# BILL ANALYSIS

Senate Research Center
87R17270 JCG-D

H.B. 1338
By: Coleman (Miles)
Local Government
5/7/2021
Engrossed

## AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

Last session, legislation was enacted creating the Harris County Hospital District health care provider participation program. Like most of these programs, the district's program was enacted with a two-year expiration date. Legislation is needed to continue the program and make a few minor changes to help the program run effectively. H.B. 1338 seeks to continue the program and make these changes by revising the program's governing provisions.

H.B. 1338 amends current law relating to the continuation and operations of a health care provider participation program by the Harris 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 299.001, Health and Safety Code, by adding Subdivision (6), to define "qualifying assessment basis" for purposes of Chapter 299 (Harris County Hospital District Health Care Provider Participation Program)

SECTION 2. Amends Section 299.004, Health and Safety Code, as follows:

Sec. 299.004. EXPIRATION. (a) Provides that subject to Section 299.153(d) (relating to the circumstances under which the district is authorized to assess and collect a mandatory payment), the authority of the Harris County Hospital District (district) to administer and operate a program under Chapter 299 expires December 31, 2023, rather than December 31, 2021.

(b) Provides that Chapter 299 expires December 31, 2023, rather than December 31, 2021.

SECTION 3. Amends Section 299.053, Health and Safety Code, as follows:

Sec. 299.053. 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:

(1) the provider's Medicare cost report for the most recent fiscal year, rather than the report submitted for the previous fiscal year for the closest subsequent fiscal year, for which the provider submitted the Medicare cost report; or

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

SECTION 4. Amends Section 299.103(c), Health and Safety Code, as follows:

(c) Provides that money deposited to the local provider participation fund of the district is only authorized to be used for certain purposes, including to refund to a paying provider, in an amount that is proportionate to the mandatory payments made under this chapter by the provider during the 12 months preceding the date of the refund, the money attributable to certain mandatory payments collected by the district under this chapter.

SECTION 5. Amends the heading to Section 299.151, Health and Safety Code, to read as follows:

Sec. 299.151. MANDATORY PAYMENTS.

SECTION 6. Amends Section 299.151, Health and Safety Code, by amending Subsections (a), (b), and (c), and adding Subsections (a-1) and (a-2), as follows:

(a) Authorizes the board, if the board authorizes a health care provider participation program under this chapter, to require mandatory payments to be assessed against each institutional health care provider located in the district, either annually or periodically throughout the year at the discretion of the board, on the basis of a health care item, health care service, or other health care-related basis that is consistent with the requirements of 42 U.S.C. Section 1396b(w), rather than on the net patient revenue of each institutional health care provider located in the district. Requires that the qualifying assessment basis be the same for each institutional health care provider in the district. Provides that the board is required to provide an institutional health care provider written notice of each assessment under this section, rather than this subsection, and the provider has 30 calendar days following the date of receipt of the notice to pay the assessment. Makes nonsubstantive changes.

(a-1) Requires that the qualifying assessment basis, except as otherwise provided by this subsection, be determined by the board using information contained in an institutional health care provider's Medicare cost report for the most recent fiscal year for which the provider submitted the report. Authorizes the board, if the provider is not required to submit a Medicare cost report, or if the Medicare cost report submitted by the provider does not contain information necessary to determine the qualifying assessment basis, to determine the qualifying assessment basis using information contained in another report the board considers reliable that is submitted by or to the provider for the most recent fiscal year. Requires the board, to the extent practicable, to use the same type of report to determine the qualifying assessment basis for each paying provider in the district.

(a-2) Requires the district, if mandatory payments are required, to update the amount of the mandatory payments on an annual basis and authorizes the district to update the amount on a more frequent basis. Deletes existing text providing that in the first year in which the mandatory payment is required, the mandatory payment is assessed on the net patient revenue of an institutional health care provider, as determined by 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.

(b) Requires that the amount of a mandatory payment authorized under this chapter be uniformly proportionate with the qualifying assessment basis for each paying provider in the district, rather than uniformly proportionate with the amount of net patient revenue generated by each paying provider in the district, as permitted under federal law. Prohibits 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) Increases the maximum aggregate amount of the mandatory payments required of all paying providers in the district from four to six percent of the aggregate net patient revenue from hospital services provided by all paying providers in the district.

SECTION 7. Amends Subchapter D, Chapter 299, Health and Safety Code, by adding Section 299.154, as follows:

Sec. 299.154. REQUEST FOR CERTAIN RELIEF. Authorizes the board, if 42 U.S.C. Section 1396b(w) or 42 C.F.R. Part 433 Subpart B is revised or interpreted in a manner that impedes the operations of a program under Chapter 299, and the operations may be improved by a request for relief under 42 C.F.R. Section 433.72, to request the Health and Human Services Commission (HHSC) to submit, and if requested HHSC is required to submit, a request to the Centers for Medicare and Medicaid Services for relief under 42 C.F.R. Section 433.72.

SECTION 8. Effective date: upon passage or September 1, 2021.