By: Coleman H.B. No. 4289

Substitute the following for H.B. No. 4289:

By: Huberty C.S.H.B. No. 4289

A BILL TO BE ENTITLED

AN ACT

relating to the authority of certain local governments to create and operate health care provider participation programs.

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 300 to read as follows:

CHAPTER 300. HEALTH CARE PROVIDER PARTICIPATION PROGRAMS IN CERTAIN POLITICAL SUBDIVISIONS IN THIS STATE

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 300.0001. PURPOSE. The purpose of this chapter is to authorize a hospital district, county, or municipality in this state to administer a health care provider participation program to provide additional compensation to certain hospitals located in the hospital district, county, or municipality by collecting mandatory payments from each of those hospitals to be used to provide the nonfederal share of a Medicaid supplemental payment program and for other purposes as authorized under this chapter.

Sec. 300.0002. DEFINITIONS. In this chapter:

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

(2) "Local government" means a hospital district, county, or municipality to which this chapter applies.

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

chapter.

(4) "Program" means a health care provider participation program authorized by this chapter.

Sec. 300.0003. APPLICABILITY. This chapter applies only to:

(1) a hospital district that is not participating in a health care provider participation program authorized by another chapter of this subtitle; and

(2) a county or municipality that:

(A) is not participating in a health care provider participation program authorized by another chapter of this subtitle; and

(B) is not served by a hospital district or a public hospital.

Sec. 300.0004. LOCAL JURISDICTION HEALTH CARE PROVIDER PARTICIPATION PROGRAM; ORDER REQUIRED FOR PARTICIPATION. The governing body of a local government may only adopt an order or ordinance authorizing that local government to participate in a health care provider participation program after an affirmative vote of the majority of the governing body.

SUBCHAPTER B. POWERS AND DUTIES OF GOVERNING BODY

Sec. 300.0051. LIMITATION ON AUTHORITY TO REQUIRE MANDATORY PAYMENT. The governing body of a local government may require a mandatory payment authorized under this chapter by an institutional health care provider located in that hospital district, county, or municipality, as applicable, only in the manner provided by this chapter.

Sec. 300.0052. RULES AND PROCEDURES. The governing body of a local government may adopt rules relating to the administration of the health care provider participation program in the local government, including collection of the mandatory payments, expenditures, audits, and any other administrative aspects of the program.

Sec. 300.0053. INSTITUTIONAL HEALTH CARE PROVIDER REPORTING. If the governing body of a local government authorizes the local government to participate in a health care provider participation program under this chapter, the governing body shall require each institutional health care provider to submit to the local government 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. 300.0101. HEARING. (a) In each year that the governing body of a local government authorizes a health care provider participation program under this chapter, the governing body shall hold a public hearing on the amounts of any mandatory payments that the governing body 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 governing body shall publish notice of the hearing in a newspaper of general circulation in the hospital district, county, or municipality, as applicable,

and provide written notice of the hearing to the chief operating officer of each institutional health care provider located in the hospital district, county, or municipality, as applicable.

(c) A representative of a paying hospital is entitled to appear at the time and place designated in the public notice and to be heard regarding any matter related to the mandatory payments authorized under this chapter.

Sec. 300.0102. LOCAL PROVIDER PARTICIPATION FUND; DEPOSITORY. (a) Each governing body of a local government that collects a mandatory payment authorized under this chapter shall create a local provider participation fund.

(b) If a governing body of a local government creates a local provider participation fund, the governing body shall designate one or more banks as a depository for the mandatory payments received by the local government.

(c) The governing body of a local government may withdraw or use money in the local provider participation fund of the local government only for a purpose authorized under this chapter.

(d) All funds collected under this chapter shall be secured in the manner provided for securing other funds of the local government.

