BILL ANALYSIS

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S.B. 1545
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AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

Since 2013, Texas hospitals in 19 cities and counties across the state have created local provider participation funds (LPPFs) for the purpose of generating parts of the non-federal share of Medicaid payments. Of the 19 currently authorized, eight counties or hospital districts were approved to create an LPPF during the 85th legislative session, highlighting the growing support for this funding method throughout the state.

The state's healthcare system has become highly dependent on several Medicaid supplemental funding sources that require locally generated intergovernmental transfers (IGTs). Currently IGTs in Bexar County are solely dependent on hospital district property tax revenue to drawdown the non-federal share of Medicaid supplemental funding sources: Medicaid 1115 Waiver payments (DSRIP and UC), and the Uniform Hospital Rate Increase Program (UHRIP).

S.B. 1545 will allow Bexar county to create an LPPF that primarily seeks to provide the non-federal share of Medicaid payments to eligible hospitals through an IGT. Specifically, LPPF would authorize the use of: IGTs for waiver payments to non-public hospitals, IGTs for UHRIP payments to hospitals in the Bexar service delivery area, and administrative expenses for the hospital district of 2.5 percent of the total assessment collected. This funding will ensure that critical services in the Medicaid program are available for those who seek healthcare in Bexar county.

As proposed, S.B. 1545 amends current law relating to the creation and operations of a health care provider participation program by the Bexar County Hospital District.

RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to the board of hospital managers of the Bexar County Hospital District in SECTION 1 (Sections 298F.052 and 298F.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 298F, as follows:

CHAPTER 298F. BEXAR COUNTY HOSPITAL DISTRICT HEALTH CARE PROVIDER PARTICIPATION PROGRAM

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 298F.001. DEFINITIONS. (1) Defines "board" as the board of hospital managers of the Bexar County Hospital District (board; district).

(2) Defines "district."

(3) Defines "institutional health care provider."

(4) Defines "paying provider."

(5) Defines "program" as the health care provider participation program authorized by this chapter (program).

Sec. 298F.002. APPLICABILITY. Provides that this chapter applies only to the Bexar County Hospital District.

Sec. 298F.003. HEALTH CARE PROVIDER PARTICIPATION PROGRAM; PARTICIPATION IN PROGRAM. Authorizes the board to authorize the district to participate in the program on the affirmative vote of a majority of the board, subject to the provisions of this chapter.

Sec. 298F.004. EXPIRATION. (a) Provides that, subject to Section 298F.153(d), the authority of the district to administer and operate a program under this chapter expires December 31, 2023.

(b) Provides that this chapter expires December 31, 2023.

SUBCHAPTER B. POWERS AND DUTIES OF BOARD

Sec. 298F.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 in the district only in the manner provided by this chapter.

Sec. 298F.052. RULES AND PROCEDURES. Authorizes the board to adopt rules relating to the administration of the program, including collection of the mandatory payments, expenditures, audits, and any other administrative aspects of the program.

Sec. 298F.053. INSTITUTIONAL HEALTH CARE PROVIDER REPORTING. Requires the board, if the board authorizes the district to participate in a program under this chapter, to require each institutional health care provider to submit to the district a copy of any financial and utilization data reported 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.

SUBCHAPTER C. GENERAL FINANCIAL PROVISIONS

Sec. 298F.101. HEARING. (a) Requires the board, in each year that the board authorizes a program under this chapter, 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 each paying provider in the district.

(c) Entitles a representative of a paying provider to appear at the public hearing and be heard regarding any matter related to the mandatory payments authorized under this chapter.

Sec. 298F.102. DEPOSITORY. (a) Requires the board, if the board requires a mandatory payment authorized under this chapter, to designate one or more banks as a depository for the district's local provider participation fund.

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

Sec. 298F.103. LOCAL PROVIDER PARTICIPATION FUND; AUTHORIZED USES OF MONEY. (a) Requires the district, if the district requires a mandatory payment authorized under this chapter, to create a local provider participation fund.

(b) Provides that the local provider participation fund consists of all revenue received by the district attributable to mandatory payments authorized under this chapter, money received from the Health and Human Services Commission (HHSC) as a refund of an intergovernmental transfer under the program, provided that the intergovernmental transfer does not receive a federal matching payment, and the earnings of the fund.

