

1-1 By: Coleman, et al. (Senate Sponsor - Kolkhorst) H.B. No. 4289
 1-2 (In the Senate - Received from the House May 8, 2019;
 1-3 May 10, 2019, read first time and referred to Committee on Health &
 1-4 Human Services; May 17, 2019, reported favorably by the following
 1-5 vote: Yeas 9, Nays 0; May 17, 2019, sent to printer.)

1-6 COMMITTEE VOTE

	Yea	Nay	Absent	PNV
1-7				
1-8	X			
1-9	X			
1-10	X			
1-11	X			
1-12	X			
1-13	X			
1-14	X			
1-15	X			
1-16	X			

1-17 A BILL TO BE ENTITLED
 1-18 AN ACT

1-19 relating to the authority of certain local governments to create
 1-20 and operate health care provider participation programs.

1-21 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

1-22 SECTION 1. Subtitle D, Title 4, Health and Safety Code, is
 1-23 amended by adding Chapter 300 to read as follows:

1-24 CHAPTER 300. HEALTH CARE PROVIDER PARTICIPATION PROGRAMS IN CERTAIN
 1-25 POLITICAL SUBDIVISIONS IN THIS STATE
 1-26 SUBCHAPTER A. GENERAL PROVISIONS

1-27 Sec. 300.0001. PURPOSE. The purpose of this chapter is to
 1-28 authorize a hospital district, county, or municipality in this
 1-29 state to administer a health care provider participation program to
 1-30 provide additional compensation to certain hospitals located in the
 1-31 hospital district, county, or municipality by collecting mandatory
 1-32 payments from each of those hospitals to be used to provide the
 1-33 nonfederal share of a Medicaid supplemental payment program and for
 1-34 other purposes as authorized under this chapter.

1-35 Sec. 300.0002. DEFINITIONS. In this chapter:

1-36 (1) "Institutional health care provider" means a
 1-37 nonpublic hospital that provides inpatient hospital services.

1-38 (2) "Local government" means a hospital district,
 1-39 county, or municipality to which this chapter applies.

1-40 (3) "Paying hospital" means an institutional health
 1-41 care provider required to make a mandatory payment under this
 1-42 chapter.

1-43 (4) "Program" means a health care provider
 1-44 participation program authorized by this chapter.

1-45 Sec. 300.0003. APPLICABILITY. This chapter applies only
 1-46 to:

1-47 (1) a hospital district that is not participating in a
 1-48 health care provider participation program authorized by another
 1-49 chapter of this subtitle; and

1-50 (2) a county or municipality that:

1-51 (A) is not participating in a health care
 1-52 provider participation program authorized by another chapter of
 1-53 this subtitle; and

1-54 (B) is not served by a hospital district or a
 1-55 public hospital.

1-56 Sec. 300.0004. LOCAL JURISDICTION HEALTH CARE PROVIDER
 1-57 PARTICIPATION PROGRAM; ORDER REQUIRED FOR PARTICIPATION. The
 1-58 governing body of a local government may only adopt an order or
 1-59 ordinance authorizing that local government to participate in a
 1-60 health care provider participation program after an affirmative
 1-61 vote of the majority of the governing body.

2-1 SUBCHAPTER B. POWERS AND DUTIES OF GOVERNING BODY

2-2 Sec. 300.0051. LIMITATION ON AUTHORITY TO REQUIRE MANDATORY
 2-3 PAYMENT. The governing body of a local government may require a
 2-4 mandatory payment authorized under this chapter by an institutional
 2-5 health care provider located in that hospital district, county, or
 2-6 municipality, as applicable, only in the manner provided by this
 2-7 chapter.

2-8 Sec. 300.0052. RULES AND PROCEDURES. The governing body of
 2-9 a local government may adopt rules relating to the administration
 2-10 of the health care provider participation program in the local
 2-11 government, including collection of the mandatory payments,
 2-12 expenditures, audits, and any other administrative aspects of the
 2-13 program.

2-14 Sec. 300.0053. INSTITUTIONAL HEALTH CARE PROVIDER
 2-15 REPORTING. If the governing body of a local government authorizes
 2-16 the local government to participate in a health care provider
 2-17 participation program under this chapter, the governing body shall
 2-18 require each institutional health care provider to submit to the
 2-19 local government a copy of any financial and utilization data
 2-20 required by and reported to the Department of State Health Services
 2-21 under Sections 311.032 and 311.033 and any rules adopted by the
 2-22 executive commissioner of the Health and Human Services Commission
 2-23 to implement those sections.

2-24 SUBCHAPTER C. GENERAL FINANCIAL PROVISIONS

2-25 Sec. 300.0101. HEARING. (a) In each year that the
 2-26 governing body of a local government authorizes a health care
 2-27 provider participation program under this chapter, the governing
 2-28 body shall hold a public hearing on the amounts of any mandatory
 2-29 payments that the governing body intends to require during the year
 2-30 and how the revenue derived from those payments is to be spent.

