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City of Laredo Health Assessment

January 13, 2023

TABLE OF CONTENTS

EXECUTIVE SUMMARY

In February 2022, the City of Laredo issued a Request for Proposal for professional consulting services to assess healthcare facilities and services in Laredo, including the local healthcare workforce; and to identify opportunities to create a new hospital district or municipal hospital authority. In July 2022, the City selected Health Management Associates (HMA) to perform the assessment and feasibility study, and in August 2022, the City and HMA executed a contract for the services.

The assessment included quantitative and qualitative analyses of state and federal data sources, benchmarking the numbers of clinicians of different specialties and facility capacity in Laredo against other similar communities and statewide proportions, and identifying where Laredo has fewer professionals or less facility capacity per capita. The assessment also included a site visit during which HMA consultants toured and met with the leadership of local healthcare facilities. With input from local healthcare stakeholders, we focused our analysis on primary care, pediatrics, cardiology, neurology, and endocrinology. Based on these different analytic approaches, we confirmed the perception that Laredo had shortages of almost all physician specialties. In addition to shortages of certain physician specialties, nurse staffing was identified as an ongoing challenge.

We also reviewed and summarized various authorities, obligations, and characteristics of municipal hospital authorities and hospital districts, two types of local government entities that communities can create to provide or support hospital services. Hospital districts are much more common in the Texas healthcare ecosystem than municipal hospital authorities. There are 84 hospital districts in the state, but only eight municipal hospital authorities. Hospital districts, unlike municipal hospital authorities, have a property tax authority. Another key difference is that hospital districts must be created by a popular election, whereas the vote of a local governing body may create municipal hospital authorities. When a county creates a hospital district, the hospital district takes on the responsibility for providing indigent care from the county and typically does so by owning and administering a public hospital or contracting with one or more private hospitals to provide services to this population.

Through our research, we identified several strategies for recruiting healthcare professionals, largely relevant for physicians and nurses, including financial incentives such as signing bonuses and loan repayment, and non-financial tactics such as work schedule flexibility. We also reviewed local healthcare workforce training programs and identified opportunities for expanding the local production of healthcare professionals, particularly nurses. A common theme during our interviews with local stakeholders was the lack of inpatient psychiatric capacity. Our analysis included the development of a financial model for inpatient psychiatric services that could be part of a larger package of healthcare financing.

Through our research, we validated the perception that Laredo is medically underserved and identified opportunities for bringing the healthcare services capacity in Laredo up to levels found in similar communities. However, since many of the strategies we identified will require coordination and funding, one or more local organizations will need to take the lead on implementing these strategies, and local stakeholders will need to identify funding mechanisms.

SECTION 1- LOCAL HEALTHCARE SERVICES

As part of more considerable city-wide improvement planning efforts, the City of Laredo Public Health Department commissioned a comprehensive health assessment to identify and prioritize Laredo's healthcare service needs and develop sustainable, viable recommendations.

This health services assessment describes the healthcare infrastructure and workforce in and around Laredo. It outlines Laredo's healthcare landscape, catalogs existing facilities and services, and identifies health priorities and gaps. Subsequently, this information may inform decisions and guide efforts to improve community health and wellness unique to the healthcare needs of Laredo's residents - including committing resources to those areas, thereby making the most significant impact possible on community health status. Specifically, the assessment examines the following:

- Current and projected outpatient ambulatory services (e.g., federally qualified health centers, public health clinics)
- Current health system community health needs assessment/strategic plans
- Current and projected deficits in care and health disparities
- Impact and response to COVID-19
- Healthcare workforce and forecasted future needs

HMA conducted this assessment, the largest consulting firm in the US, and has focused exclusively on healthcare since 1985.

Methodology

HMA's methodology includes incorporating data from both quantitative and qualitative sources. Qualitative data input includes primary research documented through key stakeholder interviews and site visits. Quantitative data input includes secondary research (vital statistics and other existing health-related data) to allow for trending and comparison to benchmark state and national data. This assessment draws from the latest available data from external sources:

- The Texas Department of State Health Services
- Centers for Disease Control and Prevention (CDC) databases
- Health Resources and Services Administration (HRSA) databases
- Torch Insight database and analytic tool (a proprietary data platform developed by Leavitt Partners and subsequently sold to Milliman before HMA acquired Leavitt Partners)
- County Health Rankings
- Texas Medical Board
- The latest available data from local providers that opted to share internal sources such as service quality measures and utilization.

Key Stakeholder Interview Summary

HMA conducted site visits at six major healthcare providers in Laredo with Border Region Behavioral Health Center, City of Laredo Health Department, Doctors Hospital of Laredo, Gateway Community Health Center, Laredo Medical Center, and Laredo Specialty and Rehabilitation Hospitals. Leadership staff from each provider offered their experiences working across the healthcare continuum and provided a broad understanding of Laredo's community needs and opportunities for improvement.

Below is a consolidation of themes organized by strengths, weaknesses, opportunities, and threats (SWOT) to inform a structured analysis as outlined in Table 1.

Table 1: Key Stakeholder SWOT

STRENGTHS	**WEAKNESSES**
• [Limited] High-quality level of care • Resiliency through crises (e.g., COVID) • Effective coordination efforts connecting patients to services that address social needs • Strong partnerships and collaborations with academic institutions	• A broad range of healthcare services was difficult for Medicaid and uninsured patients to access, including assisted living supports • Specialty care shortages, especially in cardiology, endocrinology, and psychiatry • Limited ambulatory transportation services • No inpatient psychiatric capacity
OPPORTUNITIES	**THREATS**
• Strengthen partnerships among providers to leverage resources and improve access • Increase preventative care • Address stigma for mental health services • Increase community health worker's efforts to bolster health literacy in high-risk communities • Provide transportation services for individuals	• Physician and medical professional recruitment barriers • Untenable unmet needs for mental health and substance use services for all ages • Long wait times for psychiatric care, mammograms, and public health services (6+ weeks on average)

Laredo Today

As the nation's largest inland port, Laredo continues to be one of the fastest-growing cities in the US and serves as the port of entry for more than $210 billion in international trade with Mexico.[1] Laredo's sister city, Nuevo Laredo, is on the other side of the Rio Grande River, across from Laredo, with a population of 425,058 as of 2020. It is the largest port of entry on the Mexico-United States border, and tariff and customs collections are more significant than any other customs office in the Republic of Mexico.

Figure 1: Laredo City Limits

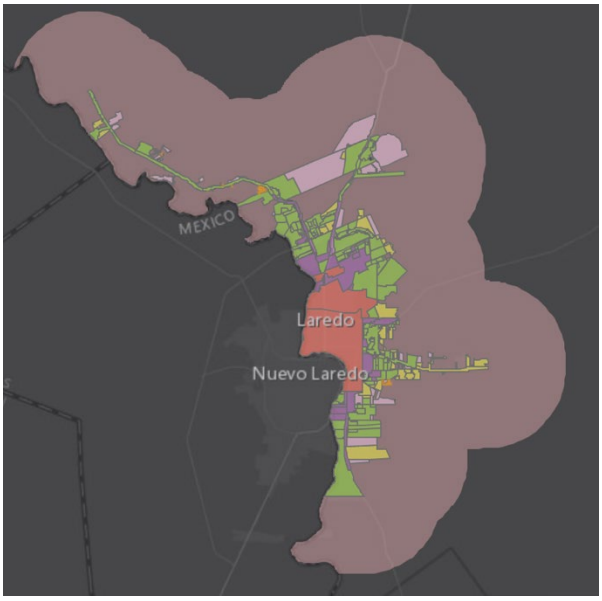
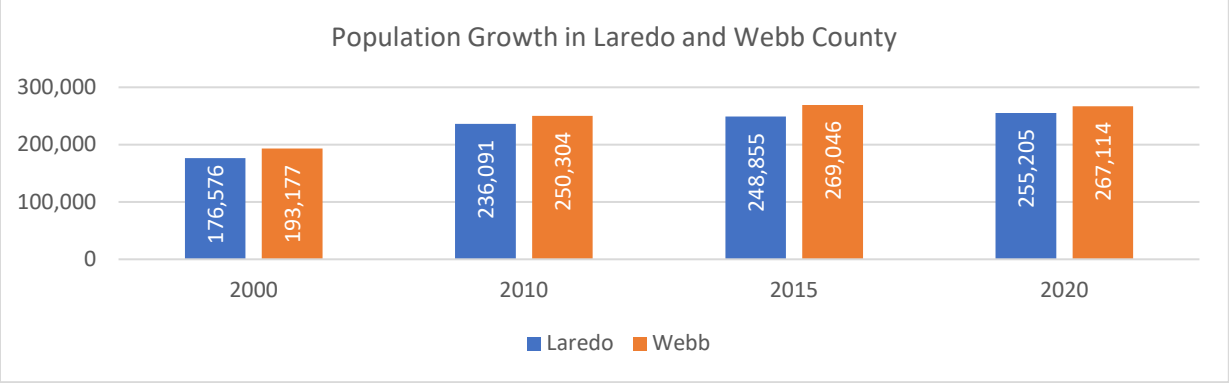


Figure 1 shows Laredo's city limits, annexation tracts, and extraterritorial jurisdiction. *The porous nature of these two cities creates a dynamic of interrelated social, cultural, and economic communities.* Additional city characteristics include high poverty and unemployment levels, high uninsured and underinsured, and high prevalence of high-risk health factors (diabetes, obesity, heart disease).

Defined Geographic Area

Laredo (256,153) comprises 95 percent of Webb County's population (267,114). The remaining population lives in surrounding rural areas.[2] Laredo's most populous zip codes – 78040, 78041, 70842, and 78043 – represent the primary service area in this assessment. Chart 1 shows the population growth trends in Laredo and Webb County throughout the last 20 years.

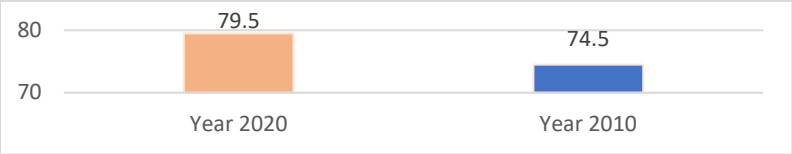
Chart 1: Population Growth in Laredo and Webb County from 2000-2020



[1] https://www.laredoedc.org/site-selection/internationaltrade/#:~:text=The%20Port%20of%20Laredo%20is,Bureau%20data%20analyzed%20by%20WorldCity
[2] American Community Survey

Geography

Chart 2: Population Per Sq. Mile Comparison | 2020 Census



Population Demographics

Table 2 is a demographic comparison for Laredo, Webb County, and Texas. Laredo's largely homogenous population self-identifies as white (81%) and ethnically Hispanic (96%). Laredo's population is notably younger (ages 0-17) than the Texas average by more than 10%.

Table 2: Texas Demographics | 2019 Census Reporter Population Estimate Characteristics

		Laredo	%	Webb County	%	Texas	%
Gender	Male	125,050	49.0%	132,221	49.5%	14,385,762	50.0%
	Female	130,155	51.0%	134,893	50.5%	14,610,119	50.0%
Age Group	0-17	83,962	32.9%	87,881	32.9%	7,396,631	22.0%
	18-64	147,508	57.8%	154,125	57.7%	17,860,52	62.0%
	65+	23,734	9.3%	25,109	9.4%	3,738,727	13.0%
Race/ Ethnicity	White	206,716	81.0%	260,436	97.5%	11,929,56	98.0%
	Black	1,276	0.5%	2,137	0.8%	3,442,881	12.0%
	Am. Indian	510	0.2%	1,603	0.6%	77,748	0.3%
	Asian	1,276	0.5%	1,603	0.6%	1,430,236	5.0%
	Pacific Islander	51	0.02%	53	0.02%	21,484	0.1%
	Hispanic	243,721	95.5%	254,827	95.4%	11,524,84	40.0%
Total Population		**255,205**		**267,114**		**28,995,881**	

Immigration

Due to its proximity to the Mexico border and reluctance to disclose information accounted for in U.S. Census data (possibly due to legal status and implications associated with changing political climate and citizenship policies), population totals are likely to be misrepresented. Foreign-born individuals account for 26% in Webb County, compared to 13.5% in the US.[3] Approximately several hundred thousand Temporary Protected Status beneficiaries (who are not technically unauthorized) in the US were excluded from the legally resident immigrant population because population estimates data are unavailable.[4]

Culture and Language

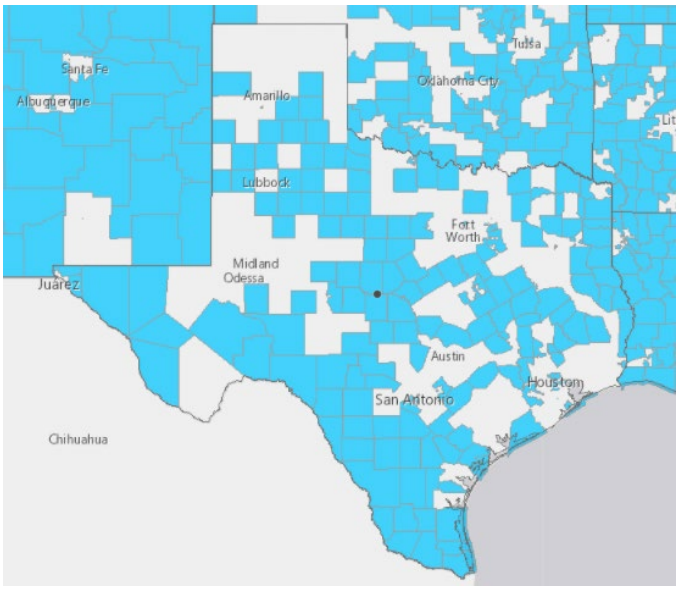
The US Census Bureau ACS 2019 survey shows 86% of residents over the age of five speak a language other than English at home, and only 14% are English-only speakers in Webb County and Laredo.[5]

[3] https://www.census.gov/quickfacts/fact/table/webbcountytexas,US/PST045221
[4] https://www.dhs.gov/immigration-statistics/population-estimates/unauthorized-resident
[5]https://data.census.gov/cedsci/table?q=DP02&g=0600000US4847992145_1600000US4841464&tid=ACSDP1Y2021.DP02

Health Factors

Medically Underserved Area

Figure 2: Texas Medically Underserved Areas



The Health Resources and Services Administration (HRSA) developed a mapping system to identify and designate Medically Underserved Areas (MUAs) and Health Professional Shortage Areas (HPSAs). MUAs are geographic areas and populations with a lack of access to primary care services, high infant mortality, high poverty, and a high elderly population. Medically Underserved Populations (MUPs) are specific populations that may face barriers to health care. Examples include people experiencing homelessness, people who are eligible for Medicaid, and Native Americans.

Figure 2 indicates designated MUA/Ps (blue clusters) in Texas during 2020 and highlights areas where healthcare services are needed.[6] MUA designation is based on an Index of Medical Underservice (IMU) score between 0-100, 0 being wholly underserved and 100 being least underserved. An IMU of 62 or quantifies MUA designation.[7] The score is a sum of the weighted values of:

1. The ratio of primary medical care physicians per 1,000 population
2. Infant Mortality Rate
3. Percentage of the population with incomes below the poverty level
4. Percentage of the population age 65 or over

Laredo was designated an MUA in 2019, scoring 54 out of 100.[8]

Health Professional Shortage

A Health Professional Shortage Area (HPSA) is a geographic area, population, or facility severely lacking primary care, dental, or mental health providers. The areas receive a score between 0-25 for primary and mental health and 0-26 for dental, with 25/26 being the highest degree of shortage.[9] Table 8 on page 23 shows Webb County's current HPSA scores for primary care (14), mental health (18), and dental services for low-income populations (19).[10] The Texas Department of State Health Services studied the supply and demand of healthcare workers in Texas and released its latest report in 2020. The criterion to identify critical shortages in Region 11 was a projected FTE deficit greater than 100. Projections show that every

[6] https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation
[7] Texas Shortage Designation Guide 2022
[8] https://data.hrsa.gov/tools/shortage-area/mua-find
[9] Texas Shortage Designation Guide 2022
[10] https://data.hrsa.gov/tools/shortage-area/mua-find

state region will have physician specialty shortages over the next ten years. Those shortages vary by region.[11] Region 11 may also face critical shortages of physicians specializing in anesthesiology, family medicine, pediatrics, and psychiatry.

Social Determinants of Health

County Health Rankings & Roadmaps rank population health in US counties based on various markers. Length and quality of life determine health outcomes. The ranking is based on health outcomes and factors, comprising over 30 measures. Webb County ranks 75 of 254 counties.[12] Webb County ranks 29 in Texas for the length of life and 185 for quality of life.

Four factors, shown in Table 3, determine ***quality of life***. Webb County has a 10% greater population reporting poor or fair physical health than Texas and twice that of top US performers. Webb County has more reported poor mental health days weekly than Texas or top US performers. Webb ranked 185 out of 254 Texas counties for quality of life.

Table 3: Quality of Life in Webb County | County Health Rankings, 2022

Category	Webb County	Top U.S Performers	Texas	Rank of 254 Texas Counties
Poor or fair health	34%	15%	21%	16
Poor physical health days	5	3.4	3.6	25
Poor mental health days	4.5	4	3.9	167
Low birth weight	8%	6%	8%	127

Table 4 below shows cancer and heart disease as the leading causes of death in Webb County.

Table 4: Webb County Leading Causes of Death |County Health Rankings, 2022

Leading Causes of Death Under Age 75	Deaths	Age-Adjusted Rate per 100,000
Malignant neoplasms	512	72
Diseases of heart	419	59
COVID-19	298	42
Accidents	208	28
Diabetes mellitus	164	23

There are four ***health factors***: health behaviors, clinical care, social and economic factors, and physical environment. Webb County health factor rating was 225 of 244 Texas counties, ranking second to last in physical environment and low in social and economic factors and clinical care.

[11] https://www.dshs.state.tx.us/legislative/2020-Reports/TexasPhysicianSupplyDemandProjections-2018-2032.pdf
[12] https://www.countyhealthrankings.org/explore-health-rankings/our-methods/rankings-overview

Education

Chart 3: Webb County vs. TX Academic Profile for Age 25 and Over |2021 Census Data Estimates

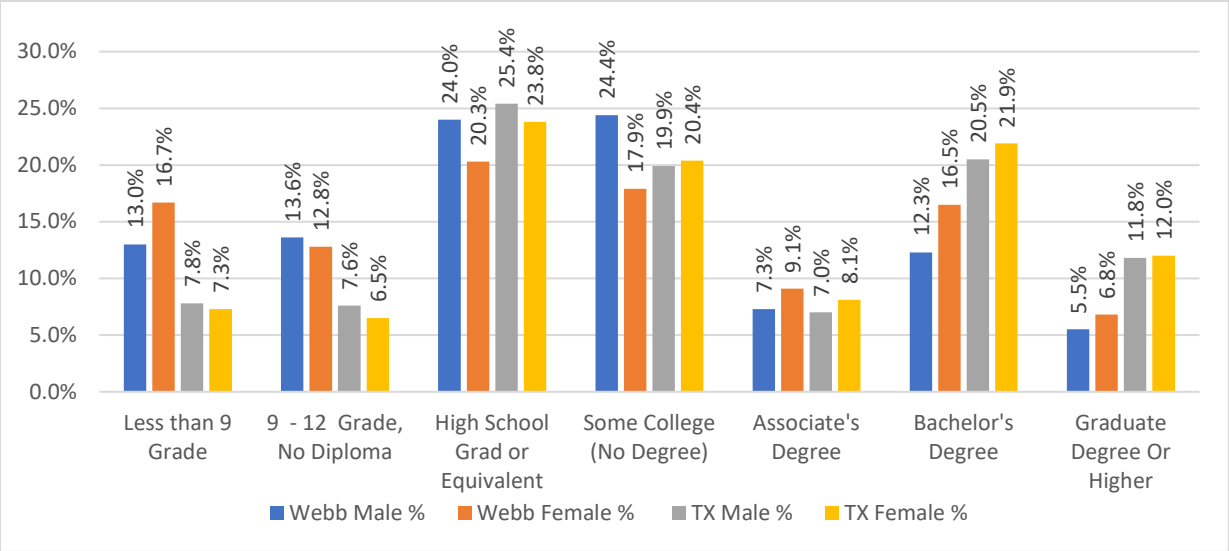
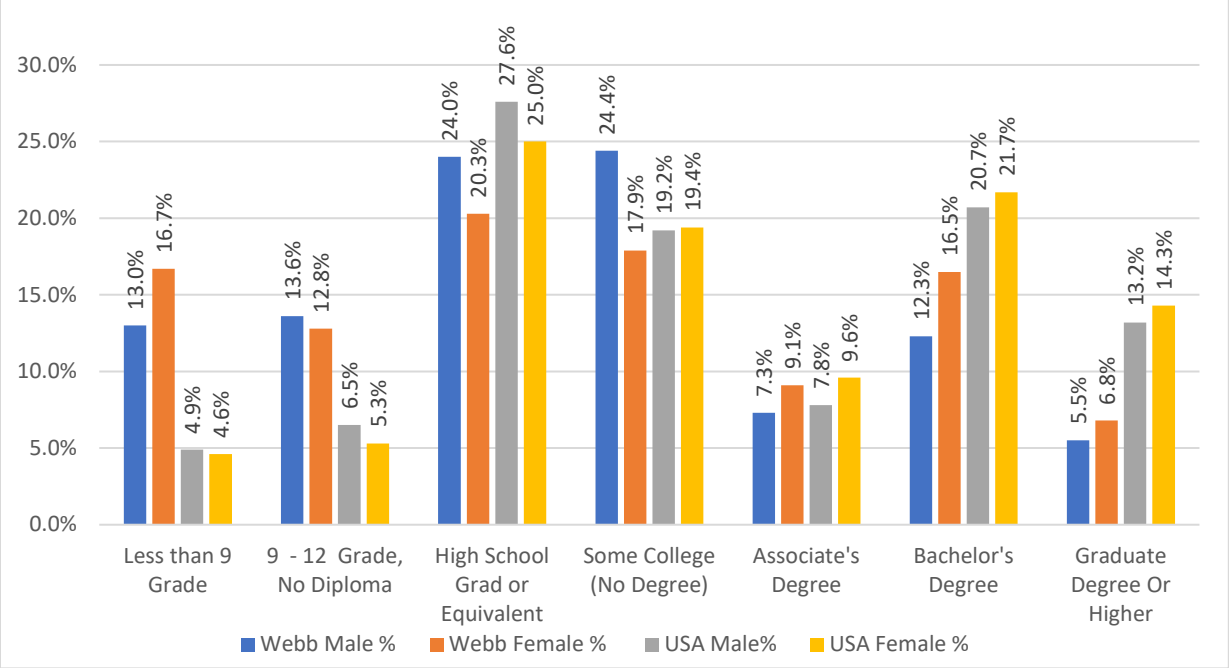


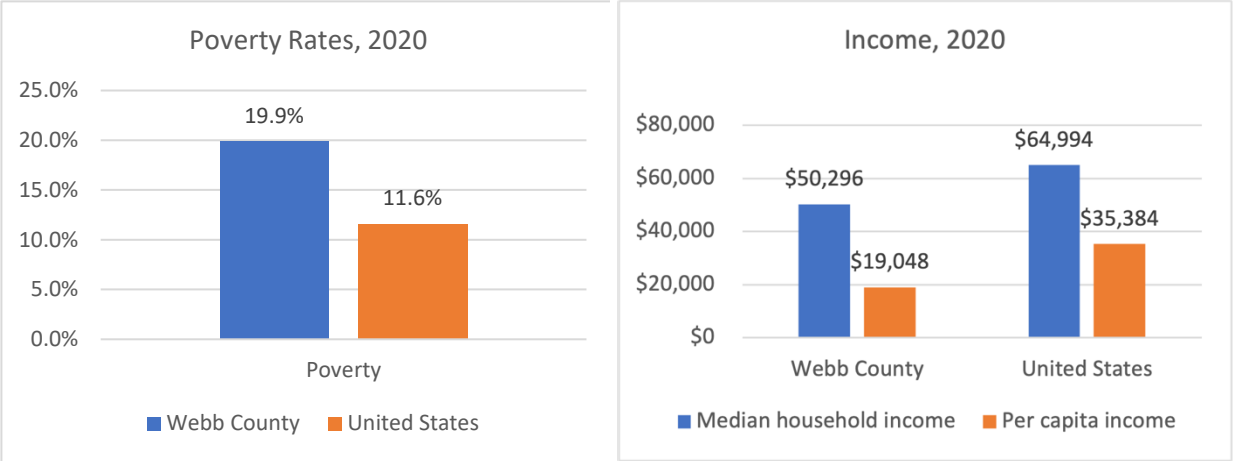
Chart 4: Webb County vs. USA Academic Profile for Age 25 and above |2021 Census Data Estimates



INCOME AND POVERTY RATES

Webb County employment rates (61%) are comparable to the US (63%), with a 5% lower unemployment rate for females.[13] Webb County has a high poverty rate (20%) compared to US rates (12%). Median household income is $14,698 less than the US, and per capita income is $16,336 less than the US rate.

