BILL ANALYSIS

Senate Research Center

S.B. 1155
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Local Government
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AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

Around 10 years ago, Texas entered into the 1115 waiver program with the Center for Medicare Services, which requires a local match from counties or public hospital districts (PHDs) in order to fully participate in the program. This local match needs to be a certified public expenditure, and though counties could put down this amount in property taxes, this is difficult for rural and small counties. Ideally, counties would rather keep their property taxes low.

To solve this issue, counties without PHDs began local provider participation funds (LPPFs), as they had to raise money from private and nonprofit hospitals inside of their county. LPPFs are a method of finance for local governments to generate and collect local funding for programs such as the 1115 waiver.

In 2019, large counties in Texas, such as Bexar, Travis, and Harris realized that it would be beneficial to create LPPFs in order for private and nonprofit hospitals to be assessed with the fee and use it for the local match needed for the 1115 waiver program. Before this, University Health System (UHS) was putting up all of the public matches needed for hospitals in Bexar County. Therefore, UHS created its own LPPF under Health and Safety Code Chapter 298. Bexar County's LPPF now needs to be reauthorized, as it is set to expire at the end of this year.

S.B. 1155 would renew the Bexar County Hospital District LPPF until 2027.

As proposed, S.B. 1155 amends current law relating to the continuation and operations of a health care provider participation program by the Bexar County Hospital District.

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 Section 298F.001, Health and Safety Code, by adding Subdivision (6) to define "assessment basis."

SECTION 2. Amends Section 298F.004, Health and Safety Code, as follows:

> Sec. 298F.004. EXPIRATION. (a) Provides that the authority of the Bexar County Hospital District (district) to administer and operate a program under Chapter 298F (Bexar County Hospital District Health Care Provider Participation Program), subject to Section 298F.153(d) (relating to authorizing the district to only assess and collect a mandatory payment under this chapter if a waiver program, uniform rate enhancement, reimbursement, or other payment is available to nonpublic hospitals in the district), expires December 31, 2027, rather than December 31, 2023.
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> (b) Provides this chapter expires December 31, 2027, rather than December 31, 2023.

SECTION 3. Amends Section 298F.053, Health and Safety Code, as follows:

Sec. 298F.053. INSTITUTIONAL HEALTH CARE PROVIDER REPORTING. Authorizes, rather than requires, the board of hospital managers of the district (board), if the board authorizes the district to participate in a program under this chapter, to require each institutional health care provider to submit to the district a copy of any financial and utilization data as reported in the provider's Medicare cost report or other reasonable data source, as determined by the district, submitted for the previous fiscal year or for the closest subsequent fiscal year for which the provider submitted the Medicare cost report or other reasonable data source.

SECTION 4. Amends Section 298F.103, Health and Safety Code, by revising Subsection (c-4), as follows:

(c-4) refund to paying providers in proportion to each paying provider's assessment paid during the twelve months preceding such refund the money that the district, rather than a proportionate share of the money that the district:

SECTION 5. Amends the heading to Section 298F.151, Health and Safety Code, to read as follows:

Sec. 298F.151. MANDATORY PAYMENTS BASED ON PAYING PROVIDER ASSESSMENT BASIS.

SECTION 6. Amends Section 298F.151, Health and Safety Code, by revising Subsections (a), (b), and (c), as follows:

(a) Authorizes the board to require mandatory payments, rather than a mandatory payment, to be assessed on the Assessment Basis, rather than on the net patient revenue, of each institutional health care provider located in the district if the board authorized a health care provider participation program under this chapter. Authorizes the board to provide for the mandatory payments to be assessed periodically throughout the year. Requires the board to provide an institutional health care provider written notice of each assessment under Section 298F.151 (Mandatory Payments Based on Paying Provider Net Patient Revenue) rather than this subsection, and provides that the provider has 30 calendar days following the date of receipt of the notice to pay the assessment. Provides that the Assessment Basis will be calculated using the Medicare cost report or other reasonable data source for the most recent fiscal year for which the institutional health care provider submitted the report or other reasonable data source. Requires the district to use the same data source for all institutional health care providers unless it is unavailable for an institutional health care provider. Authorizes the district to rely on an alternative reasonable data source for such institutional health care provider if the Assessment Basis is unavailable for any institutional health care provider under the primary data source selected by the district. Requires the district to update the amount of the mandatory payment periodically, rather than on an annual basis, if the mandatory payment is required. Deletes existing text providing that the mandatory payment, in the first year in which mandatory payment is required, is assessed on the net patient revenue of an institutional health care provider, which is the amount of that revenue as reported in the provider's Medicare cost report submitted for the previous fiscal year or for the closest subsequent fiscal year for which the provider submitted the Medicare cost report. Makes nonsubstantive and conforming changes.

(b) Requires that the amount of a mandatory payment authorized under this chapter be determined in a manner that ensures the revenue generated qualifies for federal matching funds under federal law, consistent with 42 U.S.C. Section 1396b(w). Deletes existing text requiring 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 district as permitted under federal law. Deletes existing text prohibiting a health care provider participation program authorized under this chapter from holding harmless any institutional health care provider, as required under 42 U.S.C. Section 1396b(w).

(c) Deletes existing text prohibiting the aggregate amount of the mandatory payments required of all paying providers in the district from exceeding six percent of the aggregate net patient revenue from hospital services provided by all paying providers in the district.

SECTION 7. Amends Section 298F.152, Health and Safety Code, by adding Subsection (d), as follows:

(d) Authorizes a qualifying local government to impose and collect interest charges and penalties on delinquent mandatory payments authorized under this chapter in amounts up to the maximum authorized for any other delinquent payment required to be made to the district.

SECTION 8. Effective date: upon passage or September 1, 2023.