2-31 (b) Not later than the fifth day before the date of the
 2-32 hearing required under Subsection (a), the governing body shall
 2-33 publish notice of the hearing in a newspaper of general circulation
 2-34 in the hospital district, county, or municipality, as applicable,
 2-35 and provide written notice of the hearing to the chief operating
 2-36 officer of each institutional health care provider located in the
 2-37 hospital district, county, or municipality, as applicable.

2-38 (c) A representative of a paying hospital is entitled to
 2-39 appear at the time and place designated in the public notice and to
 2-40 be heard regarding any matter related to the mandatory payments
 2-41 authorized under this chapter.

2-42 Sec. 300.0102. LOCAL PROVIDER PARTICIPATION FUND;
 2-43 DEPOSITORY. (a) Each governing body of a local government that
 2-44 collects a mandatory payment authorized under this chapter shall
 2-45 create a local provider participation fund.

2-46 (b) If a governing body of a local government creates a
 2-47 local provider participation fund, the governing body shall
 2-48 designate one or more banks as a depository for the mandatory
 2-49 payments received by the local government.

2-50 (c) The governing body of a local government may withdraw or
 2-51 use money in the local provider participation fund of the local
 2-52 government only for a purpose authorized under this chapter.

2-53 (d) All funds collected under this chapter shall be secured
 2-54 in the manner provided for securing other funds of the local
 2-55 government.

2-56 Sec. 300.0103. LOCAL PROVIDER PARTICIPATION FUND;
 2-57 AUTHORIZED USES OF MONEY. (a) The local provider participation
 2-58 fund established by a local government under Section 300.0102
 2-59 consists of:

2-60 (1) all revenue received by the local government
 2-61 attributable to mandatory payments authorized under this chapter;

2-62 (2) money received from the Health and Human Services
 2-63 Commission as a refund of an intergovernmental transfer from the
 2-64 local government to the state for the purpose of providing the
 2-65 nonfederal share of Medicaid supplemental payment program
 2-66 payments, provided that the intergovernmental transfer does not
 2-67 receive a federal matching payment; and

2-68 (3) the earnings of the fund.

2-69 (b) Money deposited to the local provider participation

3-1 fund of a local government may be used only to:

3-2 (1) fund intergovernmental transfers from the local
3-3 government to the state to provide the nonfederal share of Medicaid
3-4 payments for:

3-5 (A) uncompensated care payments to nonpublic
3-6 hospitals, if those payments are authorized under the Texas
3-7 Healthcare Transformation and Quality Improvement Program waiver
3-8 issued under Section 1115 of the federal Social Security Act (42
3-9 U.S.C. Section 1315);

3-10 (B) uniform rate enhancements for nonpublic
3-11 hospitals in the Medicaid managed care service area in which the
3-12 local government is located;

3-13 (C) payments available under another waiver
3-14 program authorizing payments that are substantially similar to
3-15 Medicaid payments to nonpublic hospitals described by Paragraph (A)
3-16 or (B); or

3-17 (D) any reimbursement to nonpublic hospitals for
3-18 which federal matching funds are available;

3-19 (2) subject to Section 300.0151(d), pay the
3-20 administrative expenses of the local government in administering
3-21 the program, including collateralization of deposits;

3-22 (3) refund all or a portion of a mandatory payment
3-23 collected in error from a paying hospital;

3-24 (4) refund to paying hospitals a proportionate share
3-25 of the money that the local government:

3-26 (A) receives from the Health and Human Services
3-27 Commission that is not used to fund the nonfederal share of Medicaid
3-28 supplemental payment program payments; or

3-29 (B) determines cannot be used to fund the
3-30 nonfederal share of Medicaid supplemental payment program
3-31 payments;

3-32 (5) transfer funds to the Health and Human Services
3-33 Commission if the local government is required by law to transfer
3-34 the funds to address a disallowance of federal matching funds with
3-35 respect to payments, rate enhancements, and reimbursements for
3-36 which the local government made intergovernmental transfers
3-37 described by Subdivision (1); and

3-38 (6) reimburse the local government if the local
3-39 government is required by the rules governing the uniform rate
3-40 enhancement program described by Subdivision (1)(B) to incur an
3-41 expense or forego Medicaid reimbursements from the state because
3-42 the balance of the local provider participation fund is not
3-43 sufficient to fund that rate enhancement program.

3-44 (c) Money in the local provider participation fund of a
3-45 local government may not be commingled with other funds of the local
3-46 government.

3-47 (d) Notwithstanding any other provision of this chapter,
3-48 with respect to an intergovernmental transfer of funds described by
3-49 Subsection (b)(1) made by the local government, any funds received
3-50 by the state, local government, or other entity as a result of that
3-51 transfer may not be used by the state, local government, or any
3-52 other entity to:

3-53 (1) expand Medicaid eligibility under the Patient
3-54 Protection and Affordable Care Act (Pub. L. No. 111-148) as amended
3-55 by the Health Care and Education Reconciliation Act of 2010 (Pub. L.
3-56 No. 111-152); or

3-57 (2) fund the nonfederal share of payments to nonpublic
3-58 hospitals available through the Medicaid disproportionate share
3-59 hospital program or the delivery system reform incentive payment
3-60 program.

