By: Nelson S.B. No. 7

Substitute the following for S.B. No. 7:

By: McReynolds C.S.S.B. No. 7

A BILL TO BE ENTITLED

AN ACT

relating to strategies for and improvements in quality of health care and care management provided through health care facilities and through the child health plan and medical assistance programs designed to improve health outcomes.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. CHILD HEALTH PLAN AND MEDICAID PILOT PROGRAMS. Subchapter B, Chapter 531, Government Code, is amended by adding Sections 531.0993 and 531.0994 to read as follows:

Sec. 531.0993. OBESITY PREVENTION PILOT PROGRAM. (a) The commission and the Department of State Health Services shall coordinate to establish a pilot program designed to:

(1) decrease the rate of obesity in child health plan program enrollees and Medicaid recipients;

(2) improve the nutritional choices and increase physical activity levels of child health plan program enrollees and Medicaid recipients; and

(3) achieve long-term reductions in child health plan and Medicaid program costs incurred by the state as a result of obesity.

(b) The commission and the Department of State Health Services shall implement the pilot program for a period of at least 24 months in one or more health care service regions in this state, as selected by the commission. In selecting the regions for

participation, the commission shall consider the degree to which child health plan program enrollees and Medicaid recipients in the region are at higher than average risk of obesity.

(c) In developing the pilot program, the commission and the Department of State Health Services in consultation with the Health Care Quality Advisory Committee established under Section 531.0995 shall identify measurable goals and specific strategies for achieving those goals. The specific strategies may be evidence-based to the extent evidence-based strategies are available for the purposes of the program.

(d) The commission shall submit a report on or before each November 1 that occurs during the period the pilot program is operated to the standing committees of the senate and house of representatives having primary jurisdiction over the child health plan and Medicaid programs regarding the results of the program. In addition, the commission shall submit a final report to the committees regarding those results not later than three months after the conclusion of the program. Each report must include:

(1) a summary of the identified goals for the program and the strategies used to achieve those goals;

(2) an analysis of all data collected in the program as of the end of the period covered by the report and the capability of the data to measure achievement of the identified goals;

(3) a recommendation regarding the continued operation of the program; and

(4) a recommendation regarding whether the program should be implemented statewide.

(e) The executive commissioner may adopt rules to implement this section.

Sec. 531.0994. MEDICAL HOME FOR CHILD HEALTH PLAN PROGRAM ENROLLEES AND MEDICAID RECIPIENTS. (a) In this section, "medical home" means a primary care provider who provides preventive and primary care to a patient on an ongoing basis and coordinates with specialists when health care services provided by a specialist are needed.

(b) The commission shall establish and operate for a period of at least 24 months a pilot program in one or more health care service regions in this state designed to establish a medical home for each child health plan program enrollee and Medicaid recipient participating in the pilot program. A primary care provider participating in the program may designate a care coordinator to support the medical home concept.

(c) The commission shall develop in consultation with the Health Care Quality Advisory Committee established under Section 531.0995 the pilot program in a manner that:

(1) bases payments made, or incentives provided, to a participant's medical home on factors that include measurable wellness and prevention criteria, use of best practices, and outcomes; and

(2) allows for the examination of measurable wellness and prevention criteria, use of best practices, and outcomes based on type of primary care provider.

(d) The commission shall submit a report on or before each January 1 that occurs during the period the pilot program is

operated to the standing committees of the senate and house of representatives having primary jurisdiction over the child health plan and Medicaid programs regarding the status of the pilot program. Each report must include:

(1) preliminary recommendations regarding the continued operation of the program or whether the program should be implemented statewide; or

(2) if the commission cannot make the recommendations described by Subdivision (1) due to an insufficient amount of data having been collected at the time of the report, statements regarding the time frames within which the commission anticipates collecting sufficient data and making those recommendations.

(e) The commission shall submit a final report to the committees specified by Subsection (d) regarding the results of the pilot program not later than three months after the conclusion of the program. The final report must include:

(1) an analysis of all data collected in the program; and

(2) a final recommendation regarding whether the program should be implemented statewide.