Chart 5: Income and Poverty Rates comparison Webb County vs. the United States |2020 Census Data



PHYSICAL ENVIRONMENT

Pollution in Laredo is a major health factor for long-term health. An article by the Texas Tribune identified a commercial sterilizer in Laredo that operates 24 hours a day, seven days a week, and emits the most toxic air pollution in the US. The pollutant ethylene oxide is the most toxic the EPA regulates and contributes to most of the excess cancer risk caused by industrial air pollutants in the US. The impact of ethylene oxide may already be evident in Laredo. A cluster study found a particular cancer in the area associated with ethylene oxide exposure was significantly greater than expected.[14]

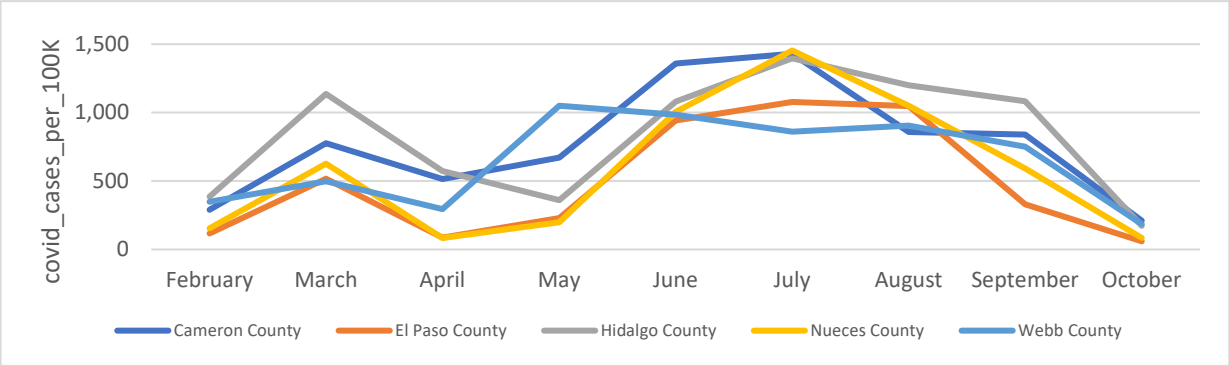
Ethylene oxide is especially harmful to children, and this plant is near an elementary school. The air toxin is 30 times more carcinogenic for those who continuously inhale it as adults and 50 times more carcinogenic for those who inhale it since birth. The chemical is especially harmful to children as their bodies cannot mend the genetic damage as well as adults. The plant's proximity to an elementary school and its harmful effects on children pose a serious health risk.

[13] 2020 Census Data
[14] https://www.texastribune.org/2021/12/27/laredo-texas-ethylene-oxide/

COVID-19

Laredo experienced a total of 107,705 reported COVID cases and 1,061 reported deaths. The highest rate of COVID cases was May 2022, when cases skyrocketed after a gradual increase since late March.

Chart 6: 2022 COVID-19 Trends County Comparison | CDC COVID Data Tracker



In January 2021, almost half of the region's hospital capacity was COVID patients, the state's highest percentage.[15] Webb County also has high rates of underlying health conditions such as obesity, diabetes, and hypertension. These conditions are known to exacerbate COVID complications.[16]

COVID-19 VACCINATIONS

As of October 26, 2022, 899,724 COVID vaccines had been administered in Webb County.[17] Over 99% of Webb County is vaccinated, like many Texas border counties such as El Paso, Cameron, and Hidalgo County. However, 99.9% of all age groups are vaccinated in Webb and Starr Counties. Pharmacies, public health/government, and medical clinics/doctor's offices administered most vaccinations.

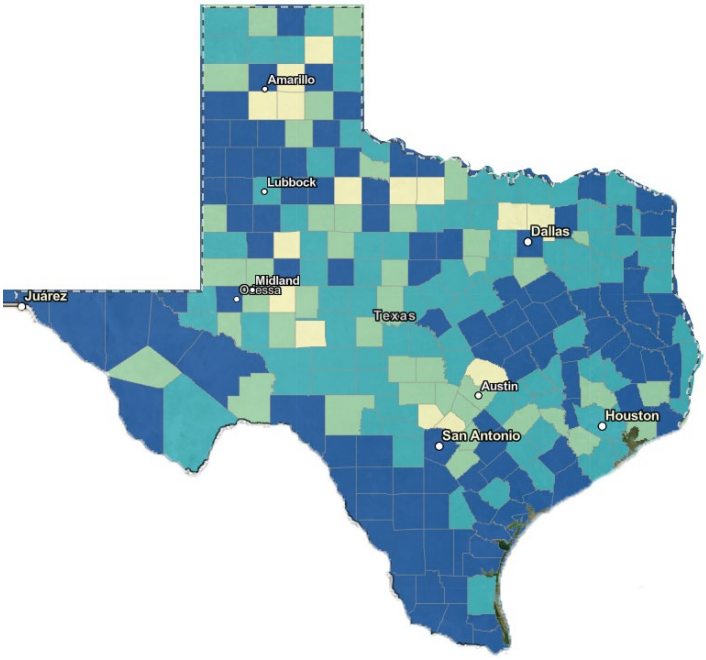
While vaccination rates are high now, Webb County faced difficulty receiving vaccines in early 2021. Online vaccination appointments filled up within nine minutes in early January 2021 and vaccination lines for the first dose extended six miles.[18]

[15] https://www.texastribune.org/2022/02/18/texas-border-laredo-covid/
[16] https://www.hopkinsmedicine.org/health/conditions-and-diseases/coronavirus/coronavirus-and-covid19-who-is-at-higher-risk
[17]https://tabexternal.dshs.texas.gov/t/THD/views/COVIDVaccineinTexasDashboard/VaccineDosesAdministered?%3Aorigin=card_share_link&%3Aembed=y&%3AisGuestRedirectFromVizportal=y
[18] https://www.texastribune.org/2021/02/03/laredo-next-steps-coronavirus/

Social Vulnerability Index

The places of our lives – our homes, workplaces, schools, parks, and houses of worship – affect the quality of our health and influence our experience with disease and well-being. Social vulnerability indexes are a relative measure of the impact of these community-level factors on well-being. Figure 3 is the CDC's geospatial determinates of health - Social Vulnerability Index, which is based on 15 social factors, including poverty, lack of vehicle access, and crowded housing.[19] Possible scores range from 0 (lowest vulnerability) to one (highest vulnerability). The dark blue areas represent the highest vulnerability. Some of the highest rankings are along the Texas – Mexico border.

Figure 3: CDC Geospatial Determinants of Health



Cameron- 0.9723
Dimmit- 1
Duval- 0.9486
Hidalgo- 0.9881
Jim Hogg- 0.9091
McMullen- 0.6047
La Salle – 0.7826
Starr - 0.9802
Zavala- 0.9051
Zapata- 0.996
Webb- 0.9605[20]

[19] https://www.atsdr.cdc.gov/placeandhealth/svi/index.html
[20] https://www.atsdr.cdc.gov/placeandhealth/svi/interactive_map.html

Health Insurance

Alarmingly, about one-third of Webb County's population (32%) is uninsured, compared to Texas (20%) and national (10%) rates, according to CMS. Texas has the most significant percentage of uninsurance in the US, and the highest uninsurance rates are along the border.[21,22] Groups with an increased likelihood of uninsurance in Texas include:[23]

- Adults aged 19-34: 32% of adults aged 19-34 are uninsured, the highest of all age groups
- Hispanics: Hispanics make up 61% of the total uninsured; 27% of the overall Hispanic population has the highest rate of any race/ethnicity
- Adults with a high school education or less: Approximately 70% of the uninsured in Texas have a high school education or less; 48% of adults with less than a high school education are uninsured
- Citizenship: 54% of non-citizens are uninsured; Those in a family with at least one non-citizen are 36% likely to be uninsured
- Poverty: People with income below 200 percent of the poverty level[24]

Table 5: Insurance Status | 2020 Census, Texas HHS, CMS

Population	Webb County		Texas		National	
	Count	Percentage	Count	Percentage	Count	Percentage
Medicaid	84,000	32%	5,174,224	18%	79,436,046	24%
Uninsured	76,127	29%	5,799,955	20%	30,581,074	9%
> 150% of FPL	85,330	32%	10,121,633	35%	101,279,97	31%
Uninsured and > 150% FPL	91,353	34%	3,037,605	10%	15,292,036	5%
Disability (> age 65)	20,292	0.1%	2,159,445	7%	32,659,407	10%
Medicare	34,314	13%	4,435,562	15%	63,964,675	19%

Quality of Life and Health Trends

These indicators contribute to a population's overall health. Webb County's health trends demonstrate a higher-than-average distress level for citizens in their physical and mental well-being. The high prevalence of diabetes (18%) likely contributes to the high mortality during the pandemic. *Webb County had more than twice as COVID deaths per 100,000 as Texas and almost three times as the US.*

[21]https://census.gov/quickfacts/fact/table/webbcountytexas,US/PST045221
[22] https://www.census.gov/data-tools/demo/sahie/#/expandedMap?s_statefips=48&s_agecat=0&s_year=2020&s_searchtype=sc
[23] https://www.urban.org/sites/default/files/publication/99498/uninsured_in_texas_2.pdf
[24]https://www.texmed.org/Uninsured_in_Texas/#:~:text=Texas%20is%20the%20uninsured%20capital%20of%20the%20United,and%20delivery%20of%20health%20care%20to%20all%20Texans.

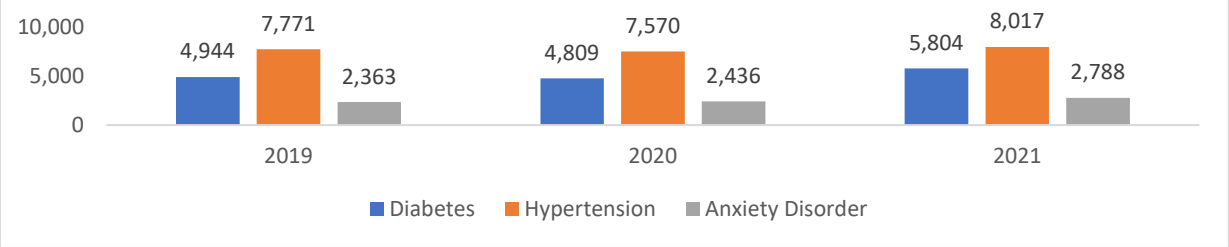
Table 6: Quality of Life Indicators | County Health Rankings, 2022

Category	Webb County	Texas	U.S.
COVID-19 age-adjusted mortality	237	105	85
Life expectancy	79	78	78.5
Premature age-adjusted mortality	360	360	360
Child mortality	40	50	50
Infant mortality	5	6	6
Frequent physical distress	17%	11%	12%
Frequent mental distress	15%	12%	14%
Diabetes prevalence	18%	12%	9%

Chronic Health Conditions

A Community Needs Assessment conducted by Gateway Community Health identifies the top three patient diagnoses recorded in 2019-21: hypertension (7,771), diabetes (5,804), and anxiety disorder (2,788).[25] Both diabetes and anxiety disorder diagnoses increased by approximately 17% from 2019 to 2021. The greatest increase was diabetes, with 860 cases.

Chart 7: 2019-2021 Top 3 Diagnoses at Gateway Community Health Center | 2021 Gateway Needs Assessment



Diabetes

Diabetes is the most prevalent healthcare condition in Webb County, affecting 23% of the population.[26] In 2016, Webb had about 51 hospital admissions for uncontrolled diabetes per 100,000 population. Webb County had the highest rate among Nueces (35), El Paso (33), and Cameron (48) and came second to Hidalgo (62). Webb also had a high rate of amputations among patients with diabetes at 42 per 100,000 population, well above the state average of 31. Amputation rate in Webb was higher than El Paso (20), equal to Hidalgo (42), and lower than Nueces (45) and Cameron (47). However, the average cost of each amputation in Webb County was $214,300, much higher than the state average ($123,857), Cameron ($148,804), El Paso ($118,183), Hidalgo ($135,518), and Nueces ($134,442) County.[27]

[25] 2021 Gateway Community Needs Assessment
[26] CDC Behavioral Risk Factor Surveillance System, 2018
[27] https://www.dshs.state.tx.us/thcic/publications/hospitals/PQIReport2016/Preventable-Hospitalizations-and-Prevention-Quality-Indicators/

Table 7: Texas counties 2016 Diabetes Hospitalization Ages 18 and Older | Texas Health Care Information Collection

	Uncontrollable Diabetes Hospitalizations, 2016	Amputations for Patients with Diabetes, 2016		
County	**Admission Rate per 100K Population**	**Mean charge per admission**	**Admission Rate per 100K**	**Mean charge per admission**
Cameron	48	$42,712	46	$148,804
El Paso	33	$24,698	20	$118,183
Hidalgo	62	$34,955	42	$135,518
Nueces	35	$38,054	45	$134,442
Webb	50	$35,341	42	$214,300
State Average	40	$33,534	31	$123,857

Heart Disease and Stroke

The average estimated total cardiovascular disease hospitalization rate for Medicare beneficiaries in Webb County was 56 per 1,000 in 2017-2019.[28] While this is lower than the state (61) and national (61) rates, much of Web County are uninsured and below the age of 65.

The average estimated stroke death rate for ages 35+ in Web County was higher in Hispanics (75.5 per 1,000) than for white non-Hispanics (56 per 1,000) in 2017-2019. Similarly, stroke death rates are higher than the national average for all races (73). Compared to Nueces, Cameron, and Hidalgo County, Webb has the most individuals who have had a stroke (3%).

Mental Health and Substance Use Disorders

Substance use and mental health (behavioral health) needs have been and continue to grow in Laredo, including co-occurring mental illness and substance use disorder (SUD).[2,3] Research shows that over 60 percent of adolescents in community-based substance use disorder treatment programs are diagnosed with a mental illness. Participants ages varied evenly between the age of 30-60+. [4] Most participants were unemployed, not looking for work (312), had less than a high school education (505), and had a household income between $0-$9,999 (487).

Psychiatric patients admitted to an emergency department face long wait times for admission to a psychiatric facility. Emergency departments are not designed or equipped for psychiatric treatment, and psychiatric patients often experience worse health outcomes in the ED. Not only do patients fare worse in the ED, but it is far more expensive. It costs the ED more and prevents other patients from utilizing the ED. Inpatient psychiatric patients remain in the ED 3.2 times longer than non-psychiatric patients resulting in an average cost of $2,250 per patient bed.[29] In addition to higher, long stays waiting for appropriate placements.

[28] CDC Interactive Atlas of Heart Disease and Stroke
[29] The Impact of Boarding Psychiatric Patients on the Emergency Department: Scope, Impact and Proposed Solutions

The top five mental health and substance use (MHSU) diagnoses in ED visits for Texas resulting in an inpatient admission are:[30]

1. Alcohol-related disorder
2. Depressive disorders
3. Schizophrenia spectrum and psychotic disorders
4. Bipolar and related disorders
5. Trauma and stressor-related disorders

Most patients utilizing the ED for MHSU needs were uninsured (29%) and between 18-44 years of age (51%) in 2020.[31]

Figure 4: MHSU Visits by Payer Status | Texas DSHS

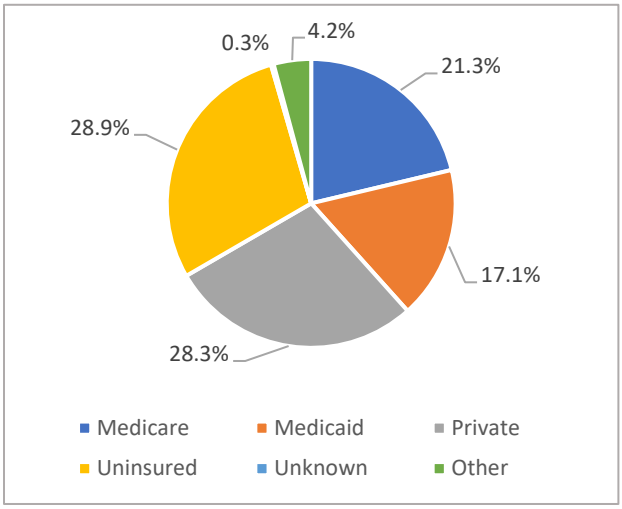
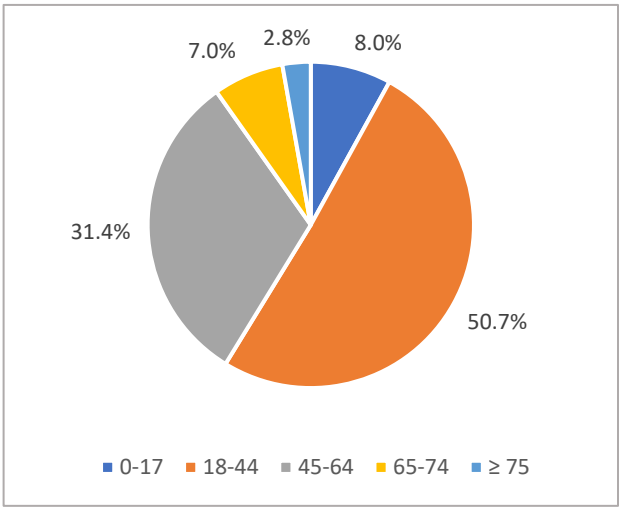
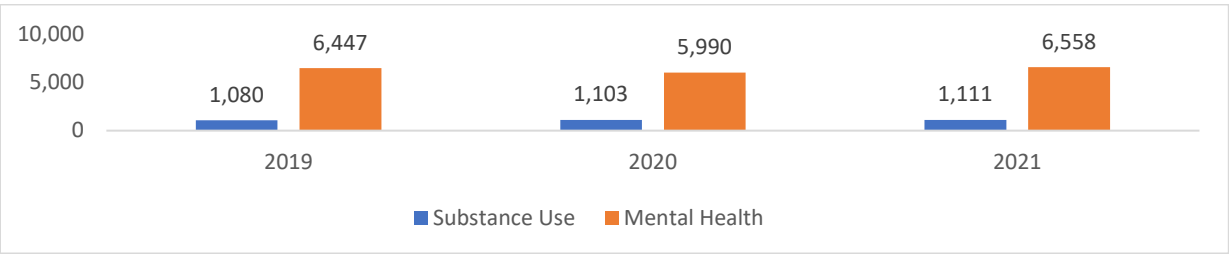


Figure 5: MHSU Visits by Age Group | Texas DSHS



A report developed by Gateway Community Health Center (see more about Gateway on pg. 29) shows the growing diagnoses for behavioral health services in the last three years.[32] A decrease in diagnoses for 2020 results from fewer people seeking healthcare services during COVID. Volume will grow as patients return to clinics.

Chart 8: Behavioral Health Diagnoses | 2021 Gateway Community Needs Assessment



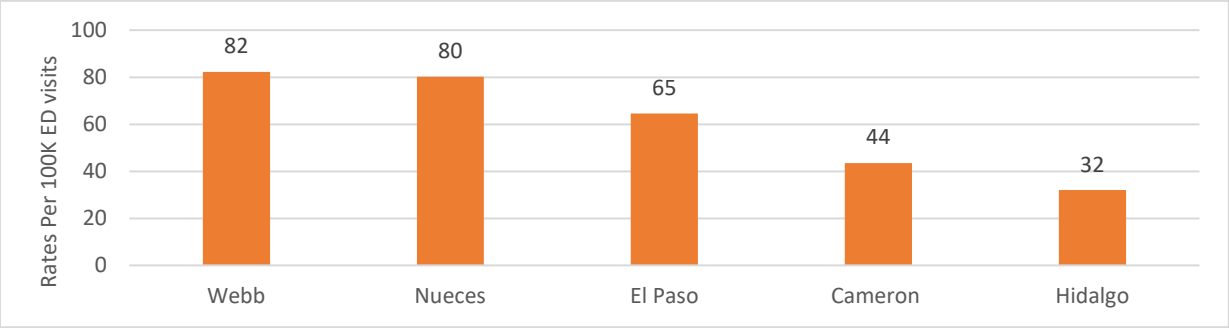
[30] Texas DSHS Hospital Emergency Department Data Collection 2020
[31] Texas DSHS Hospital Emergency Department Data Collection 2020
[32] 2021 Gateway Community Needs Assessment

People with SUD frequently have one or more associated chronic health conditions such as heart disease, stroke, cancer, or mental health. Clinical comorbidities for Texas MHSU ED visits include hypertension, diabetes, heart failure, depression, and asthma. *In 2020, hypertension accounted for most comorbidities (50%).*

Inhalants negatively affect the nervous system, and intravenous drug use increases the risk of contracting infectious diseases such as HIV and hepatitis C.[33] *HIV cases have been increasing in Webb County from 299 cases in 2010 to 483 cases in 2019, a 61% increase.*[34]

Opioid use in Webb County accounts for many ED visits relative to nearby counties. In 2021, there were 82 opioid-related visits for every 100,000 ED visits.[35]

Chart 9: Opioid-Related Emergencies by County |Texas DSHS Health

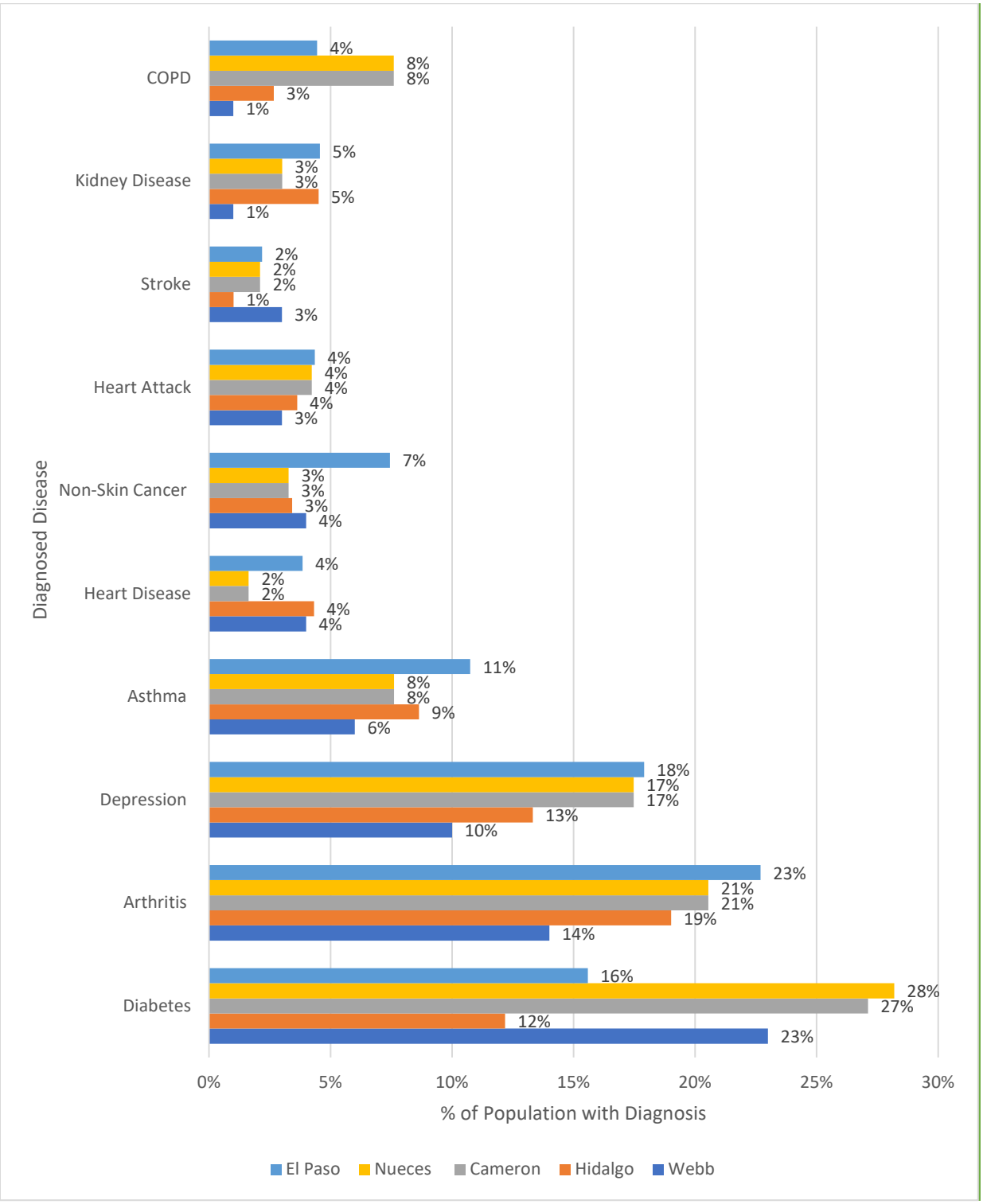


[33] https://nida.nih.gov/publications/drugs-brains-behavior-science-addiction/addiction-health
[34] https://healthdata.dshs.texas.gov/dashboard/diseases/people-living-with-hiv
[35] https://healthdata.dshs.texas.gov/dashboard/drugs-and-alcohol/opioids/opioid-related-emergency-department-visits

Chronic Health Conditions and Disparities

Chart 10 compares Laredo's general health statistics with four counties along the region.

