By: Huffines S.B. No. 2170

A BILL TO BE ENTITLED

AN ACT

relating to the creation and operations of health care provider participation programs in hospital districts established under Chapter 281, Health & Safety Code.

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 298 to read as follows:

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

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 298.001. DEFINITIONS. In this chapter:

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

(2) "Collection Agent" means an official of the district or another person engaged by the district to assess and collect mandatory payments.

(3) "District" means a hospital district to which this chapter is applicable.

(4) "Institutional health care provider" means a nonpublic health care provider that provides inpatient hospital services in the jurisdiction governed by the District.

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

(6) "Provider participation program" means a district health care provider participation program authorized under this chapter.

Sec. 298.002. APPLICABILITY. This chapter applies only to a hospital district located in Dallas County.

Sec. 298.003. DISTRICT HEALTH CARE PROVIDER PARTICIPATION PROGRAM. A district, pursuant to the affirmative vote of a majority of the members of the board, is authorized to have a provider participation 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. A board may require a mandatory payment authorized under this chapter by an institutional health care provider in its district only in the manner provided by this chapter.

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

Sec. 298.053. INSTITUTIONAL HEALTH CARE PROVIDER REPORTING; INSPECTION OF RECORDS. A board that has enacted a provider participation program under this chapter shall require each institutional health care 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 under Sections 311.032 and 311.033, as amended, and any rules adopted by the executive commissioner of the Health and Human Services Commission to implement those sections.

Sec. 298.054. EXPIRATION. The authority of the district to administer and operate a provider participation program expires December 31, 2019.

SUBCHAPTER C. GENERAL FINANCIAL PROVISIONS

Sec. 298.101. HEARING. (a) Each year, the board that has enacted a provider participation program under this chapter 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 5th 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 its district and provide written notice of the hearing to each institutional health care provider in its district.

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

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

Sec. 298.103. LOCAL PROVIDER PARTICIPATION FUND; AUTHORIZED USES OF MONEY. (a) A district collecting mandatory payments authorized under this chapter shall create a local provider participation fund.

(b) The local provider participation fund of a district shall consist 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 this 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, where such payments are available 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) or any successor program, (B) uniform rate enhancements for nonpublic hospitals in the Medicaid managed care service area in which the district is located, (C) payments available under a successor waiver program authorizing substantially similar Medicaid payments to nonpublic hospitals, or (D) any reimbursement that provides matching funds to such providers;

(2) subject to the limitation set forth in Sec. 298.103(d) below, pay the administrative expenses incurred by the district in administering the provider participation program, including collateralization of deposits;

(3) make refunds of any mandatory payment collected in

error from a paying provider;

(4) refund to paying providers the proportionate share of money received by the district from the Health and Human Services Commission that is not used to fund the nonfederal share of Medicaid supplemental payment program payments;

(5) refund to paying providers the proportionate share of money that cannot be used to fund the nonfederal share of Medicaid supplemental payment program payments; and

(6) transfer funds to the Health and Human Services Commission, if the district is legally required to transfer funds to address a disallowance of federal matching funds with respect to programs for which the district made intergovernmental transfers as described in Sec. 298.103(c)(1) above.

(7) reimburse the district, if the district is required by the rules governing the uniform rate enhancement program described in subsection (c)(1)(B) of this Section to incur an expense or forego Medicaid reimbursements from the State due to a shortfall in the local provider participation fund for funding the rate enhancement program for the nonpublic hospitals in the district's service delivery area.

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

(e) Notwithstanding any other provision of this Chapter 298, with respect to any intergovernmental transfer of funds, as described by Subsection (c)(1), made by a district, any funds received by the state, the district, or any other entity as a result of such an intergovernmental transfer may not be 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) Except as provided by Subsection (d), a board that has authorized the collection of a mandatory payment under this chapter may require an annual mandatory payment to be assessed on the net patient revenue of each institutional health care provider located in its 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 recently completed fiscal year. If the institutional health care provider did not report any data under those sections, then the net patient revenue shall be determined by the institutional health care 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 uniformly proportionate with the amount of net patient revenue generated by each paying provider in such district as permitted under federal law. A provider participation program may not hold harmless any institutional health care provider, as required under 42 U.S.C. Section 1396b(w).

(c) A board that has authorized the collection of a mandatory payment under this chapter shall, within the limitations set out in this Chapter 298, set the amount of the mandatory payment. 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), a board that has authorized the collection of a mandatory payment under this chapter 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 intergovernmental transfers described by Section 298.103. The annual amount to be paid for the administrative expenses of the district shall be $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 imposed under this chapter is not a "tax for hospital purposes" as referenced in Article IX, Section 4 of the Texas Constitution or in Section 281.045 of the Health and Safety Code.

Sec. 298.152. ASSESSMENT AND COLLECTION OF MANDATORY PAYMENTS. (a) If the Collection Agent is not an official of the district, the Collection Agent shall collect the mandatory payments on behalf of the district and shall 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) If determined to be appropriate by the board, the board may contract for the assessment and collection of mandatory payments authorized under this chapter.

(c) Revenue from a fee charged by the Collection Agent for collecting the mandatory payment shall be deposited in the district general fund and, if appropriate, shall be reported as fees of the district.

Sec. 298.153. 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 that enables the district to collect mandatory payments from institutional health care 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 health care by institutional health care providers to those in need. 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) 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, 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. Nothing in this section shall be construed to require the district to adopt any such rule. Any such remedial rule shall not create, impose, or materially expand the legal or financial liability or program responsibilities of either the district or any institutional healthcare provider beyond the provisions of this subchapter.

(c) The district may 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 waiver 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. 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.