

By: Hughes

S.B. No. 1073

A BILL TO BE ENTITLED

AN ACT

relating to the operations of health care provider participation programs in certain counties.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Section 291A.001, Health and Safety Code, is amended by amending Subdivisions (1) and (2) and adding Subdivision (4) to read as follows:

(1) "Institutional health care provider" means a ~~nonpublic~~ hospital that is not owned and operated by a federal or state government and provides inpatient hospital services. The term includes a hospital that is owned and operated by a municipality or county and provides inpatient hospital services.

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

(4) "Qualifying assessment basis" means the health care item, health care service, or other health care-related basis consistent with 42 U.S.C. Section 1396b(w) on which a commissioner's court requires mandatory payments to be assessed under this chapter.

SECTION 2. Section 291A.003(a), Health and Safety Code, is amended to read as follows:

(a) A county health care provider participation program authorizes a county to collect a mandatory payment from each

1 institutional health care provider located in the county to be
2 deposited in a local provider participation fund established by the
3 county. Money in the fund may be used by the county to fund certain
4 intergovernmental transfers [~~and indigent care programs~~] as
5 provided by this chapter.

6 SECTION 3. Section 291A.054(a), Health and Safety Code, is
7 amended to read as follows:

8 (a) The commissioners court of a county that collects a
9 mandatory payment authorized under this chapter may [~~shall~~] require
10 each institutional health care provider to submit to the county a
11 copy of any financial and utilization data as [~~required by and~~]
12 reported in:

13 (1) the provider's Medicare cost report for the most
14 recent fiscal year for which the provider submitted the Medicare
15 cost report; or

16 (2) a report other than the report described by
17 Subdivision (1) that the commissioners court considers reliable and
18 is submitted by or to the provider for the most recent fiscal year
19 [~~to the Department of State Health Services under Sections 311.032~~
20 ~~and 311.033 and any rules adopted by the executive commissioner of~~
21 ~~the Health and Human Services Commission to implement those~~
22 ~~sections].~~

23 SECTION 4. Section 291A.101, Health and Safety Code, is
24 amended to read as follows:

25 Sec. 291A.101. HEARING. (a) Each year, the commissioners
26 court of a county that collects a mandatory payment authorized
27 under this chapter shall hold at least one [~~a~~] public hearing on the

1 amounts of the [~~any~~] mandatory payments that the commissioners
2 court intends to require during the year and how the revenue derived
3 from those payments is to be spent.

4 (b) Not later than the fifth day before the date of a [~~the~~]
5 hearing required under Subsection (a), the commissioners court of
6 the county shall publish notice of the hearing in a newspaper of
7 general circulation in the county.

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

12 SECTION 5. Section 291A.103(c), Health and Safety Code, is
13 amended to read as follows:

14 (c) Money deposited to the local provider participation
15 fund may be used only to:

16 (1) fund intergovernmental transfers from the county
17 to the state to provide:

18 (A) the nonfederal share of [~~a~~] Medicaid
19 supplemental payment program payments authorized under the state
20 Medicaid plan, the Texas Healthcare Transformation and Quality
21 Improvement Program waiver issued under Section 1115 of the federal
22 Social Security Act (42 U.S.C. Section 1315), or a successor waiver
23 program authorizing similar Medicaid supplemental payment
24 programs; or

25 (B) payments to Medicaid managed care
26 organizations that are dedicated for payment to hospitals;

27 (2) [~~subsidize indigent programs,~~

1 ~~[(3)]~~ pay the administrative expenses of the county
2 solely for activities under this chapter;

3 (3) ~~[(4)]~~ refund a portion of a mandatory payment
4 collected in error from a paying provider ~~[hospital]~~; and

5 (4) ~~[(5)]~~ refund to a paying provider, in an amount
6 that is proportionate to the mandatory payments made under this
7 chapter by the provider during the 12 months preceding the date of
8 the refund, the ~~[hospitals the proportionate share of]~~ money
9 attributable to mandatory payments collected under this chapter
10 that the county:

11 (A) receives from the Health and Human Services
12 Commission ~~[received by the county]~~ that is not used to fund the
13 nonfederal share of Medicaid supplemental payment program
14 payments; or

15 (B) determines cannot be used to fund the
16 nonfederal share of Medicaid supplemental payment program
17 payments.