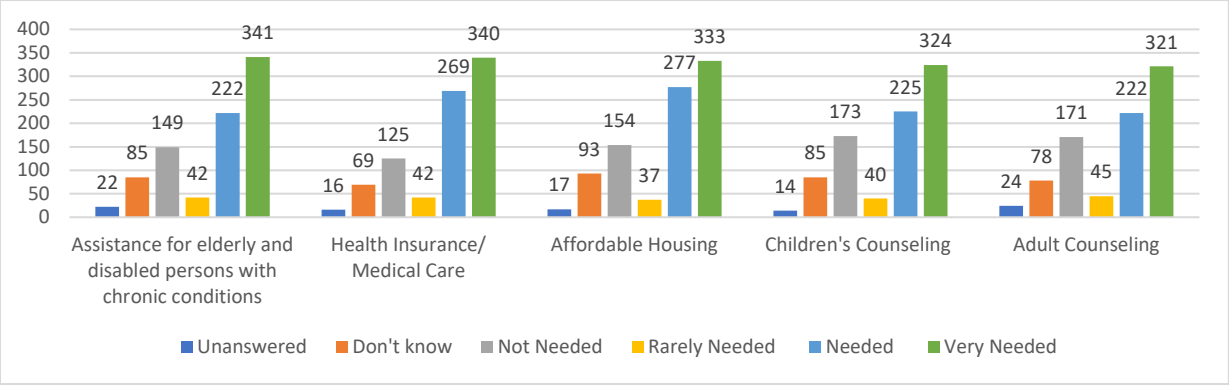
Chart 10: Top Health Conditions in Five Texas Counties, 2018 | Torch Insights & CDC



COMMUNITY NEEDS

A 2018 Webb County Community Action Agency Needs Assessment found that of 25 community needs, the one with the second-most votes of "Very Needed" was Health Insurance/Medical Care with 340 votes. Prescription assistance was also mostly reported as "Needed" or "Very Needed," with 267 "Very Needed" and 291 "Needed" votes. Chart 11 shows the top five community needs based on reported needs.

Chart 11: Top Five Webb County Community Needs | 2018 WCCAA Community Needs Assessment



Major gaps in service included:[36]

1. Inpatient program for people with substance use disorders
2. Mobile crisis units for mental health services, to include adults, seniors, and children
3. Lack of or reduced funding for social service agencies

The report also found various barriers facing low-income families, including:[37]

1. Not having access to insurance, including dental and pharmaceutical services
2. Not earning a living wage
3. Not having access to prenatal care
4. Affordable vocational programs so they can secure gainful employment

[36]WCCAA Community Needs Assessment 2018
[37] WCCAA Community Needs Assessment 2018

Healthcare Provider Capacity

There is a substantial medical service capacity gap and need in Webb County. Webb County is currently short 20 full-time employees (FTE) primary care providers, 30 FTE dentists for low-income populations, and 11 FTE mental health providers. Column (HPSA FTE Short) in Figure 16 indicates the number of FTE providers Webb County needs to meet provider-to-population ratio needs adequately. All designations were formulated in 2019 and updated in 2021.[38] Note that psychiatrists are the only designated mental health providers (as opposed to counselors and other professionals) for HPSA designation in Texas.[39]

(Note: This section includes data on the number of physicians of different specialties from the Texas Medical Board who identified Webb County as their practice location. In some cases, these physicians may not reside in the county but rather provide services via telemedicine through a single facility, which they list as their practice location.)

Table 8: Webb County Health Professional Shortages

Discipline	HPSA Name	Designation Type	County Name	HPSA FTE Short	HPSA Score
Primary Care	Webb County	Geographic HPSA	Webb County	20	14
Dental Health	LI-Webb County	Low-Income Population HPSA	Webb County	30	19
Mental Health (psychiatrist)	Webb County	Geographic HPSA	Webb County	11	18

Laredo ranked last across the US in provider supply. Laredo has almost twice the population-to-provider ratio for PCPs and dentists. Mental health provider shortage is greater, nearly three times the Texas average. Webb County and US provider ratios are in Table 9.[40] This shortage will grow based on a projected 2% annual increase in primary care service demand through 2029.[41]

Table 9: Population to Clinical Care Provider Ratio | County Health Rankings, 2022

Clinical Care Provider	Webb County	Texas	US
Primary Care Physicians	3,290:1	1,630:1	1,310:1
Dentists	3,120:1	1,660:1	1,400:1
Mental Health Providers	2,550:1	760:1	350:1

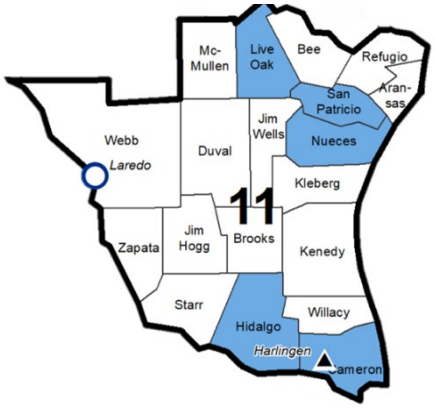
[38] https://data.hrsa.gov/tools/shortage-area/mua-find
[39] Texas Shortage Designation Guide 2022
[40] https://www.countyhealthrankings.org/app/texas/2022/rankings/webb/county/outcomes/overall/snapshot
[41] https://www.trillianthealth.com/insights/the-compass/geographic-analysis-reveals-mismatch-in-supply-of-and-demand-for-behavioral-health-providers-and-primary-care-physicians

Regional Supply and Demand Projections

Region 11 is one of eight public health regions classified by The Texas Department of State Health Services (DSHS). Region 11 serves a 19-county area in south Texas. Webb County is in Region 11, along with Hidalgo, Cameron, and Nueces County.[42]

DSHS periodically produces supply and demand projections for different categories of health professionals across the state's public health regions. Most of our analysis included below is based on comparisons between the relative number of health professionals in Webb County, other border counties in the state, and statewide ratios. The DSHS supply and demand projections below are for Region 11, not just Webb County.

Figure 4: Public Health Region 11 | Texas DSHS



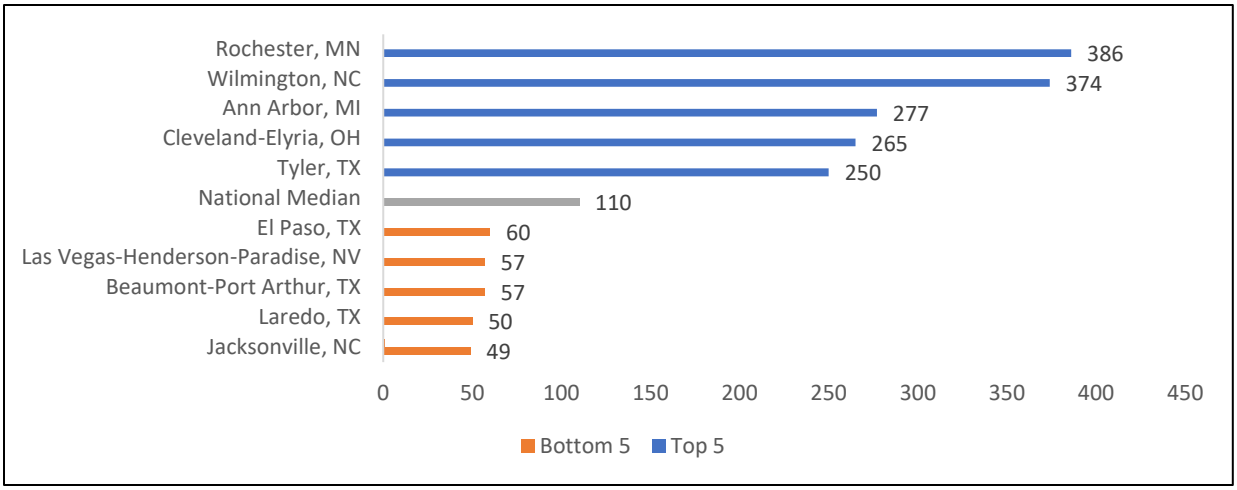
Primary Care

A 2022 geographic analysis ranks Webb County in the bottom 15 counties nationwide for primary care physicians per 100,000 population. Laredo ranked second to last in primary care physicians across all US cities, with a population of at least 200,000.[43] Region 11 is expected to have the greatest shortages, with PCP demand growing from 423 to 722, a 70% increase in shortage by 2030.[44]

Webb County has the most disproportionately low number of physicians, nurse practitioners (NPs), and nursing professionals.

[42]https://www.dshs.texas.gov/region11/default.shtm
[43] https://www.trillianthealth.com/insights/the-compass/geographic-analysis-reveals-mismatch-in-supply-of-and-demand-for-behavioral-health-providers-and-primary-care-physicians
[44] Texas Projections of Supply and Demand for Primary Care Physicians and Psychiatrists, 2017-2030

Figure 5: Top and Bottom 5 US Cities for Primary Care Physicians per 100K Population | Trilliant Health, 2022



Specialty Care

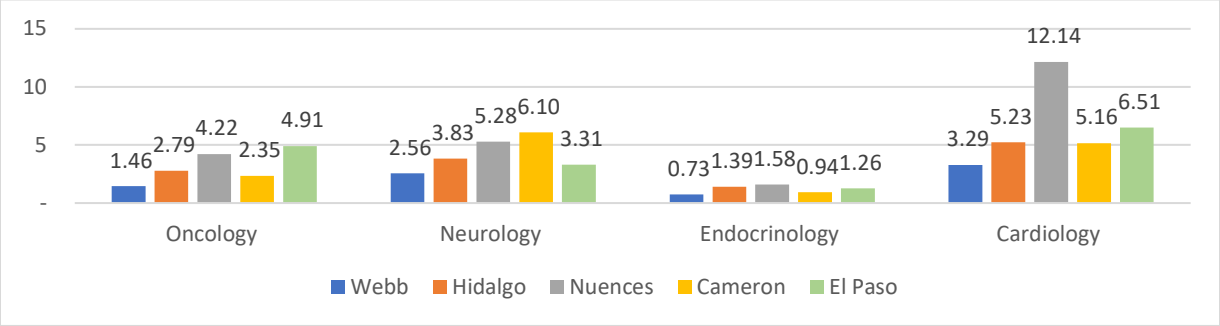
Specialty care in Webb County lags compared to similar counties in Texas despite the great need for specialty care. Table 9 shows Webb County has the least amount of specialty physicians in oncology, psychiatry, endocrinology, psychiatry, and cardiology.

Table 10: Specialty Care Providers in Five Texas Counties | Texas DSHS Health Data

	Oncology	Neurology	Endocrinology	Cardiology
Webb	4	7	2	9
Hidalgo	24	33	12	45
Nueces	16	20	6	46
Cameron	10	26	4	22
El Paso	43	29	11	57

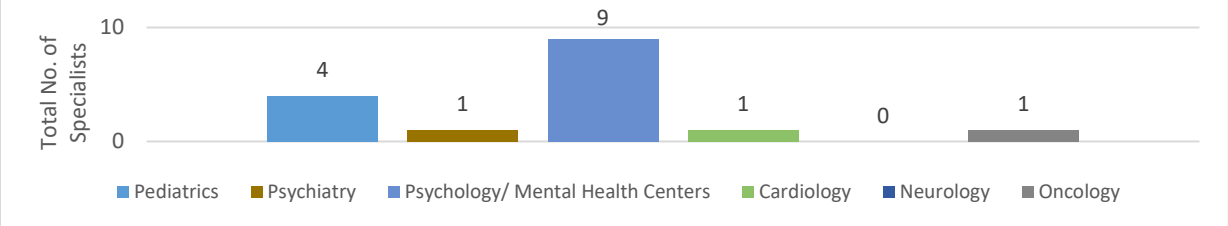
Chart 12 shows these specialties per 100,000. Despite population size, Webb County is last across four similar counties in Texas.

Chart 12: Specialty Care Providers per 100,000 Population | Texas DSHS Health Data



Laredoans receive referrals to Nuevo Laredo, Mexico, for specialty treatment; however, it needs to meet the needs of Nuevo Laredo and Laredo. There is only one psychiatric, cardiological, and oncological health center in Nuevo Laredo and no neurological health centers.[45]

Chart 13: Nuevo Laredo Specialty Health Centers | 2021 Data Mexico



CARDIOLOGY

Cardiology is a critical shortage area with a physician FTE shortage of 100 or more. This shortage in Region 11 will grow as demand for cardiologists grows and supply drops. Cardiologist FTEs are expected to drop from 70 to 55, and demand will increase from 106 to 129.

The cardiologist shortage in Laredo is expected to increase from 34% to 57% by 2032 - a staggering 24%.[46]

[45] https://datamexico.org/en/profile/geo/nuevo-laredo#health
[46] Texas Physician Supply and Demand Projections, 2018-2032

Chart 14: Cardiology FTE Supply and Demand in Border Status Region 11 | Texas DSHS Health Data, 2020

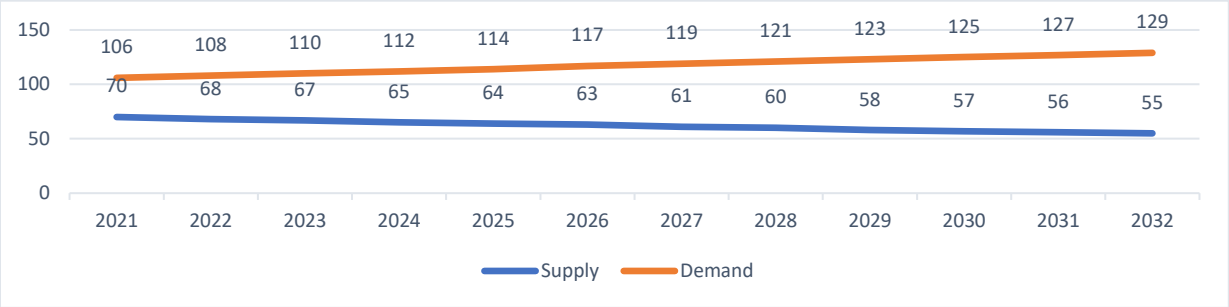


Table 11: Projected % of Unmet Cardiology FTE Demand per year | Texas DSHS Health Data, 2020

	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032
Gap	33.8%	36.6%	39.4%	41.7%	44.0%	46.3%	48.7%	50.5%	52.7%	54.3%	55.9%	57.4%

ENDOCRINOLOGY

Endocrinology demand and supply will increase, maintaining a shortage gap over the next 10 years. The gap is expected to lessen from 45% to 32%.

Figure 6: Endocrinology FTE Supply and Demand in Border Status Region 11 | Texas DSHS Health Data, 2020

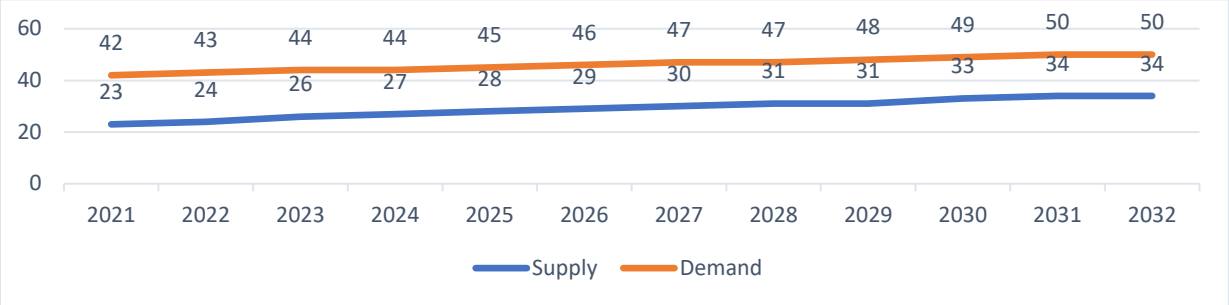


Table 12: Projected % of Unmet Endocrinology FTE Demand per year | Texas DSHS Health Data, 2020

Year	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032
Gap	44.7%	43.7%	41.5%	39.8%	38.8%	37.7%	36.3%	35.3%	34.5%	33.3%	32.1%	32.0%

NEUROLOGY

The shortage of neurology physician FTEs will widen as supply remains steady over the next ten years and demand increases by eight FTEs. This is an increase from 38% to 47% unmet demand in 2032.

Figure 7: Neurology FTE Supply and Demand in Border Status Region 11 | Texas DSHS Health Data, 2020

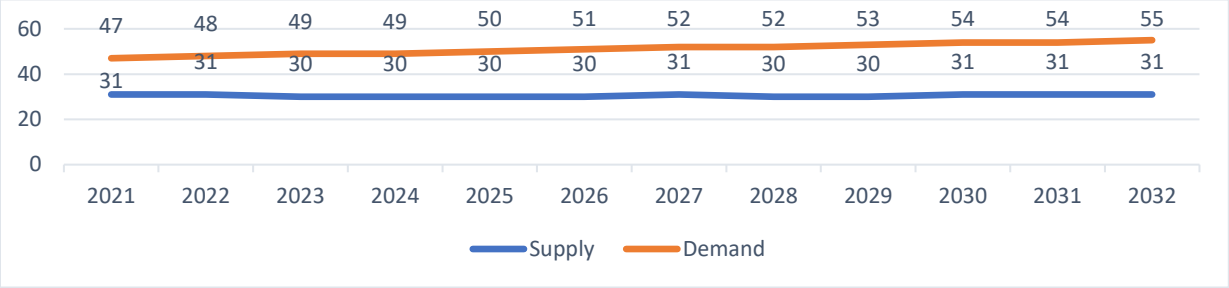


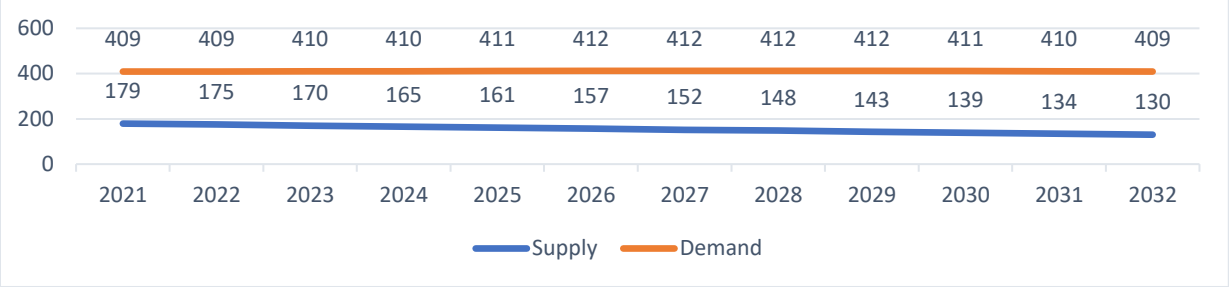
Table 13: Projected % of Unmet Neurology FTE Demand per year| Texas DSHS Health Data, 2020

	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032
Gap	38.1%	39.2%	40.2%	41.1%	41.5%	41.8%	42.6%	43.6%	44.5%	45.1%	45.8%	46.5%

PEDIATRICS

Pediatrics is another critical shortage for Region 11, with a predicted shortage of 149 FTEs in 2032. Demand for pediatrics is expected to increase slightly in the next five years but decrease to 409 in 2032. The shortage is expected to increase by 12% as the supply of pediatric physicians will decline over the next ten years by 27%.

Chart 15: Projected Pediatric FTE Supply and Demand in Border Status Region 11 | Texas DSHS Health Data, 2020



Behavioral Health

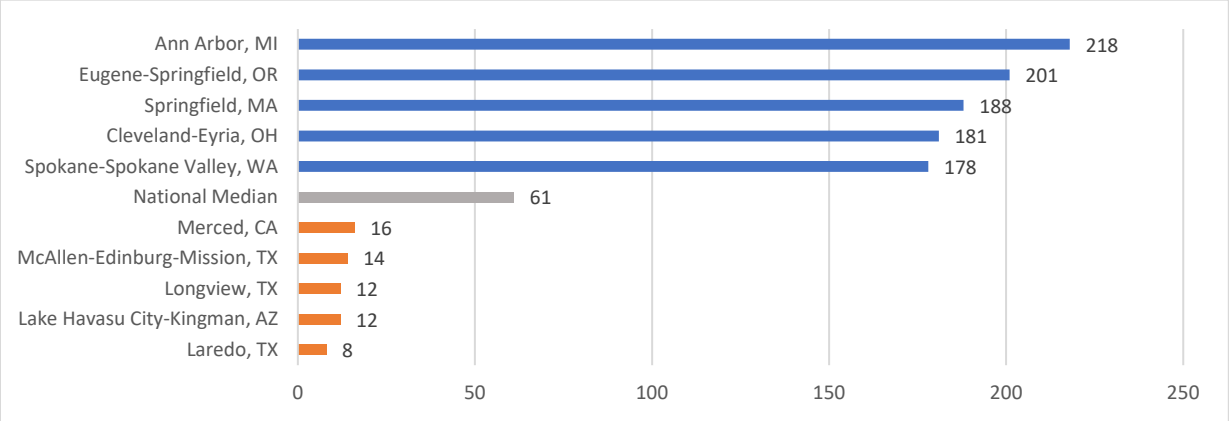
Table 14:Projected % Unmet Demand for Pediatric FTE | Texas DSHS Health Data, 2020

	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032
Gap	56.2%	57.3%	58.6%	59.7%	60.7%	61.9%	63.1%	64.1%	65.2%	66.3%	67.2%	38.3%

Behavioral health providers, which include mental health and SUD treatment professionals, are severely lacking in Texas. Three of the bottom five cities in the US for behavioral health providers are in Texas.

