1-1 By: Watson S.B. No. 1350
1-2 (In the Senate - Filed February 28, 2019; March 7, 2019,
1-3 read first time and referred to Committee on Intergovernmental
1-4 Relations; April 23, 2019, reported adversely, with favorable
1-5 Committee Substitute by the following vote: Yeas 6, Nays 0;
1-6 April 23, 2019, sent to printer.)

1-7 COMMITTEE VOTE

1-8		Yea	Nay	Absent	PNV
1-9	Lucio	X			
1-10	Schwertner	X			
1-11	Alvarado	X			
1-12	Campbell	X			
1-13	Fallon	X			
1-14	Menéndez			X	
1-15	Nichols	X			

1-16 COMMITTEE SUBSTITUTE FOR S.B. No. 1350 By: Alvarado

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

1-19 relating to the creation and operations of a health care provider
1-20 participation program by a certain hospital district.
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 298E to read as follows:
1-24 CHAPTER 298E. HEALTH CARE PROVIDER PARTICIPATION PROGRAM IN
1-25 CERTAIN HOSPITAL DISTRICTS
1-26 SUBCHAPTER A. GENERAL PROVISIONS
1-27 Sec. 298E.001. DEFINITIONS. In this chapter:
1-28 (1) "Board" means the board of hospital managers of a
1-29 district.
1-30 (2) "District" means a hospital district to which this
1-31 chapter applies.
1-32 (3) "Institutional health care provider" means a
1-33 hospital that is not owned and operated by a federal, state, or
1-34 local government and provides inpatient hospital services.
1-35 (4) "Paying provider" means an institutional health
1-36 care provider required to make a mandatory payment under this
1-37 chapter.
1-38 (5) "Program" means a health care provider
1-39 participation program authorized by this chapter.
1-40 Sec. 298E.002. APPLICABILITY. This chapter applies only to
1-41 a hospital district created in a county with a population of more
1-42 than 800,000 that was not included in the boundaries of a hospital
1-43 district before September 1, 2003.
1-44 Sec. 298E.003. HEALTH CARE PROVIDER PARTICIPATION PROGRAM;
1-45 PARTICIPATION IN PROGRAM. The board of a district may authorize the
1-46 district to participate in a health care provider participation
1-47 program on the affirmative vote of a majority of the board, subject
1-48 to the provisions of this chapter.
1-49 Sec. 298E.004. EXPIRATION. (a) Subject to Section
1-50 298E.153(d), the authority of a district to administer and operate
1-51 a program under this chapter expires December 31, 2023.
1-52 (b) This chapter expires December 31, 2023.
1-53 SUBCHAPTER B. POWERS AND DUTIES OF BOARD
1-54 Sec. 298E.051. LIMITATION ON AUTHORITY TO REQUIRE MANDATORY
1-55 PAYMENT. The board of a district may require a mandatory payment
1-56 authorized under this chapter by an institutional health care
1-57 provider located in the district only in the manner provided by this
1-58 chapter.
1-59 Sec. 298E.052. RULES AND PROCEDURES. The board of a
1-60 district may adopt rules relating to the administration of the

2-1 program, including collection of the mandatory payments,
2-2 expenditures, audits, and any other administrative aspects of the
2-3 program.
2-4 Sec. 298E.053. INSTITUTIONAL HEALTH CARE PROVIDER
2-5 REPORTING. If the board of a district authorizes the district to
2-6 participate in a program under this chapter, the board shall
2-7 require each institutional health care provider located in the
2-8 district to submit to the district a copy of any financial and
2-9 utilization data required by and reported to the Department of
2-10 State Health Services under Sections 311.032 and 311.033 and any
2-11 rules adopted by the executive commissioner of the Health and Human
2-12 Services Commission to implement those sections.
2-13 SUBCHAPTER C. GENERAL FINANCIAL PROVISIONS
2-14 Sec. 298E.101. HEARING. (a) In each year that the board of
2-15 a district authorizes a program under this chapter, the board shall
2-16 hold a public hearing on the amounts of any mandatory payments that
2-17 the board intends to require during the year and how the revenue
2-18 derived from those payments is to be spent.
2-19 (b) Not later than the fifth day before the date of the
2-20 hearing required under Subsection (a), the board shall publish
2-21 notice of the hearing in a newspaper of general circulation in the
2-22 district and provide written notice of the hearing to each
2-23 institutional health care provider located in the district.
2-24 Sec. 298E.102. DEPOSITORY. (a) If the board of a district
2-25 requires a mandatory payment authorized under this chapter, the
2-26 board shall designate one or more banks as a depository for the
2-27 district's local provider participation fund.
2-28 (b) All funds collected by a district under this chapter
2-29 shall be secured in the manner provided for securing other funds of
2-30 the district.
2-31 Sec. 298E.103. LOCAL PROVIDER PARTICIPATION FUND;
2-32 AUTHORIZED USES OF MONEY. (a) If a district requires a mandatory
2-33 payment authorized under this chapter, the district shall create a
2-34 local provider participation fund.
2-35 (b) A district's local provider participation fund consists
2-36 of:
2-37 (1) all revenue received by the district attributable
2-38 to mandatory payments authorized under this chapter;
2-39 (2) money received from the Health and Human Services
2-40 Commission as a refund of an intergovernmental transfer under the
2-41 program, provided that the intergovernmental transfer does not
2-42 receive a federal matching payment; and
2-43 (3) the earnings of the fund.
2-44 (c) Money deposited to the local provider participation
2-45 fund of a district may be used only to:
2-46 (1) fund intergovernmental transfers from the
2-47 district to the state to provide the nonfederal share of Medicaid
2-48 payments for:
2-49 (A) uncompensated care payments to hospitals in
2-50 the Medicaid managed care service area in which the district is
2-51 located, if those payments are authorized under the Texas
2-52 Healthcare Transformation and Quality Improvement Program waiver
2-53 issued under Section 1115 of the federal Social Security Act (42
2-54 U.S.C. Section 1315);
2-55 (B) uniform rate enhancements for hospitals in
2-56 the Medicaid managed care service area in which the district is
2-57 located;
2-58 (C) payments available under another waiver
2-59 program authorizing payments that are substantially similar to
2-60 Medicaid payments to hospitals described by Paragraph (A) or (B);
2-61 or
2-62 (D) any reimbursement to hospitals for which
2-63 federal matching funds are available;
2-64 (2) subject to Section 298E.151(d), pay the
2-65 administrative expenses of the district in administering the
2-66 program, including collateralization of deposits;
2-67 (3) refund a mandatory payment collected in error from
2-68 a paying provider;
2-69 (4) refund to paying providers a proportionate share