18 SECTION 6. Section [291A.151](#), Health and Safety Code, is
19 amended to read as follows:

20 Sec. 291A.151. MANDATORY PAYMENTS ~~[BASED ON PAYING HOSPITAL~~
21 ~~NET PATIENT REVENUE]~~. (a) The ~~[Except as provided by Subsection~~
22 ~~(e), the]~~ commissioners court of a county that authorizes a county
23 health care provider participation program ~~[collects a mandatory~~
24 ~~payment authorized]~~ under this chapter may require ~~[an annual]~~
25 mandatory payments ~~[payment]~~ to be assessed against ~~[on the net~~
26 ~~patient revenue of]~~ each institutional health care provider located
27 in the county, either annually or periodically throughout the year

1 at the discretion of the commissioners court, on the basis of a
2 health care item, health care service, or other health care-related
3 basis that is consistent with the requirements of 42 U.S.C. Section
4 1396b(w). The commissioners court shall provide an institutional
5 health care provider written notice of each assessment under this
6 section not later than 30 days before the date the assessment is
7 due. The qualifying assessment basis must be the same for each
8 institutional health care provider in the county.

9 (a-1) Except as otherwise provided by this subsection, the
10 qualifying assessment basis must be determined by the commissioners
11 court using information contained in an institutional health care
12 provider's Medicare cost report for the most recent fiscal year for
13 which the provider submitted the report. If the provider is not
14 required to submit a Medicare cost report, or if the Medicare cost
15 report submitted by the provider does not contain information
16 necessary to determine the qualifying assessment basis, the
17 qualifying assessment basis may be determined by the commissioners
18 court using information contained in another report the
19 commissioners court considers reliable that is submitted by or to
20 the provider for the most recent fiscal year. To the extent
21 practicable, the commissioners court shall use the same type of
22 report to determine the qualifying assessment basis for each paying
23 provider in the county.

24 (a-2) If mandatory payments are required, the [The]
25 commissioners court [may provide for the mandatory payment to be
26 assessed quarterly. In the first year in which the mandatory
27 payment is required, the mandatory payment is assessed on the net

1 ~~patient revenue of an institutional health care provider as~~
2 ~~determined by the data reported to the Department of State Health~~
3 ~~Services under Sections 311.032 and 311.033 in the fiscal year~~
4 ~~ending in 2015 or, if the institutional health care provider did not~~
5 ~~report any data under those sections in that fiscal year, as~~
6 ~~determined by the institutional health care provider's Medicare~~
7 ~~cost report submitted for the 2015 fiscal year or for the closest~~
8 ~~subsequent fiscal year for which the provider submitted the~~
9 ~~Medicare cost report. The county]~~ shall update the amount of the
10 mandatory payments periodically [~~payment on an annual basis~~].

11 (b) The amount of a mandatory payment authorized under this
12 chapter must be determined in a manner that ensures the revenue
13 generated qualifies for federal matching funds under federal law,
14 consistent with [~~uniformly proportionate with the amount of net~~
15 ~~patient revenue generated by each paying hospital in the county. A~~
16 ~~mandatory payment authorized under this chapter may not hold~~
17 ~~harmless any institutional health care provider, as required under]~~
18 42 U.S.C. Section 1396b(w).

19 (c) The commissioners court of a county that authorizes a
20 county health care provider participation program [~~collects a~~
21 ~~mandatory payment authorized~~] under this chapter shall set the
22 amount of the mandatory payment. The amount of the mandatory
23 payment required of each paying provider [~~hospital~~] may not exceed
24 an amount that, when added to the amount of the mandatory payments
25 required from all other paying providers in the county, equals an
26 amount of revenue that exceeds six percent of the aggregate net
27 patient revenue of all paying providers in the county [~~hospital's~~

1 ~~net patient revenue~~].