SECTION 2. HEALTH CARE QUALITY ADVISORY COMMITTEE. (a) Subchapter B, Chapter 531, Government Code, is amended by adding Section 531.0995 to read as follows:

Sec. 531.0995. HEALTH CARE QUALITY ADVISORY COMMITTEE. (a) The commission shall establish the Health Care Quality Advisory Committee to assist the commission as specified by Subsection (e) with defining best practices and quality performance

with respect to health care services and setting standards for quality performance by health care providers and facilities for purposes of programs administered by the commission or a health and human services agency.

(b) The executive commissioner shall appoint the members of the advisory committee. The committee must consist of:

(1) the following types of health care providers:

(A) a physician from an urban area who has clinical practice expertise and who may be a pediatrician;

(B) a physician from a rural area who has clinical practice expertise and who may be a pediatrician; and

(C) a nurse practitioner;

(2) a representative of each of the following types of health care facilities:

(A) a general acute care hospital; and

(B) a children's hospital;

(3) a representative from a care management organization;

(4) a member of the Advisory Panel on Health Care-Associated Infections and Preventable Adverse Events who meets the qualifications prescribed by Section 98.052(a)(4), Health and Safety Code; and

(5) a representative of health care consumers.

(c) The credentials of a single member of the advisory committee may satisfy more than one of the criteria required of the advisory committee members under Subsection (b).

(d) The executive commissioner shall appoint the presiding

officer of the advisory committee.

(e) The advisory committee shall advise the commission on:

(1) measurable goals for the obesity prevention pilot program under Section 531.0993;

(2) measurable wellness and prevention criteria and best practices for the medical home pilot program under Section 531.0994;

(3) quality of care standards, evidence-based protocols, and measurable goals for quality-based payment initiatives pilot programs implemented under Subchapter W; and

(4) any other quality of care standards, evidence-based protocols, measurable goals, or other related issues with respect to which a law or the executive commissioner specifies that the committee shall advise.

(b) The executive commissioner of the Health and Human Services Commission shall appoint the members of the Health Care Quality Advisory Committee not later than November 1, 2009.

SECTION 3. UNCOMPENSATED HOSPITAL CARE DATA. (a) The heading to Section 531.551, Government Code, is amended to read as follows:

Sec. 531.551. UNCOMPENSATED HOSPITAL CARE REPORTING AND ANALYSIS; HOSPITAL AUDIT FEE.

(b) Section 531.551, Government Code, is amended by amending Subsections (a) and (d) and adding Subsections (a-1), (a-2), and (m) to read as follows:

(a) Using data submitted to the Department of State Health Services under Subsection (a-1), the [~~The~~] executive commissioner

shall adopt rules providing for:

(1) a standard definition of "uncompensated hospital care" that reflects unpaid costs incurred by hospitals and accounts for actual hospital costs and hospital charges and revenue sources;

(2) a methodology to be used by hospitals in this state to compute the cost of that care that incorporates the standard set of adjustments described by Section 531.552(g)(4); and

(3) procedures to be used by those hospitals to report the cost of that care to the commission and to analyze that cost.

(a-1) To assist the executive commissioner in adopting and amending the rules required by Subsection (a), the Department of State Health Services shall require each hospital in this state to provide to the department, not later than a date specified by the department, uncompensated hospital care data prescribed by the commission. Each hospital must submit complete and adequate data, as determined by the department, not later than the specified date.

(a-2) The Department of State Health Services shall notify the commission of each hospital in this state that fails to submit complete and adequate data required by the department under Subsection (a-1) on or before the date specified by the department. Notwithstanding any other law and to the extent allowed by federal law, the commission may withhold Medicaid program reimbursements owed to the hospital until the hospital complies with the requirement.

(d) If the commission determines through the procedures adopted under Subsection (b) that a hospital submitted a report described by Subsection (a)(3) with incomplete or inaccurate

information, the commission shall notify the hospital of the specific information the hospital must submit and prescribe a date by which the hospital must provide that information. If the hospital fails to submit the specified information on or before the date prescribed by the commission, the commission shall notify the attorney general of that failure. On receipt of the notice, the attorney general shall impose an administrative penalty on the hospital in an amount not to exceed $10,000. In determining the amount of the penalty to be imposed, the attorney general shall consider:

(1) the seriousness of the violation;

(2) whether the hospital had previously committed a violation; and

(3) the amount necessary to deter the hospital from committing future violations.