3-61 SUBCHAPTER D. MANDATORY PAYMENTS

3-62 Sec. 300.0151. MANDATORY PAYMENTS. (a) Except as provided
3-63 by Subsection (e), if the governing body of a local government
3-64 authorizes a health care provider participation program under this
3-65 chapter, the governing body shall require an annual mandatory
3-66 payment to be assessed on the net patient revenue of each
3-67 institutional health care provider located in the hospital
3-68 district, county, or municipality, as applicable. The governing
3-69 body of the local government shall provide that the mandatory

4-1 payment is to be assessed at least annually, but not more often than
 4-2 quarterly. In the first year in which the mandatory payment is
 4-3 required, the mandatory payment is assessed on the net patient
 4-4 revenue of an institutional health care provider located in the
 4-5 hospital district, county, or municipality, as applicable, as
 4-6 determined by the data reported to the Department of State Health
 4-7 Services under Sections 311.032 and 311.033 in the most recent
 4-8 fiscal year for which that data was reported. If the institutional
 4-9 health care provider did not report any data under those sections,
 4-10 the provider's net patient revenue is the amount of that revenue as
 4-11 contained in the provider's Medicare cost report submitted for the
 4-12 previous fiscal year or for the closest subsequent fiscal year for
 4-13 which the provider submitted the Medicare cost report. The local
 4-14 government shall update the amount of the mandatory payment on an
 4-15 annual basis.

4-16 (b) The amount of a mandatory payment authorized under this
 4-17 chapter for a local government must be uniformly proportionate with
 4-18 the amount of net patient revenue generated by each paying hospital
 4-19 in the hospital district, county, or municipality, as applicable,
 4-20 as permitted under federal law. A health care provider
 4-21 participation program authorized under this chapter may not hold
 4-22 harmless any institutional health care provider, as required under
 4-23 42 U.S.C. Section 1396b(w).

4-24 (c) The governing body of a local government that authorizes
 4-25 a program under this chapter shall set the amount of the mandatory
 4-26 payment. The aggregate amount of the mandatory payments required
 4-27 of all paying hospitals in the hospital district, county, or
 4-28 municipality, as applicable, may not exceed six percent of the
 4-29 aggregate net patient revenue from hospital services provided by
 4-30 all paying hospitals in the hospital district, county, or
 4-31 municipality, as applicable.

4-32 (d) Subject to Subsection (c), the governing body of a local
 4-33 government shall set the mandatory payments in amounts that in the
 4-34 aggregate will generate sufficient revenue to cover the
 4-35 administrative expenses of the local government for activities
 4-36 under this chapter and to fund an intergovernmental transfer
 4-37 described by Section 300.0103(b)(1). The annual amount of revenue
 4-38 from mandatory payments that shall be paid for administrative
 4-39 expenses for activities under this chapter by the local government
 4-40 may not exceed \$150,000, plus the cost of collateralization of
 4-41 deposits, regardless of actual expenses.

4-42 (e) A paying hospital may not add a mandatory payment
 4-43 required under this section as a surcharge to a patient.

4-44 (f) A mandatory payment required by the governing body of a
 4-45 hospital district under this chapter is not a tax for purposes of
 4-46 the applicable provision of Article IX, Texas Constitution.

4-47 Sec. 300.0152. ASSESSMENT AND COLLECTION OF MANDATORY
 4-48 PAYMENTS. (a) A hospital district may designate an official of the
 4-49 district or contract with another person to assess and collect the
 4-50 mandatory payments authorized under this chapter.

4-51 (b) A county or municipality may collect or, using a
 4-52 competitive bidding process, contract for the assessment and
 4-53 collection of mandatory payments authorized under this chapter.

4-54 (c) The person charged by the local government with the
 4-55 assessment and collection of mandatory payments shall charge and
 4-56 deduct from the mandatory payments collected for the local
 4-57 government a collection fee in an amount not to exceed the person's
 4-58 usual and customary charges for like services.

4-59 (d) If the person charged with the assessment and collection
 4-60 of mandatory payments is an official of the local government, any
 4-61 revenue from a collection fee charged under Subsection (c) shall be
 4-62 deposited in the local government general fund and, if appropriate,
 4-63 shall be reported as fees of the local government.

4-64 Sec. 300.0153. CORRECTION OF INVALID PROVISION OR
 4-65 PROCEDURE. (a) This chapter does not authorize a local government
 4-66 to collect mandatory payments for the purpose of raising general
 4-67 revenue or any amount in excess of the amount reasonably necessary
 4-68 to fund the nonfederal share of a Medicaid supplemental payment
 4-69 program or Medicaid managed care rate enhancements for nonpublic

5-1 hospitals and to cover the administrative expenses of the local
 5-2 government associated with activities under this chapter and other
 5-3 uses of the fund described by Section 300.0103(b).