Sec. 300.0103. LOCAL PROVIDER PARTICIPATION FUND; AUTHORIZED USES OF MONEY. (a) The local provider participation fund established by a local government under Section 300.0102 consists of:

(1) all revenue received by the local government 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 from the local government to the state for the purpose of providing 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 of a local government may be used only to:

(1) fund intergovernmental transfers from the local government 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) uniform rate enhancements for nonpublic hospitals in the Medicaid managed care service area in which the local government is located;

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

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

(2) subject to Section 300.0151(d), pay the

administrative expenses of the local government in administering the program, including collateralization of deposits;

(3) refund all or a portion of a mandatory payment collected in error from a paying hospital;

(4) refund to paying hospitals a proportionate share of the money that the local government:

(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;

(5) transfer funds to the Health and Human Services Commission if the local government is required by law to transfer the funds to address a disallowance of federal matching funds with respect to payments, rate enhancements, and reimbursements for which the local government made intergovernmental transfers described by Subdivision (1); and

(6) reimburse the local government if the local government is required by the rules governing the uniform rate enhancement program described by Subdivision (1)(B) to incur an expense or forego Medicaid reimbursements from the state because the balance of the local provider participation fund is not sufficient to fund that rate enhancement program.

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

(d) Notwithstanding any other provision of this chapter, with respect to an intergovernmental transfer of funds described by Subsection (b)(1) made by the local government, any funds received by the state, local government, or other entity as a result of that transfer may not be used by the state, local government, or any other entity to:

(1) 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

(2) fund the nonfederal share of payments to nonpublic hospitals available through the Medicaid disproportionate share hospital program or the delivery system reform incentive payment program.

SUBCHAPTER D. MANDATORY PAYMENTS

Sec. 300.0151. MANDATORY PAYMENTS. (a) Except as provided by Subsection (e), if the governing body of a local government authorizes a health care provider participation program under this chapter, the governing body shall require an annual mandatory payment to be assessed on the net patient revenue of each institutional health care provider located in the hospital district, county, or municipality, as applicable. The governing body of the local government shall provide that the mandatory payment is to be assessed 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 located in the

hospital district, county, or municipality, as applicable, 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 local government shall update the amount of the mandatory payment on an annual basis.

(b) The amount of a mandatory payment authorized under this chapter for a local government must be uniformly proportionate with the amount of net patient revenue generated by each paying hospital in the hospital district, county, or municipality, as applicable, as permitted under federal law. A health care provider participation program 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 governing body of a local government that authorizes a program under this chapter shall set the amount of the mandatory payment. The aggregate amount of the mandatory payments required of all paying hospitals in the hospital district, county, or municipality, as applicable, may not exceed six percent of the aggregate net patient revenue from hospital services provided by all paying hospitals in the hospital district, county, or municipality, as applicable.

(d) Subject to Subsection (c), the governing body of a local government shall set the mandatory payments in amounts that in the aggregate will generate sufficient revenue to cover the administrative expenses of the local government for activities under this chapter and to fund an intergovernmental transfer described by Section 300.0103(b)(1). The annual amount of revenue from mandatory payments that shall be paid for administrative expenses for activities under this chapter by the local government may not exceed $150,000, plus the cost of collateralization of deposits, regardless of actual expenses.

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

(f) A mandatory payment required by the governing body of a hospital district under this chapter is not a tax for purposes of the applicable provision of Article IX, Texas Constitution.

Sec. 300.0152. ASSESSMENT AND COLLECTION OF MANDATORY PAYMENTS. (a) A hospital district may designate an official of the district or contract with another person to assess and collect the mandatory payments authorized under this chapter.

(b) A county or municipality may collect or, using a competitive bidding process, contract for the assessment and collection of mandatory payments authorized under this chapter.

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

(d) If the person charged with the assessment and collection of mandatory payments is an official of the local government, any revenue from a collection fee charged under Subsection (c) shall be deposited in the local government general fund and, if appropriate, shall be reported as fees of the local government.

Sec. 300.0153. CORRECTION OF INVALID PROVISION OR PROCEDURE. (a) This chapter does not authorize a local government 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 local government associated with activities under this chapter and other uses of the fund described by Section 300.0103(b).

(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, the local government 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 local government or an institutional health care provider in the local hospital district, county, or municipality, as applicable, beyond the provisions of this chapter. This section does not require the governing body of a local government to adopt a rule.

(c) The local government may only assess and collect a

mandatory payment authorized under this chapter if a waiver program, uniform rate enhancement, or reimbursement described by Section 300.0103(b)(1) is available to the local government.

Sec. 300.0154. REPORTING REQUIREMENTS. (a) The governing body of each local government that authorizes a program under this chapter shall report information to the Health and Human Services Commission regarding the program on a schedule determined by the commission.