(m) The commission may require each hospital that is required under 42 C.F.R. Section 455.304 to be audited to pay a fee to offset the cost of the audit in an amount determined by the commission. The total amount of fees imposed on hospitals as authorized by this subsection may not exceed the total cost incurred by the commission in conducting the required audits of the hospitals.

(c) As soon as possible after the date the Department of State Health Services requires each hospital in this state to initially submit uncompensated hospital care data under Subsection (a-1), Section 531.551, Government Code, as added by this section, the executive commissioner of the Health and Human Services

Commission shall adopt rules or amendments to existing rules that conform to the requirements of Subsection (a), Section 531.551, Government Code, as amended by this section.

SECTION 4. MEDICAL TECHNOLOGY; ELECTRONIC HEALTH INFORMATION EXCHANGE PROGRAM. (a) Chapter 531, Government Code, is amended by adding Subchapter V to read as follows:

SUBCHAPTER V. ELECTRONIC HEALTH INFORMATION EXCHANGE PROGRAM

Sec. 531.901. DEFINITIONS. In this subchapter:

(1) "Electronic health record" means an electronic record of aggregated health-related information concerning a person that conforms to nationally recognized interoperability standards and that can be created, managed, and consulted by authorized health care providers across two or more health care organizations.

(2) "Electronic medical record" means an electronic record of health-related information concerning a person that can be created, gathered, managed, and consulted by authorized clinicians and staff within a single health care organization.

(3) "Health information exchange system" means the electronic health information exchange system created under this subchapter that electronically moves health-related information among entities according to nationally recognized standards.

(4) "Local or regional health information exchange" means a health information exchange operating in this state that securely exchanges electronic health information, including information for patients receiving services under the child health plan or Medicaid program, among hospitals, clinics, physicians'

offices, and other health care providers that are not owned by a single entity or included in a single operational unit or network.

Sec. 531.902. ELECTRONIC HEALTH INFORMATION EXCHANGE SYSTEM. (a) The commission shall develop an electronic health information exchange system to improve the quality, safety, and efficiency of health care services provided under the child health plan and Medicaid programs. In developing the system, the commission shall ensure that:

(1) the confidentiality of patients' health information is protected and the privacy of those patients is maintained in accordance with applicable federal and state law, including:

(A) Section 1902(a)(7), Social Security Act (42 U.S.C. Section 1396a(a)(7));

(B) the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191);

(C) Chapter 552, Government Code;

(D) Subchapter G, Chapter 241, Health and Safety Code;

(E) Section 12.003, Human Resources Code; and

(F) federal and state rules and regulations, including:

(i) 42 C.F.R. Part 431, Subpart F; and

(ii) 45 C.F.R. Part 164;

(2) appropriate information technology systems used by the commission and health and human services agencies are interoperable;

(3) the system and external information technology systems are interoperable in receiving and exchanging appropriate electronic health information as necessary to enhance:

(A) the comprehensive nature of the information contained in electronic health records; and

(B) health care provider efficiency by supporting integration of the information into the electronic health record used by health care providers;

(4) the system and other health information systems not described by Subdivision (3) and data warehousing initiatives are interoperable; and

(5) the system has the elements described by Subsection (b).

(b) The health information exchange system must include the following elements:

(1) an authentication process that uses multiple forms of identity verification before allowing access to information systems and data;

(2) a formal process for establishing data-sharing agreements within the community of participating providers in accordance with the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191) and the American Recovery and Reinvestment Act of 2009 (Pub. L. No. 111-5);

(3) a method by which the commission may open or restrict access to the system during a declared state emergency;

(4) the capability of appropriately and securely sharing health information with state and federal emergency

responders;

(5) compatibility with the Nationwide Health Information Network (NHIN) and other national health information technology initiatives coordinated by the Office of the National Coordinator for Health Information Technology;

(6) an electronic master patient index or similar technology that allows for patient identification across multiple systems; and

(7) the capability of allowing a health care provider to access the system if the provider has technology that meets current national standards.