5-4 (b) To the extent any provision or procedure under this
 5-5 chapter causes a mandatory payment authorized under this chapter to
 5-6 be ineligible for federal matching funds, the local government may
 5-7 provide by rule for an alternative provision or procedure that
 5-8 conforms to the requirements of the federal Centers for Medicare
 5-9 and Medicaid Services. A rule adopted under this section may not
 5-10 create, impose, or materially expand the legal or financial
 5-11 liability or responsibility of the local government or an
 5-12 institutional health care provider in the local hospital district,
 5-13 county, or municipality, as applicable, beyond the provisions of
 5-14 this chapter. This section does not require the governing body of a
 5-15 local government to adopt a rule.

5-16 (c) The local government may only assess and collect a
 5-17 mandatory payment authorized under this chapter if a waiver
 5-18 program, uniform rate enhancement, or reimbursement described by
 5-19 Section 300.0103(b)(1) is available to the local government.

5-20 Sec. 300.0154. REPORTING REQUIREMENTS. (a) The governing
 5-21 body of each local government that authorizes a program under this
 5-22 chapter shall report information to the Health and Human Services
 5-23 Commission regarding the program on a schedule determined by the
 5-24 commission.

5-25 (b) The information must include:

5-26 (1) the amount of the mandatory payments required and
 5-27 collected in each year the program is authorized;

5-28 (2) any expenditure of money attributable to mandatory
 5-29 payments collected under this chapter, including:

5-30 (A) any contract with an entity for the
 5-31 administration or operation of a program authorized by this
 5-32 chapter; or

5-33 (B) a contract with a person for the assessment
 5-34 and collection of a mandatory payment as authorized under Section
 5-35 300.0152; and

5-36 (3) the amount of money attributable to mandatory
 5-37 payments collected under this chapter that is used for any other
 5-38 purpose.

5-39 (c) The executive commissioner of the Health and Human
 5-40 Services Commission shall adopt rules to administer this section.

5-41 Sec. 300.0155. EXPIRATION OF AUTHORITY. The authority of a
 5-42 local government to administer and operate a program under this
 5-43 chapter expires on September 1 following the second anniversary of
 5-44 the date the governing body of the local government adopted the
 5-45 order or ordinance authorizing the local government to participate
 5-46 in the program as provided by Section 300.0004.

5-47 Sec. 300.0156. AUTHORITY TO REFUSE FOR VIOLATION. The
 5-48 Health and Human Services Commission may refuse to accept money
 5-49 from a local provider participation fund established under this
 5-50 chapter if the commission determines that doing so may violate
 5-51 federal law.

5-52 SECTION 2. Subtitle D, Title 4, Health and Safety Code, is
 5-53 amended by adding Chapter 300A to read as follows:

5-54 CHAPTER 300A. HEALTH CARE PROVIDER PARTICIPATION PROGRAM IN
 5-55 DISTRICTS COMPOSED OF CERTAIN LOCAL GOVERNMENTS

5-56 SUBCHAPTER A. GENERAL PROVISIONS

5-57 Sec. 300A.0001. PURPOSE. The purpose of this chapter is to
 5-58 authorize certain local governments to create a district to
 5-59 administer a health care provider participation program to provide
 5-60 additional compensation to certain hospitals in the district by
 5-61 collecting mandatory payments from each of those hospitals in the
 5-62 district to be used to provide the nonfederal share of a Medicaid
 5-63 supplemental payment program and for other purposes as authorized
 5-64 under this chapter.

5-65 Sec. 300A.0002. DEFINITIONS. In this chapter:

5-66 (1) "Board" means the board of directors of a
 5-67 district.

5-68 (2) "Director" means a member of the board.

5-69 (3) "District" means a health care provider

6-1 participation district created under this chapter.

6-2 (4) "Institutional health care provider" means a
 6-3 nonpublic hospital that provides inpatient hospital services.

6-4 (5) "Local government" means a hospital district,
 6-5 county, or municipality to which this chapter applies.

6-6 (6) "Paying hospital" means an institutional health
 6-7 care provider required to make a mandatory payment under this
 6-8 chapter.

6-9 (7) "Program" means a health care provider
 6-10 participation program authorized by this chapter.

6-11 Sec. 300A.0003. APPLICABILITY. This chapter applies only
 6-12 to:

6-13 (1) a hospital district that:

6-14 (A) is not participating in a health care
 6-15 provider participation program authorized by another chapter of
 6-16 this subtitle; and

6-17 (B) has only one institutional health care
 6-18 provider located in the district; and

6-19 (2) a county or municipality that:

6-20 (A) is not participating in a health care
 6-21 provider participation program authorized by another chapter of
 6-22 this subtitle;

6-23 (B) is not served by a hospital district or a
 6-24 public hospital; and

6-25 (C) has only one institutional health care
 6-26 provider located in the county or municipality.

6-27 SUBCHAPTER B. CREATION, OPERATION, AND DISSOLUTION OF DISTRICT

6-28 Sec. 300A.0021. CREATION BY CONCURRENT ORDERS. (a) A local
 6-29 government and one or more other local governments may create a
 6-30 district by adopting concurrent orders.

