BILL ANALYSIS

Senate Research Center
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S.B. 2117
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Intergovernmental Relations
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As Filed

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

S.B. 2117 grants the Amarillo Hospital District the ability to create a local provider participation fund (LPPF).

As proposed, S.B. 2117 amends current law relating to the creation and operations of a health care provider participation program by the City of Amarillo Hospital District.

RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to the board of hospital managers of the Amarillo Hospital District in SECTION 1 (Sections 1001.455 and 1001.462, Special District Local Laws Code) of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Chapter 1001, Special District Local Laws Code, by adding Subchapter J, as follows:

SUBCHAPTER J. HEALTH CARE PROVIDER PARTICIPATION PROGRAM

Sec. 1001.451. PURPOSE. Sets forth the purpose of this subchapter.

Sec. 1001.452. DEFINITIONS. Defines "institutional health care provider," "paying hospital," and "program."

Sec. 1001.453. HEALTH CARE PROVIDER PARTICIPATION PROGRAM; PARTICIPATION IN PROGRAM. Authorizes the board of hospital managers of the district (board) to authorize the City of Amarillo Hospital District (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 subchapter.

Sec. 1001.454. LIMITATION ON AUTHORITY TO REQUIRE MANDATORY PAYMENT. Authorizes the board to require a mandatory payment authorized under this subchapter by an institutional health care provider in the district only in the manner provided by this subchapter.

Sec. 1001.455. RULES AND PROCEDURES. Authorizes the board to adopt rules relating to the administration of the health care provider participation program, including collection of the mandatory payments, expenditures, audits, and any other administrative aspects of the program.

Sec. 1001.456. INSTITUTIONAL HEALTH CARE PROVIDER REPORTING. Requires the board, if the board authorizes the district to participate in a health care provider participation program under this subchapter, to require each institutional health care provider to submit to the district a copy of any financial and utilization data required by and reported to the Department of State Health Services (DSHS) under Sections 311.032 (Department Administration of Hospital Reporting and Collection System) and 311.033 (Financial and Utilization Data Required), Health and Safety Code, and any

rules adopted by the executive commissioner of the Health and Human Services Commission to implement those sections.

Sec. 1001.457. HEARING. (a) Requires the board, in each year that the board authorizes a health care provider participation program under this subchapter, to 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) Requires the board, not later than the fifth day before the date of the hearing required under Subsection (a), to publish notice of the hearing in a newspaper of general circulation in the district and provide written notice of the hearing to the chief operating officer of each institutional health care provider in the district.

Sec. 1001.458. LOCAL PROVIDER PARTICIPATION FUND; DEPOSITORY. (a) Requires the board, if the board collects a mandatory payment authorized under this subchapter, to create a local provider participation fund in one or more banks designated by the district as a depository for public funds.

(b) Authorizes the board to withdraw or use money in the fund only for a purpose authorized under this subchapter.

(c) Requires that all funds collected under this subchapter be secured in the manner provided by this subchapter for securing other public funds of the district.

Sec. 1001.459. DEPOSITS TO FUND; AUTHORIZED USES OF MONEY. (a) Provides that the local provider participation fund established under Section 1001.458 consists of certain funds.

(b) Authorizes money deposited to the local provider participation fund to be used only to fund certain intergovernmental transfers, pay costs associated with indigent care provided by institutional health care providers in the district, pay the administrative expenses of the district in administering the program, including collateralization of deposits, refund a portion of a mandatory payment collected in error from a paying hospital, and refund to paying hospitals a proportionate share of certain money.

(c) Prohibits money in the local provider participation fund from being commingled with other district funds.

(d) Prohibits an intergovernmental transfer of funds described by Subsection (b)(1) (relating to the funding of intergovernmental transfers from the district to the state for certain purposes) and any funds received by the district as a result of an intergovernmental transfer described by that subsection from being used by the district or any other entity to expand certain Medicaid eligibility.

Sec. 1001.460. MANDATORY PAYMENTS. (a) Requires the board, except as provided by Subsection (e), if the board authorizes a health care provider participation program under this subchapter, to require an annual mandatory payment to be assessed on the net patient revenue of each institutional health care provider located in the district. Requires the board to provide that the mandatory payment is to be collected at least annually, but not more often than quarterly. Provides that 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 DSHS under Sections 311.032 and 311.033, Health and Safety Code, in the most recent fiscal year for which that data was reported. Provides that 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. Requires the district to update the amount of the mandatory payment on an annual basis.

(b) Requires that the amount of a mandatory payment authorized under this subchapter be a uniform percentage of the amount of net patient revenue generated by each paying hospital in the district. Provides that a mandatory payment authorized under this subchapter may not hold harmless any institutional health care provider, as required under 42 U.S.C. Section 1396b(w).

(c) Prohibits the aggregate amount of the mandatory payments required of all paying hospitals in the district from exceeding six percent of the aggregate net patient revenue of all paying hospitals in the district.

(d) Requires the board, subject to the maximum amount prescribed by Subsection (c), to 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 subchapter, fund a certain intergovernmental transfer, or make other payments authorized under this subchapter. Prohibits the amount of revenue from mandatory payments authorized to be used for administrative expenses by the district in a year from exceeding a certain amount. Authorizes the district, if the board makes a certain demonstration to the paying hospitals that the costs of administering the program, excluding certain costs, exceed $25,000 in any year, on consent of all of the paying hospitals, to use additional revenue from mandatory payments received under this subchapter to compensate the district for its administrative expenses. Prohibits a paying hospital from unreasonably withholding consent to compensate the district for administrative expenses.

(e) Prohibits a paying hospital from adding a mandatory payment required under this section as a surcharge to a patient or insurer.

(f) Provides that a mandatory payment under this subchapter is not a tax for purposes of Section 5(a), Article IX, Texas Constitution, or this chapter.

Sec. 1001.461. ASSESSMENT AND COLLECTION OF MANDATORY PAYMENTS. Authorizes the district to collect or contract for the assessment and collection of mandatory payments authorized under this subchapter.

Sec. 1001.462. CORRECTION OF INVALID PROVISION OR PROCEDURE. Authorizes the board, to the extent any provision or procedure under this subchapter causes a mandatory payment authorized under this subchapter to be ineligible for federal matching funds, to provide by rule for an alternative provision or procedure that conforms to the requirements of the federal Centers for Medicare and Medicaid Services. Prohibits a rule adopted under this section from creating, imposing, or materially expanding the legal or financial liability or responsibility of the district or an institutional health care provider in the district beyond the provisions of this subchapter. Provides that this section does not require the board to adopt a rule.

SECTION 2. Requires a state agency, if necessary for implementation of a provision of this Act, to request a waiver or authorization from a federal agency, and authorizes delay of implementation until such a waiver or authorization is granted.

SECTION 3. Effective date: upon passage or September 1, 2017.