 9 Counties. Section 4. The Legislature may by law authorize the creation of county-wide Hospital Districts in counties having a population in excess of 190,000 and in Galveston County, with power to issue bonds for the purchase, acquisition, construction, maintenance and operation of any county owned hospital, or where the hospital system is jointly operated by a county and city within the county, and to provide for the transfer to the county-wide Hospital District of the title to any land, buildings or equipment, jointly or separately owned, and for the assumption by the district of any outstanding

[16] The Chronicle Editorial Board, "Gish Elected Temporary Chairman of Hospital Group Tuesday Night."

> bonded indebtedness theretofore issued by any county or city for the establishment of hospitals or hospital facilities; to levy a tax not to exceed seventy-five ($.75) cents on the One Hundred ($100.00) Dollars valuation of all taxable property within such district, provided, however, that such district shall be approved at an election held for that purpose, and that only qualified, property taxpaying voters in such county shall vote therein; provided further, that such Hospital District shall assume full responsibility for providing medical and hospital care to needy inhabitants of the county, and thereafter such county and cities therein shall not levy any other tax for hospital purposes; and provided further that should such Hospital District construct, maintain and support a hospital or hospital system, that the same shall never become a charge against the State of Texas, nor shall any direct appropriation ever be made by the Legislature for the construction, maintenance or improvement of the said hospital or hospitals. Should the Legislature enact enabling laws in anticipation of the adoption of this amendment, such Acts shall not be invalid because of their anticipatory character.

This proposition was adopted with 61 percent of the vote, with 307,573 votes for and 193,826 votes against.[17] Interestingly but unrelatedly, this same election also amended the Texas Constitution to allow women to serve on juries. Progressive times indeed.

This section of the constitution was later amended in 1999 to address some of the language to extend the voter base. The words “and that only qualified, property taxpaying voters in such county shall vote therein” were amended to “and that only qualified voters in such county shall vote therein.” Furthermore, “Should the Legislature enact enabling laws in anticipation of the adoption of this amendment, such Acts shall not be invalid because of their anticipatory character" was omitted in the same amendment.

Soon following the 1954 constitutional amendments that pertained to counties of a defined population, then greater than 190,000 people, Texas voters approved

[17] “SJR 2, 53rd Regular Session, Relating to Proposing a Constitutional Amendment by Providing That the Legislature May Authorize the Creation of County-Wide Hospital Districts in Certain Counties If Approved by the Qualified Voters at an Election.”

additional constitutional amendments to further expand the creation of hospital districts. The lawmakers had approved a set of standards that was too restrictive for the demand of these special districts which necessitated additional amendments.

For example, the entire population of Jefferson County, Texas, in the 1950s made it eligible for a hospital district.[18] This would require the entire county to be in the district, but there was a demand for a special district that had different borders and a different taxpayer base. The 1958 amendment to the constitution created hospital districts in the City of Amarillo, Wichita County, and Jefferson County. These districts would have unique district geographies, a shift away from the district boundaries that were intended to be coterminous with the county borders. Yet another constitutional amendment was passed in 1960 to allow the creation of a hospital district to share borders with County Commissioners Precinct no. 4 of Comanche County.

Two relevant amendments were approved in the 1962 election. Seemingly as a mechanism to hedge the outcomes of the election, voters were asked to approve two hospital-district-specific measures. One was to allow the legislature to create hospital districts in Ochiltree, Castro, Hansford, and Hopkins Counties. This amendment followed the form and function of the previous amendments that were county-specific. Additionally, in the same election, the Texas Constitution was amended once again to give the legislature broader authority to create hospital districts without the consent of the

[18] "Texas Counties Decennial Census Data." US Census Bureau Statistics per Texas County 1850-2010.

statewide vote. The new power given to the legislature comes from Article 9 Sec. 9 of the Constitution. It provides for these powers:

- Legislature may pass general or special law to create Hospital District
- District may be entire county, part of a county, or multiple counties
- Districts cannot tax more than 75 cents per 100 dollar valuation
- Public notice of at least 30 days to the intended district
- Creation of the district must include an affirmative vote of a majority of the qualified voters in the district concerned.[19]

The voters granted the legislature the authority to pass laws that would then create future hospital districts, which made the newly amended section 11 for Ochiltree, Castro, Hansford, and Hopkins Counties unnecessary after the fact. It is likely an instance of ensuring the individual named county districts were created if the voters decided against the legislative authority to create more and more special taxing districts.

Then, a 1966 constitutional amendment provided for methods to dissolve existing hospital districts. The legislature was compelled to provide a process to dissolve the district that contains these three elements.

1. To determine that a majority of the voters within the district voted to dissolve it,
2. Disposal of or transferring of assets of the district, and

[19] The Texas Constitution Article 9. Counties.

3. Satisfy debt and bond obligations in a way that protects the interests of the citizens in the district and their collective property rights.

The amendment also limits the frequency of the district's elections to dissolve a hospital district to no more than once each year. This provision apparently is included to prevent a series of repetitive district votes that would fatigue the voters until an eventual result to dissolve could be manifested. In a few instances of communities attempted to dissolve their hospital districts. The particularly interesting cases of Somervell and Young Counties are described later in this chapter.

With the adoption of the constitutional amendment to Section 9, the Texas Legislature was empowered to create hospital districts under its own authority and without a statewide election. Each of the 142 hospital districts now in existence have similar standards set out in either the constitution or statute. Many of the districts required an act of the Texas Legislature to create it. Most of the districts may not exceed the maximum taxing limit of 75 cents per 100 dollar valuation, and each had to be approved by a majority vote by voters in the in the district's boundaries. Due to the piecewise and individualized approach to the initial run of rapid hospital district creations, Hidalgo County's hospital district was initially limited to 10 cents per 100 dollar valuation. A successful campaign to repeal the constitutional amendment pertaining specifically to Hidalgo County was approved by Texas voters in 2013. This would allow Hidalgo County to follow the now normalized process of hospital district operations by which other hospital district in Texas abide.

In 1989, two important amendments were approved. First, the length of terms served by hospital district governing boards were authorized to be extended to four-year durations. Governing board terms had been inconsistent among some hospital districts, and many of the board terms were limited to two-years for their members. Second, voters also approved a measure to empower the legislature to create hospital districts in counties with a population of 75,000 or less. This amendment, Sec. 9B., adds to the general power to create hospital districts amendment from 1962. The provisions for the counties with 75,000 or less does not grant the same taxing power to these low-population districts. Whereas other more populous districts have broader authority to set tax rates up to 75 cents per 100 dollar valuation, these less populated districts have special circumstances. Their property tax rate is either set by the Texas Legislature or the district can employ a sales and use tax. This is discussed in Chapter 5, Taxes and Money.

The Texas Health and Safety Code provides the process for initiating an election to both create and to dissolve a hospital district. At least 15 percent of the registered voters in the district must petition for the election measure. Several communities have attempted to dissolve their hospital districts. One such community that had voters try to eliminate their hospital district is in Young County.

Some tax-conscious citizens of Young County attempted this procedure in 2014, when they petitioned to dissolve the Graham Hospital District. The petition failed to meet the minimum requirement of the law, “with 1,289 votes submitted and only 509

valid, which represented 43 percent of the required votes."[20] Despite website advertising, social media campaigning, and higher than normal turnout to hospital district meetings, the attempt to garner enough support to put the measure on a ballot failed. Voters in this same district attempted the same procedure again in October 2018. As of this publication, the requisite 1,338 valid signatures have not been submitted to the county officials for consideration.

Hospital districts, despite their presence in so many Texas communities, are often contentious and difficult entities to create. Convincing people to voluntarily increase their taxes for what may seem like a nebulous community good and may not directly benefit an individual taxpayer can be a difficult enterprise. Voters in Somervell County recently created their hospital district by a margin of two votes. Election turnout was relatively low, with an overall turnout of 13 percent of eligible voters. The district creation was contentious enough to elicit an immediate petition drive from some community members, but the threshold to cause an election to dissolve the district is 15 percent of eligible voters, which is significantly more signatures required to force another election than the number of voters who turned out to create it. When the petition drive to dissolve the district failed, a vocal opponent to the district ran for its board. Paul Harper, a resident of Somervell County, was elected on a platform of reducing the tax rate of the hospital district to zero cents per 100 dollar valuation. Events that followed became the interesting legal case of Harper v. Best.

[20] The Graham Leader Staff Report, "Petition Created to Dissolve Graham Hospital District."

After attempts to dissolve the hospital district failed petition standards, one approach to render the hospital district ineffective. A vocal opponent of the very existence of the new hospital district, Paul Harper stood for and was elected to its board of managers under campaign promises to reduce the effective tax rate to nothing. Another resident of Somervell County Hospital District, George Best, "filed a petition to remove Paul Reed Harper as a board member of the Somervell County Hospital District."[21] Best argued that Harper was "incompetent by gross ignorance of his official duties and gross carelessness in discharging those duties" and "that, by trying to reduce or eliminate the hospital district tax, Harper committed treason against the hospital district which, once elected, Harper had taken an oath to protect… by not voting to tax the citizens to allow for the continued existence of the hospital, Harper has failed in his duties to the hospital district."[22]

An argument over the governance of hospital districts influenced Texas case law. The case's majority opinion states

> The question, as applied to this suit, is whether we have arrived at the place where an unhappy politically active citizen who runs for office and is elected in a general election can then be charged as incompetent when, as an elected officeholder, the elected official tries to constrain or even eliminate the organization to which he was elected. If the State of Texas can maintain a suit to hold an elected official incompetent under these circumstances, we have effectively criminalized the ability to shrink government by the political process.

