BILL ANALYSIS

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S.B. 1578
By: Parker
Local Government
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AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

Since 2013, Texas counties have utilized local provider participation funds (LPPFs) to pool a portion of hospital revenue, creating the non-federal share of Medicaid matching funds without impacting taxpayers or hospital patients. Currently, 32 LPPFs operate statewide.

Medicaid funding is a shared federal and state responsibility, with local funds matched by federal dollars and distributed by the Health and Human Services Commission to healthcare providers. LPPFs enable Texas to fund its Medicaid portion through locally-based, uniform hospital assessments rather than new taxes. These funds support key supplemental and directed payment programs, including uncompensated care payments and CHIRP.

In June 2024, Denton County established an LPPF with unanimous county commissioners' support under a 2019 bipartisan statewide statute (Health and Safety Code, Chapter 300). By law, new LPPFs expire two years after adoption, unless extended by the legislature.

State law provides key protections for Denton County residents:

- Hospitals cannot pass LPPF assessments onto patients. (Section 300.0131(e))
- Counties are reimbursed for administrative costs.
- LPPFs are not classified as taxes. (Section 300.0151(f))
- Prevent new taxes by leveraging local hospital revenue to draw federal Medicaid funds, avoiding property tax increases or use of state general revenue.
- Ensures Denton County hospitals receive reimbursement for care already provided, freeing up funds for expanded services and innovation.

S.B. 1578 seeks a legislative extension of the existing Denton County LPPF to ensure continued Medicaid funding for local hospitals. Without action, the LPPF will expire, risking the loss of critical safety-net funding.

As proposed, S.B. 1578 amends current law relating to the creation and operations of a health care provider participation program in certain counties.

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 292E, as follows:

CHAPTER 292E. COUNTY HEALTH CARE PROVIDER PARTICIPATION PROGRAM IN CERTAIN COUNTIES BORDERING TWO POPULOUS COUNTIES

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 292.001. DEFINITIONS. Defines "institutional health care provider," "paying provider," and "program."

Sec. 292E.002. APPLICABILITY. Provides that this chapter applies only to a county that is not served by a hospital district, has a population of more than 900,000, and borders two counties, each of which has a population of two million or more.

Sec. 292.003. COUNTY HEALTH CARE PROVIDER PARTICIPATION PROGRAM; PARTICIPATION IN PROGRAM. (a) Provides that a county health care provider participation program (program) authorizes a county to collect a mandatory payment from each institutional health care provider located in the county to be deposited in a local provider participation fund established by the county. Authorizes money in the fund to be used by the county as provided by Section 292E.103(c).

(b) Authorizes the commissioners court of a county to adopt an order authorizing the county to participate in the program, subject to the limitations provided by this chapter.

SUBCHAPTER B. POWERS AND DUTIES ON COMMISSIONERS COURT

Sec. 292E.052. MAJORITY VOTE REQUIRED. Prohibits the commissioners court of a county from authorizing the county to collect a mandatory payment under this chapter without an affirmative vote of a majority of the members of the commissioners court.

Sec. 292E.053. RULES AND PROCEDURES. Authorizes the commissioners court of a county, after the commissioners court has voted to require a mandatory payment authorized under this chapter, to adopt rules relating to the administration of the program, including the collection of a mandatory payment, expenditures, an audit, and any other administrative aspect of the program.

Sec. 292E.054. INSTITUTIONAL HEALTH CARE PROVIDER REPORTING. Requires the commissioners court of a county, if the commissioners court authorizes the county to participate in a program under this chapter, to require each institutional health care provider to submit to the county a copy of any financial and utilization data required by and reported to the Department of State Health Services (DSHS) under Sections 311.032 (Department Administration of Hospital Reporting and Collection System) and 311.033 (Financial and Utilization Data Required) and any rules adopted by the executive commissioner of the Health and Human Services Commission (HHSC) to implement those sections.

SUBCHAPTER C. GENERAL FINANCIAL PROVISIONS

Sec. 292E.101. HEARING. (a) Requires the commissioners court of a county, in each year that the commissioners court authorizes a mandatory payment under this chapter, to hold a public hearing on the amounts of any mandatory payments that the county intends to require during the year and how the revenue derived from those payments is to be spent.

(b) Requires the commissioners court, 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 county and provide written notice of the hearing to each institutional health care provider located in the county.

(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. 292E.102. DEPOSITORY. (a) Requires the commissioners court of a county that requires a mandatory payment under this chapter to designate one or more banks as the depository for the county's local provider participation fund.

(b) Provides that all income received by a county under this chapter is required to be deposited with the depository designated under Subsection (a) in the county's

local provider participation fund and authorized to be withdrawn only as provided by this chapter.

(c) Requires that all money collected under this chapter be secured in the manner provided for securing other county money.

Sec. 292E.103. LOCAL PROVIDER PARTICIPATION FUND; AUTHORIZED USES OF MONEY. (a) Requires a county that requires a mandatory payment under this chapter to create a local provider participation fund.

(b) Provides that the local provider participation fund of a county consists of certain monies.

