BILL ANALYSIS

H.B. 4799
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Intergovernmental Affairs
Committee Report (Unamended)

BACKGROUND AND PURPOSE

The bill author has informed the committee that in many counties in Texas, particularly those not served by a hospital district or public hospital, there is limited access to health care services and that, in these counties, institutional health care providers such as nonpublic hospitals often struggle to provide adequate care for residents due to insufficient funding. The bill author has also informed the committee that, with Medicaid expansion being a complex and ongoing issue at both the state and federal levels, counties need alternative ways to generate revenue to support the nonfederal share of Medicaid payments. H.B. 4799 seeks to address this issue by providing for a county health care provider participation program in certain counties in order to ensure that such counties have an additional avenue to secure the necessary funds to cover the costs of essential health care services for their residents.

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

H.B. 4799 amends the Health and Safety Code to provide for a county health care provider participation program in a county that is not served by a hospital district or a public hospital, has a population of more than 46,000 and less than 50,000, and is adjacent to the county containing the state capital. The bill establishes that such a program authorizes an applicable county to collect a mandatory payment from each institutional health care provider located in the county to be deposited in a local provider participation fund established by the county. Money in the fund may be used by the county as provided by the bill's provisions. The bill authorizes an applicable county commissioners court to adopt an order authorizing the county to participate in the program, subject to the limitations provided by the bill. The bill defines "institutional health care provider" as a nonpublic hospital that provides inpatient hospital services.

Powers and Duties of Commissioners Court

H.B. 4799 establishes that an applicable county commissioners court may require a mandatory payment by an institutional health care provider in the county only in the manner provided by the bill and prohibits such a county commissioners court from authorizing the county to collect a mandatory payment without an affirmative vote of a majority of the members of the commissioners court. The bill authorizes the commissioners court, after voting to require a

mandatory payment, to adopt rules relating to the administration of the program, including the collection of a mandatory payment, expenditures, an audit, and any other administrative aspect of the program. If a county commissioners court authorizes the county to participate in the program, the commissioners court must require each institutional health care provider to submit to the county a copy of any financial and utilization data required by and reported to the Department of State Health Services (DSHS) under statutory provisions relating to the collection of hospital financial and utilization data and any rules adopted by the executive commissioner of the Health and Human Services Commission (HHSC) to implement those provisions.

General Financial Provisions

Hearing

H.B. 4799 requires an applicable county commissioners court, in each year that the commissioners court authorizes a mandatory payment, to hold a public hearing on the amounts of any mandatory payments that the county intends to require during the year and how the revenue derived from those payments is to be spent. The bill requires the commissioners court, not later than the fifth day before the date of the hearing, to publish notice of the hearing in a newspaper of general circulation in the county and to provide written notice of the hearing to each institutional health care provider located in the county. The bill entitles a representative of a paying provider, defined by the bill as an institutional health care provider required to make a mandatory payment, to appear at the public hearing and be heard regarding any matter related to the mandatory payments.

Depository

H.B. 4799 requires an applicable county commissioners court that requires a mandatory payment to designate one or more banks as the depository for the county's local provider participation fund. The bill requires the following:

- all income received by a county under the bill's provisions to be deposited with the designated depository in the county's local provider participation fund; and
- all money collected under the bill's provisions to be secured in the manner provided for securing other county money.

The bill establishes that all income received by a county under the bill's provisions may be withdrawn from the depository only as provided by the bill's provisions.

Authorized Uses of Money in the Local Provider Participation Fund

H.B. 4799 requires an applicable county that requires a mandatory payment to create a local provider participation fund that consists of the following:

- all revenue received by the county attributable to mandatory payments;
- money received from HHSC as a refund of an intergovernmental transfer described by the bill, provided that the intergovernmental transfer does not receive a federal matching payment; and
- the earnings of the fund.

The bill restricts the purposes for which money deposited to a county's local provider participation fund may be used to the following:

- the funding of intergovernmental transfers from the county to the state to provide the nonfederal share of Medicaid payments for:
    - uncompensated care payments to nonpublic hospitals authorized under the Texas Healthcare Transformation and Quality Improvement Program waiver issued under Section 1115 of the federal Social Security Act or a successor waiver program authorizing similar Medicaid supplemental payment programs;
    - uniform rate enhancements or other directed payment programs for nonpublic hospitals;

    - payments available under another waiver program authorizing payments that are substantially similar to such uncompensated care payments, uniform rate enhancements, or other directed payments programs; or
    - any reimbursement to nonpublic hospitals, or that may benefit nonpublic hospitals as determined by the commissioners court, for which federal matching funds are available;
- subject to the bill's provisions, the payment of the county's administrative expenses in administering the program, including collateralization of deposits;
- the refunding of all or a portion of a mandatory payment collected in error from a paying provider;
- the refunding to paying providers of a proportionate share of the money that the county:
    - receives from HHSC that is not used to fund the nonfederal share of Medicaid supplemental payment program payments; or
    - determines cannot be used to fund the nonfederal share of Medicaid supplemental payment program payments; and
- the transferring of funds to HHSC if the county is legally required to transfer the funds to address a disallowance of federal matching funds with respect to any program for which intergovernmental transfers were made.

