By: Seliger S.B. No. 2117

(In the Senate - Filed March 10, 2017; March 28, 2017, read first time and referred to Committee on Intergovernmental Relations; April 26, 2017, reported adversely, with favorable Committee Substitute by the following vote: Yeas 5, Nays 0, 1 present not voting; April 26, 2017, sent to printer.)

COMMITTEE VOTE

	Yea	Nay	Absent	PNV
Lucio	X			
Bettencourt	X			
Campbell	X			
Garcia	X			
Huffines	X			
Menéndez			X	
Taylor of Collin				X

COMMITTEE SUBSTITUTE FOR S.B. No. 2117 By: Bettencourt

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. Subtitle D, Title 4, Health and Safety Code, is amended by adding Chapter 295A to read as follows:

CHAPTER 295A. CITY OF AMARILLO HOSPITAL DISTRICT HEALTH CARE PROVIDER PARTICIPATION PROGRAM

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 295A.001. PURPOSE. The purpose of this chapter 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 chapter.

Sec. 295A.002. DEFINITIONS. In this chapter:

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

(2) "District" means the City of Amarillo Hospital District.

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

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

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

Sec. 295A.003. APPLICABILITY. This chapter applies only to the City of Amarillo Hospital District.

Sec. 295A.004. HEALTH CARE PROVIDER PARTICIPATION PROGRAM; PARTICIPATION IN PROGRAM. The board 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. 295A.051. LIMITATION ON AUTHORITY TO REQUIRE MANDATORY PAYMENT. The board may require a mandatory payment authorized under this chapter by an institutional health care provider in the district only in the manner provided by this chapter.

Sec. 295A.052. RULES AND PROCEDURES. The board may 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. 295A.053. INSTITUTIONAL HEALTH CARE PROVIDER REPORTING. If the board authorizes the district to participate in a health care provider participation program under this chapter, the board shall 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 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. 295A.101. HEARING. (a) In each year that the board authorizes a health care provider participation 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 the chief operating officer of each institutional health care provider in the district.

Sec. 295A.102. LOCAL PROVIDER PARTICIPATION FUND; DEPOSITORY. (a) If the board collects a mandatory payment authorized under this chapter, the board shall create a local provider participation fund in one or more banks designated by the district as a depository for public funds.

(b) The board may withdraw or use money in the fund only for a purpose authorized under this chapter.

(c) All funds collected under this chapter shall be secured in the manner provided by Chapter 1001, Special District Local Laws Code, for securing other public funds of the district.

Sec. 295A.103. DEPOSITS TO FUND; AUTHORIZED USES OF MONEY. (a) The local provider participation fund established under Section 295A.102 consists of:

(1) all mandatory payments authorized under this chapter and received by the district;

(2) money received from the Health and Human Services Commission as a refund of an intergovernmental transfer from the district to the state as the nonfederal share of Medicaid supplemental payment program payments, provided that the intergovernmental transfer does not receive a federal matching payment; and

(3) the earnings of the fund.

(b) Money deposited to the local provider participation fund may be used only to:

(1) fund intergovernmental transfers from the district to the state to provide:

(A) the nonfederal share of a Medicaid supplemental payment program authorized under the state Medicaid plan, 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), or a successor waiver program authorizing similar Medicaid supplemental payment programs; or

(B) payments to Medicaid managed care organizations that are dedicated for payment to hospitals;

(2) pay costs associated with indigent care provided by institutional health care providers in the district;

(3) pay the administrative expenses of the district in administering the program, including collateralization of deposits;

(4) refund a portion of a mandatory payment collected in error from a paying hospital; and

(5) refund to paying hospitals 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.

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

(d) An intergovernmental transfer of funds described by Subsection (b)(1) and any funds received by the district as a result of an intergovernmental transfer described by that subsection may not be used by 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).

SUBCHAPTER D. MANDATORY PAYMENTS

Sec. 295A.151. MANDATORY PAYMENTS. (a) Except as provided by Subsection (e), if the board authorizes a health care provider participation program under this chapter, the board shall 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 shall provide that the mandatory payment is to be collected at least annually, but not more often than 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. The district shall update the amount of the mandatory payment on an annual basis.

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

(c) The aggregate amount of the mandatory payments required of all paying hospitals in the district may not exceed six percent of the aggregate net patient revenue of all paying hospitals in the district.

(d) Subject to the maximum amount prescribed by Subsection (c), 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, fund an intergovernmental transfer described by Section 295A.103(b)(1), or make other payments authorized under this chapter. The amount of revenue from mandatory payments that may be used for administrative expenses by the district in a year may not exceed $25,000, plus the cost of collateralization of deposits. If the board demonstrates to the paying hospitals that the costs of administering the health care provider participation program under this chapter, excluding those costs associated with the collateralization of deposits, exceed $25,000 in any year, on consent of all of the paying hospitals, the district may use additional revenue from mandatory payments received under this chapter to compensate the district for its administrative expenses. A paying hospital may not unreasonably withhold consent to compensate the district for administrative expenses.

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

(f) A mandatory payment under this chapter is not a tax for purposes of Section 5(a), Article IX, Texas Constitution, or Chapter 1001, Special District Local Laws Code.

Sec. 295A.152. ASSESSMENT AND COLLECTION OF MANDATORY PAYMENTS. The district may collect or contract for the assessment and collection of mandatory payments authorized under this chapter.

Sec. 295A.153. CORRECTION OF INVALID PROVISION OR PROCEDURE. 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 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.

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, 2017.

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