Laredo ranked last nationwide with only eight mental health providers per 100,000.[47]

Chart 16: Top and Bottom 5 US Cities by Behavioral Health Provider per 100K Population | Trilliant Health, 2022



Webb County ranks 65th in Texas for the number of psychiatrists per 100,000 population. Currently, there are no inpatient substance use facilities in Laredo (although one is underway), and only one addiction medicine specialist exists in Webb County.[48]

[47] https://www.trillianthealth.com/insights/the-compass/geographic-analysis-reveals-mismatch-in-supply-of-and-demand-for-behavioral-health-providers-and-primary-care-physicians
[48] Texas Department of State Health Services

Table 15: Behavioral Health Providers by County | Texas DSHS Health Data

County	Psychiatrist Total, 2020	Population to Psychiatrist Ratio, 2020	Psychiatrists to 100,000 Population Ratio, 2020
El Paso	47	18,641	5
Hidalgo	23	37,842	3
Cameron	20	21,394	5
Nueces	23	16,683	6
Webb	8	34,523	3

**These data are from the Texas Medical Board and reflect psychiatrists with Texas licenses who have identified Webb County as their practice location. It appears that most of them are, in fact, physically located out-of-state and list Webb County as their practice location because they provide telemedicine services through a single facility (e.g., Border Regions Behavioral Health Center).*

An international expert panel recently recommended a minimum of 30 inpatient psychiatric beds per 100,000 population.[49] *This suggests Laredo needs a minimum of 78 acute psychiatric inpatient beds.* Supply and demand for psychiatry FTEs are expected to increase at a similar rate, creating an ongoing shortage between 38-40% for psychiatry FTEs. This gap in psychiatric care is expected to continue for Region 11 in the next ten years.[50]

Chart 17: Region 11 Projected Psychiatry FTE Supply and Demand | Texas DSHS Health Data, 2020

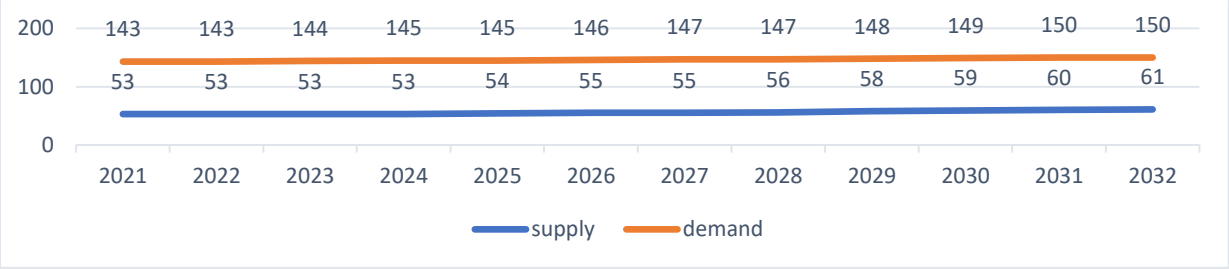


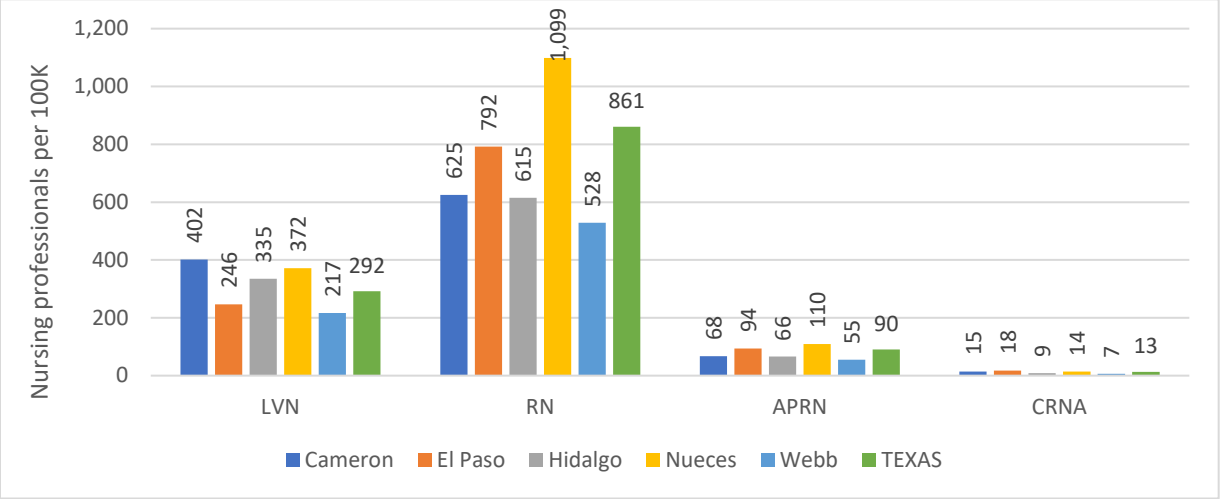
Chart 18: Psychiatrists per 100K, 2020 | Texas DSHS Health Data

[49] https://www.nature.com/articles/s41380-021-01435-0#:~:text=Recommendations%20established%20by%20our%20panel,15%5D%2C%20which%20has%20been%20especially

[50] Texas Department of State and Health Services

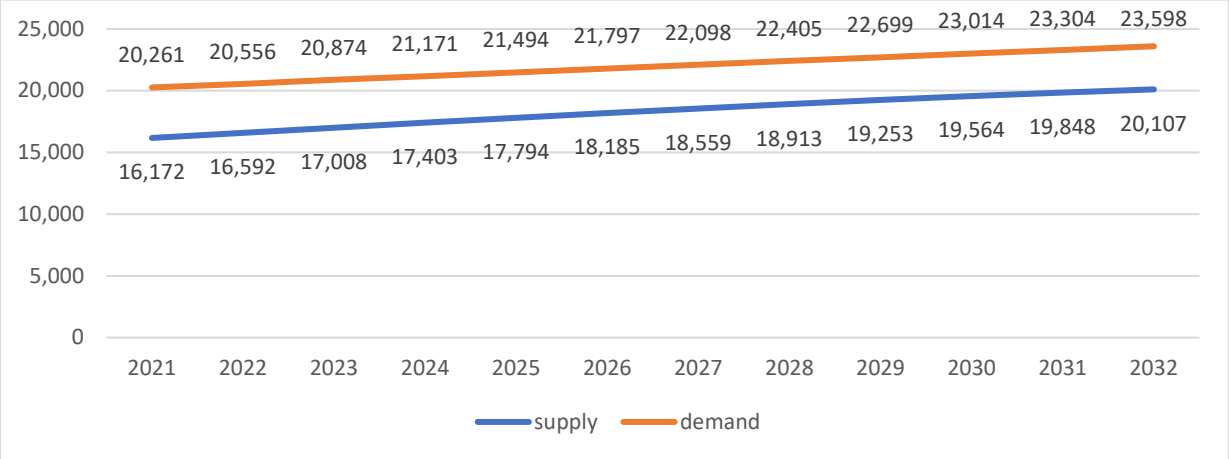
Nursing

Chart 19: Nursing Professionals Across Five Texas Counties, 2019 | Texas DSHS Health Professions Data



There is a current gap of 19% of nursing professionals in Region 11, expected to slowly decrease over the next 10 years and projected to have an unmet demand of 15% by 2032.

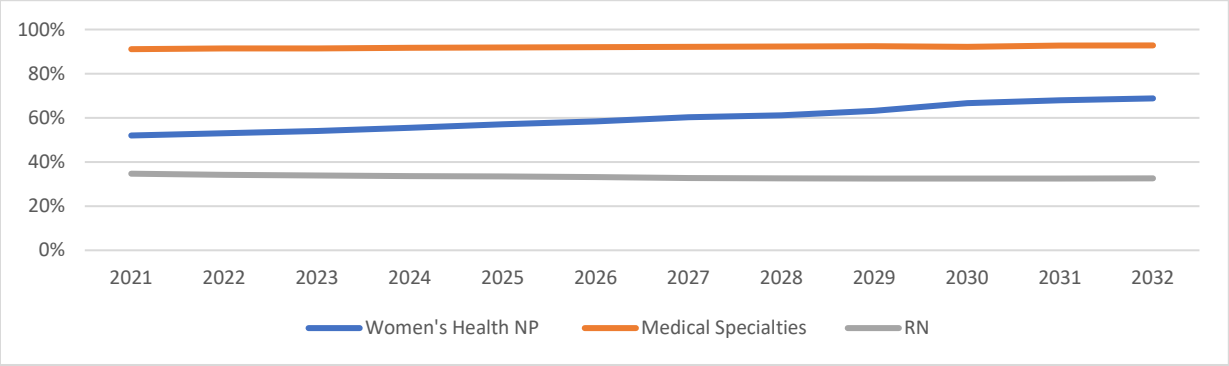
Chart 20: Region 11 Projected Nursing Supply and Demand | Texas DSHS Health Data, 2022



While the gap in nursing is generally expected to decrease, some nursing specialties are experiencing major gaps that are expected to increase over the next ten years. Chart 21 shows the change in unmet nursing demand over the next 10 years. *Medical specialties nursing is at a current shortage of about 91%*

with a slight increase to 93% by 2032. The gap in women's health NP is expected to grow 16% from a 53% to 69% gap. Unmet demand for RN FTEs is expected to be over 30% over the next 10 years.

Chart 21: Percentage of Unmet Nursing Demand by Category | Texas DSHS Health Data, 2022



Indigent Care

GATEWAY COMMUNITY HEALTH CENTER

Gateway is a Federally Qualified Health Center (FQHC) that provides comprehensive healthcare services to underserved communities and receives federal funding through the Bureau of Primary Health Care.[51] Gateway currently operates seven locations in Laredo. The health center serves Webb, Zapata, and Jim Hogg counties and is the "leading primary healthcare provider in the tri-county region."[52] The total patient population served by Gateway in 2021 was 29,247, with 25,2014 patients from Webb County.[53] Patient demographics reflect the city's demographics with 97.65% Hispanic/Latino patients.[54] Almost half of Gateway's patients were uninsured (44%), 29.5% had private insurance, and 20.4% had Medicaid. Only 6% were Medicare patients, and 65 patients had CHIP. Gateway also serves special populations. They serve 1,454 special population patients, of which 91% are homeless.

CITY OF LAREDO PUBLIC HEALTH DEPARTMENT

The City of Laredo Public Health Department (Department) provides low-cost health care and accepts Medicaid, Medicare, CHIP, and sliding fee scale for payment. They do not deny services due to their inability to pay, making it an important resource for indigent populations. Clinical services include various screenings, including diabetes, cholesterol, high blood pressure, immunizations, dental services, and behavioral health services. They have a class D pharmacy that provides services to clients enrolled in specific programs such as Maternal & Child Health and Texas Healthy Women.[55]

[51] https://dshs.texas.gov/TPCO/fqhc/
[52] Gateway Community Needs Assessment 2021
[53] Gateway Community Needs Assessment 2021
[54] Gateway Community Needs Assessment 2021
[55] https://www.cityoflaredo.com/health/health.htm

The Department also works to assess and surveil notable chronic diseases in Laredo. They offer obesity prevention programs that include educational and physical activity workshops. They have eight locations in Laredo: a main clinic and administration site, seven WIC clinics (including the main clinic), and a resource center. The health department also administers seven WIC clinics outside Laredo.

Chart 22: City of Laredo Health Department Sites | City of Laredo Health Dept.

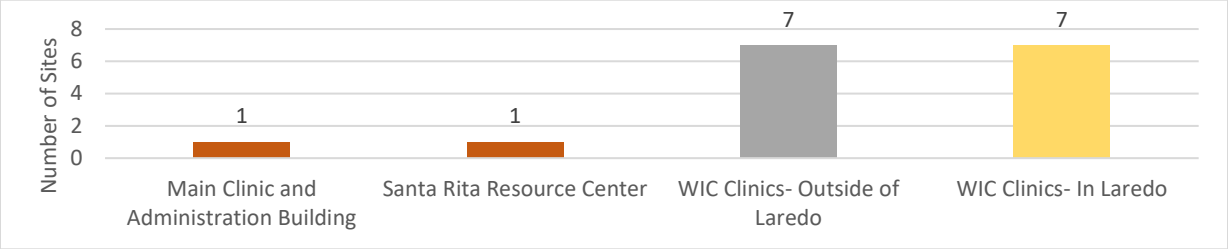


Figure 9: Webb County Department Clinic Locations

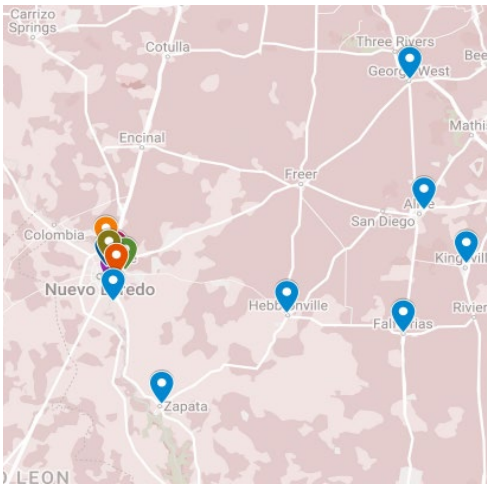
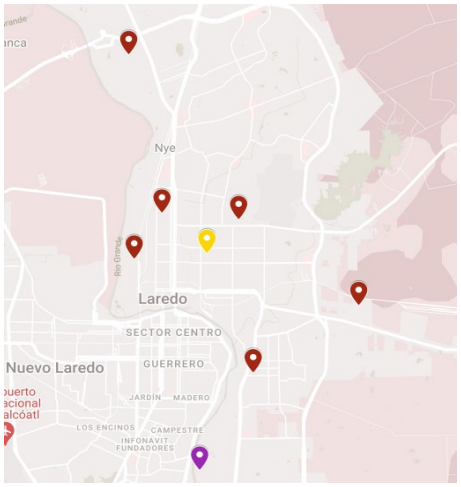


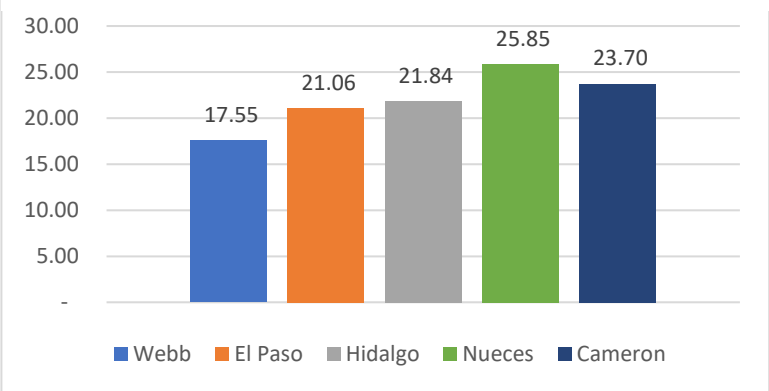
Figure 8: Laredo Department Clinic Locations



Pharmacy Services

There are 48 pharmacies in Webb County, all located in Laredo. Pharmacy locations are largely retail chains such as CVS (40%) and hospitals (27%). Other locations include: private practice or independent (11%), medical

Figure 10: Pharmacies by County per 100K |Texas State Board of Pharmacy

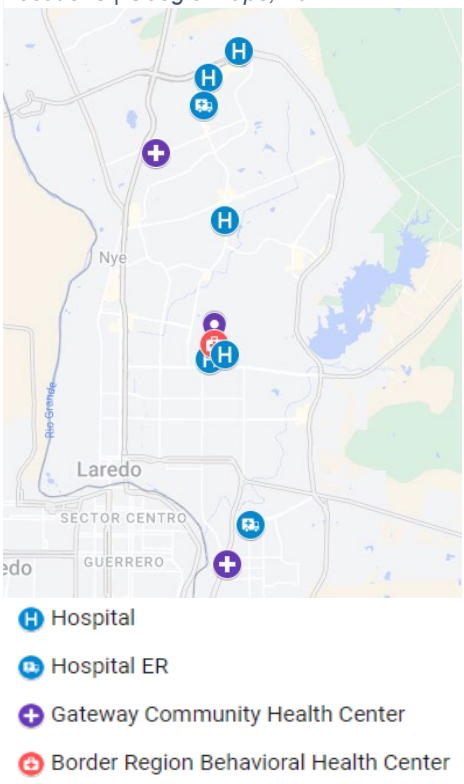


plaza/center (10%), community health centers (8%) and clinics (4%).[56]

Hospitals

Laredo has four private hospitals- *Doctors Hospital of Laredo (Doctors)*, *Laredo Medical Center (LMC), Laredo Rehabilitation Hospital, LLC., and Laredo Specialty Hospital*.

Figure 11: Laredo Provider Facility Locations | Google Maps, 2022



Doctors is an acute care facility with 183 staffed beds that also operates one clinic, four diagnostic centers, two freestanding emergency rooms, a mobile clinic, and an MRI site. The hospital's primary and secondary service areas include Webb, Jim Hogg, La Salle, and Zapata counties. Specialty services include bariatric (weight loss) surgery, maternity services, a level III NICU, emergency services, and pediatrics.[57] Doctors pediatric patients with emergency injuries are directed to the pediatric Intensive Care Unit at South Texas Health System two hours away by ambulance.[58]

LMC is an acute care facility with 314 staffed beds and more than 13 additional sites, including primary care clinics, specialty clinics, and walk-in care clinics.[59] They offer orbital atherectomy to clear calcified coronary artery blockages and are an accredited chest pain center. Laredo Medical Center has conducted over 100 bariatric surgeries and 156 robotic-assisted orthopedic surgeries. They also have a level III NICU, the leading trauma facility in Laredo.

Laredo Rehabilitation Hospital provides inpatient and outpatient rehabilitation services to patients with disabling diseases or injuries such as recovering from stroke. Rehabilitation services include nursing care, physical therapy, occupational therapy, and speech, memory, and cognitive therapy.[60]

Laredo Specialty Care Hospital is a critical care hospital that provides long-term acute and critical care to patients in need of ventilation. All rooms are equipped with specialty beds and equipment including ventilators. Their specialized programs include a ventilator weaning program, cardio/pulmonary recovery program, and a wound care program. They are the first hospital in Laredo to receive the Joint Commission's Gold Seal of Approval for Respiratory Failure.[61]

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[56]https://www.pharmacy.texas.gov/dbsearch/phy_results.asp?phy_lic=&phy_name=&own_name=&own_pht_lic=&phy_st1=&phy_city=-1&phy_cnty=WEBB&phy_zip=&B1=Search
[57] Doctors Hospital 2020 Community Profile
[58] Doctors Hospital 2020 Community Profile
[59] LMC 2021 Community Benefit Report
[60] https://lrh.ernesthealth.com/service/inpatient-rehabilitation/
[61] https://lsh.ernesthealth.com/service/national-recognition/

Staffed bed space in Webb County (208 to 100K) is slightly above average for Texas (206 to 100K) [62] and lower than the national average (277 to 100K).[63]

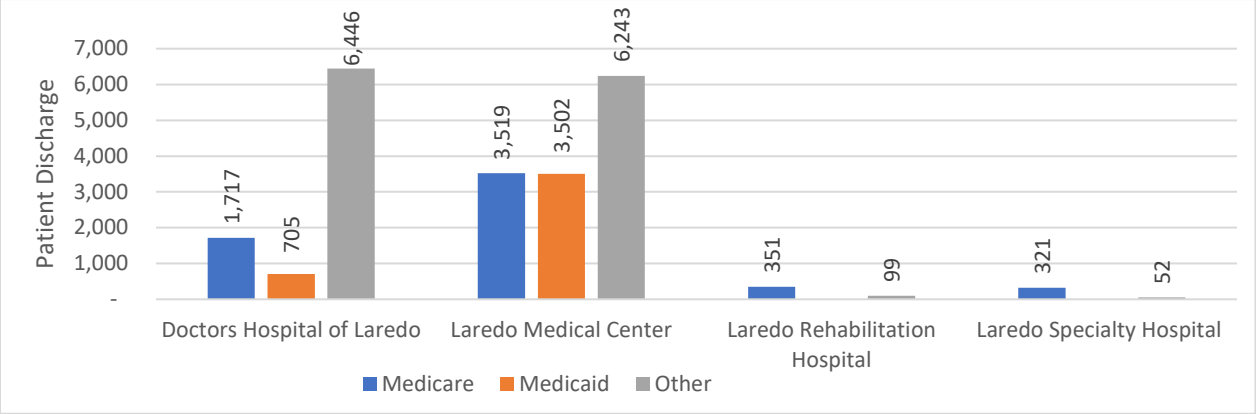
Table 16: 2019 Webb County Staffed Beds and Revenue | Torch Insight

Facility Name	Beds (Total Staffed), 2019	Net Patient Revenue, 2019
Doctors Hospital of Laredo	183	$139,325,960
Laredo Medical Center	314	$295,199,977
Laredo Rehabilitation Hospital, LLC	20	$9,353,389
Laredo Specialty Hospital LP	40	$13,690,766

Table 17: 2019 Webb County Hospital Discharges by Type | Torch Insight

Facility Name	Medicare Discharges, 2019	Medicaid Discharges, 2019	Other Discharge, 2019	Total Discharges, 2019
Doctors Hospital of Laredo	1,717	705	6,446	8,868
Laredo Medical Center	3,519	3,502	6,243	13,264
Laredo Rehabilitation Hospital	351	0	99	450
Laredo Specialty Hospital	321	0	52	373

Chart 23: 2019 Webb County Hospital Discharges | Torch Insight



[62] https://www.ahd.com/state_statistics.html
[63] https://www.aha.org/statistics/fast-facts-us-hospitals

SECTION 2 – SELECT OPTIONS FOR PUBLIC FINANCING OF HEALTHCARE SERVICES

Workstream 2 of this project calls for gathering information to inform city policymakers on the implications of forming either a hospital district or a municipal hospital authority. Hospital districts are much more common than municipal hospital authorities within the Texas healthcare ecosystem. There are between 70 and 80 hospital districts in the state. (data from the Texas Department of State Health Services annual hospital survey report identified 78 hospitals that self-reported their ownership as "hospital district," whereas tax data from the Texas Comptroller's office identified 72 hospital districts). Hospital districts, unlike municipal hospital authorities, have a property and sales tax authority. Another key difference is that hospital districts must be created or approved by a popular election, whereas municipal hospital authorities may be created by the vote of a local governing body. The statutory authority for creating hospital districts permits their potential boundaries to being within one or more counties. While municipal hospital authorities can be created by city or county governing bodies, as an empirical matter, all but one existing municipal hospital authority in Texas was established at the county level, and the only exception was established jointly through the county and city.

Hospital Districts

This subsection summarizes select legal requirements for hospital districts in Texas, focusing on a high-level understanding of their establishment, governance, and financing. It does not attempt to include all requirements, and it is inclusive only of select statutory and regulatory provisions. Although a literature review was conducted through The University of Texas library, very few relevant articles were found, and nothing was deemed necessary or appropriate for inclusion. Opinions of the Texas Attorney General are incorporated where relevant. The subsection is expressly exclusive of case law.

Definition

Generally, a hospital district (HD or district) is a legal entity formed by one or more counties to provide health care services.[64] Within Texas, HDs can be contrasted with municipal hospitals,[65] municipal hospital authorities,[66] and county hospital authorities[67].

