By: Seliger S.B. No. 2117

A BILL TO BE ENTITLED

AN ACT

relating to the creation and operations of a health care provider participation program by the City of Amarillo Hospital District.

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

SECTION 1. Chapter 1001, Special District Local Laws Code, is amended by adding Subchapter J to read as follows:

SUBCHAPTER J. HEALTH CARE PROVIDER PARTICIPATION PROGRAM

Sec. 1001.451. PURPOSE. The purpose of this subchapter is to authorize the district to administer a health care provider participation program to provide additional compensation to hospitals in the district by collecting mandatory payments from each hospital in the district to be used to provide the nonfederal share of a Medicaid supplemental payment program and for other purposes as authorized under this subchapter.

Sec. 1001.452. DEFINITIONS. In this subchapter:

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

(2) "Paying hospital" means an institutional health care provider required to make a mandatory payment under this subchapter.

(3) "Program" means the health care provider participation program authorized by this subchapter.

Sec. 1001.453. HEALTH CARE PROVIDER PARTICIPATION PROGRAM; PARTICIPATION IN PROGRAM. The board may authorize the district to

1 participate in a health care provider participation program on the
2 affirmative vote of a majority of the board, subject to the
3 provisions of this subchapter.
4 Sec. 1001.454. LIMITATION ON AUTHORITY TO REQUIRE MANDATORY
5 PAYMENT. The board may require a mandatory payment authorized
6 under this subchapter by an institutional health care provider in
7 the district only in the manner provided by this subchapter.
8 Sec. 1001.455. RULES AND PROCEDURES. The board may adopt
9 rules relating to the administration of the health care provider
10 participation program, including collection of the mandatory
11 payments, expenditures, audits, and any other administrative
12 aspects of the program.
13 Sec. 1001.456. INSTITUTIONAL HEALTH CARE PROVIDER
14 REPORTING. If the board authorizes the district to participate in a
15 health care provider participation program under this subchapter,
16 the board shall require each institutional health care provider to
17 submit to the district a copy of any financial and utilization data
18 required by and reported to the Department of State Health Services
19 under Sections 311.032 and 311.033, Health and Safety Code, and any
20 rules adopted by the executive commissioner of the Health and Human
21 Services Commission to implement those sections.
22 Sec. 1001.457. HEARING. (a) In each year that the board
23 authorizes a health care provider participation program under this
24 subchapter, the board shall hold a public hearing on the amounts of
25 any mandatory payments that the board intends to require during the
26 year and how the revenue derived from those payments is to be spent.
27 (b) Not later than the fifth day before the date of the

1 hearing required under Subsection (a), the board shall publish
2 notice of the hearing in a newspaper of general circulation in the
3 district and provide written notice of the hearing to the chief
4 operating officer of each institutional health care provider in the
5 district.
6 Sec. 1001.458. LOCAL PROVIDER PARTICIPATION FUND;
7 DEPOSITORY. (a) If the board collects a mandatory payment
8 authorized under this subchapter, the board shall create a local
9 provider participation fund in one or more banks designated by the
10 district as a depository for public funds.
11 (b) The board may withdraw or use money in the fund only for
12 a purpose authorized under this subchapter.
13 (c) All funds collected under this subchapter shall be
14 secured in the manner provided by this subchapter for securing
15 other public funds of the district.
16 Sec. 1001.459. DEPOSITS TO FUND; AUTHORIZED USES OF MONEY.
17 (a) The local provider participation fund established under
18 Section 1001.458 consists of:
19 (1) all mandatory payments authorized under this
20 chapter and received by the district;
21 (2) money received from the Health and Human Services
22 Commission as a refund of an intergovernmental transfer from the
23 district to the state as the nonfederal share of Medicaid
24 supplemental payment program payments, provided that the
25 intergovernmental transfer does not receive a federal matching
26 payment; and
27 (3) the earnings of the fund.

1 (b) Money deposited to the local provider participation
2 fund may be used only to:
3 (1) fund intergovernmental transfers from the
4 district to the state to provide the nonfederal share of a Medicaid
5 supplemental payment program authorized under the state Medicaid
6 plan including through the Medicaid managed care program, the Texas
7 Healthcare Transformation and Quality Improvement Program waiver
8 issued under Section 1115 of the federal Social Security Act (42
9 U.S.C. Section 1315), or a successor waiver program authorizing
10 similar Medicaid supplemental payment programs;
11 (2) pay costs associated with indigent care provided
12 by institutional health care providers in the district;
13 (3) pay the administrative expenses of the district in
14 administering the program, including collateralization of
15 deposits;
16 (4) refund a portion of a mandatory payment collected
17 in error from a paying hospital; and
18 (5) refund to paying hospitals a proportionate share
19 of the money that the district:
20 (A) receives from the Health and Human Services
21 Commission that is not used to fund the nonfederal share of Medicaid
22 supplemental payment program payments; or
23 (B) determines cannot be used to fund the
24 nonfederal share of Medicaid supplemental payment program
25 payments.
26 (c) Money in the local provider participation fund may not
27 be commingled with other district funds.

