

By: Coleman

H.B. No. 1338

A BILL TO BE ENTITLED

1 AN ACT

2 relating to the continuation and operations of a health care  
3 provider participation program by the Harris County Hospital  
4 District.

5 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

6 SECTION 1. Section 299.001, Health and Safety Code, is  
7 amended by adding Subdivision (6) to read as follows:

8 (6) "Qualifying assessment basis" means the health  
9 care item, health care service, or other health care-related basis  
10 consistent with 42 U.S.C. Section 1396b(w) on which the board  
11 requires mandatory payments to be assessed under this chapter.

12 SECTION 2. Section 299.004, Health and Safety Code, is  
13 amended to read as follows:

14 Sec. 299.004. EXPIRATION. (a) Subject to Section  
15 299.153(d), the authority of the district to administer and operate  
16 a program under this chapter expires December 31, 2023 [~~2021~~].

17 (b) This chapter expires December 31, 2023 [~~2021~~].

18 SECTION 3. Section 299.053, Health and Safety Code, is  
19 amended to read as follows:

20 Sec. 299.053. INSTITUTIONAL HEALTH CARE PROVIDER  
21 REPORTING. If the board authorizes the district to participate in a  
22 program under this chapter, the board may [~~shall~~] require each  
23 institutional health care provider to submit to the district a copy  
24 of any financial and utilization data as reported in:

1           (1) the provider's Medicare cost report [submitted]  
2 for the most recent [~~previous fiscal year or for the closest~~  
3 ~~subsequent~~] fiscal year for which the provider submitted the  
4 Medicare cost report; or

5           (2) a report other than the report described by  
6 Subdivision (1) that the board considers reliable and is submitted  
7 by or to the provider for the most recent fiscal year.

8           SECTION 4. Section 299.103(c), Health and Safety Code, is  
9 amended to read as follows:

10           (c) Money deposited to the local provider participation  
11 fund of the district may be used only to:

12           (1) fund intergovernmental transfers from the  
13 district to the state to provide the nonfederal share of Medicaid  
14 payments for:

15           (A) uncompensated care payments to nonpublic  
16 hospitals, if those payments are authorized under the Texas  
17 Healthcare Transformation and Quality Improvement Program waiver  
18 issued under Section 1115 of the federal Social Security Act (42  
19 U.S.C. Section 1315);

20           (B) uniform rate enhancements for nonpublic  
21 hospitals in the Medicaid managed care service area in which the  
22 district is located;

23           (C) payments available under another waiver  
24 program authorizing payments that are substantially similar to  
25 Medicaid payments to nonpublic hospitals described by Paragraph (A)  
26 or (B); or

27           (D) any reimbursement to nonpublic hospitals for

1 which federal matching funds are available;

2 (2) subject to Section 299.151(d), pay the  
3 administrative expenses of the district in administering the  
4 program, including collateralization of deposits;

5 (3) refund a mandatory payment collected in error from  
6 a paying provider;

7 (4) refund to a paying provider, in an amount that is  
8 proportionate to the mandatory payments made under this chapter by  
9 the provider during the 12 months preceding the date of the refund,  
10 ~~[providers a proportionate share of]~~ the money attributable to  
11 mandatory payments collected under this chapter that the district:

12 (A) receives from the Health and Human Services  
13 Commission that is not used to fund the nonfederal share of Medicaid  
14 supplemental payment program payments; or

15 (B) determines cannot be used to fund the  
16 nonfederal share of Medicaid supplemental payment program  
17 payments; and

18 (5) transfer funds to the Health and Human Services  
19 Commission if the district is legally required to transfer the  
20 funds to address a disallowance of federal matching funds with  
21 respect to programs for which the district made intergovernmental  
22 transfers described by Subdivision (1).