The bill prohibits money in the local provider participation fund from being commingled with other county money. With respect to an intergovernmental transfer made by the county, the bill prohibits any funds received by the state, county, or other entity as a result of the transfer from being used by the state, county, or other entity to expand Medicaid eligibility under the federal Patient Protection and Affordable Care Act as amended by the federal Health Care and Education Reconciliation Act of 2010.

Mandatory Payments

Mandatory Payments Based on Paying Provider Net Patient Revenue

H.B. 4799, except as otherwise provided by the bill's provisions, authorizes an applicable county commissioners court that authorizes a county health care provider participation program to require an annual mandatory payment to be assessed on the net patient revenue of each institutional health care provider located in the county. The bill authorizes the commissioners court to provide for the mandatory payment to be assessed quarterly. The bill establishes the following with respect to the assessment of the mandatory payment:

- 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 data reported to DSHS under statutory provisions relating to the collection of hospital financial and utilization data in the most recent fiscal year for which that data was reported; and
- if the institutional health care provider did not report any data under those provisions, the provider's net patient revenue is the amount of that revenue as contained in the provider's Medicare cost report submitted for the most recent fiscal year for which the provider submitted the Medicare cost report.

The bill requires the commissioners court to update the amount of the mandatory payment on an annual basis if the mandatory payment is required.

H.B. 4799 requires a county commissioners court that requires a mandatory payment to provide each institutional health care provider on which the payment will be assessed written notice of an assessment under the bill and requires the institutional health care provider to pay the assessment not later than the 30th day after the date the provider receives the written notice. The bill requires the amount of a mandatory payment to be uniformly proportionate with the amount of net patient revenue generated by each paying provider in the administering county and prohibits a program from holding harmless any institutional health care provider, as required under applicable federal law and federal regulations.

H.B. 4799 requires a county commissioners court that requires a mandatory payment to set the amount of the mandatory payment, provided that the aggregate amount of the mandatory payment required of all paying providers in the county does not exceed six percent of the aggregate net patient revenue from hospital services provided by all paying providers in the county. The bill also requires such a commissioners court, subject to that cap, to set the mandatory payments in amounts that in the aggregate will generate sufficient revenue to cover the county's administrative expenses for activities under the bill's provisions and to fund an intergovernmental transfer, provided that the annual amount of revenue from mandatory payments that may be used to pay the county's administrative expenses for such activities may not exceed $20,000, plus the cost of collateralization of deposits, regardless of actual expenses. The bill prohibits a paying provider from adding a mandatory payment as a surcharge to a patient. The bill establishes that a mandatory payment assessed under the bill's provisions is not a tax for hospital purposes for purposes of certain provisions of the Texas Constitution relating to county-wide hospital districts in certain large counties.

Assessment and Collection of Mandatory Payments

H.B. 4799 authorizes an applicable county to collect or contract for the assessment and collection of mandatory payments. The bill requires the person charged by the county with the assessment and collection of mandatory payments to charge and deduct from the mandatory payments collected for the county a collection fee in an amount not to exceed the person's usual and customary charges for like services. If the person charged with the assessment and collection of mandatory payments is a county official, any revenue from such a collection fee must be deposited in the county general fund and, if appropriate, reported as fees of the county.

Purpose

H.B. 4799 establishes that the purpose of the bill's provisions is to authorize an applicable county to establish a county health care provider participation program to enable the county to collect mandatory payments from institutional health care providers to fund the nonfederal share of certain Medicaid programs as described by the bill's provisions.

Correction of Invalid Provision or Procedure

H.B. 4799 authorizes an applicable county commissioners court administering the program, to the extent any provision or procedure under the bill causes a mandatory payment to be ineligible for federal matching funds, to provide by rule for an alternative provision or procedure that conforms to the requirements of the federal Centers for Medicare and Medicaid Services. Such a rule may not create, impose, or materially expand the legal or financial liability or responsibility of the county or an institutional health care provider located in the county beyond the bill's provisions. The bill specifies that these provisions do not require the county commissioners court to adopt a rule.

Limitation of Authority

H.B. 4799 establishes that a county administering a program may only assess and collect a mandatory payment if a waiver program, uniform rate enhancement, or reimbursement described by the bill's provisions is available to the county. The bill expressly does not authorize such a county to collect mandatory payments for the purpose of raising general revenue or any amount in excess of the amount reasonably necessary to fund the nonfederal share of a Medicaid supplemental payment program or Medicaid managed care rate enhancements for nonpublic hospitals and to cover the county's administrative expenses associated with activities under the bill.

Waiver or Authorization From a Federal Agency

H.B. 4799 establishes that, if before implementing any provision of the bill a state agency determines that a waiver or authorization from a federal agency is necessary for implementation of that provision, the agency affected by the provision must request the waiver or authorization and may delay implementing that provision until the waiver or authorization is granted.

EFFECTIVE DATE

On passage, or, if the bill does not receive the necessary vote, September 1, 2025.