BILL ANALYSIS

C.S.H.B. 1338
By: Coleman
County Affairs
Committee Report (Substituted)

BACKGROUND AND PURPOSE

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. C.S.H.B. 1338 seeks to continue the program and make these changes by revising the program's governing provisions.

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. 1338 amends the Health and Safety Code to change the basis on which the board of hospital managers of the Harris County Hospital District may assess a mandatory payment against an institutional health care provider under the district's health care provider participation program. Rather than making such an assessment on the basis of the provider's net patient revenue, the board instead may assess on a qualifying assessment basis of a health care item, health care service, or other health care-related basis that is consistent with the requirements of specified federal law. The bill makes related changes, including the following:

- requiring the qualifying assessment basis to be the same for each institutional health care provider in the district;
- setting out provisions regarding the determination of the qualifying assessment basis; and
- raising the cap on the aggregate amount of the mandatory payments required of all paying providers in the district from four percent to six percent of the aggregate net patient revenue from hospital services provided by all paying providers in the district.

C.S.H.B. 1338 changes, as follows, the provision requiring the district's board to require that, under the health care provider participation program, each institutional health care provider submit to the district a copy of any financial and utilization data that is reported in the provider's applicable Medicare cost report:

- the board is authorized, rather than required, to require the submission of the financial and utilization data; and
- the provider may submit a copy of its financial and utilization data reported in a report other than the provider's Medicare cost report that:

- the board considers reliable; and
- is submitted by or to the provider for the most recent fiscal year.

C.S.H.B. 1338 specifies that the proportionate amount of certain money that may be refunded to a paying provider from the district's local provider participation fund is an amount that is proportionate to the mandatory payments made by the provider during the 12 months preceding the date of the refund.

C.S.H.B. 1338 authorizes the district's board, if certain federal law is revised or interpreted in a manner that impedes the operations of the district's health care provider participation program and the operations may be improved by a request for relief under specified federal law, to request the Health and Human Services Commission (HHSC) to submit a request to the Centers for Medicare and Medicaid Services for the relief and requires HHSC to submit the request if requested.

C.S.H.B. 1338 postpones the expiration of the district's health care provider participation program from December 31, 2021, to December 31, 2023.

EFFECTIVE DATE

On passage, or, if the bill does not receive the necessary vote, September 1, 2021.

COMPARISON OF ORIGINAL AND SUBSTITUTE

While C.S.H.B. 1338 may differ from the original in minor or nonsubstantive ways, the following summarizes the substantial differences between the introduced and committee substitute versions of the bill.

The substitute does not include revisions that do the following:

- replace the requirement that the amount of a mandatory payment be uniformly proportionate with the amount of net patient revenue generated by each paying provider in the district as permitted under federal law with a requirement that the amount of the mandatory payment be determined in a manner that ensures the revenue generated qualifies for federal matching funds under federal law; and
- remove the prohibition against the district's health care provider participation program holding harmless any institutional health care provider.

The substitute includes language that changes the item with which the amount of a mandatory payment must be uniformly proportionate from an amount that is uniformly proportionate with the net patient revenue generated by each paying provider in the district as permitted under federal law to an amount that is uniformly proportionate with the qualifying assessment basis for each such provider as so permitted.

The substitute includes a provision authorizing the district's board, if certain federal law is revised or interpreted in a manner that impedes the operations of the district's health care provider participation program and the operations may be improved by a request for relief under specified federal law, to request HHSC to submit a request to the Centers for Medicare and Medicaid Services for the relief and requiring HHSC to submit the request if requested.