(c) Authorizes money deposited to the local provider participation fund of the district to 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, if those payments are authorized under 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);

(B) payments to nonpublic hospitals available through the delivery system reform incentive payment program;

(C) uniform rate enhancements for nonpublic hospitals in the Medicaid managed care service area in which the district is located;

(D) payments available under another waiver program authorizing payments that are substantially similar to Medicaid payments to nonpublic hospitals described by Paragraph (A), (B), or (C); or

(E) any reimbursement to nonpublic hospitals for which federal matching funds are available;

(2) subject to Section 298F.151(d), pay the administrative expenses of the district in administering the program, including collateralization of deposits;

(3) refund a mandatory payment collected in error from a paying provider;

(4) refund to paying providers a proportionate share of the money that the district receives from HHSC that is not used to fund the nonfederal share of Medicaid supplemental payment program payments or that the district determines cannot be used to fund the nonfederal share of Medicaid supplemental payment program payments; and

(5) transfer funds to HHSC if the district is legally required to transfer the funds to address a disallowance of federal matching funds with respect to programs for which the district made intergovernmental transfers described by Subdivision (1).

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

(e) Prohibits any funds received by the state, district, or other entity as a result of that transfer, notwithstanding any other provision of this chapter, with respect to an intergovernmental transfer of funds described by Subsection (c)(1) made by

the district, from being used by the state, 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. 298F.151. MANDATORY PAYMENTS BASED ON PAYING PROVIDER NET PATIENT REVENUE. (a) Authorizes the board, if the board authorizes a health care provider participation program under this chapter, to require an annual mandatory payment to be assessed on the net patient revenue of each institutional health care provider located in the district. Authorizes the board to provide for the mandatory payment to be assessed periodically throughout the year. Requires the board to provide an institutional health care provider written notice of each assessment under this subsection, and provides that the provider has 30 calendar days following the date of receipt of the notice to pay the assessment. 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, which is the amount of that revenue as reported 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, if the mandatory payment is required, 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 the district as permitted under federal law. Prohibits a health care provider participation program authorized under this chapter from holding harmless any institutional health care provider, as required under 42 U.S.C. Section 1396b(w).

(c) Requires the board, if the board requires a mandatory payment authorized under this chapter, to set the amount of the mandatory payment, subject to the limitations of this chapter. 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 the board, subject to Subsection (c), if the board requires a mandatory payment authorized under this chapter, 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 an intergovernmental transfer described by Section 298F.103(c)(1). Prohibits the annual amount of revenue from mandatory payments that are required to be paid for administrative expenses of the program by the district from exceeding 2.5 percent of the total revenue generated from the mandatory payments, 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 assessed under this chapter is not a tax for hospital purposes for purposes of Section 4 (County-Wide Hospital Districts in Certain Large Counties), Article IX, Texas Constitution, or Section 281.045 of this code.

Sec. 298F.152. ASSESSMENT AND COLLECTION OF MANDATORY PAYMENTS. (a) Authorizes the district to designate an official of the district or contract with another person to assess and collect the mandatory payments authorized under this chapter.

(b) Requires the person charged by the district with the assessment and collection of mandatory payments to charge and deduct from the mandatory payments collected for the district a collection fee in an amount not to exceed the person's usual and customary charges for like services.

(c) Requires any revenue from a collection fee charged under Subsection (b), if the person charged with the assessment and collection of mandatory payments is an official of the district, to be deposited in the district general fund and, if appropriate, to be reported as fees of the district.

Sec. 298F.153. PURPOSE; CORRECTION OF INVALID PROVISION OR PROCEDURE; LIMITATION OF AUTHORITY. (a) Provides that the purpose of this chapter is to authorize the district to establish a program to enable the district to collect mandatory payments from institutional health care providers to fund the nonfederal share of a Medicaid supplemental payment program or the Medicaid managed care rate enhancements for nonpublic hospitals to support the provision of health care by institutional health care providers to district residents in need of health care.

(b) Provides that this chapter does not authorize the district to collect mandatory payments for the purpose of raising general revenue or any amount in excess of the amount reasonably necessary to fund the nonfederal share of a Medicaid supplemental payment program or Medicaid managed care rate enhancements for nonpublic hospitals and to cover the administrative expenses of the district associated with activities under this chapter and other amounts for which the fund is authorized to be used as described by Section 298F.103(c).

(c) Authorizes the board, 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. 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 chapter. Provides that this section does not require the board to adopt a rule.

(d) Authorizes the district to only assess and collect a mandatory payment authorized under this chapter if a waiver program, uniform rate enhancement, or reimbursement described by Section 298F.103(c)(1) is available to the district.

SECTION 2. Requires the board, as soon as practicable after the expiration of the authority of the district to administer and operate a program under Chapter 298F, Health and Safety Code, as added by this Act, to transfer to each institutional health care provider in the district that provider's proportionate share of any remaining funds in any local provider participation fund created by the district under Section 298F.103, Health and Safety Code, as added by this Act.

SECTION 3. 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 a delay of implementation until such a waiver or authorization is granted.

SECTION 4. Effective date: upon passage or September 1, 2019.