Other aspects of the case such as violations of Open Meetings Act rules were considered too, but ultimately, Harper was not removed from his office and could vote to set the

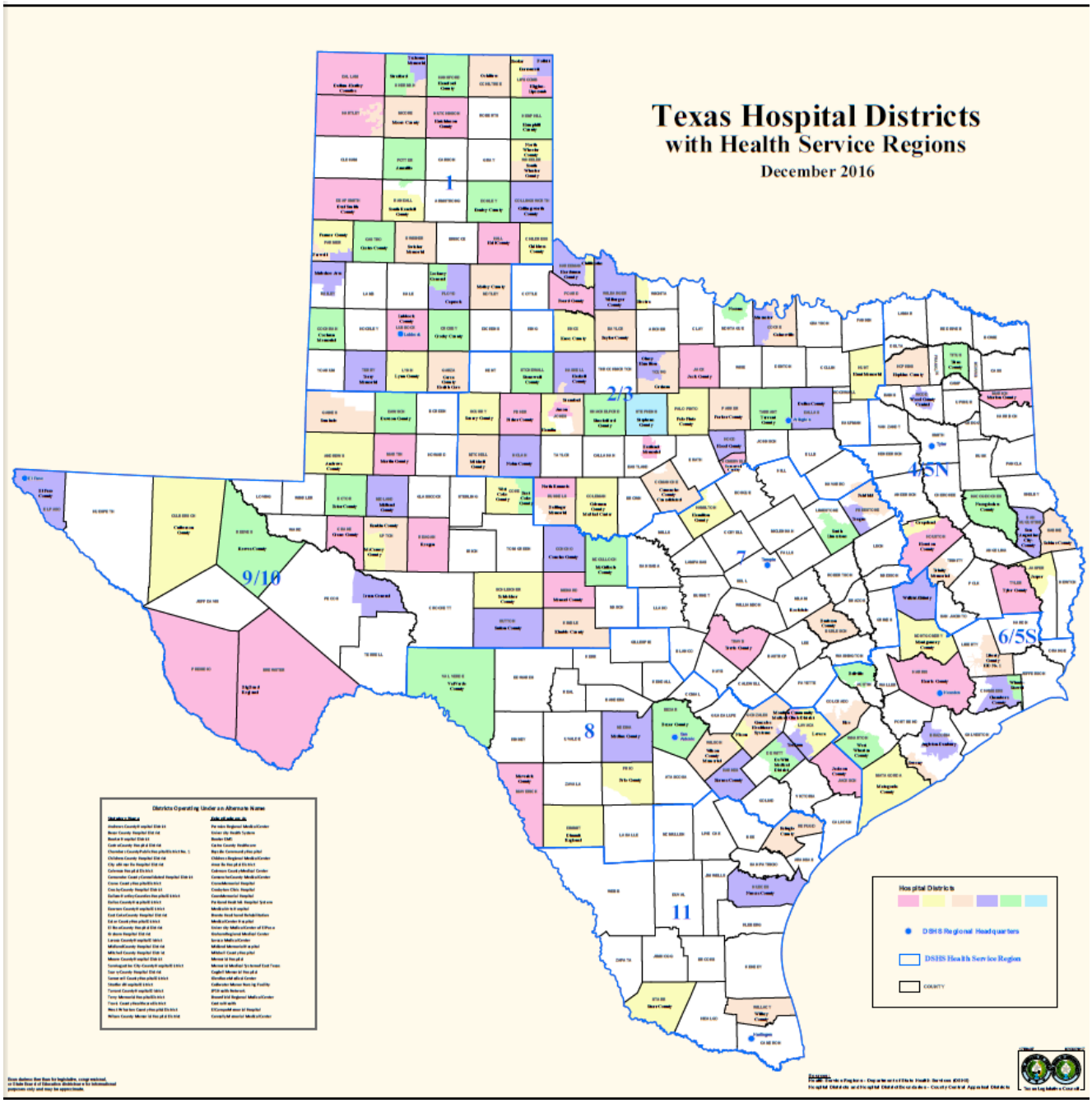
[21] "Paul Reed Harper, Appellant v. George Darrell Best, Appellee."
[22] "Paul Reed Harper, Appellant v. George Darrell Best, Appellee."

hospital district, whose existence he politically opposes, to the effective taxation rate of zero. Despite Harper's activism, the board still enacted a tax rate of 11.95 cents per 100 dollar valuation.[23]

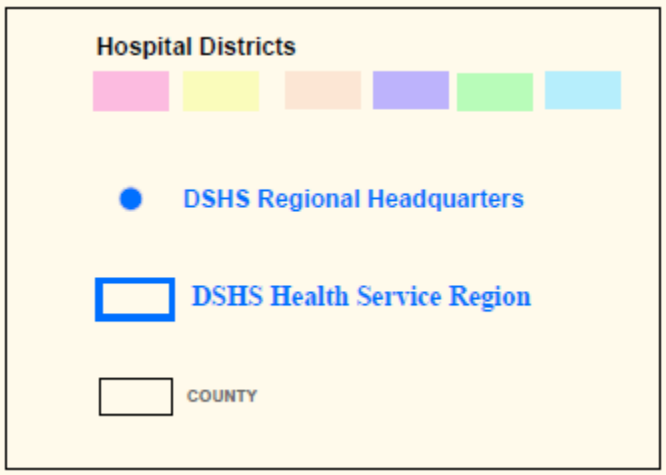
Today, despite the occasional vocal minority action to reduce the number, there are 142 hospital districts in the State of Texas. All have authority to ad valorem tax property within their district boundaries as bestowed upon them as political sub-entities of the state of Texas. The districts identified in this report and their 2017 tax rates are listed in Appendix 1. A geographical map follows as well; the map is all the hospital districts as of 2016, which is the latest map data available from the Texas Department of State Health Services.

[23] "Somervell County Hospital District Budget FY2015."

Map B:
Texas Hospital Districts



Map B:
Texas Hospital Districts continued



Sources:
Health Service Regions - Department of State Health Services (DSHS)
Hospital Districts and Hospital District Boundaries - County Central Appraisal Districts

Chapter 3: Structure and Function

The governance model of those hospital districts operating today follows the design from the mid-1950s. The model first depends on an established geographic definition of the hospital district with limits on its taxing boundaries. The district is defined in terms of existing political boundaries. For instance, the geographic limit of the Hidalgo County Hospital District is described very simply as "The boundaries of the district are coextensive with the boundaries of Hidalgo County."[24] Another method of identifying the district territory is to link the geography with existing precincts or other political demarcations, as in North Wheeler County Hospital District, which has boundaries that "are coextensive with the boundaries of County Commissioners Precincts 1 and 2 of Wheeler County, Texas, as those boundaries existed on January 1, 1963."[25] Wood County Central Hospital District limits are defined in terms of "the territory in the boundaries of the Quitman Independent School District located in Wood County as those boundaries existed on May 25, 1967."[26]

After the boundaries are established, we look to the board of managers or directors. Different boards have different names for their boards, either managers or directors, and it is not obvious what the distinction between the two identifiers is, if indeed there is a difference. Aside from the superficial naming of the board, the boards have a couple of variables between districts. How the boards are selected and how many

[24] "Chapter 1122. Hidalgo County Healthcare District."
[25] "Chapter 1083. North Wheeler County Hospital District."
[26] "Chapter 1116. Wood County Central Hospital District of Wood County, Texas."

members the boards have are district specific and not consistent among the range of hospital districts. The method for selecting board members falls into two categories: elected or appointed.

Within the elected category of board members, many hospital districts have very simple instructions set out in statute. The Chillicothe Hospital District statute says that "The board consists of seven directors elected from the district at large."[27] Conversely, the most convoluted example of identifying a representative board from a hospital district is the set of instructions for electing the nine-person board of the Angleton-Danbury Hospital District of Brazoria County, Texas.

The latter district, already defined in another part of the statute, is divided into three component areas for the purposes of establishing geographically representative board membership. "Area Angleton" is composed of "all territory within Brazoria County election precincts Nos. 1, 2, and 5 that is within the boundaries of the Angleton Independent School District," and "that part of Brazoria County election precinct No. 6 that is west of Chocolate Bayou and within the boundaries of the Angleton Independent School District as those precincts and those boundaries existed on January 1, 1967." Then, "Area Danbury" is defined as all territory within the boundaries of the Danbury Independent School District. Finally, "Area Rosharon" is identified as "all territory within Brazoria County election precinct No. 9 that is not within the boundaries of the Danbury Independent School District, all territory within Brazoria County election

[27] "Chapter 1008. Chillicothe Hospital District."

precinct No. 21 that is not within the boundaries of the Manvel Independent School District."[28] Positions 1, 2, 3, 4, and 5 are to be elected from Area Angleton. Area Danbury gets positions 6 and 7. The 8th position must be a resident of Area Rosharon, and the 9th position for the Angleton-Danbury Hospital District of Brazoria County must be a resident of the district at large.[29]

Some districts were designed to govern without direct election of their boards. While the direct election of board members could help persuade a tax-reluctant community, it does leave a board more open to political forces and increases the likelihood of a board consisting not of subject matter experts but rather of politically active citizens who may not have relevant experience or expertise in hospital and healthcare system oversight. Travis County Healthcare District and the Matagorda County Hospital District are examples of several appointed boards.

