BILL ANALYSIS

Senate Research Center
88R7196 SRA-F

S.B. 706
By: Miles
Local Government
3/8/2023
As Filed

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

In 2019, legislation was enacted creating Harris County's Local Provider Participation Fund. Under this program, nonpublic hospitals agree to impose an assessment on their total net patient revenues. These funds are matched with federal Medicaid dollars and paid to the hospitals in the jurisdiction to supplement the below-cost Medicaid payment. 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.

S.B. 706 reauthorizes Harris County's Local Provider Participation Fund and makes these changes by revising the program's governing provisions.

As proposed, S.B. 706 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."

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

> Sec. 299.004. EXPIRATION. (a) Provides that the authority of the Harris County Hospital District (district) to administer and operate a program under Chapter 299 (Harris County Hospital District Health Care Provider Participation Program), subject to Section 299.153(d) (relating to authorizing the district to only assess and collect a certain mandatory payment if a waiver program, uniform rate enhancement, or reimbursement is available to the district), expires December 31, 2025, rather than December 31, 2023.
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> (b) Provides that this chapter expires December 31, 2025, rather than December 31, 2023.

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:
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> (1) the provider's Medicare cost report for the most recent fiscal year for which the provider submitted the Medicare cost report, rather than submitted for the previous fiscal year or for the closest subsequent fiscal year; 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 Subchapter B, Chapter 299, Health and Safety Code, by adding Sections 299.054 and 299.055, as follows:

Sec. 299.054. REQUEST FOR CERTAIN RELIEF. (a) Authorizes the board to request that the Health and Human Services Commission submit a request to the Centers for Medicare and Medicaid Services for relief under 42 C.F.R. Section 433.72 for purposes of assuring the program is administered efficiently, transparently, and in a manner that complies with federal law.

(b) Authorizes the board to act in compliance with the terms of the relief if the request for relief under Subsection (a) is granted. Provides that the terms of the relief prevail to the extent of a conflict between the terms of the relief and another law, including a provision of Subtitle D (Hospital Districts) requiring mandatory payments be assessed in a uniform or broad-based manner.

Sec. 299.055. PROHIBITION ON IMPOSITION OF TAXES. Provides that this chapter does not authorize the board to impose a bed tax or any other tax under the laws of this state.

SECTION 5. Amends the heading of 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 to require a mandatory payment 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 a qualifying assessment basis if the board authorizes a health care provider participation program under this chapter. Requires that the qualifying assessment basis be the same for each institutional health care provider in the district. Requires the board to provide an institutional health care provider written notice of each assessment under this section, rather than subsection, and provides that the provider has 30 calendar days following the date of receipt of the notice to pay the assessment.

Deletes existing test authorizing the board to require a mandatory payment to be assessed, either annually or periodically throughout the year at the discretion of the board, on the net patient revenue of each institutional health care provider located in the district if the board authorizes a health care provider participation program under this chapter.

(a-1) Requires that the qualifying assessment basis 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, except as otherwise provided by this subsection. Authorizes the qualifying assessment basis to be determined by the board using information contained in another report the board considers reliable that is submitted by or to the provider for the most recent fiscal year 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. Requires the board to use the same type of report to determine the qualifying assessment basis for each paying provider in the district to the extent practicable.

(a-2) Deletes existing text providing that the mandatory payment is assessed, in the first year in which the mandatory payment is required, 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. Makes a nonsubstantive change.

(b) Requires that the amount of a mandatory payment authorized under this chapter be determined in a manner that ensures the revenue generated qualifies for federal matching funds under federal law, consistent with 42 U.S.C. Section 1396b(w). Deletes existing text requiring that the amount of a mandatory payment authorized under this chapter be uniformly proportionate with the amount of net patient revenue generated by each paying provider in the district as permitted under federal law. Deletes existing text prohibiting 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) Prohibits the aggregate amount of the mandatory payments required of all paying providers in the district from exceeding six percent of the aggregate net patient revenue from hospital services provided in the district, rather than 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. INTEREST AND PENALTIES. Requires the district to impose and collect interest and penalties on delinquent mandatory payments imposed under this chapter in any amount that does not exceed the maximum amount authorized for other payments that are owed to the district and are delinquent.

SECTION 8. Effective date: upon passage or September 1, 2023.