SUBJECT: Allowing a local provider participation fund in Harris Hospital District

COMMITTEE: District Affairs — committee substitute recommended

VOTE: 9 ayes — Coleman, Bohac, Anderson, Biedermann, Cole, Dominguez, Huberty, Rosenthal, Stickland

0 nays

WITNESSES: For — Steve Hand, MHHS (*Registered, but did not testify*: Christina Hoppe, Children's Hospital Association of Texas; Meghan Weller, HCA Healthcare; Maureen Milligan, Teaching Hospitals of Texas; Rick Thompson, Texas Association of Counties; Orlando Jones, Texas Children's Hospital; Gabriela Villareal, Texas Conference of Urban Counties; Jennifer Banda, Texas Hospital Association)

Against — None

On — (*Registered, but did not testify*: King Hillier, Harris Health System)

BACKGROUND: Local provider participation funds were first authorized by the Legislature in 2013 as a way for counties to access federal funding for their nonpublic hospitals without expanding Medicaid, requiring state funding, or taxing the residents of the county. The funds provide a mechanism by which the county can collect mandatory payments from such institutions to provide the nonfederal share of Medicaid supplemental payments in order to access federal matching funds. Local provider participation funds are administered by county health care provider participation programs.

DIGEST: CSHB 3459 would allow the board of hospital managers of the Harris County Hospital District, by majority vote, to participate in a health care provider participation program.

Powers and duties. The board would be authorized to adopt rules relating to the administration of the program, including collection of mandatory payments, expenditures, and audits. If the board authorized a program, it

would have to require each nonpublic hospital in the district that provided inpatient hospital services to submit to the district any financial and utilization data as reported in the hospital's Medicare cost report submitted for the most recent fiscal year for which the hospital submitted the Medicare cost report.

Mandatory payments. CSHB 3459 would authorize the board to require mandatory payments from institutional health care providers.

The board would be required to assess the payments from each hospital on the basis of the hospital's net patient revenue. The board would be required to provide written notice of each assessment, and the hospital would be required to pay the assessment within 30 calendar days. The hospital district would be required to update the amount of this payment annually but would be allowed to update it on a more frequent basis.

The bill would require that the amount of an annual payment be uniformly proportionate to the amount of net patient revenue generated by each hospital and adequate to cover the expenses of the program. The bill would limit the aggregate amount of the mandatory payments required of all hospitals participating in the health care provider program to no more than 4 percent of the aggregate net patient revenue from hospital services provided by all hospitals participating in the program.

The board would have to set mandatory payments in amounts that in the aggregate would generate sufficient revenue to cover the administrative expenses of the district and the intergovernmental transfers relating to the health care provider program. The bill would not allow the district to use annually more than $600,000 plus the collateralization of deposits for administrative expenses related to the program, regardless of actual expenses. The bill does not authorize the district to collect mandatory payments for the purpose of raising general revenue or any amount in excess of the amount reasonably necessary for the purposes of the program.

CSHB 3459 would prohibit a hospital from adding a mandatory payment

required under the bill as a surcharge to a patient. As required by federal law, the bill would prohibit a mandatory payment under the program from holding harmless any hospital.

Collection and holding of funds. The bill would require the board, if it decided to establish a health care provider program, to hold a public hearing for which it provided public notice in each year that it authorized a health care provider participation program on the amounts of any mandatory payments and the manner in which the collected funds would be spent. A representative of any paying hospital would be required to be allowed to attend and to be heard at any such meeting.

Local provider participation fund. If the board required a mandatory payment, then it would be required to establish a local provider participation fund in one or more banks that would be designated as depositories for the fund. The fund would consist only of the mandatory payments, money received from the Health and Human Services Commission as a refund of federal Medicaid supplemental program payments, and fund earnings. Money in the fund could not be commingled with other funds.

CSHB 3459 would allow money in the fund to be used only for the following purposes:

Intergovernmental transfers. The local provider participation fund would be allowed to fund intergovernmental transfers from the district to the state. These transfers would include uncompensated care payments to nonpublic hospitals under a Medicaid 1115 waiver, uniform rate enhancements for nonpublic hospitals in the Medicaid managed care service area, payments available under another waiver program that is substantially similar to Medicaid, or any reimbursement to nonpublic hospitals for which federal matching funds are available.

Refunds. The bill also would allow the district to use the fund to refund mandatory payments collected in error and to refund to hospitals a proportionate share of any funds that were received by the district from

the Health and Human Services Commission but not used to fund the payment of the nonfederal share of the Medicaid supplemental payment program.

Other permitted uses. The bill also would allow the district to use the fund to pay the administrative expenses of the program, including those related to the collateralization of deposits, and to transfer funds to the Health and Human Services Commission to address a disallowance of federal matching funds with respect to intergovernmental transfers.

Prohibited uses of intergovernmental transfers. The bill would prohibit the use of intergovernmental transfers from the district to the state under this program to fund expanded Medicaid eligibility under the federal Affordable Care Act or to fund the nonfederal share of payments to nonpublic hospitals available through the Medicaid disproportionate share hospital program or the delivery system reform incentive program.

Expiration. The district's authority to operate the program would expire on December 31, 2021, whereupon the district's board of hospital managers would be required to transfer any remaining funds to institutional health care providers.

If a state agency determined that a waiver or authorization from a federal agency was necessary to implement a provision of the bill, it could delay implementation of that provision until the waiver or authorization was granted.

The bill would take immediate effect if finally passed by a two-thirds record vote of the membership of each house. Otherwise, it would take effect September 1, 2019.