6-31 (b) A concurrent order to create a district must:

6-32 (1) be approved by the governing body of each creating
 6-33 local government;

6-34 (2) contain identical provisions; and

6-35 (3) define the boundaries of the district to be
 6-36 coextensive with the combined boundaries of each creating local
 6-37 government.

6-38 Sec. 300A.0022. POWERS. A district may authorize and
 6-39 administer a health care provider participation program in
 6-40 accordance with this chapter.

6-41 Sec. 300A.0023. BOARD OF DIRECTORS. (a) If three or more
 6-42 local governments create a district, the presiding officer of the
 6-43 governing body of each local government that creates the district
 6-44 shall appoint one director.

6-45 (b) If two local governments create a district:

6-46 (1) the presiding officer of the governing body of the
 6-47 most populous local government shall appoint two directors; and

6-48 (2) the presiding officer of the governing body of the
 6-49 other local government shall appoint one director.

6-50 (c) Directors serve staggered two-year terms, with as near
 6-51 as possible to one-half of the directors' terms expiring each year.

6-52 (d) A vacancy in the office of director shall be filled for
 6-53 the unexpired term in the same manner as the original appointment.

6-54 (e) The board shall elect from among its members a
 6-55 president. The president may vote and may cast an additional vote
 6-56 to break a tie.

6-57 (f) The board shall also elect from among its members a vice
 6-58 president.

6-59 (g) The board shall appoint a secretary, who need not be a
 6-60 director.

6-61 (h) Each officer of the board serves for a term of one year.

6-62 (i) The board shall fill a vacancy in a board office for the
 6-63 unexpired term.

6-64 (j) A majority of the members of the board voting must
 6-65 concur in a matter relating to the business of the district.

6-66 Sec. 300A.0024. QUALIFICATIONS FOR OFFICE. (a) To be
 6-67 eligible to serve as a director, a person must be a resident of the
 6-68 local government that appoints the person under Section 300A.0023.

6-69 (b) An employee of the district may not serve as a director.

7-1 Sec. 300A.0025. COMPENSATION. (a) Directors and officers
 7-2 serve without compensation but may be reimbursed for actual
 7-3 expenses incurred in the performance of official duties.

7-4 (b) Expenses reimbursed under this section must be:

7-5 (1) reported in the district's minute book or other
 7-6 district records; and

7-7 (2) approved by the board.

7-8 Sec. 300A.0026. AUTHORITY TO SUE AND BE SUED. The board may
 7-9 sue and be sued on behalf of the district.

7-10 Sec. 300A.0027. DISTRICT FINANCES. Subchapter F, Chapter
 7-11 287, other than Sections 287.129 and 287.130, applies to the
 7-12 district in the same manner that those provisions apply to a health
 7-13 services district created under Chapter 287. This section does not
 7-14 authorize the district to issue bonds.

7-15 Sec. 300A.0028. DISSOLUTION. A district shall be dissolved
 7-16 if the local governments that created the district adopt concurrent
 7-17 orders to dissolve the district and the concurrent orders contain
 7-18 identical provisions.

7-19 Sec. 300A.0029. ADMINISTRATION OF PROPERTY, DEBTS, AND
 7-20 ASSETS AFTER DISSOLUTION. (a) After dissolution of a district
 7-21 under Section 300A.0028, the board shall continue to control and
 7-22 administer any property, debts, and assets of the district until
 7-23 all funds have been disposed of and all district debts have been
 7-24 paid or settled.

7-25 (b) As soon as practicable after the dissolution of the
 7-26 district, the board shall transfer to each institutional health
 7-27 care provider in the district the provider's proportionate share of
 7-28 any remaining funds in any local provider participation fund
 7-29 created by the district under Section 300A.0102.

7-30 (c) If, after administering any property and assets, the
 7-31 board determines that the district's property and assets are
 7-32 insufficient to pay the debts of the district, the district shall
 7-33 transfer the remaining debts to the local governments that created
 7-34 the district in proportion to the funds contributed to the district
 7-35 by each local government, including a paying hospital in the local
 7-36 government.

7-37 (d) If, after complying with Subsections (b) and (c) and
 7-38 administering the property and assets, the board determines that
 7-39 unused funds remain, the board shall transfer the unused funds to
 7-40 the local governments that created the district in proportion to
 7-41 the funds contributed to the district by each local government,
 7-42 including a paying hospital in the local government.

7-43 Sec. 300A.0030. ACCOUNTING AFTER DISSOLUTION. After the
 7-44 district has paid all its debts and has disposed of all its assets
 7-45 and funds as prescribed by Section 300A.0029, the board shall
 7-46 provide an accounting to each local government that created the
 7-47 district. The accounting must show the manner in which the assets
 7-48 and debts of the district were distributed.

7-49 SUBCHAPTER C. HEALTH CARE PROVIDER PARTICIPATION PROGRAM; POWERS
 7-50 AND DUTIES OF DISTRICT BOARD

7-51 Sec. 300A.0051. HEALTH CARE PROVIDER PARTICIPATION
 7-52 PROGRAM. The board of a district may authorize the district to
 7-53 participate in a health care provider participation program on the
 7-54 affirmative vote of a majority of the board, subject to the
 7-55 provisions of this chapter.

