BRIEFING MEMORANDUM

TO: Board of Managers

FROM: Jonny F. Hipp, Administrator

DATE: September 22, 2026

RE: Overview of Health & Safety Code Chapter 298C — Nueces County Hospital District Provider Participation Program

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I. Purpose of This Memorandum

This memorandum summarizes Chapter 298C of the Texas Health and Safety Code, which authorizes the Nueces County Hospital District (the "District") to establish a local health care provider participation program. The statute allows the District to assess mandatory payments on local institutional health care providers to fund the nonfederal share of Medicaid supplemental payments and managed care rate enhancements, thereby drawing down additional federal matching funds for hospitals operating in the District.

II. Statutory Origin and Scope

Chapter 298C was added by the 86th Texas Legislature, Regular Session (2019), through Senate Bill 2315 (Acts 2019, Ch. 694), effective June 10, 2019. By its own terms (Sec. 298C.002), the chapter applies only to the Nueces County Hospital District; it is not a program of general applicability to hospital districts statewide.

III. Key Definitions (Sec. 298C.001)

- **Board —** the board of hospital managers of the District.
- **District —** the Nueces County Hospital District.
- **Institutional health care provider —** a hospital not owned and operated by a federal or state government that provides inpatient hospital services.
- **Paying provider —** an institutional health care provider required to make a mandatory payment under the chapter.
- **Program —** the health care provider participation program authorized by the chapter.

IV. Program Authorization

Under Sec. 298C.003, the Board may authorize the District to participate in a health care provider participation program on the affirmative vote of a majority of the Board, subject to the remaining provisions of the chapter. Participation is therefore discretionary, not mandatory.

V. Powers and Duties of the Board (Subchapter B)

- **Limited authority to compel payment (Sec. 298C.051):** The Board may require mandatory payments from institutional health care providers only in the manner expressly provided by the chapter.

- **Rulemaking (Sec. 298C.052):** The Board may adopt rules governing administration of the program, including collection of payments, expenditures, audits, and other administrative matters.
- **Provider reporting (Sec. 298C.053):** Participating providers must submit to the District the same financial and utilization data they are already required to report to the Department of State Health Services (DSHS) under Sections 311.032 and 311.033, and any related HHSC rules.

VI. General Financial Provisions (Subchapter C)

A. Public Hearing (Sec. 298C.101)

In any fiscal year the program is authorized, the Board must hold a public hearing on the amount of mandatory payments it intends to require and how the resulting revenue will be spent. Notice must be published in a newspaper of general circulation in the District and given in writing to each institutional provider at least five days before the hearing.

B. Depository (Sec. 298C.102)

If mandatory payments are required, the Board must designate one or more banks as depository for the District's local provider participation fund, and all collected funds must be secured in the same manner as other District funds.

C. Local Provider Participation Fund (Sec. 298C.103)

The District must create a local provider participation fund ("LPPF") consisting of: (1) revenue from mandatory payments; (2) certain refunds from HHSC of intergovernmental transfers that did not receive federal match; and (3) fund earnings. LPPF money may not be commingled with other District funds and may be used only for the following purposes:

- Funding intergovernmental transfers to the State to provide the nonfederal share of Medicaid payments — including uncompensated care payments, delivery system reform incentive payments, uniform rate enhancements, and substantially similar waiver payments, or any reimbursement for which federal matching funds are available;
- Paying the District's administrative expenses in administering the program (subject to the cap described in Section VII.D below), including collateralization of deposits;
- Refunding mandatory payments collected in error;
- Refunding to paying providers a proportionate share of funds received from HHSC that are not used, or cannot be used, to fund the relevant Medicaid supplemental payments or rate enhancements;
- Transferring funds back to HHSC if legally required to address a disallowance of federal matching funds; and
- Reimbursing the District where insufficient LPPF funds force it to incur expenses or forgo Medicaid reimbursements under the uniform rate enhancement program.

Notably, funds received through these intergovernmental transfers may not be used by the State, District, or any other entity to expand Medicaid eligibility under the Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010.