(b) The information must include:

(1) the amount of the mandatory payments required and collected in each year the program is authorized;

(2) any expenditure of money attributable to mandatory payments collected under this chapter, including:

(A) any contract with an entity for the administration or operation of a program authorized by this chapter; or

(B) a contract with a person for the assessment and collection of a mandatory payment as authorized under Section 300.0152; and

(3) the amount of money attributable to mandatory payments collected under this chapter that is used for any other purpose.

(c) The executive commissioner of the Health and Human Services Commission shall adopt rules to administer this section.

Sec. 300.0155. EXPIRATION OF AUTHORITY. The authority of a local government to administer and operate a program under this chapter expires on September 1 following the second anniversary of

the date the governing body of the local government adopted the order or ordinance authorizing the local government to participate in the program as provided by Section 300.0004.

Sec. 300.0156. AUTHORITY TO REFUSE FOR VIOLATION. The Health and Human Services Commission may refuse to accept money from a local provider participation fund established under this chapter if the commission determines that doing so may violate federal law.

SECTION 2. Subtitle D, Title 4, Health and Safety Code, is amended by adding Chapter 300A to read as follows:

CHAPTER 300A. HEALTH CARE PROVIDER PARTICIPATION PROGRAM IN DISTRICTS COMPOSED OF CERTAIN LOCAL GOVERNMENTS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 300A.0001. PURPOSE. The purpose of this chapter is to authorize certain local governments to create a district to administer a health care provider participation program to provide additional compensation to certain hospitals in the district by collecting mandatory payments from each of those hospitals 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. 300A.0002. DEFINITIONS. In this chapter:

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

(2) "Director" means a member of the board.

(3) "District" means a health care provider participation district created under this chapter.

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

(5) "Local government" means a hospital district, county, or municipality to which this chapter applies.

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

(7) "Program" means a health care provider participation program authorized by this chapter.

Sec. 300A.0003. APPLICABILITY. This chapter applies only to:

(1) a hospital district that:

(A) is not participating in a health care provider participation program authorized by another chapter of this subtitle; and

(B) has only one institutional health care provider located in the district; and

(2) a county or municipality that:

(A) is not participating in a health care provider participation program authorized by another chapter of this subtitle;

(B) is not served by a hospital district or a public hospital; and

(C) has only one institutional health care provider located in the county or municipality.

SUBCHAPTER B. CREATION, OPERATION, AND DISSOLUTION OF DISTRICT

Sec. 300A.0021. CREATION BY CONCURRENT ORDERS. (a) A local

government and one or more other local governments may create a district by adopting concurrent orders.

(b) A concurrent order to create a district must:

(1) be approved by the governing body of each creating local government;

(2) contain identical provisions; and

(3) define the boundaries of the district to be coextensive with the combined boundaries of each creating local government.

Sec. 300A.0022. POWERS. A district may authorize and administer a health care provider participation program in accordance with this chapter.

Sec. 300A.0023. BOARD OF DIRECTORS. (a) If three or more local governments create a district, the presiding officer of the governing body of each local government that creates the district shall appoint one director.

(b) If two local governments create a district:

(1) the presiding officer of the governing body of the most populous local government shall appoint two directors; and

(2) the presiding officer of the governing body of the other local government shall appoint one director.

(c) Directors serve staggered two-year terms, with as near as possible to one-half of the directors' terms expiring each year.

(d) A vacancy in the office of director shall be filled for the unexpired term in the same manner as the original appointment.

(e) The board shall elect from among its members a president. The president may vote and may cast an additional vote

to break a tie.

(f) The board shall also elect from among its members a vice president.

(g) The board shall appoint a secretary, who need not be a director.

(h) Each officer of the board serves for a term of one year.

(i) The board shall fill a vacancy in a board office for the unexpired term.

(j) A majority of the members of the board voting must concur in a matter relating to the business of the district.

Sec. 300A.0024. QUALIFICATIONS FOR OFFICE. (a) To be eligible to serve as a director, a person must be a resident of the local government that appoints the person under Section 300A.0023.

(b) An employee of the district may not serve as a director.