(c) Provides that money deposited to a county's local provider participation fund is authorized to be used only to:

(1) fund intergovernmental transfers from the county to the state to provide the nonfederal share of Medicaid payments for certain payments;

(2) subject to Section 292E.151(e), pay the administrative expenses of the county in administering the program, including collateralization of deposits;

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

(4) refund to paying providers a proportionate share of the money that the county receives from HHSC that is not used to fund the nonfederal share of Medicaid supplemental payment program payments or determines cannot be used to fund the nonfederal share of Medicaid supplemental payment program payments; and

(5) transfer funds to HHSC if the county is legally required to transfer the funds to address a disallowance of federal matching funds with respect to any intergovernmental transfers described by Subdivision (1).

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

(e) Prohibits any funds received by the state, county, or other entity as a result of the transfer, notwithstanding any other provision of this chapter, with respect to an intergovernmental transfer of funds described by Subsection (c)(1) made by the county, from being used by the state, county, or entity to expand Medicaid eligibility under the Patient Protection and Affordable Care Act (Pub. L. No.A111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. No.A111-152) or fund the nonfederal share of payments to nonpublic hospitals available through the Medicaid disproportionate share hospital program.

SUBCHAPTER D. MANDATORY PAYMENTS

Sec. 292E.151. MANDATORY PAYMENTS BASED ON PAYING PROVIDER NET PATIENT REVENUE. (a) Authorizes the commissioners court, except as provided by Subsection (f), if the commissioners court of a county authorizes a program under this chapter, to require an annual mandatory payment to be assessed on the net patient revenue of each institutional health care provider located in the county. Authorizes the commissioners court to provide for the mandatory payment to be assessed quarterly. 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 data reported to DSHS under Sections 311.032 and 311.033 in the

most recent fiscal year for which that data was reported. Provides that, if the institutional health care provider did not report any data under those sections, the provider's net patient revenue is the amount of that revenue as contained in the provider's Medicare cost report submitted for the most recent fiscal year for which the provider submitted the Medicare cost report. Requires the commissioners court, if the mandatory payment is required, to update the amount of the mandatory payment on an annual basis.

(b) Requires the commissioners court of a county that requires a mandatory payment under this chapter to provide each institutional health care provider on which the payment will be assessed written notice of an assessment under this chapter. Requires the institutional health care provider to pay the assessment not later than the 30th day after the date the provider receives the written notice.

(c) Requires that the amount of a mandatory payment authorized under this chapter be uniformly proportionate with the amount of net patient revenue generated by each paying provider in the county. Prohibits a mandatory payment authorized under this chapter from holding harmless any institutional health care provider, as required under 42 U.S.C. Section 1396b(w) and 42 C.F.R. Section 433.68.

(d) Requires the commissioners court of a county that requires a mandatory payment under this chapter to set the amount of the mandatory payment. Prohibits the aggregate amount of the mandatory payment required of all paying providers from exceeding six percent of the aggregate net patient revenue from hospital services provided by all paying providers in the county.

(e) Requires the commissioners court of a county that requires a mandatory payment under this chapter, subject to Subsection (d), to set the mandatory payments in amounts that in the aggregate will generate sufficient revenue to cover the administrative expenses of the county for activities under this chapter and to fund an intergovernmental transfer described by Section 292E.103(c)(1). Prohibits the annual amount of revenue from mandatory payments that is authorized to be used to pay the administrative expenses of the county for activities under this chapter from exceeding $150,000, plus the cost of collateralization of deposits, regardless of actual expenses.

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

Sec. 292E.152. ASSESSMENT AND COLLECTION OF MANDATORY PAYMENTS. (a) Authorizes the county to collect or contract for the assessment and collection of mandatory payments authorized under this chapter.

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

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

Sec. 292E.153. PURPOSE; CORRECTION OF INVALID PROVISION OR PROCEDURE; LIMITATION OF AUTHORITY. (a) Provides that the purpose of this chapter is to authorize a county to establish a program to enable the county to collect mandatory payments from institutional health care providers to fund the nonfederal share of certain Medicaid programs as described by Section 292E.103(c)(1).

(b) Authorizes the commissioners court of the county administering the program, 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 county or an institutional health care provider located in the county beyond the provisions of this chapter. Provides that this section does not require the commissioners court of a county to adopt a rule.

(c) Authorizes a county administering a program to only assess and collect a mandatory payment authorized under this chapter if a waiver program, uniform rate enhancement, or reimbursement described by Section 292E.103(c)(1) is available to the county.

(d) Provides that this chapter does not authorize a county administering a program to collect mandatory payments for the purpose of raising general revenue or any amount in excess of the amount reasonably necessary to fund the nonfederal share of a Medicaid supplemental payment program or Medicaid managed care rate enhancements for nonpublic hospitals and to cover the administrative expenses of the county associated with activities under this chapter.

SECTION 2. Requires a state agency, if necessary for implementation of a provision of this Act, to request a waiver or authorization from a federal agency, and authorizes delay of implementation under such a waiver or authorization is granted.

SECTION 3. Effective date: September 1, 2025.