BILL ANALYSIS

Senate Research Center
88R20646 MPF-F

H.B. 4700
By: Clardy (Nichols)
Local Government
5/11/2023
Engrossed

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

The Texas Legislature has recognized that collaborations between local governmental entities and local hospitals help to preserve the state's health care safety net. The legislature has authorized, by statute, certain local governmental entities to create health care provider participation programs to help with such collaborations. Currently, there are a number of authorized jurisdictions throughout Texas that operate such programs. The Nacogdoches County Hospital District adopted and began operating such a program in the summer of 2022. While a number of jurisdictions have a statute authorizing a program that is specific to their jurisdiction, the district's program was authorized under a statewide statute that allows the creation, during an interim period when the legislature is not in session, of a program for a jurisdiction that does not have their own governing statute. However, without legislative action, the district's authority to operate the program will expire in the summer of 2024, roughly two years after the program's creation, since it was created under the statewide statute. H.B. 4700 seeks to keep the district's program viable until December 31, 2027, by providing for a health care provider participation program specific to the Nacogdoches County Hospital District.

H.B. 4700 amends current law relating to the creation and operations of a health care provider participation program by the Nacogdoches County Hospital District.

RULEMAKING AUTHORITY

This bill does not expressly grant any additional rulemaking authority to a state officer, institution, or agency.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Subtitle D, Title 4, Health and Safety Code, by adding Chapter 298H, as follows:

CHAPTER 298H. NACOGDOCHES COUNTY HOSPITAL DISTRICT HEALTH CARE PROVIDER PARTICIPATION PROGRAM

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 298H.001. DEFINITIONS. Defines "board," "district," "institutional health care provider," "paying provider," and "program."

Sec. 298H.002. APPLICABILITY. Provides that this chapter applies only to the Nacogdoches County Hospital District (district).

Sec. 298H.003. HEALTH CARE PROVIDER PARTICIPATION PROGRAM; PARTICIPATION IN PROGRAM. (a) Authorizes the board of directors of the district (board) to 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.

(b) Prohibits the board from authorizing the district to participate in a health care provider participation program under Chapter 300 (Health Care Provider

Participation Programs in Certain Political Subdivisions in This State) or 300A (Health Care Provider Participation Program in Districts Composed of Certain Local Governments).

Sec. 298H.004. EXPIRATION. (a) Provides that the authority of the district to administer and operate a program under this chapter, subject to Section 298H.153(d), expires December 31, 2027.

(b) Provides that this chapter expires December 31, 2027.

SUBCHAPTER B. POWERS AND DUTIES OF BOARD

Sec. 298H.051. LIMITATION ON AUTHORITY TO REQUIRE MANDATORY PAYMENT. Authorizes the board to require a mandatory payment authorized under this chapter by an institutional health care provider located in the district only in the manner provided by this chapter.

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

Sec. 298H.053. INSTITUTIONAL HEALTH CARE PROVIDER REPORTING. Authorizes the board, if the board authorizes the district to participate in a program under this chapter, to require each institutional health care provider to submit to the district a copy of any financial and utilization data reported in the provider's Medicare cost report submitted for the most recent fiscal year for which the provider submitted the Medicare cost report.

SUBCHAPTER C. GENERAL FINANCIAL PROVISIONS

Sec. 298H.101. HEARING. (a) Requires the board, in each year that the board authorizes a program under this chapter, to hold a public hearing on the amounts of any mandatory payments that the board intends to require during the year and how the revenue derived from those payments is to be spent.

(b) Requires the board, not later than the fifth day before the date of the hearing required under Subsection (a), to publish notice of the hearing in a newspaper of general circulation in the district.

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

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

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

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

(b) Provides that the local provider participation fund consists of:

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

(2) money received from the Health and Human Services Commission (HHSC) as a refund of an intergovernmental transfer under the program, provided that the intergovernmental transfer does not receive a federal matching payment; and

(3) the earnings of the fund.