VII. Mandatory Payments (Subchapter D)

A. Basis of Assessment (Sec. 298C.151(a))

If the program is authorized, the Board may assess mandatory payments — annually or periodically, at the Board's discretion — based on each institutional health care provider's net patient revenue. Providers receive written notice of each assessment and have 30 calendar days from receipt to pay. In the program's first fiscal year, net patient revenue is determined from the most recent DSHS-reported data under Sections 311.032–.033, or from the provider's Medicare cost report if no DSHS data was reported. The mandatory payment amount must be updated annually.

B. Uniformity and Federal Compliance (Sec. 298C.151(b))

Payments must be uniformly proportionate to each paying provider's net patient revenue, as permitted under federal law, and the program may not "hold harmless" any provider, consistent with 42 U.S.C. § 1396b(w).

C. Statutory Cap (Sec. 298C.151(c))

The aggregate mandatory payments required of all paying providers in the District may not exceed six percent (6%) of the aggregate net patient revenue from hospital services provided by all paying providers in the District.

D. Administrative Expense Allowance (Sec. 298C.151(d))

Subject to the 6% cap, the Board must set mandatory payments to generate revenue sufficient to cover the District's administrative expenses and to fund the intergovernmental transfer described above. The annual amount of mandatory-payment revenue allocated to administrative expenses is fixed at $150,000, plus the cost of collateralizing deposits, regardless of the District's actual costs.

E. Additional Limitations (Sec. 298C.151(e)–(f))

- Paying providers may not pass a mandatory payment on to patients as a surcharge.
- A mandatory payment under this chapter is not considered a "tax" for purposes of Article IX, Section 4 of the Texas Constitution or Section 281.045 of the Health and Safety Code.

F. Assessment and Collection (Sec. 298C.152)

The District may designate a district official or contract with a third party to assess and collect mandatory payments. The collecting party may charge and deduct a collection fee not exceeding its usual and customary rates for similar services. If a District official performs this role, collection-fee revenue is deposited in the District's general fund and reported as District fees, where appropriate.

G. Statutory Purpose, Corrective Rulemaking, and Conditions Precedent (Sec. 298C.153)

- Purpose limitation: The chapter exists solely to let the District fund the nonfederal share of a Medicaid supplemental payment program or Medicaid managed care rate enhancements — not to raise general revenue or collect amounts beyond what is reasonably necessary for those purposes and related administrative costs.

- Corrective rules: If any provision or procedure would render a mandatory payment ineligible for federal matching funds, the Board may adopt an alternative provision or procedure conforming to CMS requirements — but such a rule may not materially expand the legal or financial liability of the District or any provider beyond what the chapter already provides. The Board is not required to adopt such a rule.
- Condition precedent to collection: The District may assess and collect a mandatory payment only if a qualifying waiver program, uniform rate enhancement, or reimbursement (as described in Sec. 298C.103(c)(1)) is actually available to at least one institutional health care provider in the District.

VIII. Summary Assessment

Chapter 298C is a narrowly tailored, single-district enabling statute that follows a template used elsewhere in the Health and Safety Code for hospital-district "provider participation programs." It gives the Nueces County Hospital District Board explicit, but bounded, authority to assess local hospitals in order to generate the nonfederal share needed to access federal Medicaid matching funds. Key guardrails include: (1) a hard 6% cap on aggregate assessments relative to providers' net patient revenue; (2) a fixed $150,000 annual administrative-expense allowance; (3) mandatory public notice and hearing requirements; (4) a prohibition on passing costs to patients; (5) a prohibition on using resulting funds to expand ACA Medicaid eligibility; and (6) a purpose limitation confining the program strictly to Medicaid supplemental-payment and rate-enhancement funding rather than general revenue generation.

Source: Tex. Health & Safety Code ch. 298C (enacted by Acts 2019, 86th Leg., R.S., Ch. 694 (S.B. 2315), eff. June 10, 2019).