3-1 of the money that the district:
3-2 (A) receives from the Health and Human Services
3-3 Commission that is not used to fund the nonfederal share of Medicaid
3-4 supplemental payment program payments; or
3-5 (B) determines cannot be used to fund the
3-6 nonfederal share of Medicaid supplemental payment program
3-7 payments;
3-8 (5) transfer funds to the Health and Human Services
3-9 Commission if the district is legally required to transfer the
3-10 funds to address a disallowance of federal matching funds with
3-11 respect to programs for which the district made intergovernmental
3-12 transfers described by Subdivision (1); and
3-13 (6) reimburse the district if the district is required
3-14 by the rules governing the uniform rate enhancement program
3-15 described by Subdivision (1)(B) to incur an expense or forego
3-16 Medicaid reimbursements from the state because the balance of the
3-17 local provider participation fund is not sufficient to fund that
3-18 rate enhancement program.
3-19 (d) Money in the local provider participation fund of a
3-20 district may not be commingled with other district funds.
3-21 (e) Notwithstanding any other provision of this chapter,
3-22 with respect to an intergovernmental transfer of funds described by
3-23 Subsection (c)(1) made by a district, any funds received by the
3-24 state, district, or other entity as a result of that transfer may
3-25 not be used by the state, district, or any other entity to:
3-26 (1) expand Medicaid eligibility under the Patient
3-27 Protection and Affordable Care Act (Pub. L. No. 111-148) as amended
3-28 by the Health Care and Education Reconciliation Act of 2010 (Pub. L.
3-29 No. 111-152); or
3-30 (2) fund the nonfederal share of payments to hospitals
3-31 available through the Medicaid disproportionate share hospital
3-32 program or the delivery system reform incentive payment program.
3-33 SUBCHAPTER D. MANDATORY PAYMENTS
3-34 Sec. 298E.151. MANDATORY PAYMENTS BASED ON PAYING PROVIDER
3-35 NET PATIENT REVENUE. (a) Except as provided by Subsection (e), if
3-36 the board of a district authorizes a health care provider
3-37 participation program under this chapter, the board may require an
3-38 annual mandatory payment to be assessed on the net patient revenue
3-39 of each institutional health care provider located in the district.
3-40 The board may provide for the mandatory payment to be assessed
3-41 quarterly. In the first year in which the mandatory payment is
3-42 required, the mandatory payment is assessed on the net patient
3-43 revenue of an institutional health care provider as reported in the
3-44 provider's Medicare cost report submitted for the most recent
3-45 fiscal year for which the provider submitted a Medicare cost
3-46 report. If the mandatory payment is required, the district shall
3-47 update the amount of the mandatory payment on an annual basis.
3-48 (b) The amount of a mandatory payment assessed under this
3-49 chapter by the board of a district must be uniformly proportionate
3-50 with the amount of net patient revenue generated by each paying
3-51 provider in the district as permitted under federal law. A health
3-52 care provider participation program authorized under this chapter
3-53 may not hold harmless any institutional health care provider
3-54 located in the district, as required under 42 U.S.C. Section
3-55 1396b(w).
3-56 (c) If the board of a district requires a mandatory payment
3-57 authorized under this chapter, the board shall set the amount of the
3-58 mandatory payment, subject to the limitations of this chapter. The
3-59 aggregate amount of the mandatory payments required of all paying
3-60 providers in the district may not exceed six percent of the
3-61 aggregate net patient revenue from hospital services provided by
3-62 all paying providers in the district.
3-63 (d) Subject to Subsection (c), if the board of a district
3-64 requires a mandatory payment authorized under this chapter, the
3-65 board shall set the mandatory payments in amounts that in the
3-66 aggregate will generate sufficient revenue to cover the
3-67 administrative expenses of the district for activities under this
3-68 chapter and to fund an intergovernmental transfer described by
3-69 Section 298E.103(c)(1). The annual amount of revenue from