Matagorda County Hospital District's board is designed by statute to consist of "not fewer than five and not more than seven managers appointed by the Matagorda County Commissioners Court."[30] Travis County's arrangement is more complex, with four board members appointed from the County Commissioners Court, 4 members appointed by the Austin City Council, and a final member nominated by both the Austin City Council and the Travis County Commissioners Court together. The reason why these appointment and elected structures vary among communities is ultimately because

[28] "Chapter 1002. Angleton-Danbury Hospital District of Brazoria County, Texas."
[29] "Chapter 1002. Angleton-Danbury Hospital District of Brazoria County, Texas."
[30] "Chapter 1057. Matagorda County Hospital District of Matagorda County, Texas."

the creation of each hospital district must be approved by the voters of the intended district. Stakeholders who desire a new taxing district must convince the voting population of their communities to approve the measure, and different communities have different expectations and individual contexts that influence the designs of their district governance.

A rural community may be relatively new-tax averse compared to an urban center. This may be due to political affiliations, but it may also be driven by the resources an urban community has to campaign and sell the notion of a hospital district to its voters. Visibility of the obvious targeted population for the hospital district's services may be another factor. The primary purpose of the hospital district is to raise funds to offset the cost of providing healthcare services for the community's indigent and needy populations, and homelessness is often more concentrated and visible in urban communities. A district may also serve as a funding source for those private sector partners in the district.

District boards set their own bylaws and dictate meeting frequency and the scope of management of their healthcare services. The bylaws generally lay out the expectations for the make-up of the board with officer designations and the methods by which the officers will be elected and the duties therein. Some districts allow for board members to delegate official tasks to employees of the board, as in the case of the office of the Treasurer. In Big Bend Hospital District, their bylaws state that "The Treasurer shall maintain or cause to be maintained all financial records of the District and assist the Board of Directors in actions related to the Board's financial responsibilities. The

Treasurer will service [*sic*] as Chairman of the Finance Committee and serve as Investment Officer for the District. The Treasurer may delegate his or her duties to an employee of the District."[31] Other boards have more resources and budgets which allow for elaborate standing committees and staff members to execute the will of the board. Travis County's Central Health board bylaws instructs their treasurer to only chair the budget and finance committee and devotes some two pages of instructions for the committee's responsibilities.[32] Interestingly, Big Bend Regional Hospital District requires a two-thirds majority for amendments to their bylaws, though their board consists of five members.[33] All examples of bylaws examined had instructions for annual external audits of the organizations finances, although the method for choosing the vendor for the auditing services varied between sole discretion of the Treasurer to a full board vote requirement for the decision. The method and result of audits can be a point of contention, especially when hospital districts, subject to transparency laws and expectations of public institutions, partner with private organizations for care delivery.

[31] "Bylaws of the Board of Directors of Big Bend Regional Hospital District Brewster and Presidio Counties, Texas," January 28, 2016.
[32] "Amended and Restated Bylaws of the Travis County Healthcare District."
[33] "Bylaws of the Board of Directors of Big Bend Regional Hospital District Brewster and Presidio Counties, Texas." Article IX Amendments

Chapter 4: Hospital District Responsibilities

Some Legal Interpretation of District Responsibilities

Texas hospital districts have both statutory and constitutional obligations to provide services to their indigent and needy persons. The responsibilities are established in constitutional amendment and in statute and they are reinforced by legal opinion. In 1972, an opinion of the Texas Attorney General stated "The [Bexar County] Hospital District has the constitutional and statutory duty to furnish medical and hospital care to the indigent and needy persons residing in its District."[34] Yet, another opinion from the same office written in 1965, stated that "[A] patient should not be refused admittance to the hospital facilities simply because he may be able to pay for his care, either in whole or in part," and "It must be noted that the primary function of the Hospital District is the furnishing of medical care and hospital care for the indigent and needy of the county, and that such function, should take precedence over all others."[35]

A later opinion from the Attorney General broadened the interpretation to the provision of hospital and healthcare services to the needy residents of the district, even when the district does not own or operate a physical hospital. The district's "authority to levy and use the proceeds for the District's needy residents' hospital and medical care is neither limited to nor contingent on ownership or operation of a physical hospital. Clearly, a hospital district may provide hospital and medical care to its indigent through

[34] Op. Tex. Att'y Gen. No. M-1154, at 5.
[35] Carr, Op. Tex. Att'y Gen. No. WC-382.

its own hospital facility. But it must provide that care even if it does not own or operate a hospital facility."[36]

Indigent Health Care and Treatment Act District Responsibilities

A 1985 law called the Indigent Health Care and Treatment Act, now Chapter 61 of the Health and Safety Code, is fundamental to the legal authorities and statutory responsibilities of hospital districts. The act sets definitions for eligibility for receiving care provided by counties or hospital districts, and the primary consideration is a low income. The law establishes that individual incomes must be at or lower than 21 percent of the federal poverty level and meet a host of other eligibility components. The law declares two types of entities are ultimately responsible for providing for the healthcare services of the indigent; counties and hospital districts. Hospital districts are responsible for the eligible persons who reside in their district. Counties are responsible for their eligible residents when the counties are without hospital districts, or in the event that regions of their counties are not in a hospital district.

The state's Health and Human Services website outlines the eligibility for services in the County Indigent Health Care Program.[37] Program eligibility applies to anyone who:

- Lives in Texas.
- Has an income level at or below 21 percent of federal poverty guidelines.

[36] Op. Tex. Att'y Gen. No. JC-0220.
[37] "County Indigent Health Care Program | Texas Health and Human Services."

- Has resources less than $2,000.
- Is not eligible for Medicaid.

The state also publishes a directory of county contacts with specific names, titles, physical and e-mail addresses sorted by county name. Although the document has no key or legend to denote the coding, there is also a denoted C, HD, or PH next to each county name. When compared to the appropriate counties, it seems to indicate whether the entity providing the County Indigent Health Care Program is a County, a Hospital District, or a Public Hospital.[38] More populous counties often have more than one resource entity available, resulting in 307 program entities for the 254 counties.

Hospital districts are to "endeavor to provide the basic health care services a county is required to provide."[39] Those services are:

- primary and preventative services designed to meet the needs of the community, including:
    - immunizations;
    - medical screening services; and
    - annual physical examinations;
- inpatient and outpatient hospital services;
- rural health clinics;
- laboratory and X-ray services;

[38] "County Indigent Health Care Program Directory of County Contacts."
[39] "Indigent Health Care and Treatment Act."

- family planning services;
- physician services;
- payment for not more than three prescription drugs a month; and
- skilled nursing facility services, regardless of the patient's age.[40]

Counties and hospital districts also are permitted to provide other services, but whether those services are credited toward the eligibility for state assistance is not guaranteed. The services below are deemed important, but not essential services that the districts must provide. To be credited, the services for the indigent must fall into the following categories, so long as the county or district determines the services to be "cost-effective":

- ambulatory surgical center services;
- diabetic and colostomy medical supplies and equipment;
- durable medical equipment;
- home and community health care services;
- social work services;
- psychological counseling services;
- services provided by physician assistants, nurse practitioners, certified nurse midwives, clinical nurse specialists, and certified registered nurse anesthetists;

[40] "Indigent Health Care and Treatment Act."

- dental care;
- vision care, including eyeglasses;
- services provided by federally qualified health centers, as defined by 42 U.S.C. Section 1396d(l)(2)(B);
- emergency medical services;
- physical and occupational therapy services; and
- any other appropriate health care service identified by department rule that may be determined to be cost-effective.[41]

The term "cost-effective" is not defined in the statute but left to the entity providing those services to determine and justify.

[41] "Indigent Health Care and Treatment Act."

Chapter 5: Taxes and Money

This chapter presents the levies of hospital. These budgets are derived from the ad valorem taxation of the property within the district boundaries. Most hospital districts are limited by statute to not exceed 75 cents per 100 dollar valuation. These limits apply to the range of hospital districts, from the most rural and sparsely populated to the most metropolitan. In this chapter, I explore a fundamental issue with Texas's approach to ad valorem taxation which is the concept of productivity vs. fair market valuation.