23 SECTION 5. The heading to Section 299.151, Health and  
24 Safety Code, is amended to read as follows:

25 Sec. 299.151. MANDATORY PAYMENTS [~~BASED ON PAYING PROVIDER~~  
26 ~~NET PATIENT REVENUE~~].

27 SECTION 6. Section 299.151, Health and Safety Code, is

1 amended by amending Subsections (a), (b), and (c) and adding  
2 Subsections (a-1) and (a-2) to read as follows:

3 (a) If the board authorizes a health care provider  
4 participation program under this chapter, the board may require ~~[a]~~  
5 mandatory payments ~~[payment]~~ to be assessed against each  
6 institutional health care provider located in the district, either  
7 annually or periodically throughout the year at the discretion of  
8 the board, on the basis of a health care item, health care service,  
9 or other health care-related basis that is consistent with the  
10 requirements of 42 U.S.C. Section 1396b(w) ~~[the net patient revenue~~  
11 ~~of each institutional health care provider located in the~~  
12 ~~district]~~. The qualifying assessment basis must be the same for  
13 each institutional health care provider in the district. The board  
14 shall provide an institutional health care provider written notice  
15 of each assessment under this section ~~[subsection]~~, and the  
16 provider has 30 calendar days following the date of receipt of the  
17 notice to pay the assessment.

18 (a-1) Except as otherwise provided by this subsection, the  
19 qualifying assessment basis must be determined by the board using  
20 information contained in an institutional health care provider's  
21 Medicare cost report for the most recent fiscal year for which the  
22 provider submitted the report. If the provider is not required to  
23 submit a Medicare cost report, or if the Medicare cost report  
24 submitted by the provider does not contain information necessary to  
25 determine the qualifying assessment basis, the qualifying  
26 assessment basis may be determined by the board using information  
27 contained in another report the board considers reliable that is

1 submitted by or to the provider for the most recent fiscal year. To  
2 the extent practicable, the board shall use the same type of report  
3 to determine the qualifying assessment basis for each paying  
4 provider in the district.

5 (a-2) [~~In the first year in which the mandatory payment is~~  
6 ~~required, the mandatory payment is assessed on the net patient~~  
7 ~~revenue of an institutional health care provider, as determined by~~  
8 ~~the provider's Medicare cost report submitted for the previous~~  
9 ~~fiscal year or for the closest subsequent fiscal year for which the~~  
10 ~~provider submitted the Medicare cost report.] If [the] mandatory  
11 payments are [payment is] required, the district shall update the  
12 amount of the mandatory payments [~~payment~~] on an annual basis and  
13 may update the amount on a more frequent basis.~~

14 (b) The amount of a mandatory payment authorized under this  
15 chapter must be uniformly proportionate with the qualifying  
16 assessment basis for [~~amount of net patient revenue generated by~~]  
17 each paying provider in the district as permitted under federal  
18 law. A health care provider participation program authorized under  
19 this chapter may not hold harmless any institutional health care  
20 provider, as required under 42 U.S.C. Section 1396b(w).

21 (c) If the board requires a mandatory payment authorized  
22 under this chapter, the board shall set the amount of the mandatory  
23 payment, subject to the limitations of this chapter. The aggregate  
24 amount of the mandatory payments required of all paying providers  
25 in the district may not exceed six [~~four~~] percent of the aggregate  
26 net patient revenue from hospital services provided by all paying  
27 providers in the district.

1 SECTION 7. Subchapter D, Chapter 299, Health and Safety  
2 Code, is amended by adding Section 299.154 to read as follows:

3 Sec. 299.154. REQUEST FOR CERTAIN RELIEF. If 42 U.S.C.  
4 Section 1396b(w) or 42 C.F.R. Part 433 Subpart B is revised or  
5 interpreted in a manner that impedes the operations of a program  
6 under this chapter, and the operations may be improved by a request  
7 for relief under 42 C.F.R. Section 433.72, the board may request the  
8 Health and Human Services Commission to submit, and if requested  
9 the commission shall submit, a request to the Centers for Medicare  
10 and Medicaid Services for relief under 42 C.F.R. Section 433.72.

11 SECTION 8. This Act takes effect immediately if it receives  
12 a vote of two-thirds of all the members elected to each house, as  
13 provided by Section 39, Article III, Texas Constitution. If this  
14 Act does not receive the vote necessary for immediate effect, this  
15 Act takes effect September 1, 2021.