Authority

The Texas Health and Safety Code Title 4 authorizes the creation of hospital districts by voters,[68] and by counties with populations of less than 75,000[69] and more than 190,000.[70]

[64] Tex. Const. Art. 9
[65] *See* Tex. Health & Safety Code § 261.001(1) and 261.001(2)
[66] *See generally* Tex. Health & Safety Code Chapter 262
[67] *See generally* Tex. Health & Safety Code Chapter 264
[68] Tex. Health & Safety Code Chapter 286
[69] Tex. Health & Safety Code Chapter 282
[70] Tex. Const. Art. 9, Sec. 4; Tex. Health & Safety Code Chapter 281

VOTER INITIATED

CREATION

A new HD may not overlap with or remove territory from another HD.[71]

DISTRICTS WITHIN ONE COUNTY

Voters may petition a county judge to create an HD within one county if either three percent or 100 registered voters signs on.[72] If the district does not have at least 100 registered voters, a majority of the voters must sign the petition.[73] Regardless of district reach, the petition must contain ten specific items to be valid.[74]

DISTRICTS IN MORE THAN ONE COUNTY

There are three distinctions in the creation of an HD that HD extends beyond a single county: First, the petition must be signed by either three percent or 100 registered voters on both the county in which the judge presides and of the proposed district.[75] Second, the commissioners court in each affected county must grant the petition.[76] Third, the district may be created only within the county or counties wherein a majority of the votes cast approve the creation, as otherwise set forth in subsection 3 *infra*.[77]

THE VOTE

After a valid petition is received, the commissioners court at its next regular or special session must schedule a hearing and issue notice of the same by publication to the public.[78] If the petition is in proper form, it must be granted and an election must be ordered.[79] That election need not be held on a uniform election date,[80] but rather must be held 45 to 60 days later.[81] The election concerns three issues: confirmation of the district's creation, authorization of the levying of a tax, and, if appropriate, issuance of bonds.[82] The ballot proposal must use specific language dependent on the revenue stream.[83] If the measure passes, the HD is created, and the commissioners court must enter a specific order;[84] if it fails, a one-year ban on the question begins.[85]

EXPANSION

Registered voters in a territory that is not included in a district may petition the board to be included.[86] To be valid, the petition must be signed by the lesser of 50 registered voters of the territory or a majority of those voters.[87] Once the petition is received by the board secretary, the board must by order schedule a

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[71] Tex. Health & Safety Code § 286.029
[72] Tex. Health & Safety Code § 286.021(a)
[73] Tex. Health & Safety Code § 286.021(c)
[74] Tex. Health & Safety Code § 286.022(a)-(b)
[75] Tex. Health & Safety Code § 286.021(b)
[76] Tex. Health & Safety Code § 286.023(f)
[77] Tex. Health & Safety Code § 286.027(b)-(c)
[78] Tex. Health & Safety Code §§ 286.023(a)-(c), 286.025
[79] Tex. Health & Safety Code § 286.023(e). *See also* Tex. Health & Safety Code § 286.024.
[80] Tex. Health & Safety Code § 286.023(h)
[81] Tex. Health & Safety Code § 286.023(g)
[82] Tex. Health & Safety Code §§ 286.023(e), 286.026
[83] Tex. Health & Safety Code § 286.026
[84] Tex. Health & Safety Code §§ 286.027(a), 286.028
[85] Tex. Health & Safety Code § 286.027(d)
[86] Tex. Health & Safety Code § 286.101(a)
[87] Tex. Health & Safety Code § 286.101(a)

hearing at least thirty days later.[88] If after hearing the board finds that annexation is feasible and beneficial, it can enter a resolution approving annexation of all or part of the territory.[89]

Annexation must be approved through separate elections by a majority of voters in the district and a majority of voters in the territory to be annexed.[90] The latter group must also vote whether to assume its proportion of the debts or taxes of the district.[91] The election must be between 45 and 60 days after the date the election is ordered, and it need not follow the uniform voting schedule.[92]

DISSOLUTION

THE VOTE

An election must be held on the matter of dissolution, ordered either at the board's discretion or subsequent to a petition signed by at least fifteen percent of the electorate.[93] The election must occur no more than sixty days later, and the uniform election schedule does not control.[94] If the measure fails, dissolution cannot be voted on for at least one year; if it passes, the board must find the district is dissolved.[95]

DISPOSAL OF PROPERTY, ASSETS, AND DEBTS

After a vote to dissolve the HD, the board must transfer the land, buildings, improvements, equipment, and other assets to a governmental entity within the district, and the entity assumes all debts and obligations.[96] Alternatively, the district may continue to control and administer the property, assets, and debts until all funds have been disposed of and all debts are paid or settled.[97] If the latter, the board may continue to impose a property or sales and use tax until the debt is paid.[98] Any overpayments must be proportionally returned or credited to each taxpayer.[99]

FINALIZATION

Once the HD has no more debts or assets, the board shall file in the appropriate commissioners court(s) a report summarizing its dissolution activities.[100] No more than ten days later, the commissioners court(s) must enter a dissolution order.[101] Unless another governmental entity purchased the hospital, the county becomes responsible anew for providing indigency health care services.[102]

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[88] Tex. Health & Safety Code § 286.101(b)
[89] Tex. Health & Safety Code § 286.101(c)
[90] Tex. Health & Safety Code § 286.101(d)
[91] Tex. Health & Safety Code § 286.101(e)
[92] Tex. Health & Safety Code § 286.101(f)
[93] Tex. Health & Safety Code § 286.102(b)
[94] Tex. Health & Safety Code § 286.102(c)
[95] Tex. Health & Safety Code § 286.102(e)
[96] Tex. Health & Safety Code § 286.103(a)(1), (b)
[97] Tex. Health & Safety Code §§ 286.103(a)(2), 286.104(a)
[98] Tex. Health & Safety Code § 286.104(b)
[99] Tex. Health & Safety Code § 286.105
[100] Tex. Health & Safety Code § 286.106(a)
[101] Tex. Health & Safety Code § 286.106(b)
[102] Tex. Health & Safety Code § 61.064(c)

COUNTY INITIATED

A county with at least 190,000 inhabitants may create a countywide hospital district.[103] If the county or a municipality within the county already owns or operates a hospital system for indigent or needy persons, the district may take over.[104] Otherwise, the county may provide for the establishment of a hospital or hospital system.[105] Despite the specificity of the statutory requirements described herein for county-initiated HDs, the legislature has often crafted statutory requirements that are specific to each county or set of similarly situated counties.

Voters in the county must approve the creation of the HD through the next regular election consistent with the Texas Election Code.[106]

Business Organization

STATUS

An HD has the power to sue and be sued.[107] Although an HD is an entity in and of itself, a county-initiated district may also form a nonprofit corporation organized under Internal Revenue Code Subsections 501(c)(3) or 501(c)(4) to provide healthcare services, develop resources for health care services, or provide ancillary support services;[108] such organization is a unity of local government for litigation purposes.[109]

GOVERNANCE

An HD is governed by a Board of Directors with broad authority to manage, control, and administer its hospital system, funds, and resources.[110] Additionally, the commissioners court may delegate authority to a county-initiated district to prescribe purchasing and accounting methods and procedures.[111]

The number of directors must be odd,[112] and service is not compensated.[113] If the HD is county-created, the commissioners court must appoint five to seven persons to the board of hospital managers,[114] and, except the initial board, the directors serve two-year terms.[115] The board is uncompensated.[116]

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[103] Tex. Health & Safety Code § 281.002
[104] Tex. Health & Safety Code § 281.002(b), (c)
[105] Tex. Health & Safety Code § 281.002(a)
[106] Tex. Health & Safety Code § 281.003
[107] Tex. Health & Safety Code §§ 286.086, 281.056
[108] Tex. Health & Safety Code § 281.0565
[109] Tex. Health & Safety Code § 281.0565(c)
[110] Tex. Health & Safety Code §§ 286.074, 281.047. *See also* § 286.051 (authorizing action with majority concurrence) and 281.051 (granting contracting authority with commissioners court approval for county-initiated districts).
[111] Tex. Health & Safety Code § 241.049(b)
[112] Tex. Health & Safety Code § 286.022(c)(1)
[113] Tex. Health & Safety Code § 286.050(a)
[114] Tex. Health & Safety Code § 281.021(a)
[115] Tex. Health & Safety Code § 281.022(a)
[116] Tex. Health & Safety Code § 281.024

Eligibility and Candidacy

A person is eligible to be a director if they are a resident of the district and a qualified voter.[117] If the directors are elected from commissioners precincts, only residents of the appropriate precinct are eligible.[118] District employees are not eligible,[119] and neither are persons serving on boards for other entities with the power of taxation in overlapping territory.[120]

To be listed on the ballot as a candidate for a directorship, a person must file an application with the board secretary at least thirty-one days before the election.[121] The application must note the specific place, precinct, or at-large status if applicable.[122]

Temporary Directors

On the date of the order creating the district, the commissioners court must appoint the temporary directors named in the petition.[123] The number of directors and manner of their election may be specified in the petition,[124] but must be the same number as the permanent board.[125] If the petition does not name the temporary directors or state the number of directors, there are five directors, to be appointed by the commissioners court.[126] Vacancies are also filled by appointment.[127]

If the HD is in more than one county, the respective commissioners courts appoint the number of temporary directors that is proportional to the number of district residents in the county relative to the number of residents of the whole district.[128]

Elected Directors

As a preliminary matter, the Health and Safety Code Section 286.022(a)(8) requires that the petition include "the method by which the permanent directors will be elected, as provided by Subsection (c)" to be valid, but Subsection (c) makes permissive inclusion of "the method by which directors are to be elected." In any case, the petition may provide that directors are elected at large, by place, or both, so long as the specific number of directors are elected from each commissioner precinct and a specific number are elected at large.[129] The election must occur on the first Saturday in May following the creation of the district,[130] and, subsequently, every first Saturday in May.[131] The selection is by simple popular

[117] Tex. Health & Safety Code § 286.045(a)
[118] Tex. Health & Safety Code § 286.045(b)
[119] Tex. Health & Safety Code § 286.045(c)
[120] Tex. Atty Gen., Op. KP-0023 (June 9, 2015) ("Because each of the entities . . . has taxing authority in territory that overlaps with the other, simultaneous service on the governing body of both entities is prohibited by conflicting-loyalties incompatibility.").
[121] Tex. Health & Safety Code § 286.044(a)-(b)
[122] Tex. Health & Safety Code § 286.044(c)-(d)
[123] Tex. Health & Safety Code § 286.030(a)-(b)
[124] Tex. Health & Safety Code § 286.022(c)
[125] Tex. Health & Safety Code § 286.022(b)
[126] Tex. Health & Safety Code § 286.030(b)
[127] Tex. Health & Safety Code § 286.030(e)
[128] Tex. Health & Safety Code § 286.030(c)
[129] Tex. Health & Safety Code § 286.022(c)(2)
[130] Tex. Health & Safety Code § 286.042(a)
[131] Tex. Health & Safety Code § 286.042(e)

vote, though the code is silent on cumulation of votes. Notice by publication must issue before the thirty-fifth day before the election.[132]

Initial Board

If the HD is county-created, the commissioners court may make initial appointments for one year to stagger terms.[133]

The initial board of a voter-initiated district is divided into two classes to minimize the likelihood of turnover of the whole board at once. The creation of the two classes depends on the type of election.

At Large

The appropriate number of candidates receiving the highest number of votes at the initial election of directors are directors for the district.[134]

The number of directors equal to a majority of the board who receive the highest number of votes serves a two-year term, and the remaining directors serve for a one-year term.[135] It is unclear what happens if there is a tie in the vote for the final position of the majority.[136]

By Place

Each candidate who receives the highest number of votes for election to a place is a director for the district.[137] A director elected to fill an even-numbered place at the initial election serves for a one-year term, and a director elected to fill an odd-numbered place at the initial election serves for a two-year term.[138]

By Commissioners Precinct

The number of candidates equal to the number of directors to be elected from each precinct who receive the highest number of votes from a commissioner precinct are directors for that precinct.[139] The number of candidates equal to the number of directors to be elected at large who receive the highest number of votes from the district at large are directors for the district at large.[140]

A candidate elected from an odd-numbered precinct at the initial election serves for a two-year term, and a candidate elected from an even-numbered precinct at the initial election serves for a one-year term.[141] Additionally, a candidate elected as the director from the district at large at the initial election serves for a

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[132] Tex. Health & Safety Code § 286.043
[133] Tex. Health & Safety Code § 281.022(a)
[134] Tex. Health & Safety Code § 286.042(b)(1)
[135] Tex. Health & Safety Code § 286.042(b)(2)-(3)
[136] Tex. Atty Gen., Op. KP-0002 (Feb. 11, 2015) (opining that "[a] court could conclude that when two directors of a seven member board both receive the fourth-highest total number of votes, they both are included in the majority who serve two-year terms.")
[137] Tex. Health & Safety Code § 286.042(c)(1)
[138] Tex. Health & Safety Code § 286.042(c)(2)-(3)
[139] Tex. Health & Safety Code § 286.042(d)(1)
[140] Tex. Health & Safety Code § 286.042(d)(2)
[141] Tex. Health & Safety Code § 286.042(d)(3)-(4)

two-year term unless more than one director is elected at large; in such instance, half of the directors elected serve two-year terms, and the other half serve one-year terms.[142]

Board Composition

Before assuming the duties of the office, each director must execute a $5,000 bond payable to the district using personal or district funds.[143]

The board is required to have three officers—president, vice-president, and secretary.[144] The president and vice-president must be directors, but the secretary does not have to be.[145] Each officer serves a non-compensable one-year term.[146] Vacancies in both officers and directors generally are filled by the board for the remainder of the term.[147]

In a county-initiated HD, the board elects a chairman and vice-chairman, and then appoints a board member or the administrator to serve as secretary.[148]

RELATIONSHIP WITH THE BUSINESS COMMUNITY

County-initiated districts must "encourage and promote participation by all sectors of the business community, including small businesses and businesses owned by members of a minority group or by women, in the process by which the district enters into contracts."[149] The district is required to have a plan to "identify and remove barriers that do not have a definite or objective relationship to quality or competence and that unfairly discriminate against small businesses and businesses owned by members of a minority or by women."[150] These barriers expressly may include contracting procedures and contract specifications or conditions.[151]

MANDATED TRANSFERS AND ASSUMPTIONS UPON CREATION

Within the bounds of preemptive federal law regarding asset transfer, there are some required conveyances upon creation of a hospital district.[152] Although the transfers discussed in this subsection are required, the HD may return any property it does not find useful back to the county or municipality.[153]

Specifically, a county, municipality, or other governmental entity in which the district is located must convey or transfer to the district certain of its items, including

- land, buildings, improvements, and equipment related to the hospital system, whether located wholly in the district[154] or not;[155]

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[142] Tex. Health & Safety Code § 286.042(d)(5)-(6)
[143] Tex. Health & Safety Code § 286.046
[144] Tex. Health & Safety Code § 286.048
[145] Tex. Health & Safety Code § 286.048
[146] Tex. Health & Safety Code §§ 286.049(a), 286.050(a)
[147] Tex. Health & Safety Code §§ 286.047, 286.049(b)
[148] Tex. Health & Safety Code §§ 281.023(a)-(b)
[149] Tex. Health & Safety Code §§ 281.051(c)
[150] Tex. Health & Safety Code §§ 281.051(c)
[151] Tex. Health & Safety Code §§ 281.051(c)
[152] *See* Tex. Health & Safety Code § 281.041(f)
[153] Tex. Health & Safety Code § 281.042
[154] Tex. Health & Safety Code § 286.071(1)
[155] *See* Tex. Health & Safety Code § 281.041(a) (not providing for territorial boundaries)

- funds dedicated by the governmental entity to provide medical care for residents of the district for the remainder of the fiscal year;[156]
- taxes levied by the governmental entity for hospital purposes for district residents for the year; and[157]
- funds established for payment of indebtedness assumed by the district.[158]

In addition, the proceeds of any bonds a county-initiated HD assumes from the county or municipality must also be transferred to the HD,[159] as well as hospital system records, property, and affairs[160] in addition to unexpended facilities funds.[161] Once the new board is established and upon completion of these steps, the county or municipal board ceases to exist.[162]

However, there are exceptions to the property and funding transfer requirement for county-initiated districts, including medical facilities used for treatment of incarcerated persons of any age, property used in connection with utility services, and any realty not partially developed for medical care.[163] A county or municipality may also retain, but must lease to the district, building and related land whether that land is used for purposes related or unrelated to the hospital or hospital system.[164] It is also optional for the county or municipality to transfer its public health services and related facilities, ambulance service, emergency medical service, search-and-rescue service, or medical transport service.[165] Notably, if transfer of a federally qualified health center (FQHC) would result in loss of the federal designation, the FQHC may not be transferred to the district.[166]

At creation the county-initiated HD must also assume any outstanding contract obligations legally incurred by the county and/or municipality for the construction, support, maintenance, or operation of hospital facilities and the provision of health care services or hospital care, including mental health care, to indigent residents of the county or municipality before the creation of the district.[167]

Services

THE PATIENT POPULATION

Anyone with a home in an HD is a resident of that HD.[168] If someone is unhoused, they are a resident of the HD if they intend to reside in that district, as evidenced by any relevant information.[169] Institutionalized persons are residents of the state or federal government and are not eligible for HD services.[170]

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[156] *Cf.* Tex. Health & Safety Code § 286.071(2) *with* § 281.041(b)(2)
[157] Tex. Health & Safety Code § 286.071(3)
[158] Tex. Health & Safety Code § 286.071(4)
[159] Tex. Health & Safety Code § 281.041(b)(1)
[160] Tex. Health & Safety Code § 281.041(c)
[161] Tex. Health & Safety Code § 281.041(b)(2)
[162] Tex. Health & Safety Code § 281.041(d)
[163] Tex. Health & Safety Code § 281.041(e)(1)-(3)
[164] *See* Tex. Health & Safety Code § 281.041(e)(4)
[165] Tex. Health & Safety Code § 281.041(e)(5)-(6)
[166] Tex. Health & Safety Code § 281.041(f)
[167] Tex. Health & Safety Code § 281.043
[168] Tex. Health & Safety Code § 61.003(a)
[169] Tex. Health & Safety Code § 61.003(b)-(c)
[170] Tex. Health & Safety Code § 61.003(f)

BASIC HEALTH CARE

In addition to any services otherwise required by the Texas Constitution or in a statute creating a district,[171] an HD "shall endeavor" to provide the following basic health care services:

- 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;
- 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.[172]

An HD may arrange to provide health care services through a local health department, a publicly owned facility, or a contract with a private provider regardless of the provider's location, or through the purchase of insurance for eligible residents.[173] It may affiliate with other public hospitals, HDs, governmental entities, or, unless it was created before September 1, 2003, private entities to provide regional administration and delivery of care.[174] An HD may also purchase health coverage or other health benefits as though it were a small business.[175]

Notification and public hearing requirements apply to changes in scope of services.[176]

NURSING SERVICES

A county-initiated hospital district may contract with a school district included in the hospital district to provide nursing services and assistance to employees or students of the school district.[177]

EMERGENCY MEDICAL CARE

The HD may operate or provide for the operation of a mobile emergency medical service.[178] Furnishing the service can be through contract with the local, state, or federal government if appropriate.[179] However, ambulance services are "an ancillary function which [sic] a hospital district could undertake if it were deemed necessary," and thus are not required.[180] Should a district determine that ambulance services are necessary, it also has the discretion to determine the scope of those services.[181]

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[171] Tex. Health & Safety Code § 61.055(c)
[172] *See* Tex. Health & Safety Code § 61.055(a)-(b)
[173] Tex. Health & Safety Code § 61.056(a)
[174] Tex. Health & Safety Code § 61.056(b)-(c)
[175] Tex. Health & Safety Code § 61.056(d). For the small business options, see Texas Health and Safety Code Chapter 75.
[176] Tex. Health & Safety Code § 61.063
[177] Tex. Health & Safety Code § 281.0465
[178] Tex. Health & Safety Code § 286.073(a)(3)
[179] Tex. Health & Safety Code § 286.084
[180] Tex. Atty Gen., Op. GA-0472 at 2 (Oct. 23, 2006)
[181] Tex. Atty Gen., Op. GA-0472 (Oct. 23, 2006)

INDIGENCY POLICY

Patients who cannot afford to pay must be provided care and treatment,[182] though undocumented persons probably can be excluded.[183]

ELIGIBILITY[184]

Broadly, eligibility for indigency care is consistent with other need-based public benefits programs.

The HD must annually adopt an application procedure to determine eligibility for assistance,[185] including minimum standards, application, documentation, and verification.[186] The application must be available in written form,[187] and it must require a sworn signature.[188] Would-be applicants must be informed that assistance with applying is available.[189]

The application must solicit the applicant's name, address, social security number, household size and income excluding those receiving cash benefits, realty transfers from the last two years, amount of liquid assets, and equity value of the applicant's car and realty.[190] Although it must also include disclosure of insurance coverage or other hospital or health care benefit for which the applicant is eligible,[191] there cannot be a requirement that the person accept available employment-based insurance as a perquisite to receiving care.[192] Hospital districts are permitted to require applicants to register for work with the Teas Workforce Commission as a condition of receiving care.[193]

The maximum patient income is 21% of the federal poverty guideline,[194] or roughly $2,800 annually for a single person and roughly $5,800 annually for a family of four, which aligns with the Temporary Assistance for Needy Families (TANF) program.[195] However, persons who receive TANF, Supplemental Security Income (who would be over-income in any case), or Medicaid are categorically ineligible for indigency care services.[196]

Resources must also be counted, including car value in excess of the amount under department guidelines and realty not the homestead.[197]

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[182] Tex. Health & Safety Code § 286.082(a). *See also* § 281.046 (making county-initiated districts fully responsible for indigent medical and hospital care).
[183] *See* Tex. Atty Gen., Op. GA-0198 (June 3, 2004)
[184] *See* Tex. Health & Safety Code § 61.052(a)
[185] Tex. Health & Safety Code § 286.082(b); Tex. Health & Safety Code § 61.053(a)-(b)
[186] Tex. Health & Safety Code § 61.006(a)
[187] Tex. Health & Safety Code § 61.053(c)
[188] Tex. Health & Safety Code § 61.053(e)
[189] Tex. Health & Safety Code § 61.053(d)
[190] Tex. Health & Safety Code § 61.007
[191] Tex. Health & Safety Code § 61.007(5)
[192] Tex. Atty Gen., Op. GA-0198 (June 3, 2004)
[193] Tex. Health & Safety Code § 61.068. For conditions of a work registration requirement, see Texas Human Resources Chapter 31.
[194] Tex. Health & Safety Code § 61.006(b)
[195] Tex. Health & Safety Code § 61.006(d)
[196] Tex. Health & Safety Code § 61.006(e)
[197] Tex. Health & Safety Code § 61.008

Due process applies to applications for services, such that the HD must review applications within fourteen days and provide a written decision.[198] If the application is denied, the decision must include a reason and describe the process for appealing the denial.[199] Additionally, notification and public hearing requirements apply to changes in eligibility standards.[200]

PAYMENT

A public hospital is the payor of last resort,[201] but if the primary payment is inadequate, the hospital must pay for or provide the service for which other payment is not available.[202]

If a public hospital cannot provide the basic or emergency services, it is not liable beyond the payment standards for that service established by the department.[203]

The maximum liability for each state fiscal year for health care services provided by all assistance providers, including a hospital and a skilled nursing facility, to each eligible county resident is $30,000 or the payment of 30 days of hospitalization or treatment in a skilled nursing facility.[204]

COPAYMENT

An HD may request a nominal fee from all patients, but a patient's inability or refusal to pay that fee is not grounds for denying care.[205]

If after special inquiry the administrator finds that a patient can pay all or part of the care and treatment provided, the board must issue an order directing a weekly payment in an amount that the patient can pay.[206] Monies owed survive the death of the patient.[207] In a voter-initiated district, patients have a right to appeal the determination through a hearing before the board, whose decision is subject to judicial review by the district court system.[208] In a county-initiated district, patients have a right to a hearing in county court with appellate rights to the district court.[209] Similar due process protections are available for patients accused of defrauding the district.