In a series of constitutional amendments and tax code revisions, appraisal districts stopped appraising farming, ranch, and open-lands at their appraised fair market value and transitioned to a standard of productivity valuation. The tax code demands that farm land be "appraised at its value based on the land's capacity to produce agricultural products"[42] The Texas Manual for the Appraisal of Agriculture Land 2017, presented to the public by Glenn Hegar, Texas Comptroller of Public Accounts, notes that "In many cases, this appraisal technique substantially reduces taxation of land that qualifies for agricultural appraisal."[43]

Open-space land, timberland, and land used to manage wildlife would later be included in the property that is eligible for agricultural appraisal. These expansions of the productivity standard for land valuation exacerbated the challenges that rural communities face with property-tax based district funding. The proliferation of hospital districts in the 1950s and early 1960s occurred prior to the tax code revisions of this

[42] Tex. Tax Code §23.41(a)
[43] Hegar, "Texas Manual for the Appraisal of Agriculture Land."

means of ad valorem appraisal methodology. Proponents for the often called "agricultural exemption" point out the methodology does not exempt a landowner from taxes, but rather creates a "special valuation" of these property types. These special valuations create significantly less appraised value to be taxed by school districts, hospital districts, and all other property tax funded entities. These properties are concentrated in communities that tend to struggle with meeting healthcare and educational spending patterns and outcomes of their urban counterparts.

A 1953 editorial from the El Paso Herald-Post criticized then Mayor Fred Hervey. The editorial board argues that shifting hospital costs to a county property tax gives an advantage to "wealthy, tax-dodging farmers."[44] A similar problem exists today, though the rhetoric of "tax-dodging farmers" is unlikely to succeed as a campaign motivator. Many hospital districts were formed when property taxes were based on fair market value. These districts now have the same catchment areas for statutory service demands, but with significantly depreciated land to tax. This situation is a detriment to the ability of rural districts to deliver effective healthcare services and to attract top-performing clinicians and leaders of their healthcare enterprises. The obvious disadvantage is a disproportionate shortfall of tax revenue, but the cost of the taxing methodology goes beyond simple service delivery. Rural districts tend to have fewer resources available to the public in terms of meeting minutes, posted agendas, publicized affiliation agreements, and even offices to house their operations. These supportive

[44] El Paso Herald Post Editorial Board, "Hervey Serves Baloney."

endeavors, along with the commensurate staff to support them, are often missing or are in shorter supply in land-rich but value-poor districts.

Districts in sparsely populated districts, legally defined as counties with a population of 75,000 or less, may impose another form of taxation. These small districts, with voter approval, "may impose a sales and use tax" in "in increments of one-eighth of one percent, with a minimum rate of one-eighth of one percent and a maximum rate of two percent."[45] The Texas Comptroller's office identifies all special purpose districts that employ the sales and use tax. From that data, I compiled the hospital districts and their sales tax rates, as opposed to the property tax use by the vast majority of the other hospital districts.

Table 1:
Hospital District Sales and Use Taxes

Hospital District	Local Rate	Effective Date
Baylor County Hospital District	0.01	1/1/1991
Eastland Memorial Hospital District	0.005	1/1/1994
Ector County Hospital District	0.0075	1/1/1991
McCulloch County Hospital District	0.0025	7/1/1993
Nacogdoches County Hospital District	0.01	7/1/1992
Reeves County Hospital District	0.005	1/1/1991
Rice Hospital District	0.005	10/1/1997
Winnie-Stowell Hospital District	0.0075	1/1/2005

Source: Texas Comptroller of Public Accounts, Special Purpose District Sales and Use Tax: comptroller.texas.gov/taxes/sales/spd.php

[45] Health and Safety Code Chapter 286. Hospital Districts Created by Voter Approval.

Below are the top 10 annual budgets of hospital districts by size of the levy they imposed. These rankings are unsurprising, given property tax values in major metropolitan areas. Subject to further investigation and additional study would be what the projected movement in budget rankings would be if agricultural, ranch, timberland, open-space, and wildlife management lands were taxed at fair market value as opposed to the current scheme of special capacity-based valuation.

Table 2:
Hospital District 2017 Tax Rates and Total Levies

	District Name	2017 tax rate per $100 valuation	2017 Levy
1	Harris County Hospital District	0.171100	$735,217,465
2	Dallas County Hospital District	0.279400	$646,609,832
3	University Health System	0.276235	$433,665,650
4	Tarrant County Hospital District	0.224429	$392,545,531
5	Travis County Hospital District	0.107385	$184,236,987
6	R. E. Thomason General Hospital District	0.251943	$106,062,929
7	Nueces County Hospital District	0.121297	$ 35,005,279
8	Montgomery County Hospital District	0.066400	$ 33,895,890
9	Midland Memorial Hospital District	0.122456	$ 29,746,156
10	Lubbock County Hospital District	0.109778	$ 22,484,824

Source: Texas Comptroller of Public Accounts, Special District Rates and Levies 2017: comptroller.texas.gov/taxes/property-tax/rates/

One solution to this taxbase inequity problem is to seek additional funding from other public sources. To better participate in the federal government's programs and as a mechanism around Texas's decision not to expand Medicaid services, many hospitals

now participate in Local Provider Participation Funds. LPPFs are a voluntary and cooperative tax paid by often competing hospitals in a particular and established health care region.

One element that Medicaid requires to access matching funds is the source of those funds to be matched must originate from local tax dollars. One way to access those matching funds would be to use the state's own Medicaid budget that originated from taxes collected from the state's citizens and businesses. In turn, the state's Medicaid program would then be eligible to receive the matching federal dollars. However, in LPPFs, the taxes come not from citizens paying their income, sales, or property taxes to support a state Medicaid budget, but instead from a tax on the hospitals themselves.

In the LPPF funding model, the hospitals are paying the taxes, not the citizens of the community. By taxing themselves and paying the state those taxes, they are able to recoup additional funds from the State and Federal Medicaid budget. As the ultimate source of the tax money is not defined as ordinary citizens in a community in the Medicaid program, the hospitals in the community can agree to be the source of the tax dollars.

The Texas Senate Research Center notes that a "A county commissioners court is authorized to administer the fund, made up of fees paid by local hospitals. The fund can be utilized to apply for funding for eligible health care projects under the 1115 Waiver with a goal of improving healthcare in the community." The 1115 Waiver, which is the part of the Medicaid program dealing with this funding process, requires local government funds to support these healthcare service projects. Normally, the local

government would take in those taxes from its citizens or businesses writ large, but this funding technique changes that tax base to those hospitals who agree to participate and who themselves already receive payment for those Medicaid services rendered.

The county then completes an intergovernmental transfer payment to the Texas Health and Human Services Commission of those tax monies received. The State of Texas then uses those monies to:

> "(1) fund intergovernmental transfers from the county to the state to provide:
>
> > (A)the nonfederal share of a Medicaid supplemental payment program authorized under the state Medicaid plan, the Texas Healthcare Transformation and Quality Improvement Program waiver issued under Section 1115 of the federal Social Security Act (42 U.S.C. Section 1315), or a successor waiver program authorizing similar Medicaid supplemental payment programs; or
> >
> > (B)payments to Medicaid managed care organizations that are dedicated for payment to hospitals;
>
> (2) subsidize indigent programs;
>
> (3) pay the administrative expenses of the county solely for activities under this chapter;
>
> (4) refund a portion of a mandatory payment collected in error from a paying hospital; and
>
> (5) refund to paying hospitals the proportionate share of money received by the county from HHSC that is not used to fund the nonfederal share of Medicaid supplemental payment program payments."[46]

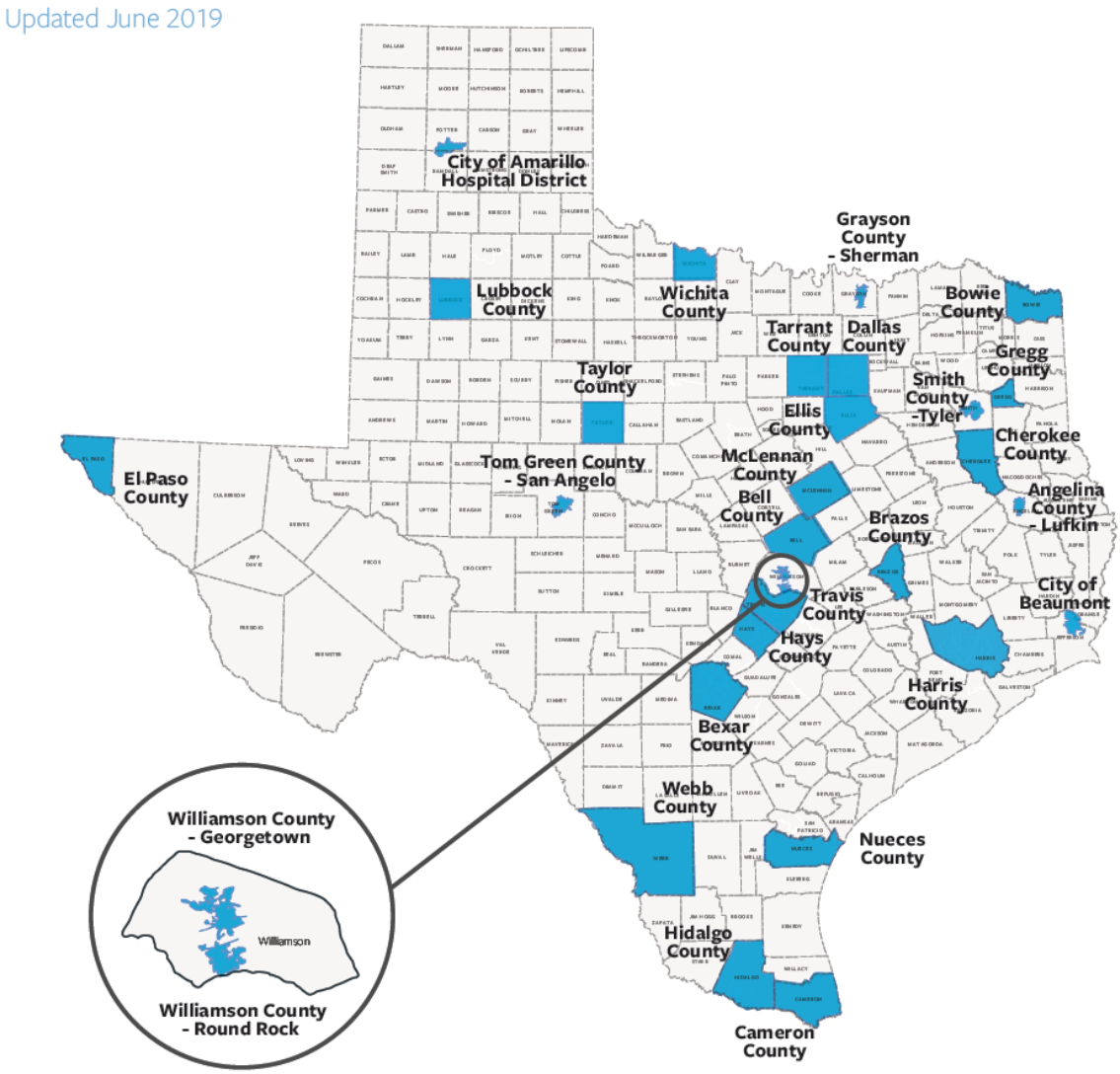
These "taxes" on specific hospitals are simply a vehicle to access federal dollars that previously were unavailable to the state under current Medicaid conditions. Hospitals