(c) Authorizes money deposited to the local provider participation fund of the district to be used only to:

(1) fund intergovernmental transfers from the district to the state to provide the nonfederal share of Medicaid supplemental 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) 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 298H.151(d), pay the administrative expenses of the district in administering the program, including collateralization of deposits;

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

(4) refund to paying providers a proportionate share of the money that the district:

(A) receives from HHSC that is not used to fund the nonfederal share of Medicaid supplemental payments or rate enhancements described by Subdivision (1); or

(B) determines cannot be used to fund the nonfederal share of Medicaid supplemental payments or rate enhancements described by Subdivision (1); and

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

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

(e) Prohibits any funds received by the state, district, or other entity as a result of an intergovernmental transfer of funds described by Subsection (c)(1) made by the district, notwithstanding any other provision of this chapter, from being used by the state, district, or other entity to expand Medicaid eligibility under the Patient Protection and Affordable Care Act (Pub. L. No. 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. No. 111-152).

SUBCHAPTER D. MANDATORY PAYMENTS

Sec. 298H.151. MANDATORY PAYMENTS BASED ON PAYING PROVIDER NET PATIENT REVENUE. (a) Authorizes the board, if the board authorizes a health care provider participation program under this chapter, to require a mandatory payment to be assessed, either annually or periodically throughout the year at the discretion of the board, on the net patient revenue of each institutional health care provider located in the district. Requires the board to provide an institutional health care provider written notice of each assessment under this subsection, and provides that the provider has 30 calendar days following the date of receipt of the notice to make the assessed mandatory payment. Provides that in the first year in which the mandatory payment is required, the mandatory payment is assessed on the net patient revenue of an institutional health care provider, as determined by the provider's Medicare cost report submitted for the most recent fiscal year for which the provider submitted the Medicare cost report. Requires the district, if the mandatory payment is required, to periodically update the amount of the mandatory payment.

(b) Requires that the amount of a mandatory payment authorized under this chapter be determined in a manner that ensures the revenue generated qualifies for federal matching funds under federal law, consistent with 42 U.S.C. Section 1396b(w).

(c) Requires the board, if the board requires a mandatory payment authorized under this chapter, to set the amount of the mandatory payment, subject to the limitations of this chapter. Prohibits the aggregate amount of the mandatory payments required of all paying providers in the district from exceeding six percent of the aggregate net patient revenue from hospital services provided in the district.

(d) Requires the board, if the board requires a mandatory payment authorized under this chapter, subject to Subsection (c), to set the mandatory payments in amounts that in the aggregate will generate sufficient revenue to cover the administrative expenses of the district for activities under this chapter and to fund an intergovernmental transfer described by Section 298H.103(c)(1). Prohibits the annual amount of revenue from the mandatory payments used by the district from exceeding $150,000, plus the cost of collateralization of deposits, regardless of actual expenses.

(e) Prohibits a paying provider from adding a mandatory payment required under this section as a surcharge to a patient.

(f) Provides that a mandatory payment assessed under this chapter is not a tax for hospital purposes for purposes of Section 9 (Creation, Operation, and Dissolution of Hospital Districts), Article IX (Counties), Texas Constitution, or Section 1069.301 (Imposition of Ad Valorem Tax), Special District Local Laws Code.

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

(b) Prohibits the person charged by the district with the assessment and collection of the mandatory payments from charging the district a fee for assessing and collecting the payments unless the district authorizes the fee in writing.

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

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

(b) Provides that this chapter does not authorize the district to collect the 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 the 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 298H.103(c).

(c) Authorizes the board, to the extent any provision or procedure under this chapter causes a mandatory payment authorized under this chapter to be ineligible for federal matching funds, to provide by rule for an alternative provision or procedure that conforms to the requirements of the federal Centers for Medicare and Medicaid Services. Prohibits a rule adopted under this section from creating, imposing, or materially expanding the legal or financial liability or responsibility of the district or an institutional health care provider in the district beyond the provisions of this chapter. Provides that this section does not require the board to adopt a rule.

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

SECTION 2. Effective date: upon passage or September 1, 2023.