BILL ANALYSIS

Senate Research Center

S.B. 2170
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AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

During the 83rd and 84th legislative sessions, the Texas Legislature passed bills that granted 11 counties the authority to create Local Provider Participation Funds. These participation funds allow hospitals in a certain county to pool money to be used as matching funds to draw down more money from the federal government.

S.B. 2170 authorizes the Dallas County Hospital District to create a Local Provider Participation Fund with participating hospitals in the county to offset the costs of uncompensated care. The bill will allow hospitals in Dallas County to increase access to health care and improve the quality of the care provided.

As proposed, S.B. 2170 amends current law relating to the creation and operations of health care provider participation programs in hospital districts established under Chapter 281, Health & Safety Code.

RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to the board of hospital managers of certain hospital districts in SECTION 1 (Sections 298.052 and 298.153, Health and Safety Code) of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Subtitle D, Title 4, Health and Safety Code, by adding Chapter 298, as follows:

CHAPTER 298. DISTRICT HEALTH CARE PROVIDER PARTICIPATION PROGRAM IN CERTAIN DISTRICTS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 298.001. DEFINITIONS. Defines "board," "collection agent," "district," "institutional health care provider," "paying provider," and "provider participation program."

Sec. 298.002. APPLICABILITY. Provides that this chapter applies only to a hospital district (district) located in Dallas County (district).

Sec. 298.003. DISTRICT HEALTH CARE PROVIDER PARTICIPATION PROGRAM. Provides that a district, pursuant to the affirmative vote of a majority of the members of the board of hospital managers of a district (board), is authorized to have a provider participation program (program), subject to the provisions of this chapter.

SUBCHAPTER B. POWERS AND DUTIES OF BOARD

Sec. 298.051. LIMITATION ON AUTHORITY TO REQUIRE MANDATORY PAYMENT. Authorizes the board to require a mandatory payment authorized under this chapter by an institutional health care provider (provider) in its district only in the manner provided by this chapter.

Sec. 298.052. RULES AND PROCEDURES. Authorizes the board to adopt rules and procedures relating to the administration, collection, administrative expenditures, audit, and other aspects of the district's program.

Sec. 298.053. INSTITUTIONAL HEALTH CARE PROVIDER REPORTING; INSPECTION OF RECORDS. Requires a board that has enacted a program under this chapter to require each provider to submit to the district a copy of all 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), as amended, and any rules adopted by the executive commissioner of the Health and Human Services Commission (HHSC) to implement those sections.

Sec. 298.054. EXPIRATION. Provides that the authority of the district to administer and operate a program expires December 31, 2019.

SUBCHAPTER C. GENERAL FINANCIAL PROVISIONS

Sec. 298.101. HEARING. (a) Requires the board that has enacted a program under this chapter to hold a public hearing each year 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 5th day before the date of the required hearing, to publish notice of the hearing in a newspaper of general circulation in its district and provide written notice of the hearing to each provider in its district.

Sec. 298.102. DEPOSITORY. (a) Requires a board that has authorized the collection of a mandatory payment under this chapter to designate one or more banks as a depository for the district's local provider participation fund (fund).

(b) Requires all depository funds collected under this chapter to be secured in the manner provided for securing other district funds.

Sec. 298.103. LOCAL PROVIDER PARTICIPATION FUND; AUTHORIZED USES OF MONEY. (a) Requires a district collecting mandatory payments authorized under this chapter to create a fund.

(b) Requires the fund of a district to consist of all revenue received by the district attributable to mandatory payments authorized under this chapter, money received from HHSC as a refund of an intergovernmental transfer under this program, provided that the intergovernmental transfer does not receive a federal matching payment, and the earnings of the fund.

(c) Authorizes money deposits to the fund of a district to be used only for certain purposes.

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

(e) Prohibits any funds received by the state, the district, or any other entity as a result of such an intergovernmental transfer, notwithstanding any other provision of this Chapter 298, with respect to any intergovernmental transfer of funds, as described by Subsection (c)(1) (relating to revenue received by the district attributable to mandatory payments), made by a district, from being used by the state, the district or any other entity to 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 to fund the non-federal share of payments to nonpublic hospitals available

through the Disproportionate Share Hospital program or the Delivery Service Reform Incentive Payment program.