[46] Senate Research Center, "Bill Analysis C.S.H.B. 2280."

volunteer to be imposed a tax on their net revenues, not to exceed six percent, so that they can later receive Medicaid dollars that would have been previously unavailable to them. Naturally, hospitals agree to this condition insofar as the Medicaid matching dollars received exceed the local tax disbursed. The matching and reimbursement rates vary, but it is easy to see why a hospital would agree to be locally taxed for one amount with the promise of an even bigger amount received back from the federal program.

As I discuss in the last chapter, some hospital districts participate in LPPF arrangments. Central Health's board has recently voted to express support and interest in the program. So far, there are some 28 cities and/or counties that may participate per Texas Statute. Below is a map of the existing LPPFs as of June 2019, provided by the Texas Hospital Association.

Map C:
Texas LPPFs



Source: Local Provider Participation Funds in Texas, Texas Hospital Association www.tha.org

Chapter 6: Case Study of a Hospital District: Central Health of Travis County

Central Health History

Central Health was established in 2004 as a limited-purpose taxing district that serves as a political subdivision of the State of Texas; it is governed by a nine-member volunteer Board of Managers. The entity was first named the Travis County Hospital District, then the Travis County Healthcare District, then finally Central Health. The Austin City Council and Travis County Commissioners Court each appoints four members to Board of Managers, with a joint appointment from both entities for the ninth member. Board members serve a four-year appointment. Prior to the 2004 referendum to create the "Travis County Hospital District," the City of Austin owned and operated many of the area clinics as well as the local acute care and trauma center known as Brackenridge Hospital. Central Health inherited an established contractual partnership with Seton Healthcare Family to manage and operate Brackenridge Hospital that dates from 1993-4 in a deal brokered by then City Manager Camille Barnett and Assistant City Managers Betty Dunkerley and Jesús Garza. I interviewed Jesús Garza, then an Assistant City Manager and later City Manager, to seek his perspective on this project which will be discussed later.

A significant insight gained from speaking with Jesús Garza is that the City of Austin's decision to partner with Seton was primarily a fiscal concern; from his perspective, it remains an essential financial benefit to the citizens of Travis County. This may be unsurprising, as Garza later served as the Chief Executive Officer for

Seton's statewide ministry. Several accounts indicate that the City of Austin began looking to contract out health services to a third party. The city was compelled to address a financial crisis surrounding an accounting practice that revealed a $21 million cash accounting discrepancy at Brackenridge and $60 million in debt accumulation.[47] The way the institution was accounting played a major factor in the decision to offload operation of Brackenridge. A hospital authority solution was recommended to the city by accounting firm Deloitte & Touche, as their ability to borrow money through revenue bonds could be a way out of the cashflow issue.[48] St. David's hospital system in Austin also was explored as a viable partnership organization but was later disregarded due to their emerging transformation from local non-profit to majority ownership by the Hospital Corporation of America, a for-profit enterprise.

Prior to the partnership with Seton, Brackenridge Hospital was operated essentially as a department of the City of Austin. This presented management and leadership challenges, as hospital and healthcare services are a fundamentally different kind of services with several variant kinds of revenue streams than that of a typical city-managed service. Seton, then just composed of Seton Medical Center Austin and Seton Northwest Hospital, were under the direction of CEO Charles Barnett. Barnett saw an opportunity to expand Seton's Austin footprint and compete for services with the rapidly amalgamating HCA/St. David's system.[49]

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[47] Rodrigues, "City Unveils Lease Plan with Seton."
[48] Luttrell, "Hospital Authority Could Bring Profit to Brack, Report Says."
[49] Barnett, Author's Personal Interview with Charles Barnett, former CEO of Seton Healthcare Family.

Trouble with The Church

Some community stakeholders were troubled by the decision to partner with a Roman Catholic healthcare institution. Seton reduced services it provided women in 2002.[50] These services, which the City of Austin had offered, included access to contraceptive services, tubal ligations, fertility assistance procedures, and vasectomies. The lack of these services at the acute care hospital was answered by moving services to other city-operated clinics, but there was at least the community perception that the services were limited by the Seton-City partnership.

Garza confirmed that vocal stakeholders were concerned about the influence of the Roman Catholic Church on a secular public healthcare entity. This issue highlights one of the risks in associating with partner organizations. After back and forth between Church hierarchy and local Seton theological leadership, Seton was forced to adhere to the Ethical and Religious Directives of the Vatican. These Directives were at least cumbersome to manage and perhaps an insurmountable obstacle to delivering on Central Health's mission to provide the full range of women's health services. The management decision to continue to include Seton as a primary partner in delivering services to the community is complicated by Seton's governing limitations which, in turn forces Central Health to partner with physicians from other local health systems. At one point, two separately licensed hospitals functioned within the one Brackenridge Hospital building, operated by two independent entities to accommodate the Vatican's Ethical and Religious

[50] Wang, "Final Hospital Lease Proposal Criticized."

Directives.[51] This increased bureaucratic and administrative demands, as well as the additional transaction costs with the additional health partners.

Value in Partnership

Nevertheless, the partnership between the City of Austin and Seton for the Brackenridge Campus was still centered on saving money and being able to better contract with physicians. The savings would come from Seton's scale of operations and role in the greater Austin healthcare landscape. As a multi-unit healthcare network with considerable leverage vis-à-vis insurers and physician groups, Seton could operate Brackenridge with the same patients, yet expect higher rates of reimbursement for those services. They also could benefit from their expanded expertise and shared resources among Seton sites. In the words of Garza, Brackenridge would go from being a "pay taker" to a "pay maker."[52] Further helping the financial issues of mounting debts incurred by the City-operated Brackenridge would be Seton's charitable mission.

Seton would come to lease the property from the City and assume management of the Brackenridge Campus. Later criticism of the deal between the City and Seton would center around the value and management of the then city-owned Children's Hospital of Austin, which at the time intended to construct and operate what is now Dell Children's Hospital. In 2002, when Seton announced it would pursue the project of standing up its

[51] Wall, "Conflict and Compromise."

[52] This references to the ability of a healthcare organization to exercise marketplace leverage on insurance companies and physician groups to negotiate better reimbursement rates and lower fees for services provided by the powerful physician groups that tend to operate as trade collectives and cooperatives.

own independent children's hospital, the news shocked many city and hospital district supporting stakeholders. The existing Children's Hospital of Austin was physically attached to and functioned as a profitable cost center of the typically underfunded Brackenridge Hospital. The concern was this: Seton would be competing against one of the few profitable aspects of the Brackenridge Hospital, all the while actively pursuing the creation of the Travis County Hospital District for ongoing tax support.[53] Brackenridge, it was speculated, then would reasonably require more tax money than initially intended to operate, since the robust children's healthcare service lines would lose volume to the newer and bigger children's hospital that Seton created.