2 (d) Subject to the maximum amount prescribed by Subsection
3 (c), the commissioners court of a county that collects a mandatory
4 payment authorized under this chapter shall set the mandatory
5 payments in amounts that in the aggregate will generate sufficient
6 revenue to cover the administrative expenses of the county for
7 activities under this chapter and [7] to fund the nonfederal share
8 of Medicaid supplemental payment program payments [~~an~~
9 ~~intergovernmental transfer described by Section 291A.103(c)(1),~~
10 ~~and to pay for indigent programs~~], except that the amount of revenue
11 from mandatory payments used for administrative expenses of the
12 county for activities under this chapter in a year may not exceed
13 the lesser of four percent of the total revenue generated from the
14 mandatory payment or \$20,000.

15 (e) A paying provider [~~hospital~~] may not add a mandatory
16 payment required under this section as a surcharge to a patient.

17 SECTION 7. Section 291A.154, Health and Safety Code, is
18 amended to read as follows:

19 Sec. 291A.154. PURPOSE; CORRECTION OF INVALID PROVISION OR
20 PROCEDURE. (a) The purpose of this chapter is to generate revenue
21 by collecting from institutional health care providers a mandatory
22 payment to be used to provide the nonfederal share of [~~a~~] Medicaid
23 supplemental payment program payments.

24 (b) To the extent any provision or procedure under this
25 chapter causes a mandatory payment authorized under this chapter to
26 be ineligible for federal matching funds, a [~~the~~] county that
27 authorizes a county health care provider participation program

1 under this chapter may provide by rule for an alternative provision
2 or procedure that conforms to the requirements of the federal
3 Centers for Medicare and Medicaid Services. A rule adopted under
4 this section may not create, impose, or materially expand the legal
5 or financial liability or responsibility of the county or an
6 institutional health care provider in the county beyond the
7 provisions of this chapter. This section does not require the
8 commissioners court to adopt a rule.

9 (c) This chapter does not authorize a county that authorizes
10 a county health care provider participation program under this
11 chapter to collect mandatory payments for the purpose of raising
12 general revenue or any amount in excess of the amount reasonably
13 necessary for the purposes described by Sections 291A.103(c)(1) and
14 (2).

15 SECTION 8. Section 292.001, Health and Safety Code, is
16 amended by amending Subdivisions (1) and (2) and adding Subdivision
17 (4) to read as follows:

18 (1) "Institutional health care provider" means a
19 ~~[nonpublic]~~ hospital that is not owned and operated by a federal or
20 state government and provides inpatient hospital services. The term
21 includes a hospital that is owned and operated by a municipality or
22 county and provides inpatient hospital services.

23 (2) "Paying provider ~~[hospital]~~" means an
24 institutional health care provider required to make a mandatory
25 payment under this chapter.

26 (4) "Qualifying assessment basis" means the health
27 care item, health care service, or other health care-related basis

1 consistent with 42 U.S.C. Section 1396b(w) on which a commissioners
2 court requires mandatory payments to be assessed under this
3 chapter.

4 SECTION 9. Section 292.003(a), Health and Safety Code, is
5 amended to read as follows:

6 (a) A county health care provider participation program
7 authorizes a county to collect a mandatory payment from each
8 institutional health care provider located in the county to be
9 deposited in a local provider participation fund established by the
10 county. Money in the fund may be used by the county to fund certain
11 intergovernmental transfers [~~and indigent care programs~~] as
12 provided by this chapter.

13 SECTION 10. Section 292.054(a), Health and Safety Code, is
14 amended to read as follows:

15 (a) The commissioners court of a county that collects a
16 mandatory payment authorized under this chapter may [~~shall~~] require
17 each institutional health care provider to submit to the county a
18 copy of any financial and utilization data as [~~required by and~~]
19 reported in:

20 (1) the provider's Medicare cost report for the most
21 recent fiscal year for which the provider submitted the Medicare
22 cost report; or

23 (2) a report other than the report described by
24 Subdivision (1) that the commissioners court considers reliable and
25 is submitted by or to the provider for the most recent fiscal year
26 [~~to the Department of State Health Services under Sections 311.032~~
27 ~~and 311.033 and any rules adopted by the executive commissioner of~~