7-56 Sec. 300A.0052. LIMITATION ON AUTHORITY TO REQUIRE
 7-57 MANDATORY PAYMENT. The board may require a mandatory payment
 7-58 authorized under this chapter by an institutional health care
 7-59 provider in the district only in the manner provided by this
 7-60 chapter.

7-61 Sec. 300A.0053. RULES AND PROCEDURES. The board may adopt
 7-62 rules relating to the administration of the health care provider
 7-63 participation program in the district, including collection of the
 7-64 mandatory payments, expenditures, audits, and any other
 7-65 administrative aspects of the program.

7-66 Sec. 300A.0054. INSTITUTIONAL HEALTH CARE PROVIDER
 7-67 REPORTING. If the board authorizes the district to participate in a
 7-68 health care provider participation program under this chapter, the
 7-69 board shall require each institutional health care provider located

8-1 in the district to submit to the district a copy of any financial
 8-2 and utilization data required by and reported to the Department of
 8-3 State Health Services under Sections 311.032 and 311.033 and any
 8-4 rules adopted by the executive commissioner of the Health and Human
 8-5 Services Commission to implement those sections.

8-6 SUBCHAPTER D. GENERAL FINANCIAL PROVISIONS

8-7 Sec. 300A.0101. HEARING. (a) In each year that the board
 8-8 authorizes a health care provider participation program under this
 8-9 chapter, the board shall hold a public hearing on the amounts of any
 8-10 mandatory payments that the board intends to require during the
 8-11 year and how the revenue derived from those payments is to be spent.

8-12 (b) Not later than the fifth day before the date of the
 8-13 hearing required under Subsection (a), the board shall publish
 8-14 notice of the hearing in a newspaper of general circulation in each
 8-15 local government that creates the district and provide written
 8-16 notice of the hearing to the chief operating officer of each
 8-17 institutional health care provider in the district.

8-18 (c) A representative of a paying hospital is entitled to
 8-19 appear at the time and place designated in the public notice and be
 8-20 heard regarding any matter related to the mandatory payments
 8-21 authorized under this chapter.

8-22 Sec. 300A.0102. LOCAL PROVIDER PARTICIPATION FUND;
 8-23 DEPOSITORY. (a) If the board collects a mandatory payment
 8-24 authorized under this chapter, the board shall create a local
 8-25 provider participation fund in one or more banks designated by the
 8-26 district as a depository for the mandatory payments received by the
 8-27 district.

8-28 (b) The board may withdraw or use money in the local
 8-29 provider participation fund of the district only for a purpose
 8-30 authorized under this chapter.

8-31 (c) All funds collected under this chapter shall be secured
 8-32 in the manner provided for securing public funds.

8-33 Sec. 300A.0103. DEPOSITS TO FUND; AUTHORIZED USES OF MONEY.

8-34 (a) The local provider participation fund established under
 8-35 Section 300A.0102 consists of:

8-36 (1) all revenue received by the district attributable
 8-37 to mandatory payments authorized under this chapter;

8-38 (2) money received from the Health and Human Services
 8-39 Commission as a refund of an intergovernmental transfer from the
 8-40 district to the state for the purpose of providing the nonfederal
 8-41 share of Medicaid supplemental payment program payments, provided
 8-42 that the intergovernmental transfer does not receive a federal
 8-43 matching payment; and

8-44 (3) the earnings of the fund.

8-45 (b) Money deposited to the local provider participation
 8-46 fund may be used only to:

8-47 (1) fund intergovernmental transfers from the
 8-48 district to the state to provide the nonfederal share of Medicaid
 8-49 payments for:

8-50 (A) uncompensated care payments to nonpublic
 8-51 hospitals, if those payments are authorized under the Texas
 8-52 Healthcare Transformation and Quality Improvement Program waiver
 8-53 issued under Section 1115 of the federal Social Security Act (42
 8-54 U.S.C. Section 1315);

8-55 (B) uniform rate enhancements for nonpublic
 8-56 hospitals in the Medicaid managed care service area in which the
 8-57 district is located;

8-58 (C) payments available under another waiver
 8-59 program authorizing payments that are substantially similar to
 8-60 Medicaid payments to nonpublic hospitals described by Paragraph (A)
 8-61 or (B); or

8-62 (D) any reimbursement to nonpublic hospitals for
 8-63 which federal matching funds are available;

8-64 (2) subject to Section 300A.0151(d), pay the
 8-65 administrative expenses of the district in administering the
 8-66 program, including collateralization of deposits;

8-67 (3) refund all or a portion of a mandatory payment
 8-68 collected in error from a paying hospital;

8-69 (4) refund to paying hospitals a proportionate share

9-1 of the money that the district:

9-2 (A) receives from the Health and Human Services
 9-3 Commission that is not used to fund the nonfederal share of Medicaid
 9-4 supplemental payment program payments; or