Proponents for the creation of a hospital district weathered the children's hospital ordeal, managing to convince Travis County voters that they ought to tax themselves for the support of a hospital district in 2004. Today, the hospital district does business under the branded name Central Health. Central Health continues to build strategic partnerships to expand the scope and services of the new institutions of Dell Medical School and the teaching hospital, Dell Seton Medical Center at The University of Texas. As a part of the "Keep Austin Healthy" initiative that passed in 2012, citizens voted in favor of increasing the tax rate from $0.0779 cents to $0.1239, still well under the statutory rate limits of a hospital district's authority to tax. In FY16, Central Health generated $151.7 million in property taxes at the rate of 11.7781 cents per $100 of property valuation. The relatively recent decision to increase the property tax for the

[53] Smith et al., "The Custody Battle at Brackenridge."

purposes of supporting Central Health and its entering into a partnership with The University of Texas at Austin to form a medical school, demonstrates the public's support of Central Health's mission and their management of their tax funds.[54]

Governance and Finances

Central Health's board serves 4-year volunteer terms and is appointed by the Travis County Commissioner's Court and the Austin City Council. The board of managers must have budgets and tax rates approved by the Travis County Commissioner's Court before they are enacted and collected. Central Health last significantly raised its tax rate by appealing directly to the voters in a bond referendum in 2012 with explicit plans to fund a medical school.

The oversight of the two governing entities over Central Health's operations have increased over time, most recently in November 2016. In response to the concerns of some vocal citizens, the financial oversight of Central Health was increased.[55] Administrative costs to provide for the additional oversight are not yet obvious. To date neither the county nor Central Health has reported any malfeasance or issues deriving from these oversight measures. Nonetheless, Central Health can expect at least continued oversight and perhaps intervention from the county in their programmatic decisions.

[54] Central Health Financial Report 2015, Independent Auditor's Report: http://www.centralhealth.net/wp-content/uploads/2014/08/FY2011%20Audit%20Report.pdf
[55] Marczynski, "Travis County Boosts Financial Oversight of Central Health."

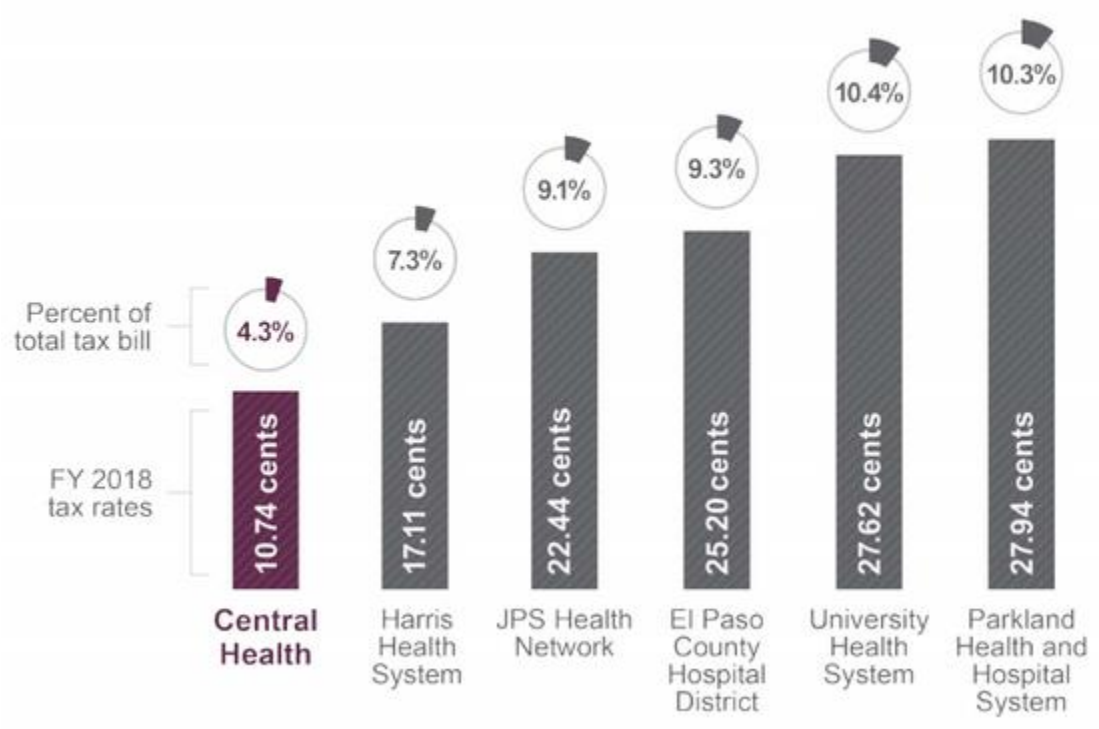
Sendero Health Plans, the Central Health insurance and cost capture partner is an expensive enterprise with Central Health's 2018-19 budgeted support of $26 million.[56] Sendero is among the partners who are most closely aligned with the Central Health hierarchy, since Sendero was created specifically to enroll Central Health clients with a version of health insurance that is funded partially with federal Medicaid dollars. Several current and former Central Health employees serve on Sendero's board.

Central Health maintains one of the lowest tax rates of all major Texas healthcare districts. Central Health is unique in its tax rate limits. Special language was included in an amended statute to keep the new hospital district's rate under 25 cents per 100 dollar valuation. The statute does not specifically refer to Travis County, but no other counties fit the law's outlines for the allowable ballot with "a county with a population of more than 800,000 that is not included in the boundaries of a hospital district before September 1, 2003, shall be printed to provide for voting for or against the proposition: "The creation of a hospital district and the levy of a tax not to exceed 25 cents on each $100 of the taxable value of property taxable by the district." Central Health is quick to boast of their comparison to other major metropolitan health districts, particularly with the graphic below. However, it does not mention that it would be illegal for them to raise taxes to the rates of El Paso, Bexar (University Health System) and Dallas (Parkland Health) counties. The report also fails to outline the contribution of Sendero's indirect support. Thus, such a comparison carries significant caveats. Little or

[56] Buchanan, "Central Health's $258 Million Budget Approved with Funding for Sendero Health Plans | Community Impact Newspaper."

no data is presented for spending per patient or adjusted spending rates for demographic and population health differences between it and other counties.

Figure 1:
Central Health's Published Major Texas Hospital Districts Comparisons



Source: www.centralhealth.net "Major Texas Hospital Districts: FY 2018 Tax Burden Comparisons"

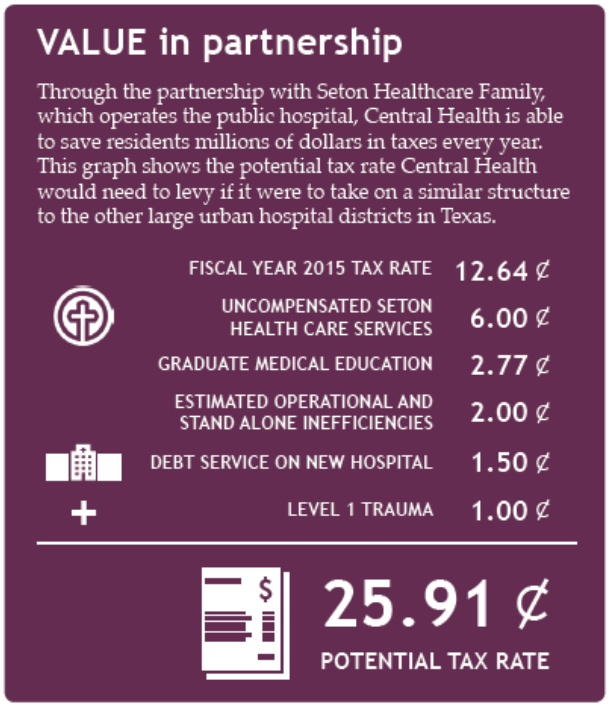
While the rates are well-advertised through Central Health publications as among the lowest, Central Health is fortunate to have one of the most valuable tax bases of any hospital district. Only Dallas and Harris Counties have more appraised value. Even a modest tax rate of 10-12 cents realizes hundreds of millions of dollars in levy. The FY 2019 budget sets a rate at 10.5221 cents per 100 and expects to realize $196,861,527 in property taxes.

Through a network management mechanism that is designed to leverage cost savings, the indigent and underinsured citizens of Travis County still have access to primary care, acute care, critical care, and trauma care services. With a relatively recent bond issuance in 2012 to aid in the construction and operation of the Dell Medical School, Central Health continued to demonstrate strength in its ability to leverage community entities and existing institutions for to advance their legal charge and mission. Though later discussed as a potential threat, the recent agreement between the Dell Medical School, a part of The University of Texas at Austin, and Central Health was heralded by supporters as an innovative and unique approach to delivering healthcare to the local indigent population. The agreement expanded the already comprehensive network of service providers under the Central Health umbrella. The financial strengths of Central Health, at least according to Central Health itself, come largely from the partnership with Seton.[57] This expressed value in Seton's partnership appears unrelated

[57] http://www.centralhealth.net/wp-content/uploads/2015/09/Placemat1_HospitalDistrictComparison.pdf

to Seton itself, but rather the value of any partnering organization in these services and encumbrances. According to external auditors Maxwell Locke & Ritter, Central Health, through its partner organization CommUnityCare (the name of their primary clinic entity) "provided health care services to over 98,900 patients" in 2018.[58]

Figure 2:
Central Health's Published Value in Partnership with Seton



Source: Centralhealth.net "A Comparative Breakdown of Texas' Largest Hospital Districts"[59]

[58] Maxwell Locke & Ritter, "Financial Statements as of and for the Year Ended September 30, 2018 and Independent Auditors' Report."
[59] "Comparative Breakdown of Texas' Largest Hospital Districts."