Sec. 300A.0025. COMPENSATION. (a) Directors and officers serve without compensation but may be reimbursed for actual expenses incurred in the performance of official duties.

(b) Expenses reimbursed under this section must be:

(1) reported in the district's minute book or other district records; and

(2) approved by the board.

Sec. 300A.0026. AUTHORITY TO SUE AND BE SUED. The board may sue and be sued on behalf of the district.

Sec. 300A.0027. DISTRICT FINANCES. Subchapter F, Chapter 287, other than Sections 287.129 and 287.130, applies to the district in the same manner that those provisions apply to a health services district created under Chapter 287. This section does not

authorize the district to issue bonds.

Sec. 300A.0028. DISSOLUTION. A district shall be dissolved if the local governments that created the district adopt concurrent orders to dissolve the district and the concurrent orders contain identical provisions.

Sec. 300A.0029. ADMINISTRATION OF PROPERTY, DEBTS, AND ASSETS AFTER DISSOLUTION. (a) After dissolution of a district under Section 300A.0028, the board shall continue to control and administer any property, debts, and assets of the district until all funds have been disposed of and all district debts have been paid or settled.

(b) As soon as practicable after the dissolution of the district, the board shall transfer to each institutional health care provider in the district the provider's proportionate share of any remaining funds in any local provider participation fund created by the district under Section 300A.0102.

(c) If, after administering any property and assets, the board determines that the district's property and assets are insufficient to pay the debts of the district, the district shall transfer the remaining debts to the local governments that created the district in proportion to the funds contributed to the district by each local government, including a paying hospital in the local government.

(d) If, after complying with Subsections (b) and (c) and administering the property and assets, the board determines that unused funds remain, the board shall transfer the unused funds to the local governments that created the district in proportion to

the funds contributed to the district by each local government, including a paying hospital in the local government.

Sec. 300A.0030. ACCOUNTING AFTER DISSOLUTION. After the district has paid all its debts and has disposed of all its assets and funds as prescribed by Section 300A.0029, the board shall provide an accounting to each local government that created the district. The accounting must show the manner in which the assets and debts of the district were distributed.

SUBCHAPTER C. HEALTH CARE PROVIDER PARTICIPATION PROGRAM; POWERS AND DUTIES OF DISTRICT BOARD

Sec. 300A.0051. HEALTH CARE PROVIDER PARTICIPATION PROGRAM. The board of a district 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.

Sec. 300A.0052. 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. 300A.0053. RULES AND PROCEDURES. The board may adopt rules relating to the administration of the health care provider participation program in the district, including collection of the mandatory payments, expenditures, audits, and any other administrative aspects of the program.

Sec. 300A.0054. 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 located in the district 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 D. GENERAL FINANCIAL PROVISIONS

Sec. 300A.0101. 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 each local government that creates the district and provide written notice of the hearing to the chief operating officer of each institutional health care provider in the district.

(c) A representative of a paying hospital is entitled to appear at the time and place designated in the public notice and be heard regarding any matter related to the mandatory payments authorized under this chapter.

Sec. 300A.0102. 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 the mandatory payments received by the district.

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

(c) All funds collected under this chapter shall be secured in the manner provided for securing public funds.

Sec. 300A.0103. DEPOSITS TO FUND; AUTHORIZED USES OF MONEY. (a) The local provider participation fund established under Section 300A.0102 consists 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 from the district to the state for the purpose of providing 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 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) uniform rate enhancements for nonpublic hospitals in the Medicaid managed care service area in which the district is located;

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

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

(2) subject to Section 300A.0151(d), pay the administrative expenses of the district in administering the program, including collateralization of deposits;

(3) refund all or a portion of a mandatory payment collected in error from a paying hospital;

(4) 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;

(5) transfer funds to the Health and Human Services Commission if the district is required by law to transfer the funds to address a disallowance of federal matching funds with respect to

payments, rate enhancements, and reimbursements for which the district made intergovernmental transfers described by Subdivision (1); and

(6) reimburse the district if the district is required by the rules governing the uniform rate enhancement program described by Subdivision (1)(B) to incur an expense or forego Medicaid reimbursements from the state because the balance of the local provider participation fund is not sufficient to fund that rate enhancement program.

(c) Money in the local provider participation fund may not be commingled with other district funds or other funds of a local government that creates the district.