If a non-citizen is a sponsored legal permanent resident, the sponsor may be held responsible for payment of services provided.[210]

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[198] Tex. Health & Safety Code § 61.053(g)-(i)
[199] Tex. Health & Safety Code § 61.053(i)
[200] Tex. Health & Safety Code § 61.063
[201] Tex. Health & Safety Code § 61.060(c).
[202] Tex. Health & Safety Code § 61.060(d).
[203] Tex. Health & Safety Code §§ 61.061, 61.034(a)
[204] Tex. Health & Safety Code §§ 61.061, 61.035
[205] Tex. Health & Safety Code § 61.005
[206] Tex. Health & Safety Code §§ 286.082(c), 281.071(a)
[207] Tex. Health & Safety Code §§ 286.082(e). 281.071(c)
[208] Tex. Health & Safety Code § 286.082(f)
[209] Tex. Health & Safety Code § 281.071(e)-(f)
[210] Tex. Health & Safety Code § 61.012(b)

PROVIDERS

Any provider in the district who delivers health care services to a patient who is eligible for HD services, including dentists and podiatrists,[211] may bill the district[212] if they comply with notification and mandate transfer requirements.[213] Providers must timely notify the HD if they deliver or plan to deliver services to a patient eligible for indigency care.[214] Routine screening by providers for patient eligibility is permissible.[215]

Public hospitals can select one or more providers, and the hospital can mandate that eligible residents obtain care from one of these mandated providers,[216] even if it means a community provider has to transfer the patient to a mandated provider.[217] Exceptions to the requirement that a patient see a mandated provider include emergencies, medical inappropriateness, and unavailability of care.[218] However, if a community provider renders emergency care, the public hospital is not liable.[219]

HOSPITAL FACILITIES

medical and hospital care for the district's needy inhabitants.[220] The board must determine the type, number, and location of buildings required to establish and maintain an adequate hospital system along with the type of equipment necessary for hospital care.[221] The board has broad authority to manage, control, and administer its hospital system, including adopting operational rules.[222] Unlike other enabling HD statutes, however, Texas Health and Safety Chapter 286 does not include a provision for the operation of or taxation to maintain long-term care facilities.[223]

As detailed *supra*, if any governmental entity in the district owns land, buildings, improvements, or equipment related to a hospital system located wholly in the district, it must transfer title to the district upon creation of the district.[224] Regardless, the board may acquire, mortgage, pledge, sell, or otherwise dispose of hospital property, facilities, or equipment as it determines appropriate to maintain an adequate hospital system.[225] It may also lease out or rent hospital facilities,[226] and it may exercise the power of eminent domain.[227] In a county-initiated HD, the commissioners court may also contract for buildings, land, facilities, equipment, or services in addition to paying the subsequent regular monthly utility bills.[228]

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[211] Tex. Health & Safety Code § 61.006(g), (h)
[212] Tex. Health & Safety Code § 61.045(a)-(b). *See also* Tex. Health & Safety Code § 61.060(a) and § 61.060(b)
[213] Tex. Health & Safety Code § 61.058(e) (nonemergency care), § 61.0059(f)
[214] Tex. Health & Safety Code § 61.058(b) (nonemergency care), § 61.0059(a)
[215] Tex. Health & Safety Code § 61.045(a), (c)
[216] Tex. Health & Safety Code § 61.057
[217] Tex. Health & Safety Code § 61.005(c)
[218] Tex. Health & Safety Code § 61.057
[219] Tex. Health & Safety Code § 61.059(g)
[220] Tex. Const. art. IX, § 9.; Tex. Health & Safety Code § 286.073(a)(1)
[221] Tex. Health & Safety Code § 286.077(a)
[222] Tex. Health & Safety Code §§ 286.074, 286.075
[223] *See*, *e.g.*, Tex. Health & Safety Code Chapter 285 Subchapter I
[224] Tex. Health & Safety Code § 286.071(1). See the subsection entitled “Required Actions” for the detailed requirements regarding the transfer of hospital facilities to the district.
[225] Tex. Health & Safety Code §§ 286.077(b)(1), (2), (4); 281.050(a)
[226] Tex. Health & Safety Code §§ 286.077(b)(3) ; 281.050(a)-(b)
[227] Tex. Health & Safety Code § 286.080, 281.054
[228] Tex. Health & Safety Code § 281.052

If the HD wishes to enter into a construction contract of more than $10,000, it must engage in the competitive bidding process prescribed at Texas Local Government Code Chapter 271 Subchapter B.[229]

TOWARD VALUE-BASED CARE

County-initiated districts may establish a health maintenance organization to provide or arrange for healthcare services.[230] A county-initiated HD probably may also partner with a medical school to create an integrated health care system that provides comprehensive health care services.[231] Such services are not statutorily defined.

Revenue

The board holds the broad authority to determine the method of making purchases and expenditures as well as the accounting and control procedures for the district.[232]

INITIAL OPERATING FUNDS, RESERVES, AND DEBT

As noted *supra*, if any governmental entity in the district holds operating funds or reserves that were budgeted for medical care or payment of debts assumed by the district, it must transfer that fiscal year's funds to the district upon creation.[233] Unexpended funds to support and maintain hospital facilities must also be transferred to county-initiated districts.[234] The HD also receives any taxes levied by a governmental entity within the district for hospital purposes for district residents for the year.[235] If the HD does not comprise the entire taxable territory, the commissioners court may on the apportionment of the operating funds, the commissioners court may use its discretion, subject to judicial review, to choose the calculation by which to divide the funds, provided the resulting transfer comports with the statutory duty to provide care for the indigent residents of the district.[236]

The HD assumes any outstanding indebtedness incurred by a governmental entity in which all or part of the district is in and that is providing hospital care for residents of the district.[237] If only part of the governmental entity is in the district, the assumption is proportional to the total indebtedness.[238]

TAXATION

As a preliminary matter, the HD is the sole owner of funds from taxes levied for hospital purposes and medical care. Specifically, if any governmental entity in the district levied a tax for hospital purposes, it must transfer that year's funds to the district upon creation,[239] including any delinquent taxes that are later

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[229] Tex. Health & Safety Code § 286.078(b)
[230] Tex. Health & Safety Code § 281.0515. HMO establishment is subject to Texas Insurance Code Chapter 843.
[231] Tex. Health & Safety Code § 281.0517. While only El Paso County Hospital District is expressly authorized in the statute to establish and operate an integrated health care system (see Subsection b), the full statute is not limited to any particular locale, and other same or similar arrangements, such as that of Travis County, are known to the authors.
[232] Tex. Health & Safety Code § 286.076
[233] Tex. Health & Safety Code § 286.071(2), (4)
[234] Tex. Health & Safety Code § 281.041(b)(2)
[235] Tex. Health & Safety Code § 286.071(3)
[236] Tex. Atty Gen., Op. GA-0353 (August 29, 2005)
[237] Tex. Health & Safety Code §§ 286.073(a)(2), 281.044(a)
[238] Tex. Health & Safety Code § 286.073(b)
[239] Tex. Health & Safety Code § 286.071(3)

collected if the district is county-initiated.[240] Regardless, no further taxes may be levied by any entity other than the district for hospital purposes or medical care.[241]

Notably, the HDs of Bexar, Nueces, El Paso, and Harris Counties are prohibited from contracting to pay into a tax increment fund.[242]

Property Tax

VOTER-INITIATED

In a voter-initiated HD, voters may approve the levying of a property tax either via the creating petition[243] or in conjunction any other district election.[244] The board may annually impose property taxes in an amount not to exceed the voter-approved amount,[245] but the total tax rate may not exceed 75 cents on each $100 valuation of all taxable property in the district.[246] In determining the tax rate, the board is required to consider the district's non-tax-based income.[247] Even in the district's initial year, taxes may be imposed for the entire year.[248]

Property tax income may be used to pay debt and to maintain and operate the district.[249] However, taxes may not be imposed to pay the principal of or interest on revenue bonds.[250]

The appraisal, assessment, and collection of property taxes is governed by the state Tax Code,[251] and is overseen by a board-appointed or contracted tax assessor-collector.[252]

COUNTY-INITIATED

Some of the statutory provisions are the same for county-initiated districts, including that the total tax rate may not exceed 75 cents on each $100 valuation of all taxable property in the district.[253] Taxes may be imposed for the entire year even in the district's first year,[254] and proceeds may be used to provide for the operation and maintenance of the hospital or hospital system.[255]

However, unlike in voter-initiated districts, county-initiated districts not only may pay the interest on bonds that are assumed or issued by the district, but also taxes must be sufficient to create an interest and sinking fund to pay the principal of and interest on the bonds as they mature.[256] Tax proceeds may also

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[240] Tex. Health & Safety Code § 281.045(b)
[241] Tex. Health & Safety Code §§ 286.072, 281.045(a)
[242] Tex. Health & Safety Code § 281.095
[243] Tex. Health & Safety Code §§ 286.022(a)(6)
[244] Tex. Health & Safety Code §§ 286.026(a), 286.161(a)
[245] Tex. Health & Safety Code § 286.161(b)
[246] Tex. Health & Safety Code § 286.161(c)
[247] Tex. Health & Safety Code § 286.163
[248] Tex. Health & Safety Code § 286.162
[249] Tex. Health & Safety Code § 286.161(d)
[250] Tex. Health & Safety Code § 286.161(e)
[251] Tex. Health & Safety Code § 286.164(a)
[252] Tex. Health & Safety Code § 286.164(b)
[253] Tex. Health & Safety Code § 281.121(b)(2)
[254] Tex. Health & Safety Code § 281.121(a)
[255] Tex. Health & Safety Code § 281.121(c)(2)
[256] *See* Tex. Health & Safety Code § 281.121(b)(1), (c)(1)

be used to make improvements and additions to the hospital system and to pay for certificates of obligation.[257]

Finally, only the commissioners court—not the district board—may exempt property from an ad valorem tax or tax otherwise exempted property.[258]

Sales And Use Tax

Under Texas Health and Safety Code Chapter 286, a sales and use tax is permissible only if all or a majority of the territory of the district is located in a county or counties each with a population of 75,000 or less,[259] and any annexed territory must fall within the same population limitation.[260] The health services sale and use tax is codified at Texas Tax Code Chapter 324.[261] But Texas Health and Safety Code Chapter 285 Subchapter E provides without applicable restriction that an HD "that is authorized to impose ad valorem taxes may adopt a sales and use tax to lower the district's ad valorem taxes at an election held as provided by this subchapter."[262]

BONDS

In addition to the automatic assumption by county-initiated districts of outstanding bonds issued by the county or municipality for hospital purposes,[263] the board of a voter-initiated HD may issue general obligation bonds, revenue, and refunding bonds. Bonds, transactions related to bonds, and profits from the sale of bonds are not taxable by the state or any political subdivision thereof.[264] District bonds are eligible as sufficient security for deposits to the extent of their value if accompanied by all unmatured coupons for public funds of the state and all political subdivisions of the state.[265] District bonds and indebtedness are also authorized investments for banks, savings banks, trust companies, savings and loan associations, insurance companies, fiduciaries, trustees, guardians, and sinking funds of political subdivisions of the state.[266]

In a county-initiated HD, the commissioner court is authorized to issue and sell bonds[267] and to issue certificates of obligation in accordance with Texas Local Government Code Chapter 271 Subchapter C.[268]

General Obligation Bonds

General obligation bonds may issue in the name of and on the faith and credit of the district to

- purchase, construct, acquire, repair, or renovate buildings or improvements;
- equip buildings or improvements for hospital purposes; or

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[257] Tex. Health & Safety Code § 281.121(c)(3)-(4)
[258] Tex. Health & Safety Code § 281.096
[259] Tex. Health & Safety Code § 286.023(d)
[260] Tex. Health & Safety Code § 286.101(g)
[261] There are also relevant provisions at Texas Health and Safety Code Subchapter I.
[262] Tex. Health & Safety Code § 285.061(a)
[263] Tex. Health & Safety Code § 281.044(a)(2). But note that if the HD defaults, the county or municipality may still be liable. Tex. Health & Safety Code § 281.044(b)-(c). Additionally, if the bonds were approved but not sold, the bond authority is cancelled rather than transferred. Tex. Health & Safety Code § 281.044(d).
[264] Tex. Health & Safety Code § 286.151
[265] Tex. Health & Safety Code § 286.150
[266] Tex. Health & Safety Code § 286.149
[267] Tex. Health & Safety Code § 281.101
[268] Tex. Health & Safety Code § 281.106

- acquire and operate a mobile emergency medical service.[269]

In a voter-initiated HD, general obligation bonds must be approved through a vote catalyzed by either board action[270] or as part of the creation of the district. The initial petition may include a request that the confirmation election determine whether the HD may issue general obligation bonds, or the petitioner may make such request directly to the commissioners court.[271] If the request is in the petition, it must specific the maximum amount of bonds to be issued and their maximum maturity date.[272]

In a county-initiated HD, voters must approve bond issuance in an election held in accordance with Texas Government Code Chapter 1251.[273]

Regardless of impetus, when the bonds are issued, the board must levy a tax that is enough to create an interest and sinking fund to pay the principal of and interest on the bonds as they mature, but not so much that it, together with any other HD tax, exceeds the limit approved by the voters at the election authorizing the levy of taxes.[274]

Revenue Bonds

Revenue bonds may issue so that the HD can

- purchase, construct, acquire, repair, equip, or renovate buildings or improvements for hospital purposes;
- acquire sites to be used for hospital purposes; or
- acquire and operate a mobile emergency medical service to assist the district in carrying out its hospital purposes.[275]

Revenue bonds may be secured by any hospital revenue, or by a mortgage or deed of trust on realty owned by the district.[276] Unlike county hospital authorities, HDs may not secure revenue bonds through chattel mortgage.[277]

In a voter-initiated district, a majority of a quorum of the board must approve the resolution to issue revenue bonds, which must then be signed, counter-signed, and imprinted with the district seal.[278] The bonds must mature serially or otherwise not more than 40 years after they are issued,[279] but they need not be senior.[280] The board otherwise has discretion in setting price and terms, with the caveat that the net effective interest rate—as computed according to Texas Government Code Chapter 1204—may not exceed 10 percent per year.[281] The board may also determine under what time and price circumstances

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[269] Tex. Health & Safety Code § 286.141
[270] Tex. Health & Safety Code § 286.143(b)
[271] Tex. Health & Safety Code § 286.0235(a)-(b)
[272] Tex. Health & Safety Code § 286.0235(a)
[273] Tex. Health & Safety Code § 281.102
[274] Tex. Health & Safety Code §§ 286.143, 281.121(b)
[275] Tex. Health & Safety Code § 286.144(a)
[276] Tex. Health & Safety Code § 286.144(b)
[277] *Cf.* Tex. Health & Safety Code § 264.041(b) (authorizing realty mortgages and personalty liens) *with* Tex. Health & Safety Code § 286.144(b) (authorizing only realty mortgages).
[278] Tex. Health & Safety Code § 264.042
[279] Tex. Health & Safety Code § 264.043(a). *But see* Tex. Health & Safety Code § 264.146 (requiring maturity "not later than the 50th anniversary of the date of their issuance).
[280] *See* Tex. Health & Safety Code § 264.046
[281] Tex. Health & Safety Code § 264.043(b)(1)

the bonds are callable before maturity,[282] and whether the bonds will be registered as to principal or as to principal and interest.[283]

To execute the bonds, the board president must sign and the secretary, countersign as provided by Texas Government Code Chapter 618.[284]

After sale of bonds, the board may set aside proceeds to pay for up to two years' interest on the bonds.[285] Other permissible set-aside include for operating expenses during the first year[286] and to fund a bond or other reserve fund.[287]

Bonds and issuance records must be submitted to the Texas Attorney General, who, upon finding them valid, binding, and secured, must approve the bonds.[288] The Texas Comptroller then registers the bonds and certifies the registration.[289]

There are two major distinctions for bond issues in a county-initiated HD: First, voters must approve bond issuance in an election held in accordance with Texas Government Code Chapter 1251.[290] Second, the county judge must execute the bonds in the name of the district, and county clerk must countersign.[291]

Refunding Bonds

In voter-initiated districts, refunding bonds may be issued either in the manner provided by Texas Government Code Chapter 1207 Subchapter D,[292] or, if they are to be sold, in the manner provided by Texas Government Code Chapter 1207 Subchapters A-C.[293]

In county-initiated districts, refunding bonds must be issued in the manner provided for other bonds of the district except that an election is not required.[294]

ALTERNATIVE CAPITAL FUNDS PROCEDURE IN COUNTY-INITIATED DISTRICTS

A process alternative to the regular revenue bond process exists for county-initiated districts seeking TO raise funds to acquire, construct, equip, and improve its hospital system. If voters have previously approved the levy and assessment of an ad valorem property tax by a county-initiated district, the commissioners court may call an election regarding issuance of combination tax and revenue bonds and other short-term and long-term obligations in the amounts and upon the terms recommended and at the times requested by the board.[295]

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[282] Tex. Health & Safety Code § 264.043(b)(2)
[283] Tex. Health & Safety Code § 264.043(b)(3)
[284] Tex. Health & Safety Code § 264.147
[285] Tex. Health & Safety Code § 264.047(a)(1)
[286] Tex. Health & Safety Code § 264.047(a)(2)
[287] Tex. Health & Safety Code § 264.047(a)(3)
[288] Tex. Health & Safety Code §§ 264.049(a), (b)(1), 286.148(a), 281.105
[289] Tex. Health & Safety Code §§ 264.049(b)(2), 286.148(a), 281.105
[290] Tex. Health & Safety Code § 281.102
[291] Tex. Health & Safety Code § 281.104.
[292] Tex. Health & Safety Code § 286.145(b)
[293] Tex. Health & Safety Code § 286.145(c)
[294] Tex. Health & Safety Code § 281.103(b)
[295] *See generally* Tex. Health & Safety Code § 281.107

CERTIFICATES OF OBLIGATION IN COUNTY-INITIATED DISTRICTS

A class of securities that may be sold for cash,[296] certificates of obligation can pay a contractual obligation incurred for many purposes, including construction; purchase of materials, supplies, equipment, machinery, buildings, land, and rights-of-way; professional services; renovations and improvements; and even destruction of dangerous structures, amongst other things.[297]

With the approval of the commissioners court, the board may issue certificates of obligation consistent with Texas Local Government Code Chapter 271, Subchapter C.[298] If after adequate notice at least five percent of qualified voters timely protest the issuance of a certificate of obligation, an election must be held.[299]

EXTERNAL REMUNERATION

As a preliminary matter, the HD may contract with the state or federal government for reimbursement of the treatment of sick, diseased, or injured persons.[300] Voter-initiated HDs may also contract with a local, state, or federal government entity to provide for the "investigatory or welfare needs of inhabitants of the district."[301]

The HD must additionally seek reimbursement in two cases: First, if the district provides care and treatment to a sick, diseased, or injured person who resides outside the district, it must require reimbursement from the appropriate governmental entity.[302] Second, if a person from outside the district is imprisoned in a county or municipal jail, the HD must seek reimbursement from the sheriff or police chief of the county or municipality for any care or treatment provided.[303]

GIFTS AND ENDOWMENTS

An HD may accept gifts and endowments to hold and administer as required by the respective donors.[304]

INVESTMENTS

The board in a voter-initiated district may invest operating, depreciation, or building reserves only in:

- U.S. bonds;[305]
- U.S. Treasury certificates of indebtedness;[306]
- Texas state, county, municipal, or school district bonds; and[307]
- Federal Deposit Insurance Corporation (FDIC)-insured shares or share accounts of Texas savings and loan associations or federal savings and loan associations domiciled in Texas.[308]

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[296] Tex. Loc. Gov't. Code § 271.050(a)
[297] For the full list, see Tex. Loc. Gov't. Code §§ 271.045—271.0461
[298] Tex. Health & Safety Code § 281.106
[299] Tex. Loc. Gov't. Code § 271.049
[300] Tex. Health & Safety Code §§ 286.083(c), 281.051(b)(2)
[301] Tex. Health & Safety Code § 286.084(2)
[302] Tex. Health & Safety Code §§ 286.083(a), 281.072; Chapter 61 Subchapter B
[303] Tex. Health & Safety Code § 286.083(b)
[304] Tex. Health & Safety Code §§ 286.085, 281.055
[305] Tex. Health & Safety Code § 286.129(b)(1)
[306] Tex. Health & Safety Code § 286.129(b)(2)
[307] Tex. Health & Safety Code § 286.129(b)(3)
[308] Tex. Health & Safety Code § 286.129(b)(4)

The board may also choose to place a portion of district funds on time deposit or to purchase certificates of deposit.[309] If a bond resolution or trust indenture so indicates, bond proceeds may be invested consistent with law relating to security for and investment of county funds except as further limited by the resolution.[310]

INTELLECTUAL PROPERTY

Only the HDs of Dallas and Tarrant Counties are expressly authorized to sell, license, or otherwise benefit from their intellectual property.[311]

Finances

The board may establish the HD's fiscal year.[312] An annual audit is required, and it, along with other district records, must be open to physical inspection during regular business hours at the principal office.[313] The board must name at least one bank to serve as depository for district funds, and if the amount exceeds the amount secured by the Federal Deposit Insurance Corporation, the bank must execute a bond or other security.[314] Selection of a depository by county-initiated HDs are subject to term limits.[315]

The proposed annual budget must be approved by the board after, in a voter-initiated district, a public hearing,[316] or, in a county-initiated district, before commissioners court approval.[317] No money may be spent that is not included in the annual budget,[318] but the budget can be amended on the board's approval.[319]

Except for construction contracts and bonds, an HD may not incur debt that cannot be repaid in the current or fiscal year.[320] The HD also may not obligate the state nor may the legislature make a direct appropriation to an HD.[321]

Workforce

The board may adopt rules for duties, functions, and responsibilities of HD staff and employees.[322] It may also enter into operating or management contracts relating to hospital facilities[323]. Because decisions by the commissioners court regarding purchasing and accounting methods and procedures are binding on

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[309] Tex. Health & Safety Code § 286.130(b)
[310] Tex. Health & Safety Code § 264.047 (c)
[311] Tex. Health & Safety Code § 281.0518—281.0519
[312] Tex. Health & Safety Code § 286.121(a).
[313] Tex. Health & Safety Code §§ 286.122, 286.123
[314] Tex. Health & Safety Code § 286.130
[315] *See* Tex. Health & Safety Code § 281.093
[316] Tex. Health & Safety Code § 286.125
[317] Tex. Health & Safety Code § 281.091(b)
[318] Tex. Health & Safety Code § 286.127
[319] Tex. Health & Safety Code § 286.126
[320] Tex. Health & Safety Code § 286.129
[321] Tex. Health & Safety Code § 286.951
[322] Tex. Health & Safety Code §§ 286.075, 281.048
[323] Tex. Health & Safety Code § 286.079

county officers, employees, and agents, the district must pay salaries and expenses for the work activities of those persons,[324] including for legal services by a county, district, or criminal district attorney.[325]

Administration

In addition to administration of required services as described in this subsection, county-initiated districts may take on the administrative functions and services for an FQHC or FQHC-look-alike.[326]

The board of a voter-initiated district may appoint an administrator, assistant administrator, and attorney, each of whom serves at the will of the board in a compensated role.[327] In a county-initiated HD, the board has express statutory authority to appoint only an administrator—to an at-will, four-year term[328]--and legal counsel.[329] County-initiated HD boards may also expressly appoint an assistant administrator in the event of the administrator's inability to perform the duties of the job.[330]

The administrator may hire non-physician staff and has the broad authority to supervise and direct the general affairs of the HD, subject to any limitations prescribed by the board.[331] Similar to the directors, the administrator must execute a personal or district-funded bond payable to the district in an amount of at least $5,000 if voter-initiated[332] or $10,000 if county-initiated.[333] The board of a county-initiated HD may determine the appropriate amount for the bond of an assistant administrator.[334]

The administrator's responsibilities include preparing a proposed annual budget inclusive of a complete financial statement[335] and, after the close of the fiscal year, a sworn statement accounting of the current money held and disbursements made.[336]

Medical And Other Staff

The board may appoint to the staff any doctors necessary for efficient operation, including temporary appointments.[337] In a county-initiated HD, medical staff appointments are subject to a four-year contractual limitation.[338]

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[324] Tex. Health & Safety Code § 281.049(c)-(d)
[325] Tex. Health & Safety Code § 281.056(d)
[326] Tex. Health & Safety Code § 281.0512
[327] Tex. Health & Safety Code § 286.052(a)-(c)
[328] Tex. Health & Safety Code § 281.026(b)
[329] Tex. Health & Safety Code § 281.056(b)-(c).
[330] Tex. Health & Safety Code § 281.027(a).
[331] Tex. Health & Safety Code §§ 286.054, 286.055; 281.026(e)
[332] Tex. Health & Safety Code § 286.052(d)
[333] Tex. Health & Safety Code § 281.026(d)
[334] Tex. Health & Safety Code § 281.027(b)
[335] Tex. Health & Safety Code §§ 286.124, 281.091(a). For the seven-part definition of a complete financial statement, see 286.124(b).
[336] Tex. Health & Safety Code §§ 286.128, 281.092
[337] Tex. Health & Safety Code § 286.053
[338] Tex. Health & Safety Code § 281.028

The HD may also employ, or delegate to the administrator to employ, other employees deemed necessary, including technicians, nurses, fiscal agents, accountants, architects, and additional attorneys.[339] The board may also appoint or contract a tax assessor-collector.[340]

Only the HDs of Dallas, Tarrant, Bexar, and El Paso Counties are expressly authorized to employ and commission peace officers.[341]

Staff Retirement Benefits

The board may provide retirement benefits for employees of the district by establishing or administering a retirement program.[342] Alternatively, the board may elect to participate in the Texas County and District Retirement System or in any other statewide retirement system in which the district is eligible to participate.[343]

Municipal Hospital Authorities

This subsection summarizes select legal requirements for municipal hospital authorities in Texas, focusing on a high-level understanding of their establishment, governance, and financing. It does not attempt to include all requirements, and it is inclusive only of select statutory and regulatory provisions applicable to Laredo, Webb County, Texas. Although a literature review was conducted through The University of Texas library, very few relevant articles were found, and nothing was deemed necessary or appropriate for inclusion. Opinions of the Texas Attorney General are incorporated where relevant, as are limited references to rules and regulations in pertinent parts.