1 ~~the Health and Human Services Commission to implement those~~
2 ~~sections].~~

3 SECTION 11. Section 292.101, Health and Safety Code, is
4 amended to read as follows:

5 Sec. 292.101. HEARING. (a) Each year, the commissioners
6 court of a county that collects a mandatory payment authorized
7 under this chapter shall hold at least one ~~a~~ public hearing on the
8 amounts of the ~~any~~ mandatory payments that the commissioners
9 court intends to require during the year and how the revenue derived
10 from those payments is to be spent.

11 (b) Not later than the fifth day before the date of a ~~the~~
12 hearing required under Subsection (a), the commissioners court of
13 the county shall publish notice of the hearing in a newspaper of
14 general circulation in the county.

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

19 SECTION 12. Section 292.103(c), Health and Safety Code, is
20 amended to read as follows:

21 (c) Money deposited to the local provider participation
22 fund may be used only to:

23 (1) fund intergovernmental transfers from the county
24 to the state to provide:

25 (A) the nonfederal share of ~~a~~ Medicaid
26 supplemental payment program payments authorized under the state
27 Medicaid plan, the Texas Healthcare Transformation and Quality

1 Improvement Program waiver issued under Section 1115 of the federal
2 Social Security Act (42 U.S.C. Section 1315), or a successor waiver
3 program authorizing similar Medicaid supplemental payment
4 programs; or

5 (B) payments to Medicaid managed care
6 organizations that are dedicated for payment to hospitals;

7 (2) [~~subsidize indigent programs,~~
8 [~~(3)~~] pay the administrative expenses of the county
9 solely for activities under this chapter;

10 (3) [~~(4)~~] refund a portion of a mandatory payment
11 collected in error from a paying provider [~~hospital~~]; and

12 (4) [~~(5)~~] refund to a paying provider, in an amount
13 that is proportionate to the mandatory payments made under this
14 chapter by the provider during the 12 months preceding the date of
15 the refund, the [~~hospitals the proportionate share of~~] money
16 attributable to mandatory payments collected under this chapter
17 that the county:

18 (A) receives [~~received by the county~~] from the
19 Health and Human Services Commission that is not used to fund the
20 nonfederal share of Medicaid supplemental payment program
21 payments; or [~~and~~]

22 (B) [~~(6) refund to paying hospitals the~~
23 ~~proportionate share of money that the county~~] determines cannot be
24 used to fund the nonfederal share of Medicaid supplemental payment
25 program payments.

26 SECTION 13. Section 292.151, Health and Safety Code, is
27 amended to read as follows:

1 Sec. 292.151. MANDATORY PAYMENTS [~~BASED ON PAYING HOSPITAL~~
2 ~~NET PATIENT REVENUE~~]. (a) The [~~Except as provided by Subsection~~
3 ~~(e), the~~] commissioners court of a county that authorizes a county
4 health care provider participation program [~~collects a mandatory~~
5 ~~payment authorized~~] under this chapter may require [~~an annual~~]
6 mandatory payments [~~payment~~] to be assessed against [~~on the net~~
7 ~~patient revenue of~~] each institutional health care provider located
8 in the county, either annually or periodically throughout the year
9 at the discretion of the commissioners court, on the basis of a
10 health care item, health care service, or other health care-related
11 basis that is consistent with the requirements of 42 U.S.C. Section
12 1396b(w). The commissioners court shall provide an institutional
13 health care provider written notice of each assessment under this
14 section not later than 30 days before the date the assessment is
15 due. The qualifying assessment basis must be the same for each
16 institutional health care provider in the county.