1 (d) An intergovernmental transfer of funds described by
2 Subsection (b)(1) and any funds received by the district as a result
3 of an intergovernmental transfer described by that subsection may
4 not be used by the district or any other entity to expand Medicaid
5 eligibility under the Patient Protection and Affordable Care Act
6 (Pub. L. No. 111-148) as amended by the Health Care and Education
7 Reconciliation Act of 2010 (Pub. L. No. 111-152).
8 Sec. 1001.460. MANDATORY PAYMENTS. (a) Except as provided
9 by Subsection (e), if the board authorizes a health care provider
10 participation program under this subchapter, the board shall
11 require an annual mandatory payment to be assessed on the net
12 patient revenue of each institutional health care provider located
13 in the district. The board shall provide that the mandatory payment
14 is to be collected at least annually, but not more often than
15 quarterly. In the first year in which the mandatory payment is
16 required, the mandatory payment is assessed on the net patient
17 revenue of an institutional health care provider as determined by
18 the data reported to the Department of State Health Services under
19 Sections 311.032 and 311.033, Health and Safety Code, in the most
20 recent fiscal year for which that data was reported. If the
21 institutional health care provider did not report any data under
22 those sections, the provider's net patient revenue is the amount of
23 that revenue as contained in the provider's Medicare cost report
24 submitted for the previous fiscal year or for the closest
25 subsequent fiscal year for which the provider submitted the
26 Medicare cost report. The district shall update the amount of the
27 mandatory payment on an annual basis.

1 (b) The amount of a mandatory payment authorized under this
2 subchapter must be a uniform percentage of the amount of net patient
3 revenue generated by each paying hospital in the district. A
4 mandatory payment authorized under this subchapter may not hold
5 harmless any institutional health care provider, as required under
6 42 U.S.C. Section 1396b(w).
7 (c) The aggregate amount of the mandatory payments required
8 of all paying hospitals in the district may not exceed six percent
9 of the aggregate net patient revenue of all paying hospitals in the
10 district.
11 (d) Subject to the maximum amount prescribed by Subsection
12 (c), the board shall set the mandatory payments in amounts that in
13 the aggregate will generate sufficient revenue to cover the
14 administrative expenses of the district for activities under this
15 subchapter, fund an intergovernmental transfer described by
16 Section 1001.459(b)(1), or make other payments authorized under
17 this subchapter. The amount of revenue from mandatory payments
18 that may be used for administrative expenses by the district in a
19 year may not exceed $25,000, plus the cost of collateralization of
20 deposits. If the board demonstrates to the paying hospitals that
21 the costs of administering the health care provider participation
22 program under this subchapter, excluding those costs associated
23 with the collateralization of deposits, exceed $25,000 in any year,
24 on consent of all of the paying hospitals, the district may use
25 additional revenue from mandatory payments received under this
26 subchapter to compensate the district for its administrative
27 expenses. A paying hospital may not unreasonably withhold consent

1 to compensate the district for administrative expenses.
2 (e) A paying hospital may not add a mandatory payment
3 required under this section as a surcharge to a patient or insurer.
4 (f) A mandatory payment under this subchapter is not a tax
5 for purposes of Section 5(a), Article IX, Texas Constitution, or
6 this chapter.
7 Sec. 1001.461. ASSESSMENT AND COLLECTION OF MANDATORY
8 PAYMENTS. The district may collect or contract for the assessment
9 and collection of mandatory payments authorized under this
10 subchapter.
11 Sec. 1001.462. CORRECTION OF INVALID PROVISION OR
12 PROCEDURE. To the extent any provision or procedure under this
13 subchapter causes a mandatory payment authorized under this
14 subchapter to be ineligible for federal matching funds, the board
15 may provide by rule for an alternative provision or procedure that
16 conforms to the requirements of the federal Centers for Medicare
17 and Medicaid Services. A rule adopted under this section may not
18 create, impose, or materially expand the legal or financial
19 liability or responsibility of the district or an institutional
20 health care provider in the district beyond the provisions of this
21 subchapter. This section does not require the board to adopt a rule.
22 SECTION 2. If before implementing any provision of this Act
23 a state agency determines that a waiver or authorization from a
24 federal agency is necessary for implementation of that provision,
25 the agency affected by the provision shall request the waiver or
26 authorization and may delay implementing that provision until the
27 waiver or authorization is granted.

1 SECTION 3. This Act takes effect immediately if it receives
2 a vote of two-thirds of all the members elected to each house, as
3 provided by Section 39, Article III, Texas Constitution. If this
4 Act does not receive the vote necessary for immediate effect, this
5 Act takes effect September 1, 2017.