BILL ANALYSIS

C.S.S.B. 2315
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County Affairs
Committee Report (Substituted)

BACKGROUND AND PURPOSE

It has been noted that a number of local governments participate in health care provider participation programs which help local safety-net hospitals reduce the costs of uncompensated care without increasing local property taxes. It has been suggested that the Nueces County Hospital District would also benefit from participation in such a program. C.S.S.B. 2315 seeks to address this issue by providing for the creation and operations of such a program by the district.

CRIMINAL JUSTICE IMPACT

It is the committee's opinion that this bill does not expressly create a criminal offense, increase the punishment for an existing criminal offense or category of offenses, or change the eligibility of a person for community supervision, parole, or mandatory supervision.

RULEMAKING AUTHORITY

It is the committee's opinion that this bill does not expressly grant any additional rulemaking authority to a state officer, department, agency, or institution.

ANALYSIS

C.S.S.B. 2315 amends the Health and Safety Code to provide for a Nueces County Hospital District health care provider participation program. The bill authorizes the district's board of hospital managers to authorize the district to participate in the program on the affirmative vote of a majority of the board. The bill sets out the district's authority to administer and operate the program and sets that authority and the bill's provisions to expire December 31, 2021.

C.S.S.B. 2315 authorizes the board to require a mandatory payment by an institutional health care provider located in the district under the program, authorizes the board to adopt rules relating to the administration of the program, provides for certain institutional health care provider reporting, and defines, among other terms, "institutional health care provider" as a hospital that is not owned and operated by a federal or state government and provides inpatient hospital services.

C.S.S.B. 2315 provides for an annual 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. The bill provides for the designation of one or more banks as a depository for the district's local provider participation fund and provides for the creation, composition, and use of the fund.

C.S.S.B. 2315 provides for the amount, assessment, and collection of a mandatory payment. The bill authorizes the board to provide by rule for an alternative provision or procedure that conforms to the requirements of the federal Centers for Medicare and Medicaid Services to the extent any provision or procedure under the bill's provisions causes a mandatory payment to be ineligible for federal matching funds, sets out provisions relating to such rules, and conditions

the district's assessment and collection of a mandatory payment on an applicable waiver program, uniform rate enhancement, or reimbursement being available to at least one institutional health care provider located in the district.

C.S.S.B. 2315 requires the board, as soon as practicable after the expiration of the district's authority to administer and operate a health care provider participation program, to transfer to each institutional health care provider in the district that provider's proportionate share of any remaining funds in any local provider participation fund created by the district.

EFFECTIVE DATE

On passage, or, if the bill does not receive the necessary vote, September 1, 2019.

COMPARISON OF SENATE ENGROSSED AND SUBSTITUTE

While C.S.S.B. 2315 may differ from the engrossed in minor or nonsubstantive ways, the following summarizes the substantial differences between the engrossed and committee substitute versions of the bill.

The substitute redefines "institutional health care provider" from a nonpublic hospital located in the district that provides inpatient hospital services to a hospital that is not owned and operated by a federal or state government and provides such services.

The substitute, with respect to the authorization for money deposited to the local provider participation fund to be used to fund intergovernmental transfers from the district to the state to provide the nonfederal share of Medicaid payments for applicable uncompensated care payments, changes the recipients of the payments from nonpublic hospitals affiliated with the district to hospitals in the Medicaid managed care service area in which the district is located. The substitute includes provisions authorizing money deposited to the fund to be used for the following:

- to fund intergovernmental transfers from the district to the state to provide the nonfederal share of Medicaid payments for delivery system reform incentive payments, if those payments are authorized under the Texas Healthcare Transformation and Quality Improvement Program waiver issued under the federal Social Security Act; and
- to refund to paying providers a proportionate share of the money that the district receives from the Health and Human Services Commission that is not used to fund applicable uniform rate enhancements or that the district determines cannot be used to fund the enhancements.

The substitute does not include a provision prohibiting, with respect to an applicable intergovernmental transfer of funds made by the district, any funds received by the state, district, or other entity as a result of that transfer from being used by the state, district, or any other entity to fund the nonfederal share of payments to nonpublic hospitals available through the Medicaid disproportionate share hospital program or the delivery system reform incentive payment program.

The substitute revises the frequency with which the board may require a mandatory payment to be assessed on the net patient revenue of each institutional health care provider located in the district. The substitute includes a provision requiring the board to provide an institutional health care provider written notice of each assessment and giving the provider 30 calendar days following the date of receipt of the notice to pay the assessment.

The substitute, with respect to a bill provision conditioning the district's assessment and collection of a mandatory payment on an applicable waiver program, uniform rate enhancement, or reimbursement being available the district, specifies that such a program, enhancement, or

reimbursement be available to at least one institutional health care provider located in the district.