An essential benefit to partnering with the external non-profit is that Seton is willing to bear uncompensated health care costs. Central Health reports that their tax rate would have to be a full six cents higher to compensate Seton for that care. Here Central Health claims significant cost savings due to Seton's willingness to accept financial loss, which is in conjunction with, but not dependent upon, their obtaining the financial savings from those associated with modern healthcare management and for-profit style cost savings measures. These deferred costs are not necessarily dependent on Seton, as other partnering organizations would bring similar benefit.

The fiscal outlook for Travis County and the taxable values of the healthcare district remain strong with continued growth in commercial and residential development. One of the contributing factors for tax base growth is the increase in population of Travis County, which is predicted to continue to grow by 25 percent between 2010 and 2019.[60] Another recent indicator of financial strength is the credit rating provided by Standard & Poors (S&P) at the behest of the Travis County Commissioners Court's financial oversight initiative. With a AAA/stable rating, Central Health has demonstrated prudent financial management and has good credit to potentially borrow even more capital to fund projects or future partnerships.[61] S&P provides a glimpse into its rating criteria, showing "Institutional Framework" and "Management" representing 30 percent of the consideration. Any known deficiencies in these fields would have had a significant effect

[60] Central Health 2015 Annual Report, http://www.centralhealth.net/wp-content/uploads/2014/07/FY2016-Central-Health-Annual-Report.pdf

[61] 2016 Public Financial Management, Inc. "Travis County Commissioners' Court Central Health Credit & Liquidity Discussion Testimony provided to TCCC"

on their credit rating. Central Health achieved the highest possible rating which indicates that this third-party independent set of experts agree that the management structure and the institutional framework are robust and well suited for their operations.

Another significant strength Central Health can boast is the level of capital projects recently completed. Through partnership with Seton Healthcare Family, the residents of Travis County have ready access to the new Dell Seton Medical Center at the University of Texas which opened to patients on May 21, 2017.[62] Central Health considers the plethora of agreements among the various care delivery partners as part of their "Integrated Delivery System" (IDS). As a function of the enhanced services offered by the Dell Medical School and Dell Seton Medical Center, Central Health has issued contractually obligated meetings among the entities at least quarterly to "communicate regarding the operations of each Party under this Agreement and to discuss and evaluate how the Parties may more effectively coordinate the obligations, mission, and goals of all the Parties under this Agreement." Further, "Each of the Parties, in good faith, shall take the recommendations of the Joint Affiliated Committee into account in coordinating their missions and operations so as to benefit the IDS, medical education, research, and patient care in Travis County."[63]

[62] http://www.centralhealth.net/about-us/community-health-partners/

[63] http://www.centralhealth.net/wp-content/uploads/2014/07/UT-Austin-CH-and-CCC-Affiliation-Agreement-Fully-Executed.pdf

Oversight Opportunities

Nevertheless, Central Health could do more to maintain robust contractual accountability of their health delivery partners. One suggestion may be to create or partner with a firm strictly in charge of reviewing the integrity of contractual agreements and the accountability measures built into those contracts. A structure such as an Inspector General or the Government Accountability Office could be employed at a smaller scale. So far, only marginal demand for this level of oversight is evident from the community, but with the apparently ever-growing network of partner organizations, it may be prudent to consider the application of a partially independent accountability structure. Central Health operates as a composition of several partner organizations that function through Central Health's governance and financing scope of control. Attempts to transform the accountability of the work being done for and by the subordinate and partner entities has resulted from of public pressure and complaint on the continued support of the Dell Medical School's operations. Public criticism exists of the strategic and financial partnership between Central Health and the Dell Medical School being too opaque and perhaps illegal. Publication of the Central Health/University of Texas Affiliation agreement seems to be an apparent response to the criticism brought forward from the attorney Fred Lewis. A petition for judgement has been filed on behalf of three citizens of Travis County seeking relief from "the illegal expenditure of funds by Central Health…."[64] The cause seeks a judgement that declares Central Health "may expend

[64] Birch, Franklin, III, and Govea v. Travis County Healthcare District.

funds only on: (1) items related to the furnishing of medical aid and/or hospital care to indigent and financially needy persons residing in Travis County; and (2) a statutorily authorized purpose such as those enumerated in Chapter 61 of the Texas Health and Safety Code."[65]

Central Health now publishes an annual report of the expenses for which the $35 million of tax money is spent through Medical School, as detailed in the list published below. The table is meant to convey that the annual $35 million is but a portion of the overall operational budgets of the categorized programs. Beyond the Affiliation Agreement, Central Health also publishes routine demographic reports, the master agreements with Ascension Seton, 1115 waiver information, budget and financial reports, and a vision for their 14-acre downtown Brackenridge Campus via their website.

[65] Birch, Franklin, III, and Govea v. Travis County Healthcare District.

Table 3:
Published Central Health Allocation to Dell Medical School and Estimated Expenses

Domain	Planned CCC Allocation for FY 2019	FY 2019 Estimated Minimum Expenditure
Women's Health	$5.0M	$7.8M
Surgery	$4.7M	$7.3M
Internal Medicine	$3.6M	$5.4M
LIVESTRONG Cancer Institutes	No Allocation	$4.8M
Neurology	No Allocation	$6.6M
Psychiatry	No Allocation	$6.0M
Population Health	$4.0M	$6.6M
Pediatrics	$2.6M	$5.0M
Diagnostic Medicine	$400K	($18M investment in equip to-date)
Clinical Practice Operations	$2.5M	$5.6M
Clinical Space Expenses	$2.3M	$9.8M
Medical Education	$4.3M	$10.0M
Dean's Office (new leaders)	$1.2M	$4.3M
Information Technology for Care	$1.0M	$2.75M
Business Office	$700K	$6.0M
Research Operations	$800K	$1.3M
Health Ecosystem (new programs)	$800K	$2.7M
Value Institute	$400K	$1.8M
Design Institute for Health	$400K	$2.5M
Student Scholarships	No Allocation	TBD
Development	No Allocation	TBD
Communications	No Allocation	TBD
Total	**$35M**	**TBD**

Source: Centralhealth.net “Dell-Meds-Support-for-CH-Mission.pdf”

While I cautiously suggest that additional partnerships considering the plenitude of existing structures for Central Health, more work is required to be done to mitigate upstream causes of indigent medical issues and indeed poverty itself. Some minor contractual changes may include standards for partner groups to directly hire the indigent population. Central Health has a vision and mission aimed at serving the medical needs of the indigent but expanding that mission and vision to address root causes of indigence could be a way to decrease demand for their services over time.

One change to benefit the operational structure of the organization may be to appeal to patients that are better able to pay for the healthcare services that Central Health and its partners offer. Akin to the financing structure of many non-profit hospitals and healthcare networks, Central Health could start to seek out a more lucrative payer mix. The ubiquitous healthcare industry phrase "no margin, no mission" typically applies to an institution that must seek a margin of profit to continue the organization's mission. While Central Health does not typically seek much or any payment from its patients, perhaps placement of their clinics in economically liminal spaces could attract patients from a wider variety of economic situations and could help subsidize their operations.

As noted, public criticism exists for the strategic and financial partnership between Central Health and the Dell Medical School. To some degree, such public critique motivated Central Health to publish the Central Health/University of Texas Affiliation agreement. This apparently responds the criticism brought forward from the concerned citizens and attorneys Bob Ozer and Fred Lewis. Beyond the Affiliation

Agreement,[66] one can also review "the Vision for the Development of Transformative Medical Education and Health Care Services in Travis County." [67]

However, the catastrophic failure of partner organizations poses potentially serious, though unlikely, threats to the operations and viability of Central Health. By placing so much of the actual healthcare service delivery in the hands of external organizations, the financial or operational failure of Seton or the Dell Medical School would have significantly affect Central Health. Each of these entities face funding struggles, face the consequences of ever-rising healthcare costs. Most problematically, they each face the destabilizing uncertainty in the government reimbursement packages in an environment of highly dynamic national and state-specific healthcare financing reforms and changes. Central Health is particularly vulnerable to the changes in the Medicare 1115 waiver in which Texas participates, and the commensurate amount of funded matching local dollars raised by the district. The Tobacco Master Settlement dollars end in 2025, which will have an approximately $2.5 million annual loss for Central Health's funding resources.

Since Central Health is very limited in its ability to recover costs for services rendered to its mission-driven and legally obliged patient population, they obviously are exposed to loss of funding risks. A real-estate market collapse would pose severe challenges to the organization's operation. A loss of market value would alter

[66] "The University of Texas at Austin, Central Health, and Community Care Collaborative Affiliation Agreement."
[67] Central Health, "Vision for the Development of Transformative Medical Education and Health Care Services in Travis County."

fundamentally the ability to deliver care at the current tax rate. The legal agreements among Seton, Central Health, and Dell Medical School all have contingency clauses in the event of financial failure of any of the institutions: this clearly indicates at least an awareness of the possibility of catastrophic failure. A notable change to real estate values would usher in a host of other economic challenges as well.