9-5 (B) determines cannot be used to fund the
 9-6 nonfederal share of Medicaid supplemental payment program
 9-7 payments;

9-8 (5) transfer funds to the Health and Human Services
 9-9 Commission if the district is required by law to transfer the funds
 9-10 to address a disallowance of federal matching funds with respect to
 9-11 payments, rate enhancements, and reimbursements for which the
 9-12 district made intergovernmental transfers described by Subdivision
 9-13 (1); and

9-14 (6) reimburse the district if the district is required
 9-15 by the rules governing the uniform rate enhancement program
 9-16 described by Subdivision (1)(B) to incur an expense or forego
 9-17 Medicaid reimbursements from the state because the balance of the
 9-18 local provider participation fund is not sufficient to fund that
 9-19 rate enhancement program.

9-20 (c) Money in the local provider participation fund may not
 9-21 be commingled with other district funds or other funds of a local
 9-22 government that creates the district.

9-23 (d) Notwithstanding any other provision of this chapter,
 9-24 with respect to an intergovernmental transfer of funds described by
 9-25 Subsection (b)(1) made by the district, any funds received by the
 9-26 state, district, or other entity as a result of the transfer may not
 9-27 be used by the state, district, or any other entity to:

9-28 (1) expand Medicaid eligibility under the Patient
 9-29 Protection and Affordable Care Act (Pub. L. No. 111-148) as amended
 9-30 by the Health Care and Education Reconciliation Act of 2010 (Pub. L.
 9-31 No. 111-152); or

9-32 (2) fund the nonfederal share of payments to nonpublic
 9-33 hospitals available through the Medicaid disproportionate share
 9-34 hospital program or the delivery system reform incentive payment
 9-35 program.

9-36 Sec. 300A.0104. ACCOUNTING OF FUNDS. The district shall
 9-37 maintain an accounting of the funds received from each local
 9-38 government that creates the district, including a paying hospital
 9-39 located in a hospital district, county, or municipality that
 9-40 created the district, as applicable.

9-41 SUBCHAPTER E. MANDATORY PAYMENTS

9-42 Sec. 300A.0151. MANDATORY PAYMENTS BASED ON PAYING HOSPITAL
 9-43 NET PATIENT REVENUE. (a) Except as provided by Subsection (e), if
 9-44 the board authorizes a health care provider participation program
 9-45 under this chapter, the district shall require an annual mandatory
 9-46 payment to be assessed on the net patient revenue of each
 9-47 institutional health care provider located in the district. The
 9-48 board shall provide that the mandatory payment is to be assessed at
 9-49 least annually, but not more often than quarterly. In the first
 9-50 year in which the mandatory payment is required, the mandatory
 9-51 payment is assessed on the net patient revenue of an institutional
 9-52 health care provider located in the district as determined by the
 9-53 data reported to the Department of State Health Services under
 9-54 Sections [311.032](#) and [311.033](#) in the most recent fiscal year for
 9-55 which that data was reported. If the institutional health care
 9-56 provider did not report any data under those sections, the
 9-57 provider's net patient revenue is the amount of that revenue as
 9-58 contained in the provider's Medicare cost report submitted for the
 9-59 previous fiscal year or for the closest subsequent fiscal year for
 9-60 which the provider submitted the Medicare cost report. The
 9-61 district shall update the amount of the mandatory payment on an
 9-62 annual basis.

9-63 (b) The amount of a mandatory payment authorized under this
 9-64 chapter must be uniformly proportionate with the amount of net
 9-65 patient revenue generated by each paying hospital in the district
 9-66 as permitted under federal law. A health care provider
 9-67 participation program authorized under this chapter may not hold
 9-68 harmless any institutional health care provider, as required under
 9-69 42 U.S.C. Section 1396b(w).

10-1 (c) The board shall set the amount of a mandatory payment
 10-2 authorized under this chapter. The aggregate amount of the
 10-3 mandatory payments required of all paying hospitals in the district
 10-4 may not exceed six percent of the aggregate net patient revenue from
 10-5 hospital services provided by all paying hospitals in the district.

10-6 (d) Subject to Subsection (c), the board shall set the
 10-7 mandatory payments in amounts that in the aggregate will generate
 10-8 sufficient revenue to cover the administrative expenses of the
 10-9 district for activities under this chapter and to fund an
 10-10 intergovernmental transfer described by Section 300A.0103(b)(1).
 10-11 The annual amount of revenue from mandatory payments that shall be
 10-12 paid for administrative expenses by the district for activities
 10-13 under this chapter may not exceed \$150,000, plus the cost of
 10-14 collateralization of deposits, regardless of actual expenses.

10-15 (e) A paying hospital may not add a mandatory payment
 10-16 required under this section as a surcharge to a patient.

10-17 (f) For purposes of any hospital district that creates a
 10-18 district under this chapter, a mandatory payment assessed under
 10-19 this chapter is not a tax for hospital purposes for purposes of the
 10-20 applicable provision of Article IX, Texas Constitution.