(d) Notwithstanding any other provision of this chapter, with respect to an intergovernmental transfer of funds described by Subsection (b)(1) made by the district, any funds received by the state, district, or other entity as a result of the transfer may not be used by the state, district, or any other entity to:

(1) 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

(2) fund the nonfederal share of payments to nonpublic hospitals available through the Medicaid disproportionate share hospital program or the delivery system reform incentive payment program.

Sec. 300A.0104. ACCOUNTING OF FUNDS. The district shall maintain an accounting of the funds received from each local

government that creates the district, including a paying hospital located in a hospital district, county, or municipality that created the district, as applicable.

SUBCHAPTER E. MANDATORY PAYMENTS

Sec. 300A.0151. MANDATORY PAYMENTS BASED ON PAYING HOSPITAL NET PATIENT REVENUE. (a) Except as provided by Subsection (e), if the board authorizes a health care provider participation program under this chapter, the district 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 assessed 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 located in the district 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 uniformly proportionate with the amount of net

patient revenue generated by each paying hospital in the district as permitted under federal law. A health care provider participation program 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 board shall set the amount of a mandatory payment authorized under this chapter. 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 from hospital services provided by all paying hospitals in the district.

(d) Subject to 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 and to fund an intergovernmental transfer described by Section 300A.0103(b)(1). The annual amount of revenue from mandatory payments that shall be paid for administrative expenses by the district for activities under this chapter may not exceed $150,000, plus the cost of collateralization of deposits, regardless of actual expenses.

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

(f) For purposes of any hospital district that creates a district under this chapter, a mandatory payment assessed under this chapter is not a tax for hospital purposes for purposes of the applicable provision of Article IX, Texas Constitution.

Sec. 300A.0152. ASSESSMENT AND COLLECTION OF MANDATORY PAYMENTS. (a) The district may designate an official of the

district or contract with another person to assess and collect the mandatory payments authorized under this chapter.

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

Sec. 300A.0153. CORRECTION OF INVALID PROVISION OR PROCEDURE; LIMITATION OF AUTHORITY. (a) 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:

(1) fund the nonfederal share of a Medicaid supplemental payment program or Medicaid managed care rate enhancements for nonpublic hospitals; and

(2) cover the administrative expenses of the district associated with activities under this chapter and other uses of the fund described by Section 300A.0103(b).

(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, 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.

(c) The district may only assess and collect a mandatory payment authorized under this chapter if a waiver program, uniform rate enhancement, or reimbursement described by Section 300A.0103(b)(1) is available to the district.

Sec. 300A.0154. REPORTING REQUIREMENTS. (a) The board of a district that authorizes a program under this chapter shall report information to the Health and Human Services Commission regarding the program on a schedule determined by the commission.

(b) The information must include:

(1) the amount of the mandatory payments required and collected in each year the program is authorized;

(2) any expenditure of money attributable to mandatory payments collected under this chapter, including:

(A) any contract with an entity for the administration or operation of a program authorized by this chapter; or

(B) a contract with a person for the assessment and collection of a mandatory payment as authorized under Section 300A.0152; and

(3) the amount of money attributable to mandatory payments collected under this chapter that is used for any other

purpose.

(c) The executive commissioner of the Health and Human Services Commission shall adopt rules to administer this section.

Sec. 300A.0155. EXPIRATION OF AUTHORITY. The authority of a district to administer and operate a program under this chapter expires on September 1 following the second anniversary of the date the board of the district authorized the district to participate in the program as provided by Section 300A.0051.

Sec. 300A.0156. AUTHORITY TO REFUSE FOR VIOLATION. The Health and Human Services Commission may refuse to accept money from a local provider participation fund established under this chapter if the commission determines that doing so may violate federal law.

SECTION 3. As soon as practicable after the expiration of the authority of a local government to administer and operate a health care provider participation program under Chapter 300 or 300A, Health and Safety Code, as added by this Act, the governing body of the local government shall transfer to each institutional health care provider in the boundaries of the local government that provider's proportionate share of any remaining funds in any local provider participation fund created by the local government under Chapter 300 or 300A, Health and Safety Code, as added by this Act.

SECTION 4. 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 5. 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, 2019.