Finally, another threat to Central Health's intentions might be shifts in activism on the City Council or County Commissioners court. Either entity may stack the volunteer board with members who are politically aligned with the dynamic governing entities. An uncooperative Commissioners Court could block tax increases to appease the generally wealthier unincorporated county residents and shield them from city residents externalizing their own costs to the rural and suburban communities. For instance, City Council approval nearly derailed when a single council member threatened to block an intended building project with Texas Capitol building view rules.[68] As mentioned, a major financial strength is Central Health's ownership of the 14-acre plot in downtown Austin where the vacant Brackenridge Hospital Campus sits, but their planning and development authority is not absolute. As the Council can limit the height of buildings in the downtown area by extending the imaginary planes outward from the Capitol building in distances and vectors of their choosing.

The voters of Travis County invested in their community's health by supporting the creation of Central Health. With a network management approach to service

[68] Anderson, "Will New Capital View Corridors Affect Brackenridge Redevelopment?"

delivery, Central Health depends on the performance of several partnering organizations. Each decision to partner or contract services to external entities comes with it a trade-off of direct control over clinical decisions, outcomes, and costs. Those costs are ultimately accountable to taxpayers who generally benefit from transparency, but that transparency can be clouded by complex network management agreements.

Central Health evolved from an existing partnership between a city-owned hospital and a private non-profit healthcare organization. Now the entire county government and city government have a role in the healthcare decisions that directly affect its poorest residents. Through the hospital district governance and funding structure, a perpetual funding source and citizen and official oversight mechanisms now exist where only an under-resourced city department existed before.

Chapter 7: Conclusion

Hospital districts provide a direct connection between a community and its healthcare. Over time, their structures and operations have adapted to the individual political and cultural differences of their communities. Whether their boards are directly elected by voters, or appointed by officials who are elected by voters, the hospital district gives their community a voice and a stake in an important local institution.

The districts are not immune to national and state healthcare economic and financial trends. As healthcare organizations grow and consolidate, so too are hospital districts tempted to partner with large multi-state healthcare companies. As property taxes are the historical and constitutional mechanism for the vast majority of hospital districts to fund their operations, later tax law changes leave property taxing districts in an uncomfortable and sometimes untenable position. The hospital district was initially designed to be a way for disparate rural communities to invest in their community's growth and health. But the dependence on property taxes that were shifted from one value to another with the state's movement away from fair market value and toward productive valuation undercut the rural community's ability to grow, prosper, and invest like their urban and suburban counterparts.

Ultimately, local property taxes are just one source of funding for local hospitals and other healthcare services in Texas. Changes to the taxing abilities of the districts require constitutional amendments, so quick adjustments to policy and practice are possible but unlikely. State laws could change to demand peer comparison models and uniform public reporting to improve transparency and outcomes of the districts. As

national and state healthcare policy seem to change constantly, the Texas hospital district remains a relatively static institution that in many ways remains identical to its earliest designs from the 1950s.

Appendix:
Hospital District Names and their 2017 Tax Rates

District Name	2017 Tax Rate Per $100 Valuation
Andrews County Hospital District	0.499110
Angleton-Danbury Memorial Medical Center	0.273681
Anson Hospital District	0.384036
Ballinger Memorial Hospital District	0.246950
Baylor County Hospital District	0.200000
Bellville Hospital District	0.058180
Big Bend Regional Hospital District	0.241600
Booker Hospital District	0.749993
Burleson Memorial Hospital District	0.094760
Caprock Hospital District	0.110500
Castro County Hospital District	0.356000
Chambers County Public Hospital District #1	0.534234
Childress County Hospital District	0.200000
Chillicothe Hospital District	0.891600
Cochran County Memorial Hospital District	0.558600
Coleman Hospital District	0.350000
Collingsworth General Hospital District	0.552939
Comanche County Consolidated Hospital District	0.378882
Concho County Hospital District	0.289800
Crane County Hospital District	0.367760
Crosby County Hospital District	0.146700
Culberson County Hospital District	0.183734
Dallam-Hartley Counties Hospital District	0.350000
Dallas County Hospital District	0.279400
Darrouzett Hospital District	0.550120
Dawson County Hospital District	0.457517
Deaf Smith County Hospital District	0.332504
DeWitt Medical District #1	0.212370
Dimmit County Regional Hospital District	0.070000

Donley County Hospital District	0.175054
East Coke County Hospital District	0.454868
Eastland Memorial Hospital District	0.059700
Ector County Hospital District	0.117920
Electra Hospital District	0.350000
Fairfield Hospital District	0.226080
Farwell Hospital District	0.027700
Fisher County Hospital District	0.279012
Foard County Hospital District	0.318705
Follett Hospital District	0.068200
Frio Hospital District	0.265430
Gainesville Hospital District	0.111300
Garza County Hospital District	0.164900
Gonzales County Hospital District	0.340000
Graham Hospital District	0.388478
Grapeland Hospital District	0.009640
Hall County Hospital District	0.156460
Hamilton Hospital District	0.162600
Hamlin Hospital District	0.481614
Hansford County Hospital District	0.500000
Harris County Hospital District	0.171100
Haskell Hospital District	0.250000
Heart of Texas Memorial Hospital District	0.117750
Hemphill County Hospital District	0.310763
Higgins/Lipscomb Hospital District	0.016780
Hopkins County Hospital District	0.250000
Houston County Hospital District	0.151876
Hunt Co Memorial Hospital District	0.241580
Hutchinson County Hospital District	0.099903
Iraan General Hospital District	0.458400
Jack County Hospital District	0.295000
Jackson County Hospital District	0.249500
Karnes County Hospital District	0.117180
Kimble County Hospital District	0.353500
Knox County Hospital District	0.367230
Lavaca County Hospital District	0.097200
Liberty County Hospital District #1	0.090000
Lockney General Hospital District	0.527550

Lubbock County Hospital District	0.109778
Lynn County Hospital District	0.289922
Marion County Hospital District	0.044550
Martin County Hospital District	0.272000
Matagorda County Hospital District	0.320960
Maverick County Hospital District	0.120245
McCamey Hospital District	0.750000
Medina County Hospital District	0.064400
Menard County Hospital District	0.540000
Midland Memorial Hospital District	0.122456
Mitchell County Hospital District	0.378334
Montgomery County Hospital District	0.066400
Moore County Hospital District	0.619929
Motley County Hospital District	0.143000
Moulton Community Medical Clinic District	0.037700
Muenster Hospital District	0.188700
Muleshoe Area Hospital District	0.800000
Nixon Hospital District	0.041200
Nocona Hospital District	0.168200
Nolan Co Hospital District	0.403970
North Runnels Hospital District	0.415600
North Wheeler County Hospital District	0.355543
Nueces County Hospital District	0.121297
Ochiltree County Hospital District	0.388583
Olney-Hamilton Hospital District	0.500000
Palo Pinto Hospital District	0.334000
Parker County Hospital District	0.111520
Parmer County Hospital District	0.254500
Quanah Hospital District	0.275839
R. E. Thomason General Hospital District	0.251943
Rankin Hospital District	0.257880
Reagan County Hospital District	0.397270
Reeves County Hospital District	0.240000
Refugio County Memorial Hospital District	0.305200
Rice Hospital District	0.175000
Sabine County Hospital District	0.202791
San Augustine County Hospital District	0.110000
Schleicher County Hospital District	0.750000

Scurry County Hospital District	0.292002
Seminole Memorial Hospital District	0.435809
Shackelford County Hospital District	0.196800
Somervell County Hospital District	0.146869
South Limestone Hospital District	0.312000
South Randall County Hospital District	0.070000
South Wheeler County Hospital District	0.671590
Stamford Hospital District	0.869800
Starr County Memorial Hospital District	0.268163
Stephens County Hospital District	0.239880
Stonewall County Hospital District	0.742692
Stratford Hospital District	0.332751
Sutton County Hospital District	0.240624
Sweeny Hospital District	0.516523
Swisher County Memorial Hospital District	0.339479
Tarrant County Hospital District	0.224429
Teague Hospital District	0.050000
Terry County Memorial Hospital District	0.300000
Texhoma Hospital District	0.010687
Titus County Memorial Hospital District	0.206900
Travis County Hospital District	0.107385
Trinity Memorial Hospital District	0.123200
Tyler County Hospital District	0.208460
University Health System	0.276235
Val Verde County Hospital District	0.107700
Walker County Hospital District	0.125400
West Coke County Hospital District	0.249923
West Wharton County Hospital District	0.203910
Wilbarger General Hospital District	0.160466
Willacy County Hospital District	0.038280
Wilson County Hospital District	0.119700
Winkler County Hospital District	0.280000
Wood County Central Hospital District	0.019500
Yoakum Hospital District	0.650400

District Name	**2017 Sales and Use Tax**
Baylor County Hospital District	$ 0.0100
Eastland Memorial Hospital District	$ 0.0050

Ector County Hospital District	$	0.0075
McCulloch County Hospital District	$	0.0025
Nacogdoches County Hospital District	$	0.0100
Reeves County Hospital District	$	0.0050
Rice Hospital District	$	0.0050
Winnie-Stowell Hospital District	$	0.0075

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