SUBJECT: Establishing the Nacogdoches County Hospital District

COMMITTEE: County Affairs — committee substitute recommended

VOTE: 6 ayes — Neave Criado, Stucky, Gerdes, J. Jones, Rosenthal, Schatzline

2 nays — Slaton, Tinderholt

1 absent — Orr

WITNESSES: For — (*Registered, but did not testify*: Michelle Apodaca, Webb Cochran, Tenet Health; Jennifer Banda, Texas Hospital Association)

Against — None

BACKGROUND: The Nacogdoches County Hospital District was created in 2022 under a statewide statute that allowed for the creation, during an interim period when the Legislature was not in session, of a program for a jurisdiction without its own governing statute. Because the hospital district would expire in 2024 without legislative action, some have suggested keeping the program viable by enabling a program specific to the district.

DIGEST: CSHB 4700 would apply only to the Nacogdoches County Hospital District.

Definitions. CSHB 4700 would define "institutional health care provider" as a nonpublic hospital located in the district that provided inpatient hospital services. "Paying provider" would mean an institutional health care provider required to make a mandatory payment under the bill.

Health care provider participation program. Under the bill, the district's board of directors could authorize the district to participate in a health care provider participation program on an affirmative majority vote. The board could not authorize the district to participate in a health care provider participation program under certain other statutes.

Board powers and duties. CSHB 4700 would allow the board to require an authorized mandatory payment by an institutional health care provider located in the district only as allowed by the bill. The board could adopt rules relating to the administration of the program, including the collection of mandatory payments, expenditures, audits, and other administrative procedures. If the board authorized the district to participate in a health care provider program, the board could require each institutional health care provider to submit a copy of financial and utilization data from Medicare cost reports.

Financial provisions. In each year that the board authorized a health care provider program, the board would be required to hold a public hearing on the amounts of mandatory payment the board intended to require during the year and how the revenue would be spent. The board would be required to publish notice of the hearing in a newspaper of general circulation in the district no later than five days before the hearing. A representative of a paying provider would be entitled to appear at the public hearing and be heard regarding any matter related to authorized mandatory hearings.

If the board required a mandatory payment, it would be required to create a local provider participation fund, which would consist of:

- all revenue the district received attributable to the authorized mandatory payments;
- money received from the Health and Human Services Commission (HHSC) as a refund of an intergovernmental transfer under the program, provided that the transfer did not receive a federal matching payment; and
- the fund's earnings.

Money deposited in the fund could be used only for certain expenditures, including to fund intergovernmental transfers from the district to the state to provide the nonfederal share of Medicaid supplemental payments for:

- authorized uncompensated care payments to nonpublic hospitals;

- rate enhancements for nonpublic hospitals in the district's Medicaid managed care service area;
- payments available under another similar Medicaid waiver program; or
- any reimbursement to nonpublic hospitals for which federal matching funds were available.

Money deposited in the fund also could be used to:

- pay the district's administrative expenses;
- refund a mandatory payment collected in error from a paying provider;
- refund to paying providers a proportionate share of money the district received from HHSC that was not used to fund the nonfederal share of Medicaid supplemental payments or rate enhancements;
- refund to paying providers a proportionate share of money the district determined could not be used to fund the nonfederal share of Medicaid supplemental payments or rate enhancements; and
- transfer funds to HHSC if the district was legally required to address a disallowance of federal matching funds regarding Medicaid supplemental payments for which the district made intergovernmental transfers.

Money in the local provider participation fund could not be commingled with other district funds. Any funds received by the state, district, or other entity as a result of an intergovernmental transfer of funds could not be used to expand Medicaid eligibility under the federal Patient Protection and Affordable Care Act.

Mandatory payments. Either annually or periodically throughout the year, the board could require the assessment of a mandatory payment on the net patient revenue of each institutional health care provider located in the district. The board would be required to provide written notice of each assessment to institutional health care providers, after which the provider would have 30 calendar days to make the mandatory payment. In the first

year in which the mandatory payment was required, the payment would be assessed on the provider's net patient revenue, as determined by the most recent Medicare cost report.

The district would periodically update the amount of the mandatory payment, which would be determined in a manner that ensured the revenue generated qualified for federal matching funds. The aggregate amount of the mandatory payments required of all paying providers in the district could not exceed 6 percent of the aggregate net patient revenue from hospital services in the district.

The board would be required to set the mandatory payments in amounts that would generate sufficient revenue to cover the district's administrative expenses and to fund certain intergovernmental transfers. The annual revenue from mandatory payments could not exceed $150,000, plus the cost of collateralization of deposits, regardless of actual expenses. A paying provider could not add a mandatory payment as a surcharge to a patient, and a mandatory payment would not be a tax for hospital purposes. The district could designate an official of the district or contract with another person to assess and collect the mandatory payments under certain circumstances.

Other provisions. To the extent any provision or procedure caused a mandatory payment to be ineligible for federal matching funds, the board could provide by rule for an alternative provision or procedure that conformed to federal requirements. A rule could not create, impose, or materially expand the legal or financial liability or responsibility of the district or an institutional health care provider. The district could only assess and collect a mandatory payment if a waiver program, rate enhancement, or reimbursement was available for nonpublic hospitals located in the district.

The authority of the district to administer and operate a program would expire December 31, 2027.

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, 2023.