Definition

Generally, a municipal hospital authority (MHA) is a sovereign formed by a local government rather than one operated directly by or under contract with the local government as a municipal hospital[344] or operated commercially, charitably, or by a national or state government. An MHA can acquire, own, or lease hospitals. Within Texas, MHAs can be contrasted with county hospital authorities[345] and hospital districts formed by voters.[346] MHAs may be a joint effort between a municipality and its county.[347]

Authority

The Hospital Authority Act, codified at , permits the governing body of one or more municipalities to create a hospital authority and designate its name.

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[339] Tex. Health & Safety Code § 286.054 (providing for the employment of the professionals cited in voter-initiated districts). *But cf.* Tex. Health & Safety Code § 281.028(a) ("technicians, nurses, and other employees the board considers advisable for the district's efficient operation").
[340] Tex. Health & Safety Code § 286.164(b)
[341] Tex. Health & Safety Code § 281.057(a)
[342] Tex. Health & Safety Code §§ 286.056(1); 281.029(b)
[343] Tex. Health & Safety Code §§ 286.056(2); 281.029(a)
[344] *See* Tex. Health & Safety Code § 261.001(1)
[345] *See generally* Tex. Health & Safety Code Chapter 264
[346] *See generally* Tex. Health & Safety Code Chapter 286
[347] *See generally* Tex. Health & Safety Code Chapter 265

CREATION

In adopting an ordinance creating a hospital authority, the municipality's governing body must find that the creation of the authority is "in the best interest of the municipality and its residents."[348] Similarly, if two or more municipalities each adopt an ordinance creating a hospital authority, the governing bodies must find that the creation of the authority is "in the best interest of the municipalities."[349]

DISSOLUTION

An MHA may be dissolved by ordinance if the MHA's assets and liabilities are sold or transferred to the municipality or another person consistent with existing bonds, warrants, or other obligations of the MHA.[350] Voters may act to stop a dissolution through an election process.[351]

Business Organization

STATUS

An MHA is both a body politic and body corporate.[352] Its legal distinctive status derives from its power of perpetual succession with its own seal.[353] MHAs enjoy other characteristics common to private corporations, such as the power to sue and be sued, and to make, amend, and repeal its own bylaws.[354] It can also form a nonprofit corporation to provide services.[355] It is considered a municipal corporation for purposes of litigation related to eminent domain,[356] but, if in a very large county, a unit of local government and not a municipality for purposes of litigation related to tortious liability.[357]

GOVERNANCE

An MHA must be governed by seven to eleven uncompensated directors serving terms of no more than two years.[358] Officers and employees of the municipality are ineligible for appointment to the board.[359] The enabling ordinance must specify the precise of number of directors, but the size of the board can be changed through amendment, assuming to do so is not inconsistent with bond or trust requirements.[360] Those requirements may dictate the selection and term of the temporary board.[361]

The manner of selecting the permanent board is fact dependent. For example, if the MHA comprises more than one municipality, they would appoint half the directors unless they agree that a different division would be better.[362] If the MHA purchases an existing hospital, that contract is controlling.[363] On

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[348] Tex. Health & Safety Code § 262.003(a)
[349] Tex. Health & Safety Code § 262.003(b)
[350] Tex. Health & Safety Code §§ 262.005(a)-(b)
[351] Tex. Health & Safety Code §§ 262.005(d)-(f)
[352] Tex. Health & Safety Code § 262.003(d)
[353] Tex. Health & Safety Code §§ 262.0021(a), (b)(1)
[354] Tex. Health & Safety Code §§ 262.0021(b)(2)-(3)
[355] Tex. Health & Safety Code §§ 262.037, 262.038
[356] Tex. Health & Safety Code § 262.028(b)
[357] Tex. Health & Safety Code § 262.035(d)
[358] Tex. Health & Safety Code §§ 262.0011(a), 262.012(a), 262.015
[359] Tex. Health & Safety Code § 262.0012(f)
[360] Tex. Health & Safety Code § 262.0011(b)
[361] Tex. Health & Safety Code § 262.0011(b)
[362] Tex. Health & Safety Code § 262.0012(a)
[363] Tex. Health & Safety Code § 262.0012(d)

the other hand, if the bonds are issued under the Hospital Project Financing Act, the municipality may require the board to submit a slate of candidates for the municipality to approve. In such an instance, the municipality can also declare the board subject to term limits.[364]

The board is required to have at least four officers—president, vice-president, secretary, and treasurer—plus any others provided for in the bylaws.[365] The president and vice-president must be directors, but the secretary and treasurer do not have to be.[366] The positions of secretary and treasurer may be combined.[367] The only termination provision under statute concerns default of a trust indenture: The trust indenture may grant the trustee authority to terminate the then-current directors and appoint new ones.[368]

ROLE OF ELECTORATE

Voters and the board may drive certain actions by the MHA. In each case, an election is required if the MHA receives a petition signed by at least 10% of the qualified voters. The election need not occur on a uniform election date. These actions include:

- Question of board resolution to sell or close a hospital owned and operated by the MHA[369]
- Question of notice of intent to sell the property to a political subdivision[370]
- Proposition for the issuance of revenue bonds, [371] and
- Referendum on ordinance dissolving the MHA[372]

Services

An MHA may provide services directly or through contract. Regardless, it does not have to provide indigent health care assistance.[373]

HOSPITAL

An MHA may construct, purchase, enlarge, furnish, or equip one or more hospitals,[374] consistent with the Hospital Project Financing Act at . Hospital projects include land, building, equipment, machinery, furniture, facilities and improvements.[375]

Permissible uses[376] for an MHA's hospital project broadly include anything related or essential to the operation of a health facility or system, such as:

- Hospital
- Clinic
- Health facility
- Extended care facility

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[364] Tex. Health & Safety Code § 262.0012(e)
[365] Tex. Health & Safety Code § 262.0013(a)
[366] Tex. Health & Safety Code § 262.0013(a)(1)-(2)
[367] Tex. Health & Safety Code § 262.0013(b)
[368] Tex. Health & Safety Code § 262.0012(c)
[369] Tex. Health & Safety Code § 262.033(c)
[370] Tex. Health & Safety Code §§ 262.032(c)-(d)
[371] Tex. Health & Safety Code §§ 262.045(a)-(b)
[372] Tex. Health & Safety Code §§ 262.005(d)-(f)
[373] County Indigent Health Care Program Handbook § 1200 (April 8, 2022)
[374] Tex. Health & Safety Code § 262.022(a)
[375] Tex. Health & Safety Code § 223.002(4)(A)
[376] Tex. Health & Safety Code § 223.002(4)(B)(i), (D)

- Outpatient facility
- Rehabilitation or recreation facility
- Pharmacy
- Medical laboratory
- Dental laboratory
- Physicians' office building
- Laundry or administrative facility

Additional acceptable structure includes a multiunit housing facility for medical staff, nurses, interns, other employees of a health facility or system, patients of a health facility, or relatives of patients admitted for treatment or care in a health facility.[377]

An MHA may operate and maintain one or more hospitals, but it must do so without the intervention of private profit unless it leases the hospital.[378] MHA hospitals must be licensed consistent with the provisions at .

CARE FOR PERSONS WHO ARE ELDERLY OR DISABLED

Once non-urban[379] MHAs own or operate a hospital, they can provide facilities and services for persons who are elderly or disabled so long as there is not a private provider available and accessible.[380]

PUBLIC HEALTH

An MHA may use its available assets to promote public health and general welfare initiatives if it no longer owns or operates a hospital because it is has sold or closed its hospital(s).[381] Although debts must be satisfied as well, in such circumstance an MHA can undertake any activity that the board determines is necessary or appropriate to improve public health, promote wellness, prevent disease, or enhance the general welfare of its residents.[382]

Eligible activities include owning, operating, or funding an indigent health care clinic, medical research facility, medical training facility, or other health care facility.[383] Similar to other services, the MHA may also provide direct or indirect financial assistance to a nonprofit organization that owns or operates the aforementioned facilities or a hospital.[384] Nonprofits that support initiatives promoting health education, wellness, or disease prevention are also eligible for direct or indirect financial assistance.[385]

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[377] Tex. Health & Safety Code § 223.002(4)(B)(ii)
[378] Tex. Health & Safety Code § 262.022(b)
[379] *See* Tex. Health & Safety Code § 262.034(e)
[380] Tex. Health & Safety Code § 262.034(f)
[381] Tex. Health & Safety Code § 262.0331(a)
[382] Tex. Health & Safety Code §§ 262.0331(a)(3), (b)
[383] Tex. Health & Safety Code § 262.0331(a)(1)
[384] Tex. Health & Safety Code § 262.0331(a)(2)(A)
[385] Tex. Health & Safety Code § 262.0331(a)(2)(B)

Revenue

TAXATION

The authority does not have taxing power.[386] Its property is exempt from taxation if held entirely for public purposes.[387]

RATE SETTING

Without tax income, proper rate setting is the means for an MHA to assure a hospital operates profitably. Thus, rates must be set and charged in sufficient amount to pay operational expenses, due interest on bonds, create a sinking fund to timely pay bonds, and maintain a bond reserved fund.[388]

BONDS

An MHA may issue revenue bonds to provide funds for its purposes,[389] but voters may defeat the issuance through a referendum.[390] The bonds must be payable from and secured by a pledge of, revenues from the operation of one or more hospitals and any other revenues from owning hospital property.[391] Additionally, revenue bonds may be secured by a mortgage or deed of trust on the MHA's real or personal property,[392] and they need not be senior.[393] Revenue bonds must mature serially or otherwise not more than forty (40) years after they are issued.[394] Bonds are negotiable, but must be approved by the state attorney general.[395] A rural MHA may issue revenue bonds and other notes to provide services or care to persons who are elderly or disabled.[396]

LOANS

Only MHAs in municipalities of less than 25,000 persons may borrow money from a lending institution.[397]

GIFTS AND ENDOWMENTS

An MHA may accept gifts and endowments to hold and administer as required by respective donors.[398]

INVESTMENTS

An MHA may invest its funds in accordance with applicable municipal law.[399]

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[386] Tex. Health & Safety Code § 262.003(e)
[387] Tex. Health & Safety Code § 262.004; Tex. Tax Code § 11.11(a). *See also* Tex. Atty Gen., Op. JC-0571 (Nov. 4, 2022); Tex. Atty Gen., Op. JC-0311 (Nov. 30, 2000).
[388] Tex. Health & Safety Code § 262.026.
[389] Tex. Health & Safety Code § 262.041(a).
[390] Tex. Health & Safety Code §§ 262.045(a)-(b).
[391] Tex. Health & Safety Code § 262.041(b).
[392] Tex. Health & Safety Code § 262.041(b).
[393] Tex. Health & Safety Code § 262.046.
[394] Tex. Health & Safety Code § 262.043.
[395] Tex. Health & Safety Code § 262.049.
[396] Tex. Health & Safety Code § 262.034(c).
[397] *See* Tex. Health & Safety Code § 262.0225
[398] Tex. Health & Safety Code § 262.029
[399] Tex. Health & Safety Code §§ 262.039, 262.047, 262.050

Workforce

Administration and Medical Staff

An MHA may employ a managing administrator and other employees, experts, agents, and legal counsel.[400] The administrator may manage the hospital, including hiring and discharging other employees.[401] It is also permissible to contract with healthcare professionals to supplement the MHA's medical staff so long as staff remuneration is consistent with federal and state anti-kickback statutes[402] as well as other anti-fraud and abuse laws.

Staff Retirement Benefits

If a municipality has its own retirement system, an MHA must provide employee retirement benefits.[403]

[400] Tex. Health & Safety Code § 262.023(a), (c)
[401] Tex. Health & Safety Code § 262.023(b)
[402] *See* Tex. Atty Gen., Op. DM-138 (July 8, 1992)
[403] Tex. Health & Safety Code § 262.036

SECTION 3 – OPTIONS FOR ADDRESSING GAPS IN LOCAL HEALTHCARE SERVICES

The following options for addressing gaps in local healthcare services in Laredo were developed to address the disparities identified in the gap analysis. Major gaps in Laredo include lack of primary care physicians, lack of specialty care, particularly cardiology, endocrinology, and neurology, lack of affordable healthcare, and insufficient behavioral healthcare. Webb County is currently a primary care, dental health, and mental health Health Professional Shortage Area (HPSA) as well as a Medically Underserved Area (MUA), as both are defined by the federal Health Resources and Services Administration. To no longer be a HPSA, Webb County needs an additional 20 FTE primary care physicians, 30 FTE dentists, and 11 FTE psychiatrists.

Necessary Preconditions for Addressing Gaps in Healthcare Services

Before any strategies to address gaps in healthcare services can be implemented, two major sets of requirements must be met – who will facilitate the implementation of the strategies, and how the strategies will be funded.

Administrative Requirements

All options available to Laredo for addressing gaps in healthcare services require someone to do something, so stakeholders must decide who will implement the chosen strategies or facilitate their execution. Major options for implementing strategies for addressing gaps in healthcare services include:

- One or more existing entities such as the City of Laredo Health Department, City of Laredo Economic Development Department, Laredo Economic Development Corporation, or one or both major hospitals; or
- A new entity such as a hospital district or newly established nonprofit corporation.

Financial Requirements

Similarly, many options for recruiting clinicians and expanding facility capacity have associated costs-requiring a financing mechanism. Clinician recruitment and facility capacity financing options include:

- Establishment of a hospital district with taxing authority
- Ongoing direct funding by the city, county, major hospitals, or other stakeholders, and
- Bond issuance by city or county for capital investments

Addressing Gaps in Healthcare Services

The following options were based on national best practices and evidence-based strategies for addressing gaps in healthcare services, particularly with respect to physicians, nurses, and behavioral health. Strategies for addressing physician gaps include financial incentives and non-financial tactics.

Addressing Gaps in Physician Specialties

Stakeholder interviews identified recruitment as a barrier to meeting the physician shortage gap in Laredo. Providers expressed challenges in getting medical professionals to move to Laredo and subsequent difficulty for others to adapt to Laredo. We recommend a combined set of strategies to overcome barriers in recruitment and retention including financial incentives and non-financial tactics for recruitment and strategies for encouraging local students to pursue medical education. In addition, we

recommend directing any strategies internationally. It seems likely that physicians in Mexico and South America might welcome the opportunity to work and live in the U.S. and hospitals are well-positioned to sponsor the appropriate visas.

Select Strategies for Addressing Gaps in Physician Specialties

- ***Contracts with income guarantees***
- ***Signing bonuses***
- ***Relocation payments***
- ***CME allowances***
- ***Medical education loan forgiveness***

FINANCIAL INCENTIVES FOR RECRUITMENT

Many of the commonly used strategies for recruiting physicians involve financial incentives. Merritt Hawkins, a large healthcare professional recruiting firm used by hospitals and other healthcare organizations to recruit clinicians, publishes an annual report describing the different clinician recruiting strategies they use on their client's behalf. Clinician recruiting strategy descriptions are below.

Starting Salaries

Average starting salaries for physicians and APNs are a useful indicator of financial incentives needed to attract professionals who are either already established in a practice or completing training. Starting salaries for primary care increased by 3% from $243,000 in 2021 to $251,000 in 2022.

Table 18: National average starting salaries by physician specialty, AMN Healthcare 2022

Specialty	2020/21	2021/22	Increase/Decrease
Cardiology (non. Inv.)	$446,000	$484,000	+8%
Cardiology (Inv.)	$611,000	$527,000	-16%
Neurology	$332,000	$356,000	+7%
Psychiatry	$279,000	$299,000	+7%
Pulmonology/Critical Care	$385,000	$412,000	+6%
Hematology/ Oncology	$385,000	$404,000	+5%

Physician Contract Structures

Most Merritt Hawkins searches (61%) offered employment contracts with starting base salary supplemented by production bonuses. Production bonuses are often offered as incentive to reward behavior such as volume of work or adherence to quality guidelines. Production bonuses determine maximum income that physicians can earn beyond their salary. Straight salary structure accounted for 33% of searches. Straight salary structure is usually adopted by FQHCs, urgent care, and academic settings. Some medical groups are moving toward the straight salary structure as they have found it is less ambiguous and results in less friction among physicians. Income guarantees are essentially loans that must be repaid but might be forgiven over time. This structure is usually for physicians in solo or

small private practices. With the decreasing number of private practices, this structure is rarely used today however contracts featuring income guarantees has grown year-over-year to 4% from 2%.[404]

Signing Bonuses

Signing bonuses are a popular recruitment incentive used by hospitals and medical groups. They provide additional motivation for candidates who may be considering multiple opportunities and offer an immediate, tangible reward that can make opportunities distinct. Signing bonuses have significantly increased post-COVID. Signing bonuses increased from 61% to 92% in the past year, a 29% increase. This significant increase indicates a more competitive market, but this may be due to a surge in demand due to COVID and may decrease in later years. Signing bonuses for physicians averaged $31,000 in 2022 up from $29,656 in 2021 a $1,344 increase.

Paid Relocation

Paid relocation is another common incentive for physician recruitment, specifically for recruiting outside of the local community. Relocation was offered in 78% of recruitment searches this year a slight increase from 74% the previous year. The average relocation allowance for physicians was $10,634 in 2022, a slight increase from the previous year ($10,634).

CME allowances

Continuing Medical Education (CME) allowances are included in most benefit packages in Merritt Hawkins searches (92%). The average CME allowance for physicians in 2022 was $3,691 and did not change significantly from the previous year ($3,695).

Medical Education Loan Repayment

Medical Education Loan Repayment is an incentive for the recruiting hospital or other facility pays the physician's medical school loans in exchange for the physician's commitment to stay in the community for a specific time. With the average medical school debt exceeding $190,000, this method may be even more effective. Offers that included medical education loan repayment have decreased from 21% the previous year to 18% in 2022. The average amount of loan forgiveness decreased from $104,630 the previous year to $101,572 in 2022. Most contracts featuring educational loan forgiveness (77%) required three-year terms, followed by two-year terms (15%), and lastly, one-year terms (8%).

NON-FINANCIAL TACTICS FOR RECRUITMENT

Virtual Interviews

The shift to virtual interviews is the most visible change in physician and APN recruitment since the COVID-19 pandemic. Some medical employers have switched to an entirely virtual interview model and found it effective. Offering virtual interviews and tours can allow more flexibility and may be more appealing to candidates than the traditional in-person interview.

Leveraging Digital Content (Marketing)

Some employers are enriching their marketing efforts through digital content such as professionally created videos showcasing various departments, testimonials from physicians, hospital tours, campus

[404] Review of Physician and Advanced Practitioner Recruiting Incentives, AMN Healthcare 2022

maps and community life. By leveraging digital content employers can reach a broader candidate market and allow assessment of a practice and community before or without an in-person visit.

COVID-19 Protocols

Vaccine requirements and COVID-19 protocols are now reasons why some candidates are looking for other opportunities and in some cases is their key motivator. Employers should be upfront about their COVID-19 requirements and protocols to save time in the recruiting process.

Flexibility

New entrants to the physician recruiting market such as urgent care centers and retail clinics are offering candidates increased flexibility with work hours, work from home options, and telemedicine which all appeal to candidates especially post-COVID. Traditional employers such as hospitals should be aware of this trend and try to provide as much practice flexibility in terms of schedules, subspeciality work, and duties in response.

Focus on Physician Well-being/Retention

Another effect of COVID is accentuated physician well-being in the workplace. This includes offering a safe environment and providing tangible support such as enhanced compensation, additional staffing through locum tenens (substitute physicians), use of NPs and PAs, telemedicine, artificial intelligence, and flexible schedules. Employers should be able to demonstrate concrete ways to improve the medical environment in response to the pandemic.

Basic Tenets

Efficiency in the recruiting process and accommodating candidate needs leads to the best chance of success for recruiters. It is important to expedite the search process, extending the offer/employment contract promptly. Consider creative incentives such as resident stipends, typically offered to physicians in their last year of training, and housing stipends.

LOCAL PROMOTION OF MEDICAL EDUCATION

With local students having to go outside of Laredo for medical school, the city or county could offer scholarships to local students who pursue medical school and agree to return to Laredo upon completion of their training.

Addressing Gaps in Nurse Staffing

Stakeholder interviews identified retention of nursing personnel as a major issue in Laredo. Many staff nurses left their positions during the pandemic, seeking higher pay and more flexible schedules through travel or contract nursing. A report by Kaufmann Hall identifies that total hospital labor expenses increased by 37% from 2020 to 2022. The financial incentives and non-financial tactics described in the section above for physicians can be applied to nurse recruitment as well and, as with physician recruitment, the scope of nurse recruiting should be international.

Select Strategies for Addressing Nurse Staffing Shortfalls
- Financial incentives as above for physicians
- Increasing local pipeline

FINANCIAL INCENTIVES FOR RECRUITMENT

Average starting salaries for nurse practitioners (NPs) and certified registered nurse anesthetists (CRNAs) have decreased from 2020/2021 to 2021/2022. NP salary for all positions decreased from $140,000 to $138,000 and CRNA salary for all positions decreased from $222,000 to $211,000, a decline of 5%. However, starting salaries for academic positions are lower than non-Academic salaries for both NP and CRNA positions. Average salary for Academic NP positions was $128,000 versus $153,000 for non-Academic positions. The gap is wider for CRNAs with average starting salary for academic CRNA positions at $170,000 versus $245,000 for non-academic CRNA positions. When only comparing non-academic NP positions to all 2021 NP positions, NP salaries increased 5% year-to-year and CRNA salaries increased by 10% year-to-year. Many Academic Medical Centers have increased their salary offers to get closer to non-Academic averages, but significant gaps persist. The decrease in starting salary for academic positions may make academic nursing positions less appealing to recruits.