17 (a-1) Except as otherwise provided by this subsection, the
18 qualifying assessment basis must be determined by the commissioners
19 court using information contained in an institutional health care
20 provider's Medicare cost report for the most recent fiscal year for
21 which the provider submitted the report. If the provider is not
22 required to submit a Medicare cost report, or if the Medicare cost
23 report submitted by the provider does not contain information
24 necessary to determine the qualifying assessment basis, the
25 qualifying assessment basis may be determined by the commissioners
26 court using information contained in another report the
27 commissioners court considers reliable that is submitted by or to

1 the provider for the most recent fiscal year. To the extent
2 practicable, the commissioners court shall use the same type of
3 report to determine the qualifying assessment basis for each paying
4 provider in the county.

5 (a-2) If mandatory payments are required, the [The]
6 commissioners court [~~may provide for the mandatory payment to be~~
7 assessed quarterly. In the first year in which the mandatory
8 payment is required, the mandatory payment is assessed on the net
9 patient revenue of an institutional health care provider as
10 determined by the data reported to the Department of State Health
11 Services under Sections [311.032](#) and [311.033](#) in the fiscal year
12 ending in 2013 or, if the institutional health care provider did not
13 report any data under those sections in that fiscal year, as
14 determined by the institutional health care provider's Medicare
15 cost report submitted for the 2013 fiscal year or for the closest
16 subsequent fiscal year for which the provider submitted the
17 Medicare cost report. The county] shall update the amount of the
18 mandatory payments periodically [~~payment on an annual basis~~].

19 (b) The amount of a mandatory payment authorized under this
20 chapter must be determined in a manner that ensures the revenue
21 generated qualifies for federal matching funds under federal law,
22 consistent with [~~uniformly proportionate with the amount of net~~
23 ~~patient revenue generated by each paying hospital in the county. A~~
24 ~~mandatory payment authorized under this chapter may not hold~~
25 ~~harmless any institutional health care provider, as required under]~~
26 42 U.S.C. Section 1396b(w).

27 (c) The commissioners court of a county that authorizes a

1 county health care provider participation program [~~collects a~~
2 ~~mandatory payment authorized~~] under this chapter shall set the
3 amount of the mandatory payment. The amount of the mandatory
4 payment required of each paying provider [~~hospital~~] may not exceed
5 an amount that, when added to the amount of the mandatory payments
6 required from all other paying providers [~~hospitals~~] in the county,
7 equals an amount of revenue that exceeds six percent of the
8 aggregate net patient revenue of all paying providers [~~hospitals~~]
9 in the county.

10 (d) Subject to the maximum amount prescribed by Subsection
11 (c), the commissioners court of a county that collects a mandatory
12 payment authorized under this chapter shall set the mandatory
13 payments in amounts that in the aggregate will generate sufficient
14 revenue to cover the administrative expenses of the county for
15 activities under this chapter and [~~7~~] to fund the nonfederal share
16 of [~~a~~] Medicaid supplemental payment program payments, [~~and to pay~~
17 ~~for indigent programs~~] except that the amount of revenue from
18 mandatory payments used for administrative expenses of the county
19 for activities under this chapter in a year may not exceed the
20 lesser of four percent of the total revenue generated from the
21 mandatory payment or \$20,000.

22 (e) A paying provider [~~hospital~~] may not add a mandatory
23 payment required under this section as a surcharge to a patient.

24 SECTION 14. Section [292.154](#), Health and Safety Code, is
25 amended to read as follows:

26 Sec. 292.154. PURPOSE; CORRECTION OF INVALID PROVISION OR
27 PROCEDURE. (a) The purpose of this chapter is to generate revenue

1 by collecting from institutional health care providers a mandatory
2 payment to be used to provide the nonfederal share of ~~[a]~~ Medicaid
3 supplemental payment program payments.

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

16 (c) This chapter does not authorize a county that authorizes
17 a county health care provider participation program under this
18 chapter to collect mandatory payments for the purpose of raising
19 general revenue or any amount in excess of the amount reasonably
20 necessary for the purposes described by Sections [292.103](#)(c)(1) and
21 (2).

22 SECTION 15. This Act takes effect immediately if it
23 receives a vote of two-thirds of all the members elected to each
24 house, as provided by Section [39](#), Article III, Texas Constitution.
25 If this Act does not receive the vote necessary for immediate
26 effect, this Act takes effect September 1, 2021.