4-1 mandatory payments that shall be paid for administrative expenses
4-2 by the district is $150,000, plus the cost of collateralization of
4-3 deposits, regardless of actual expenses.
4-4 (e) A paying provider may not add a mandatory payment
4-5 required under this section as a surcharge to a patient.
4-6 (f) A mandatory payment assessed under this chapter is not a
4-7 tax for hospital purposes for purposes of Section 4, Article IX,
4-8 Texas Constitution, or Section 281.045 of this code.
4-9 Sec. 298E.152. ASSESSMENT AND COLLECTION OF MANDATORY
4-10 PAYMENTS. (a) A district may designate an official of the
4-11 district or contract with another person to assess and collect the
4-12 mandatory payments authorized under this chapter.
4-13 (b) The person charged by the district with the assessment
4-14 and collection of mandatory payments shall charge and deduct from
4-15 the mandatory payments collected for the district a collection fee
4-16 in an amount not to exceed the person's usual and customary charges
4-17 for like services.
4-18 (c) If the person charged with the assessment and collection
4-19 of mandatory payments is an official of the district, any revenue
4-20 from a collection fee charged under Subsection (b) shall be
4-21 deposited in the district general fund and, if appropriate, shall
4-22 be reported as fees of the district.
4-23 Sec. 298E.153. PURPOSE; CORRECTION OF INVALID PROVISION OR
4-24 PROCEDURE; LIMITATION OF AUTHORITY. (a) The purpose of this
4-25 chapter is to authorize a district to establish a program to enable
4-26 the district to collect mandatory payments from institutional
4-27 health care providers to fund the nonfederal share of a Medicaid
4-28 supplemental payment program or the Medicaid managed care rate
4-29 enhancements for hospitals to support the provision of health care
4-30 by institutional health care providers located in the district to
4-31 district residents in need of health care.
4-32 (b) This chapter does not authorize a district to collect
4-33 mandatory payments for the purpose of raising general revenue or
4-34 any amount in excess of the amount reasonably necessary to fund the
4-35 nonfederal share of a Medicaid supplemental payment program or
4-36 Medicaid managed care rate enhancements for hospitals and to cover
4-37 the administrative expenses of the district associated with
4-38 activities under this chapter.
4-39 (c) To the extent any provision or procedure under this
4-40 chapter causes a mandatory payment authorized under this chapter to
4-41 be ineligible for federal matching funds, the board of a district
4-42 may provide by rule for an alternative provision or procedure that
4-43 conforms to the requirements of the federal Centers for Medicare
4-44 and Medicaid Services. A rule adopted under this section may not
4-45 create, impose, or materially expand the legal or financial
4-46 liability or responsibility of the district or an institutional
4-47 health care provider in the district beyond the provisions of this
4-48 chapter. This section does not require the board to adopt a rule.
4-49 (d) A district may only assess and collect a mandatory
4-50 payment authorized under this chapter if a waiver program, uniform
4-51 rate enhancement, or reimbursement described by Section
4-52 298E.103(c)(1) is available to the district.
4-53 SECTION 2. As soon as practicable after the expiration of
4-54 the authority of a hospital district to administer and operate a
4-55 health care provider participation program under Chapter 298E,
4-56 Health and Safety Code, as added by this Act, the board of hospital
4-57 managers of the hospital district shall transfer to each
4-58 institutional health care provider in the district that provider's
4-59 proportionate share of any remaining funds in any local provider
4-60 participation fund created by the district under Section 298E.103,
4-61 Health and Safety Code, as added by this Act.
4-62 SECTION 3. If before implementing any provision of this Act
4-63 a state agency determines that a waiver or authorization from a
4-64 federal agency is necessary for implementation of that provision,
4-65 the agency affected by the provision shall request the waiver or
4-66 authorization and may delay implementing that provision until the
4-67 waiver or authorization is granted.
4-68 SECTION 4. This Act takes effect immediately if it receives
4-69 a vote of two-thirds of all the members elected to each house, as

5-1 provided by Section 39, Article III, Texas Constitution. If this
5-2 Act does not receive the vote necessary for immediate effect, this
5-3 Act takes effect September 1, 2019.

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