By: Watson S.B. No. 1350

A BILL TO BE ENTITLED

AN ACT

relating to the creation and operations of a health care provider participation program by a certain hospital district.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Subtitle D, Title 4, Health and Safety Code, is amended by adding Chapter 298E to read as follows:

CHAPTER 298E. HEALTH CARE PROVIDER PARTICIPATION PROGRAM IN CERTAIN HOSPITAL DISTRICTS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 298E.001. DEFINITIONS. In this chapter:

(1) "Board" means the board of hospital managers of a district.

(2) "District" means a hospital district to which this chapter applies.

(3) "Institutional health care provider" means a nonpublic hospital that provides inpatient hospital services.

(4) "Paying provider" means an institutional health care provider required to make a mandatory payment under this chapter.

(5) "Program" means a health care provider participation program authorized by this chapter.

Sec. 298E.002. APPLICABILITY. This chapter applies only to a hospital district created in a county with a population of more than 800,000 that was not included in the boundaries of a hospital

district before September 1, 2003.

Sec. 298E.003. HEALTH CARE PROVIDER PARTICIPATION PROGRAM; PARTICIPATION IN PROGRAM. The board of a district may authorize the district to participate in a health care provider participation program on the affirmative vote of a majority of the board, subject to the provisions of this chapter.

SUBCHAPTER B. POWERS AND DUTIES OF BOARD

Sec. 298E.051. LIMITATION ON AUTHORITY TO REQUIRE MANDATORY PAYMENT. The board of a district may require a mandatory payment authorized under this chapter by an institutional health care provider located in the district only in the manner provided by this chapter.

Sec. 298E.052. RULES AND PROCEDURES. The board of a district may adopt rules relating to the administration of the program, including collection of the mandatory payments, expenditures, audits, and any other administrative aspects of the program.

Sec. 298E.053. INSTITUTIONAL HEALTH CARE PROVIDER REPORTING. If the board of a district authorizes the district to participate in a program under this chapter, the board shall require each institutional health care provider located in the district to submit to the district a copy of any financial and utilization data required by and reported to the Department of State Health Services under Sections 311.032 and 311.033 and any rules adopted by the executive commissioner of the Health and Human Services Commission to implement those sections.

SUBCHAPTER C. GENERAL FINANCIAL PROVISIONS

Sec. 298E.101. HEARING. (a) In each year that the board of a district authorizes a program under this chapter, the board shall hold a public hearing on the amounts of any mandatory payments that the board intends to require during the year and how the revenue derived from those payments is to be spent.

(b) Not later than the fifth day before the date of the hearing required under Subsection (a), the board shall publish notice of the hearing in a newspaper of general circulation in the district and provide written notice of the hearing to each institutional health care provider located in the district.

Sec. 298E.102. DEPOSITORY. (a) If the board of a district requires a mandatory payment authorized under this chapter, the board shall designate one or more banks as a depository for the district's local provider participation fund.

(b) All funds collected by a district under this chapter shall be secured in the manner provided for securing other funds of the district.

Sec. 298E.103. LOCAL PROVIDER PARTICIPATION FUND; AUTHORIZED USES OF MONEY. (a) If a district requires a mandatory payment authorized under this chapter, the district shall create a local provider participation fund.

(b) A district's local provider participation fund consists of:

(1) all revenue received by the district attributable to mandatory payments authorized under this chapter;

(2) money received from the Health and Human Services Commission as a refund of an intergovernmental transfer under the

program, provided that the intergovernmental transfer does not receive a federal matching payment; and

(3) the earnings of the fund.

(c) Money deposited to the local provider participation fund of a district may be used only to:

(1) fund intergovernmental transfers from the district to the state to provide the nonfederal share of Medicaid payments for:

(A) uncompensated care payments to nonpublic hospitals affiliated with the district, if those payments are authorized under the Texas Healthcare Transformation and Quality Improvement Program waiver issued under Section 1115 of the federal Social Security Act (42 U.S.C. Section 1315);

(B) uniform rate enhancements for nonpublic hospitals in the Medicaid managed care service area in which the district is located;

(C) payments available under another waiver program authorizing payments that are substantially similar to Medicaid payments to nonpublic hospitals described by Paragraph (A) or (B); or

(D) any reimbursement to nonpublic hospitals for which federal matching funds are available;

(2) subject to Section 298E.151(d), pay the administrative expenses of the district in administering the program, including collateralization of deposits;

(3) refund a mandatory payment collected in error from a paying provider;

(4) refund to paying providers a proportionate share of the money that the district:

(A) receives from the Health and Human Services Commission that is not used to fund the nonfederal share of Medicaid supplemental payment program payments; or

(B) determines cannot be used to fund the nonfederal share of Medicaid supplemental payment program payments;

(5) transfer funds to the Health and Human Services Commission if the district is legally required to transfer the funds to address a disallowance of federal matching funds with respect to programs for which the district made intergovernmental transfers described by Subdivision (1); and

(6) reimburse the district if the district is required by the rules governing the uniform rate enhancement program described by Subdivision (1)(B) to incur an expense or forego Medicaid reimbursements from the state because the balance of the local provider participation fund is not sufficient to fund that rate enhancement program.

(d) Money in the local provider participation fund of a district may not be commingled with other district funds.

