

BILL ANALYSIS

C.S.H.B. 4700
By: Clardy
County Affairs
Committee Report (Substituted)

BACKGROUND AND PURPOSE

The Texas Legislature has recognized that collaborations between local governmental entities and local hospitals help to preserve the state's health care safety net. The legislature has authorized, by statute, certain local governmental entities to create health care provider participation programs to help with such collaborations. Currently, there are a number of authorized jurisdictions throughout Texas that operate such programs. The Nacogdoches County Hospital District adopted and began operating such a program in the summer of 2022. While a number of jurisdictions have a statute authorizing a program that is specific to their jurisdiction, the district's program was authorized under a statewide statute that allows the creation, during an interim period when the legislature is not in session, of a program for a jurisdiction that does not have their own governing statute. However, without legislative action, the district's authority to operate the program will expire in the summer of 2024, roughly two years after the program's creation, since it was created under the statewide statute. C.S.H.B. 4700 seeks to keep the district's program viable until December 31, 2027, by providing for a health care provider participation program specific to the Nacogdoches County Hospital District.

CRIMINAL JUSTICE IMPACT

It is the committee's opinion that this bill does not expressly create a criminal offense, increase the punishment for an existing criminal offense or category of offenses, or change the eligibility of a person for community supervision, parole, or mandatory supervision.

RULEMAKING AUTHORITY

It is the committee's opinion that this bill does not expressly grant any additional rulemaking authority to a state officer, department, agency, or institution.

ANALYSIS

C.S.H.B. 4700 amends the Health and Safety Code to provide for a Nacogdoches County Hospital District health care provider participation program. The bill authorizes the district's board of directors to authorize the district to participate in the program on the affirmative vote of a majority of the board and sets the district's authority to administer and operate the program, and sets the bill's provisions, to expire December 31, 2027. The bill prohibits the board from authorizing the district to participate in certain other health care provider participation programs.

C.S.H.B. 4700 authorizes the board to require a mandatory payment by an institutional health care provider located in the district under the program, authorizes the board to adopt rules relating to the program's administration, and defines, among other terms, "institutional health care provider" as a nonpublic hospital located in the district that provides inpatient hospital services. The bill authorizes the board, if the board authorizes the district to participate in the program, to require each institutional health care provider to submit to the district a copy of any financial and utilization data reported in the provider's Medicare cost report submitted for the most recent fiscal year for which the provider submitted the report.

C.S.H.B. 4700 provides for an annual public hearing on the amounts of any mandatory payments that the board intends to require during the year and how the revenue derived from those payments is to be spent. The bill provides for the designation of one or more banks as a depository for the district's local provider participation fund and provides for the creation, composition, and use of the fund. The bill provides as a use of the fund the refund to paying providers of a proportionate share of the money that the district receives from the Health and Human Services Commission (HHSC) that is not used to fund the nonfederal share of certain Medicaid supplemental payments or certain rate enhancements or that the district determines cannot be used to fund that share or those enhancements.

C.S.H.B. 4700 provides for the amount, assessment, and collection of a mandatory payment that is to be assessed on the net patient revenue of each institutional health care provider located in the district. 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 most recent fiscal year for which the provider submitted the Medicare cost report. The bill establishes that a mandatory payment is not a tax for hospital purposes for purposes of constitutional provisions relating to the creation, operation, and dissolution of a hospital district or statutory provisions governing the district that require a district property tax.

C.S.H.B. 4700 authorizes the district to designate an official of the district or contract with another person to assess and collect the mandatory payments. The bill prohibits the person charged by the district with the assessment and collection from charging the district a fee for assessing and collecting the payments unless the district authorizes the fee in writing. The bill, if that person is an official of the district, requires any revenue from such a fee to be deposited in the district general fund and, if appropriate, to be reported as fees of the district.

C.S.H.B. 4700 authorizes the board to provide by rule for an alternative provision or procedure that conforms to the requirements of the federal Centers for Medicare and Medicaid Services to the extent any provision or procedure under the bill's provisions causes a mandatory payment to be ineligible for federal matching funds, sets out provisions relating to such rules, and conditions the district's assessment and collection of a mandatory payment on an applicable waiver program, rate enhancement, or reimbursement being available for nonpublic hospitals located in the district.

EFFECTIVE DATE

On passage, or, if the bill does not receive the necessary vote, September 1, 2023.

COMPARISON OF INTRODUCED AND SUBSTITUTE

While C.S.H.B. 4700 may differ from the introduced in minor or nonsubstantive ways, the following summarizes the substantial differences between the introduced and committee substitute versions of the bill.

With regard to the authorization for the board to require each institutional health care provider to submit to the district a copy of financial and utilization data reported in the provider's Medicare cost report submitted for the most recent fiscal year for which the provider submitted the report, the introduced included a provision that provides as an alternative to that report another report that the board considers reliable and is submitted by or to the provider for the most recent fiscal year, whereas the substitute does not include this provision.

With regard to the use of the local provider participation fund to refund to paying providers a proportionate share of the money that the district receives from HHSC that is not used for certain funding:

- the introduced included a specification that the proportionate share of the money is a proportionate share of the money attributable to collected mandatory payments, whereas the substitute does not include this specification; and
- the substitute specifies that the money is money received from HHSC that is not used to fund the nonfederal share of certain Medicaid supplemental payments or certain rate enhancements, whereas the introduced did not include those enhancements as an alternative to those payments.

Whereas the introduced provided for the mandatory payment to be assessed on a qualifying assessment basis, the substitute instead provides for the mandatory payment to be assessed on net patient revenue. Accordingly, the substitute does the following:

- omits the following provisions that were present in the introduced:
 - the definition of "qualifying assessment basis"; and
 - a provision establishing the determination of the qualifying assessment basis; and
- includes a provision absent from the introduced that provides for the determination of the assessment of the mandatory payment on the net patient revenue of an institutional health care provider.

Whereas the introduced established that a mandatory payment is not a tax for hospital purposes for purposes of state constitutional provisions relating to county-wide hospital districts in certain large counties or statutory provisions relating to hospital districts in counties of at least 190,000 regarding a limitation on the taxing power of a governmental entity and the disposition of delinquent taxes, the substitute instead establishes that a mandatory payment is not a tax for hospital purposes for purposes of state constitutional provisions relating to the creation, operation, and dissolution of a hospital district or statutory provisions governing the Nacogdoches County Hospital District that require a district property tax.

Whereas the introduced required the person charged by the district with the assessment and collection of the mandatory payments to charge and deduct from the mandatory payments collected for the district a collection fee in an amount not to exceed the person's usual and customary charges for like services, the substitute instead prohibits such person from charging the district a fee for assessing and collecting the payments unless the district authorizes the fee in writing.

The substitute does not include a provision included in the introduced that provided for the delayed implementation of any provision for which an applicable state agency determines a federal waiver or authorization is necessary for implementation until the waiver or authorization is requested and granted.