10-21 Sec. 300A.0152. ASSESSMENT AND COLLECTION OF MANDATORY
 10-22 PAYMENTS. (a) The district may designate an official of the
 10-23 district or contract with another person to assess and collect the
 10-24 mandatory payments authorized under this chapter.

10-25 (b) The person charged by the district with the assessment
 10-26 and collection of mandatory payments shall charge and deduct from
 10-27 the mandatory payments collected for the district a collection fee
 10-28 in an amount not to exceed the person's usual and customary charges
 10-29 for like services.

10-30 (c) If the person charged with the assessment and collection
 10-31 of mandatory payments is an official of the district, any revenue
 10-32 from a collection fee charged under Subsection (b) shall be
 10-33 deposited in the district general fund and, if appropriate, shall
 10-34 be reported as fees of the district.

10-35 Sec. 300A.0153. CORRECTION OF INVALID PROVISION OR
 10-36 PROCEDURE; LIMITATION OF AUTHORITY. (a) This chapter does not
 10-37 authorize the district to collect mandatory payments for the
 10-38 purpose of raising general revenue or any amount in excess of the
 10-39 amount reasonably necessary to:

10-40 (1) fund the nonfederal share of a Medicaid
 10-41 supplemental payment program or Medicaid managed care rate
 10-42 enhancements for nonpublic hospitals; and

10-43 (2) cover the administrative expenses of the district
 10-44 associated with activities under this chapter and other uses of the
 10-45 fund described by Section 300A.0103(b).

10-46 (b) To the extent any provision or procedure under this
 10-47 chapter causes a mandatory payment authorized under this chapter to
 10-48 be ineligible for federal matching funds, the board may provide by
 10-49 rule for an alternative provision or procedure that conforms to the
 10-50 requirements of the federal Centers for Medicare and Medicaid
 10-51 Services. A rule adopted under this section may not create, impose,
 10-52 or materially expand the legal or financial liability or
 10-53 responsibility of the district or an institutional health care
 10-54 provider in the district beyond the provisions of this chapter.
 10-55 This section does not require the board to adopt a rule.

10-56 (c) The district may only assess and collect a mandatory
 10-57 payment authorized under this chapter if a waiver program, uniform
 10-58 rate enhancement, or reimbursement described by Section
 10-59 300A.0103(b)(1) is available to the district.

10-60 Sec. 300A.0154. REPORTING REQUIREMENTS. (a) The board of a
 10-61 district that authorizes a program under this chapter shall report
 10-62 information to the Health and Human Services Commission regarding
 10-63 the program on a schedule determined by the commission.

10-64 (b) The information must include:

10-65 (1) the amount of the mandatory payments required and
 10-66 collected in each year the program is authorized;

10-67 (2) any expenditure of money attributable to mandatory
 10-68 payments collected under this chapter, including:

10-69 (A) any contract with an entity for the

11-1 administration or operation of a program authorized by this
11-2 chapter; or

11-3 (B) a contract with a person for the assessment
11-4 and collection of a mandatory payment as authorized under Section
11-5 300A.0152; and

11-6 (3) the amount of money attributable to mandatory
11-7 payments collected under this chapter that is used for any other
11-8 purpose.

11-9 (c) The executive commissioner of the Health and Human
11-10 Services Commission shall adopt rules to administer this section.

11-11 Sec. 300A.0155. EXPIRATION OF AUTHORITY. The authority of
11-12 a district to administer and operate a program under this chapter
11-13 expires on September 1 following the second anniversary of the date
11-14 the board of the district authorized the district to participate in
11-15 the program as provided by Section 300A.0051.

11-16 Sec. 300A.0156. AUTHORITY TO REFUSE FOR VIOLATION. The
11-17 Health and Human Services Commission may refuse to accept money
11-18 from a local provider participation fund established under this
11-19 chapter if the commission determines that doing so may violate
11-20 federal law.

11-21 SECTION 3. As soon as practicable after the expiration of
11-22 the authority of a local government to administer and operate a
11-23 health care provider participation program under Chapter 300 or
11-24 300A, Health and Safety Code, as added by this Act, the governing
11-25 body of the local government shall transfer to each institutional
11-26 health care provider in the boundaries of the local government that
11-27 provider's proportionate share of any remaining funds in any local
11-28 provider participation fund created by the local government under
11-29 Chapter 300 or 300A, Health and Safety Code, as added by this Act.

11-30 SECTION 4. If before implementing any provision of this Act
11-31 a state agency determines that a waiver or authorization from a
11-32 federal agency is necessary for implementation of that provision,
11-33 the agency affected by the provision shall request the waiver or
11-34 authorization and may delay implementing that provision until the
11-35 waiver or authorization is granted.

11-36 SECTION 5. This Act takes effect immediately if it receives
11-37 a vote of two-thirds of all the members elected to each house, as
11-38 provided by Section 39, Article III, Texas Constitution. If this
11-39 Act does not receive the vote necessary for immediate effect, this
11-40 Act takes effect September 1, 2019.

11-41 * * * * *