(e) Notwithstanding any other provision of this chapter, with respect to an intergovernmental transfer of funds described by Subsection (c)(1) made by a district, any funds received by the state, district, or other entity as a result of that transfer may not be used by the state, district, or any other entity to:

(1) expand Medicaid eligibility under the Patient

Protection and Affordable Care Act (Pub. L. No. 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. No. 111-152); or

(2) fund the nonfederal share of payments to nonpublic hospitals available through the delivery system reform incentive payment program.

SUBCHAPTER D. MANDATORY PAYMENTS

Sec. 298E.151. MANDATORY PAYMENTS BASED ON PAYING PROVIDER NET PATIENT REVENUE. (a) Except as provided by Subsection (e), if the board of a district authorizes a health care provider participation program under this chapter, the board may require an annual mandatory payment to be assessed on the net patient revenue of each institutional health care provider located in the district. The board may provide for the mandatory payment to be assessed quarterly. In the first year in which the mandatory payment is required, the mandatory payment is assessed on the net patient revenue of an institutional health care provider as determined by the data reported to the Department of State Health Services under Sections 311.032 and 311.033 in the most recent fiscal year for which that data was reported. If the institutional health care provider did not report any data under those sections, the provider's net patient revenue is the amount of that revenue as contained in the provider's Medicare cost report submitted for the previous fiscal year or for the closest subsequent fiscal year for which the provider submitted the Medicare cost report. If the mandatory payment is required, the district shall update the amount of the mandatory payment on an annual basis.

(b) The amount of a mandatory payment assessed under this chapter by the board of a district must be uniformly proportionate with the amount of net patient revenue generated by each paying provider in the district as permitted under federal law. A health care provider participation program authorized under this chapter may not hold harmless any institutional health care provider located in the district, as required under 42 U.S.C. Section 1396b(w).

(c) If the board of a district requires a mandatory payment authorized under this chapter, the board shall set the amount of the mandatory payment, subject to the limitations of this chapter. The aggregate amount of the mandatory payments required of all paying providers in the district may not exceed six percent of the aggregate net patient revenue from hospital services provided by all paying providers in the district.

(d) Subject to Subsection (c), if the board of a district requires a mandatory payment authorized under this chapter, the board shall set the mandatory payments in amounts that in the aggregate will generate sufficient revenue to cover the administrative expenses of the district for activities under this chapter and to fund an intergovernmental transfer described by Section 298E.103(c)(1). The annual amount of revenue from mandatory payments that shall be paid for administrative expenses by the district is $150,000, plus the cost of collateralization of deposits, regardless of actual expenses.

(e) A paying provider may not add a mandatory payment required under this section as a surcharge to a patient.

(f) A mandatory payment assessed under this chapter is not a tax for hospital purposes for purposes of Section 4, Article IX, Texas Constitution, or Section 281.045 of this code.

Sec. 298E.152. ASSESSMENT AND COLLECTION OF MANDATORY PAYMENTS. (a) A district may designate an official of the district or contract with another person to assess and collect the mandatory payments authorized under this chapter.

(b) The person charged by the district with the assessment and collection of mandatory payments shall charge and deduct from the mandatory payments collected for the district a collection fee in an amount not to exceed the person's usual and customary charges for like services.

(c) If the person charged with the assessment and collection of mandatory payments is an official of the district, any revenue from a collection fee charged under Subsection (b) shall be deposited in the district general fund and, if appropriate, shall be reported as fees of the district.

Sec. 298E.153. PURPOSE; CORRECTION OF INVALID PROVISION OR PROCEDURE; LIMITATION OF AUTHORITY. (a) The purpose of this chapter is to authorize a district to establish a program to enable the district to collect mandatory payments from institutional health care providers to fund the nonfederal share of a Medicaid supplemental payment program or the Medicaid managed care rate enhancements for nonpublic hospitals to support the provision of health care by institutional health care providers located in the district to district residents in need of health care.

(b) This chapter does not authorize a district to collect

mandatory payments for the purpose of raising general revenue or any amount in excess of the amount reasonably necessary to fund the nonfederal share of a Medicaid supplemental payment program or Medicaid managed care rate enhancements for nonpublic hospitals and to cover the administrative expenses of the district associated with activities under this chapter.

(c) To the extent any provision or procedure under this chapter causes a mandatory payment authorized under this chapter to be ineligible for federal matching funds, the board of a district may provide by rule for an alternative provision or procedure that conforms to the requirements of the federal Centers for Medicare and Medicaid Services. A rule adopted under this section may not create, impose, or materially expand the legal or financial liability or responsibility of the district or an institutional health care provider in the district beyond the provisions of this chapter. This section does not require the board to adopt a rule.

(d) A district may only assess and collect a mandatory payment authorized under this chapter if a waiver program, uniform rate enhancement, or reimbursement described by Section 298E.103(c)(1) is available to the district.

SECTION 2. If before implementing any provision of this Act a state agency determines that a waiver or authorization from a federal agency is necessary for implementation of that provision, the agency affected by the provision shall request the waiver or authorization and may delay implementing that provision until the waiver or authorization is granted.

SECTION 3. This Act takes effect immediately if it receives

a vote of two-thirds of all the members elected to each house, as provided by Section 39, Article III, Texas Constitution. If this Act does not receive the vote necessary for immediate effect, this Act takes effect September 1, 2019.