- NP and PA bonuses averaged $9,000 in 2022 up from $7,233 in 2021, a $1,767 increase.
- The average relocation allowance for NPs and PA was $8,842 in 2022.
- The average CME allowance for NPs and PAs was $2,537 in 2022, a slight decrease from the previous year ($2,956).
- Average amount of loan forgiveness for NPs and PAs dramatically decreased from $80,000 the previous year to $55,950 in 2022. This steep decrease may be an abnormality as loan repayments for NPs and PA have increased over the last 5 years and demand for NPs continues to increase.

INCREASING LOCAL PIPELINE

Laredo is home to two schools of nursing. These offer the opportunity to increase the number of available nurses in the community by identifying and attracting residents to train in Laredo and retain them once they have graduated. Expanding the pipeline for new nurses must begin with students as young as grade school. They must be exposed to STEM (science, technology, engineering , and math) professions early in their educational career. This can begin with participation by local health care professionals in career days or developing programs that invite young children into the health care setting for appropriate activities. These efforts must continue through junior high and high school to maintain students' interest. Ongoing engagement will increase the ability to recruit local talent.

The rate-limiting factor for most nursing programs is the lack of qualified faculty to teach nursing students. As cited above, the salaries for academic versus non-academic positions are low. This dissuades nurses from pursuing academic careers. In addition, training nurses and other healthcare professionals requires clinical space to achieve hands-on experience. Hospitals and other healthcare settings must be willing to open their doors to students.

Lack of Inpatient Psychiatric Capacity

Based on Laredo’s need assessment, HMA drafted a financial projection of the viability of establishing an inpatient psychiatric unit for a hospital. The projection indicates that expanding inpatient psychiatric services would require significant financial investment, and additional sources of revenue should be explored to address patient needs.

FINANCIAL SUMMARY

The pro forma model in Table 18 was developed by HMA and assumes approximately 3.5 years of operating activity to accommodate the 17 months required for construction.

Table 19: Pro Forma Financial Results

Category	Value	Note
Bed Count	14	
ADC	12	86% Utilization
Square Ft. Required	7,700	550 Sq Ft per Bed
Estimated Capital	$2.9M	$206K per Bed
Construction Timeline	17	Months
FTEs Required	73.4	All Shifts + Weekends
Average Cost per FTE	90,500	Salary + Fringe (All Employee Types)
5 Year Operating Revenue	$11.7M	
5 Year Operating Expenses	($28.2M)	
5 Year Net Income (Loss)	($16.5M)	
5 Year Net Present Value	(17.2M)	Assumes 5.5% Cost of Capital

METHODOLOGY

HMA developed a framework for its strategic financial analysis to prioritize specialty service expansion that considers the following questions:

1. Patient Need – Will the new service address patient's need?
2. Strategic Viability – Can Laredo obtain the resources required to start the service?
3. Financial Viability – Will the service be financially viable for Laredo?

HMA utilized several data sources to perform the analysis, including Medicare and Medicaid cost reports, Medicare and Medicaid agency data, publicly available data, and regulatory data. Further, HMA used its knowledge of hospital operations, clinical services, and Texas market expertise to understand the imperatives that strategic expansion planning should consider.

HMA modeled a projection based on an IP Psych unit with 14 beds. This estimate is a feasible starting point, as it would allow the hospital to create a staffing model consistent with industry standards, and potentially generate sufficient patient volume to support the additional fixed cost of the unit's operation. HMA also assumed that enough real estate is available at the existing location to accommodate the estimated 7,700 sf required for the unit. The staffing and capital requirements are based on comparable operating models from Texas and the Midwest hospitals.

The operating model projects the need for about 73.0 FTEs. With Laredo's high population of uninsured and government-sponsored insurance patients, the operation supports a $16.5M operating loss over five years. Accordingly, HMA believes that expanding Inpatient Psych services requires a significant financial and strategic investment, and recommends exploring alternative service offerings to adequately address patient and community needs.

Environmental Considerations

ECONOMIC DEVELOPMENT

Some of the barriers to the recruitment of healthcare professionals may be the perceived lack of amenities in the community compared to other cities and the perception that the city is not safe due to drug-related gang violence. Ultimately, both perceptions can potentially be addressed by efforts outside of

the healthcare space, primarily economic development. While outside the scope of our analysis, recruitment of healthcare professionals, particularly physician specialists, should be coordinated with economic development activities in the city, and any in-person visits to the city should include significant communication regarding the safety of the city and its amenities.

COMPETITIVE DYNAMICS

This report was researched and drafted during the pendency of a lawsuit involving no fewer than five healthcare institutions in the city. The allegations, if true, mean that certain professional shortages are not solely due to market-based assumptions. The lawsuit may also have effects on the professional environment into which the City of Laredo seeks to recruit.

Filed October 29, 2021, by Doctors Hospital of Laredo and Laredo Physicians Group, the lawsuit pertains to alleged anticompetitive behavior by Dr. Ricardo Cigarroa, Cigarroa Heart and Vascular Institute, Laredo Texas Hospital Company (d/b/a Laredo Medical Center), and Laredo Physician Associates.[405] The respondents are alleged to have engaged in anticompetitive and tortious behavior that (1) rendered ineffective plaintiff's recruitment of cardiologists, and especially interventional cardiologists; (2) denied patient access to cardiology care when the plaintiff was the referring provider; and (3) induced local practitioners within the broad field of cardiology to leave Doctors Hospital for practice with the respondents.[406]

In an Order on Respondent's Motion to Dismiss, the court found on August 17, 2022, that insufficient facts were alleged as to the involvement of Laredo Physician Associates and thus terminated it as a party to the lawsuit.[407] However, the court found that sufficient facts were alleged that the remaining respondents engaged in an anticompetitive conspiracy that unreasonably restrained trade,[408] monopolized or had the power to monopolize the broad cardiology market,[409] and interfered tortiously with prospective business relations.[410]

Without speaking to the ultimate merits of the claims by either side, the lawsuit may impact current clinician insufficiency and patient access to care. First, the mere fact of a lawsuit is a stressor for the parties and their professional relationships. Second, although a confidentiality and protective order were entered on December 19, 2022,[411] news of the lawsuit, as well as the now-closed status of the record, may shape the perception of Laredo's professional environment by potential recruits. Third, consistent with the findings in the Order on the Motion to Dismiss, the local supply of cardiologists, interventional cardiologists, and cardiology technicians may have been reduced specifically through anticompetitive and tortious practices, not other professional dynamics. Similarly, patient access to care may have been minimalized as an outcome of the inability of the plaintiffs to adequately staff its facilities. Finally, again consistent with the findings, patient access to care may have been reduced if referrals were not timely made and acted upon due to broken relationships.

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[405] Doctors Hospital of Laredo v. Ricardo Cigarroa, 5:21-CV-01068 (W.D. Tex.—San Antonio filed Oct. 29, 2021).
[406] Plaintiffs' Original Complaint, ECF Doc. 1 paras. 4-8.
[407] Order on Motion to Dismiss, ECF Doc. 64 p. 36.
[408] Order on Motion to Dismiss, ECF Doc. 64 p. 26-27.
[409] Order on Motion to Dismiss, ECF Doc. 64 p. 30-32.
[410] Order on Motion to Dismiss, ECF Doc. 64 p. 35.
[411] Confidentiality and Protective Order, ECF Doc. 74.

Public Financing Options

The City of Laredo may indirectly operate a hospital through the formation of one of two entities—a municipal hospital authority (MHA) under Texas Health and Safety Code Chapter 262 or a hospital district (HD or district) under Chapters 281 or 286. The entity then acquires and operates a hospital directly or through contract. MHAs and HDs have their legal status and distinct rules for formation, operation, and dissolution, but their hospitals are generally subject to the same regulations and standards as any other hospital. However, hospital districts are subject to the kind of legislative oversight that differentiates one county from another based on size, geography, or other characteristics, which can create unique statutory requirements.

Healthcare Services

MHAs and HDs have different statutory requirements for services. Still, they must provide primary outpatient and inpatient care to citizens within their boundaries, regardless of patient ability to pay.

MHA SERVICES

Express permissible uses for an MHA's hospital project broadly include anything related or essential to the operation of a health facility or system, such as a

- Hospital
- Clinic
- Health facility
- Extended care facility
- Outpatient facility
- Rehabilitation or recreation facility
- Pharmacy
- Medical laboratory
- Dental laboratory
- Physicians' office building
- Laundry or administrative facility

If an MHA sells or closes its hospitals, it may use its available assets to promote public health and general welfare initiatives if it no longer owns or operates a hospital. Eligible activities include owning, operating, or funding an indigent health care clinic, medical research facility, medical training facility, or other health care facility. The MHA may also provide direct or indirect financial assistance to a nonprofit organization that owns or operates one of these facilities or a hospital. Nonprofits that support initiatives promoting health education, wellness, or disease prevention are also eligible for direct or indirect financial assistance.

HD SERVICES

An HD must provide the following basic healthcare services:

- Primary and preventative services to meet the community needs, including immunizations, medical screening services, and annual physical examinations
- Inpatient and outpatient hospital services
- Rural health clinics
- Laboratory and x-ray services
- Family planning services
- Physician services
- Payment for not more than three prescription drugs a month

- Skilled nursing facility services, regardless of the patient's age

An HD may, but does not have to, operate or provide mobile emergency medical services.

Revenue

MHAs and HDs are also distinct in the statutory approach to financing.

MHA BONDS

An MHA does not have taxing power and does not pay property taxes on property held for the public benefit. Without tax income, proper rate-setting is key for an MHA to ensure a hospital operates profitably. Thus, rates must be set and charged sufficiently to pay operational expenses, due interest on bonds, create a sinking fund to timely pay bonds in, and maintain a bond reserve fund.

An MHA may issue revenue bonds to provide funds for its purposes, though voters may defeat the issuance through a referendum. The bonds must be payable from and secured by a pledge of revenues from the operation of one or more hospitals and any other revenues from owning hospital property. Additionally, revenue bonds may be secured by a mortgage or deed of trust on the MHA's real or personal property, though they need not be senior. Revenue bonds must mature serially or otherwise not more than forty (40) years after they are issued. Bonds are negotiable but must be approved by the state attorney general.

An MHA may invest its funds following applicable municipal law. Only MHAs in municipalities of less than 25,000 persons may borrow money from a lending institution. Still, all MHAs may accept gifts and endowments to hold and administer as the respective donors require.

HD BONDS AND TAXATION

Like MHAs, HDs may issue revenue bonds, but they have the additional options of levying a tax and requesting a nominal fee from all patients.

HOSPITAL DISTRICT TAXATION SCENARIOS

The most populous hospital districts in the state have property tax rates that range from about $0.05 to about $0.40 per $100 valuation with an average of $0.175 (all rates per $100 valuation).[412]

Table 20: Tax Rates for Largest Hospital Districts

Entity	Rate	County	Population
Harris County Hospital District	0.157	Harris	4,697,957
Dallas County Hospital District	0.285	Dallas	2,604,722
Tarrant County Hospital District	0.225	Tarrant	2,091,953
Bexar County Hospital District	0.257	Bexar	1,990,522
Travis County Healthcare District	0.103	Travis	1,267,795
University Medical Center of El Paso	0.210	El Paso	860,485
Montgomery County Hospital District	0.055	Montgomery	607,999
Angleton-Danbury Hospital District	0.149	Brazoria	368,575

[412] Texas Comptroller of Public Accounts. Special Purpose District Entities. https://data.texas.gov/Government-and-Taxes/Special-Purpose-District-Entities/vtc6-p2xal

Nueces County Hospital District	0.107	Nueces	353,594
Lubbock County Hospital District	0.103	Lubbock	308,580
Midland County Hospital District	0.091	Midland	166,964
Ector County Hospital District	0.131	Ector	161,258
Electra Hospital District	0.407	Wichita	129,419

A hospital district in Webb County could raise between $15 and $60 million annually at tax rates between $0.05 and $0.20 based on approximately $30 billion in taxable property.

Table 21: Projected Tax Revenues at Different Tax Rates

Potential tax rate	Estimated tax revenue
0.05	$14,676,874
0.10	$29,353,748
0.15	$44,030,622
0.20	$58,707,496

These potential rates would be low compared to the county's other major taxing entities.[413]

Table 22: Webb County Tax Rates for Other Entities

Entity	Tax rate (cents per $100 valuation)
Webb County	0.39
City of Laredo	0.57
Laredo ISD	1.38
Laredo Junior College District	0.29

The tax revenue collected from this taxation level is like the estimated uncompensated care costs the two major hospitals bear.[414]

Table 23: Estimated hospital uncompensated care

Hospital	Estimated uncompensated care (2020)
LMC	$20,757,976
Doctors	$12,454,786

As part of a multi-party agreement, in exchange for the establishment of a hospital district and the decrease in uncompensated care that they would then enjoy, the hospitals may be willing to make larger investments in physician and nurse recruitment than they currently do and/or establish and administer an inpatient psychiatric unit, even at a loss.

[413] Texas Comptroller of Public Accounts. County tax levies. https://comptroller.texas.gov/taxes/property-tax/rates/

[414] HMA calculations based on pro rata share of statewide uncompensated care. Texas Health and Human Services Commission. Hospital Uncompensated Care. https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2020/hb1-hospital-uncompensated-care-report-dec-2020.pdf

Sample Roadmap for Addressing Healthcare Service Gaps

Table 24: Sample Roadmap

Phase	Examples
Establish a stakeholder steering committee	
Develop consensus on priority gaps to address	• Nursing workforce • Physician specialties
Identify strategies for addressing priority gaps	• Financial incentives
Identify an administrative entity and financing mechanism	• Establish hospital district
Execute strategies	• Transfer county indigent healthcare program from county to hospital district • Broaden eligibility criteria for county indigent healthcare program • Establish contracts between hospital districts, hospitals, Gateway, and specialists • Establish and market financial incentives for recruiting physicians and nurses through hospital districts or hospitals

ATTACHMENT 1 –SITE VISITS SUMMARY

Health Management Associates (HMA) conducted site visits at six main healthcare providers in Laredo, Texas, as part of a health needs assessment sponsored by the City of Laredo through the public health department on September 19-21, 2022. Site visits were conducted with leadership staff from the following healthcare providers: Border Region Behavioral Health Center, Doctors Hospital of Laredo, Gateway Community Health Center, Laredo Medical Center, and Laredo Specialty and Rehabilitation Hospitals. Each provider was asked the questions listed below. Each answer below is a synthesis of the responses given by the providers. The answers below are not HMA's conclusions or recommendations.

1. **What are the most prevalent healthcare conditions that impact residents**
   - Diabetes (*5) and diabetic wounds
   - End-stage renal disease
   - Hep C (mainly due to intravenous drug use)
   - Hypertension (*5)
   - Infusion care for antibiotics or wound care for indigent or undocumented patients
   - Mental health and psychiatric care (*6)
   - Obesity
   - Dialysis for patients on ventilators
   - **Indicates the number of providers who identified healthcare condition*

2. **Can residents easily access care locally, or are there barriers to care? If so, what are they?**
   All providers agreed a broad range of healthcare services were difficult for Medicaid and uninsured patients to access. Laredo needs approximately 20 more **primary care** providers, with a two to three months wait. Assisted living support services were also difficult to access.

   Specialty care was especially limited, with many specialty care needs referred to San Antonio or Corpus Christi. Additionally, providers indicated it was challenging to close the loop with referrals to specialty care providers, further compromising quality care for Laredoans. Behavioral health services were severely lacking, including psychiatry and inpatient psychiatric capacity. Providers also noted limited resources due to patient needs from catchment areas (rural) in Webb County.

   Other barriers include **stigma**, especially for "Border Region" patients, **undocumented individuals** who are afraid to access services for themselves and family members, and people who do not have **transportation** from more rural areas.

3. **Do you have medical and administrative employee gaps or needs?**
   All providers discussed challenges recruiting doctors and licensed professionals to move to or live in Laredo. Many use providers hired through staffing agencies and state nurses (especially during COVID). Some providers adopted team nursing models to accommodate those working 3-4 jobs. Specialty care was an area with the greatest gaps in cardiology, psychiatry, general surgery, and pediatrics (nursing and physicians). Other employee gaps included ultrasound techs, mammographers, and ambulance services to facilitate transfers (2 ambulance companies closed during COVID).

4. **Are there any services for which you have a hard time providing access? If so, which ones?**
   Behavioral health services were overwhelmingly the most difficult to access, including step-down units, psychiatric care, detox programs, crisis stabilization, and children's mental health services. Hospital services and ambulatory transportation are generally limited, particularly for patients requiring ventilation.

Broadly, specialty care and care for specialty populations were other services providers struggled to provide. Providers also mentioned health education provided by promotores as a service they would like to offer more, especially to address the high concentration of juvenile diabetes.

5. **Are there any services for which you have long wait times? If so, which ones?**
   - Behavioral health
   - Mammograms 4-6 weeks out
   - Psychiatric care
   - Neurosurgeon, neuro-psych
   - Trauma
   - Heavy strokes
   - Public health services (1-2 month wait)
   - Rural services in Webb County

6. **What resources are needed to address those gaps?**
   - A behavioral health wing in a hospital
   - General provider and administration staffing; HR support for recruitment and retention
   - New buildings, more facilities

7. **What services do you most commonly refer patients outside of Laredo for care?**
   - Heart disease: cardiology
   - Kidney disease: endocrinology
   - ENT

8. **What challenges did you face during the pandemic?**
   Despite early protocol adoption and containment of COVID among staff among all providers, they experienced immediate staffing loss and shortages, especially in the hospitals and with tenured nurses. The national average turnover rate was approximately 30%. Through the state COVID funds, staffing companies were hiring local nurses (1/3 of nurses) and paying premium rates at $100/hour. They now struggle to recruit nurses who expect the same pay rates, especially ICU nurses covering evening shifts.

9. **How do you connect patients to services that address their social needs and enroll them in public benefits (Medicaid, Medicare, SNAP, WIC, etc.)?**
   - At eligibility
   - Strong case management and social work team that is tenured (all stayed through COVID)
   - Behavioral resources
   - Equipment and other things covered through insurance, like home health aids
   - Housing services have a wait list of over a year; they usually end up in resident services
   - Food deserts, transportation, and access to medications (antibiotics) are high SDOH needs

10. **What type of patient data do you collect (e.g., sexual orientation, gender identity [SOGI], race/ethnicity, and language [REAL]), and would you be willing to share basic patient demographic information?**
    All providers collected HHSC (All Texas Access) and CMS-required patient data, as well as REAL and SOGI data. Most providers were amendable to sharing patient quality metrics.

ATTACHMENT 2 – CATALOG OF LOCAL HEALTHCARE WORKFORCE PROGRAMS

Laredo College

Certifications

1. Licensed Vocational Nursing
2. EMS – Advanced Medical Technician
3. EMS – Emergency Medical Technician
4. EMS – Paramedic
5. Medical Assistant

Associate Degrees

6. EMS – Paramedic
7. Diagnostic Medical Sonography
8. Nursing
9. Medical Assistant
10. Physical Therapist Assistant
11. Occupational Therapy Assistant (discontinued in 2023)
12. Physical Therapy Assistant (discontinued in 2023)
13. Radiologic Technology

Bachelor Degree

14. Nursing (RN to BSN)

Texas A&M International University

Bachelors

1. Public Health
2. Kinesiology

Masters

3. Nursing – Registered Nurse
4. Nursing - Family Nurse Practitioner
5. Nursing - Nursing Administration
6. Nursing - Psychiatric Nurse Practitioner (1-year program for FNPs)
7. Clinical Psychology

The University of Texas Systems at Laredo

Certifications

1. Community Health Workers

Bachelors

2. Dental Hygiene (2023)
3. Social Work
4. Multidisciplinary Studies

Masters

5. Physician's Assistant
6. Biomedical Informatics
7. Social Work

Masters

8. Biomedical Informatics (Online)
9. Social Work (Online)

Health Career Institute of Laredo

1. Pharmacy Technician
2. Phlebotomy Technician
3. Medical Assistant Program

ATTACHMENT 3 – CONSIDERATIONS REGARDING MEDICAL RESIDENCY PROGRAMS

The City of Laredo, along with the entirety of Webb County, is designated as a Primary Care, Mental Health, and Dental Health Professional Shortage Area (HPSA). It is also designated as a Medically Underserved Area. Recognizing the need for additional providers to serve the county's health care needs, in 2017, the legislative agenda included asking for funding from the state to support developing residency programs in Laredo to help address the physician shortages. This led to the development of a Family Medicine Residency Program sponsored by the Texas Institute for Graduate Medical Education and Research (TIGMER) at Laredo Medical Center. These residents have their ambulatory clinics based at the Gateway CHC. An additional residency program, Internal Medicine, opened. Each program accepts eight residents annually for a total of 48 residents training in the city. These two programs will likely graduate 16 newly trained physicians annually. Data shows that approximately 70% of resident physicians practice within 50 miles of where they train, making it likely that the programs would add 11 new primary care physicians annually to the area.

Despite this progress, the city of Laredo will continue to be underserved for many years. The medical community is aging, and many practitioners plan to retire soon- exacerbating the shortage of practitioners for the area and limiting access to essential primary and preventive care.

While the state of Texas is supporting the current training programs, it is possible for the hospitals in Laredo to further expand their residency training with additional support from the Centers for Medicaid and Medicare Services (CMS). The Inpatient Prospective Payment System (IPPS) rule for Fiscal Year 2022 includes a policy to distribute 1,000 new residency slots, phasing in 200 new slots per year for five years. Primary care residencies in rural and underserved communities have priority over these slots. This increase represents CMS's largest new allocation of new residency slots in over 25 years.

New residency slots in hospitals in Laredo will make them eligible for two types of federal payments. CMS-approved slots receive reimbursement for direct and indirect costs of training residents. These payment calculations use the percentage of Medicare patients treated by the hospital. The direct graduate medical education (DME) payment covers the direct costs of resident salaries and benefits, including meals and supplies. The indirect graduate medical education (IME) funding uses a formula that estimates the additional cost to hospitals that support training programs. CMS anticipates increases in testing costs and length of stay, as well as the inability for faculty to have a full-time private practice while precepting medical residents in training.

In an article published on January 13, 2022, in the LMTonline, a $100,000 donation to the University of the Incarnate Word Laredo Primary Care Residency program was cited, stating additional support would enable program expansion. The state of Texas has already invested local funding into medical education. With additional funding from CMS, Laredo can further expand the 48 residents in training today.

In addition to applying for the newly allocated residency slots, any hospital that does not currently have CMS-approved resident slots is eligible to create new caps. The number of caps is established on a 3-year rolling average (the ,time most primary care residency programs take for completion). Therefore, if a “virgin” hospital in Laredo decides to support a new primary care residency program, the number of residents they accept over the first three years they are approved and accepting trainees becomes the number of caps approved by CMS. These caps will also be eligible for the DME and IME payments through the Medicare program.

Any increase in medical residency training programs requires a strong commitment from the training site and a willingness for medical staff to serve as faculty. The opportunity for new resident slots funded by the federal government offers a unique opportunity to expand the availability of medical doctors in the Laredo area.

Laredo's Capacity for Additional Medical Residency Programs

Laredo Medical Center currently has 314 Staffed Beds and 46 FTE residents. Doctors Hospital has 183 staffed beds and the potential for 146 residents. A general rule of thumb is that a hospital can support .8 residents per occupied bed, up to 250 residents. TIGMER currently sponsors two GME programs in Laredo. One is the Family Medicine program at Gateway CHC, which trains eight residents annually with a total program of 24 residents. Laredo Medical Center also houses a Community-Based Internal Medicine Residency program accepting applications.