SUBJECT: Allowing Ellis County to create a local provider participation fund

COMMITTEE: County Affairs — committee substitute recommended

VOTE: 8 ayes — Bohac, Anderson, Biedermann, Cole, Dominguez, Huberty, Rosenthal, Stickland

0 nays

1 absent — Coleman

WITNESSES: For — Jack Wilcox, Ennis Regional Medical Center; (*Registered, but did not testify*: Drew DeBerry and Adam Aseron, Adelanto Health Care Ventures; Anthony Haley, Baylor, Scott, and White Health; Jennifer Banda, Texas Hospital Association)

Against — None

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 4548 would allow a county that was not served by a public hospital or hospital district, had a population of less than 600,000, and bordered two counties with populations of 1 million or more (Ellis County) to administer a county health care provider participation program.

Establishing provider participation program. The bill would authorize the county's commissioners court, by a majority vote, to create the program and to require a mandatory payment from institutional health care providers. If the commissioners court authorized such a program, the

court would have to require each hospital in the county to submit to the county a copy of any financial and utilization data required to be submitted to the Department of State Health Services (DSHS) or the Health and Human Services Commission (HHSC). The county commissioners could inspect the records of any hospital to the extent necessary to ensure compliance with this requirement.

Collection, holding and disbursement of funds. The bill would require the commissioners court to hold a publicized public hearing on the amounts of any mandatory payments in each year that it authorized a health care provider participation program. A representative of any paying hospital could attend and be heard at any such meeting.

The commissioners court would establish a local provider participation fund in one or more banks that would be designated as depositories for the mandatory payments. The fund would consist of the required payments including penalties and interest, money received from HHSC as a refund of federal Medicaid supplemental program payments, and fund earnings. Monies in the fund could not be commingled with other funds.

Money in the fund could only be used to:

- fund intergovernmental transfers from the county to the state to provide for the nonfederal share of a Medicaid supplemental payment program or a successor waiver program, and payments to Medicaid managed care organizations;
- subsidize indigent programs;
- pay the administrative expenses of the program;
- refund mandatory payments collected in error; and
- refund to hospitals a proportionate share of any funds collected by the county but not used to fund the payment of the nonfederal share of the Medicaid supplemental payment program.

Medicaid expansion. The bill would prohibit the use of intergovernmental transfers from the county to the state under this program to fund expanded Medicaid eligibility under the federal

Affordable Care Act.

Mandatory payments. The commissioners court of a county that collected a mandatory payment authorized by the bill could require an annual mandatory payment to be assessed on the net patient revenue of each institutional health care provider in the county. The mandatory payment could be assessed quarterly. During the first year in which a mandatory payment was required, the commissioners court would assess that payment on the net patient revenue of an institutional health care provider as determined by the data reported to certain state and federal agencies. The county would be required to update the amount of the mandatory payment on an annual basis.

The amount of annual payment would be uniformly proportionate to the amount of net patient revenue generated by each hospital and adequate to cover the expenses of the program, including intergovernmental transfers and indigent programs. The amount of the mandatory payment required of each paying hospital could not exceed an amount that, when added to the amount of the mandatory payments required from all paying hospitals in the county, would exceed 6 percent of the aggregate net patient revenue of all paying hospitals in the county. The commissioners court would be prohibited from using more than the lesser of 4 percent of the mandatory payments or $20,000 per year for administrative expenses.

CSHB 4548 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.

The bill would state that any interest, penalties, and discounts on mandatory payments under this program were governed by the law applicable to county ad valorem taxes.

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.