SUBCHAPTER D. MANDATORY PAYMENTS

Sec. 298.151. MANDATORY PAYMENTS BASED ON PAYING PROVIDER NET PATIENT REVENUE. (a) Authorizes a board that has authorized the collection of a mandatory payment under this chapter, except as provided by Subsection (d), to require an annual mandatory payment to be assessed on the net patient revenue of each provider located in its district. Authorizes the board to provide for the mandatory payment to be assessed quarterly. Provides that the mandatory payment, in the first year in which the mandatory payment is required, is assessed on the net patient revenue of a provider as determined by the data reported to DSHS under Sections 311.031 and 311.033 in the most recently complete fiscal year. Requires the net patient revenue, if the provider did not report any data under those sections, to then be determined by 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 the amount of a mandatory payment authorized under this chapter to be uniformly proportionate with the amount of net patient revenue generated by each paying provider in such district as permitted under federal law. Prohibits a program from holding harmless any institutional health care provider, as required under 42 U.S.C. Section 1396(b)(w).

(c) Requires a board that has authorized the collection of a mandatory payment, within the limitations set out in this Chapter 298, to set the amount of the mandatory payment. Prohibits the aggregate amount of the mandatory payments required of all paying providers in the district from exceeding six percent of the aggregate net patient revenue from hospital services provided by all paying providers in the district.

(d) Requires a board that has authorized the collection of a mandatory payment under this chapter, subject to 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 chapter, and to fund intergovernmental transfers described by Section 298.103. Requires the annual amount to be paid for the administrative expenses of the district to be $150,000 plus the cost of collateralization of deposits, regardless of actual expenses.

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

(f) Provides that a mandatory payment imposed under this chapter is not a "tax for hospital purposes" as referenced in Article IX (Counties), Section 4 (County-Wide Hospital Districts), Texas Constitution, or Section 281.045 (Limitation on Taxing Power by Governmental Entity; Disposition of Delinquent Taxes), Health and Safety Code.

Sec. 298.152. ASSESSMENT AND COLLECTION OF MANDATORY PAYMENTS. (a) Requires the collection agent, if the collection agent is not an official of the district, to collect the mandatory payments on behalf of the district and to charge and deduct from such mandatory payments a collection fee in an amount not to exceed the collection agent's usual and customary charges for like services.

(b) Authorizes the board, if determined to be appropriate by the board, to contract for the assessment and collection of authorized mandatory payments.

(c) Requires revenue from a fee charged by the collection agent for collecting the mandatory payment to be desisted in the district general fund and, if appropriate, to be reported as fees of the district.

Sec. 298.153. PURPOSE; CORRECTION OF INVALID PROVISION OR PROCEDURE; LIMITATION OF AUTHORITY. (a) Provides that the purpose of this chapter is to authorize a district to establish a program that enables the district to collect mandatory payments from providers in order to fund the nonfederal share of a Medicaid supplemental payment program or to fund the nonfederal share of Medicaid managed care rate enhancements for nonpublic hospitals, thereby supporting the provision of healthcare by institutional health care providers to those in need. Provides that this chapter is not intended to authorize a district to collect mandatory payments for general revenue raising or to raise amounts in excess of what is reasonably necessary for funding the nonfederal share of a Medicaid supplemental payment program or the nonfederal share of Medicaid managed care rate enhancements for nonpublic hospitals, and the associated administrative expenses of the district for activities under this chapter.

(b) Authorizes a district, 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, to provide by rule for an alternative provision or procedure that conforms to the requirements of the federal Centers for Medicare and Medicaid Services. Requires nothing in this section to be construed to require the district to adopt any such rule. Prohibits any such remedial rule from creating, imposing, or materially expanding the legal or financial liability or program responsibilities of either the district or any provider beyond the provisions of this subchapter.

(c) Authorizes the district to only collect a mandatory payment authorized under this chapter as long as the Medicaid supplemental payment program authorized under the state Medicaid plan through 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), a successor wavier program authorizing substantially similar Medicaid supplemental payment program is available, or as long as enhanced, Medicaid managed care rates funded by IGTs are available.

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.