(c) The commission shall implement the health information exchange system in stages as described by this subchapter, except that the commission may deviate from those stages if technological advances make a deviation advisable or more efficient.

(d) The health information exchange system must be developed in accordance with the Medicaid Information Technology Architecture (MITA) initiative of the Center for Medicaid and State Operations and conform to other standards required under federal law.

Sec. 531.903. ELECTRONIC HEALTH INFORMATION EXCHANGE SYSTEM ADVISORY COMMITTEE. (a) The commission shall establish the Electronic Health Information Exchange System Advisory Committee to assist the commission in the performance of the commission's duties under this subchapter.

(b) The executive commissioner shall appoint to the advisory committee at least 12 and not more than 16 members who have

an interest in health information technology and who have experience in serving persons receiving health care through the child health plan and Medicaid programs.

(c) The advisory committee must include the following members:

(1) Medicaid providers;

(2) child health plan program providers;

(3) fee-for-service providers;

(4) at least one representative of the Texas Health Services Authority established under Chapter 182, Health and Safety Code;

(5) at least one representative of each health and human services agency;

(6) at least one representative of a major provider association;

(7) at least one representative of a health care facility;

(8) at least one representative of a managed care organization;

(9) at least one representative of the pharmaceutical industry;

(10) at least one representative of Medicaid recipients and child health plan enrollees;

(11) at least one representative of a local or regional health information exchange; and

(12) at least one representative who is skilled in pediatric medical informatics.

(d) The members of the advisory committee must represent the geographic and cultural diversity of the state.

(e) The executive commissioner shall appoint the presiding officer of the advisory committee.

(f) The advisory committee shall advise the commission on issues regarding the development and implementation of the electronic health information exchange system, including any issue specified by the commission and the following specific issues:

(1) data to be included in an electronic health record;

(2) presentation of data;

(3) useful measures for quality of service and patient health outcomes;

(4) federal and state laws regarding privacy and management of private patient information;

(5) incentives for increasing health care provider adoption and usage of an electronic health record and the health information exchange system; and

(6) data exchange with local or regional health information exchanges to enhance:

(A) the comprehensive nature of the information contained in electronic health records; and

(B) health care provider efficiency by supporting integration of the information into the electronic health record used by health care providers.

(g) The advisory committee shall collaborate with the Texas Health Services Authority to ensure that the health information

exchange system is interoperable with, and not an impediment to, the electronic health information infrastructure that the authority assists in developing.

Sec. 531.904. STAGE ONE: ELECTRONIC HEALTH RECORD. (a) In stage one of implementing the health information exchange system, the commission shall develop and establish an electronic health record for each person who receives medical assistance under the Medicaid program. The electronic health record must be available through a browser-based format.

(b) The commission shall consult and collaborate with, and accept recommendations from, physicians and other stakeholders to ensure that electronic health records established under this section support health information exchange with electronic medical records systems in use by physicians in the public and private sectors in a manner that:

(1) allows those physicians to exclusively use their own electronic medical records systems; and

(2) does not require the purchase of a new electronic medical records system.

(c) The executive commissioner shall adopt rules specifying the information required to be included in the electronic health record. The required information may include, as appropriate:

(1) the name and address of each of the person's health care providers;

(2) a record of each visit to a health care provider, including diagnoses, procedures performed, and laboratory test results;

(3) an immunization record;

(4) a prescription history;

(5) a list of due and overdue Texas Health Steps medical and dental checkup appointments; and

(6) any other available health history that health care providers who provide care for the person determine is important.

(d) Information under Subsection (c) may be added to any existing electronic health record or health information technology and may be exchanged with local and regional health information exchanges.

(e) The commission shall make an electronic health record for a patient available to the patient through the Internet.

Sec. 531.9041. STAGE ONE: ENCOUNTER DATA. In stage one of implementing the health information exchange system, the commission shall require for purposes of the implementation each managed care organization with which the commission contracts under Chapter 533 for the provision of Medicaid managed care services or Chapter 62, Health and Safety Code, for the provision of child health plan program services to submit to the commission complete and accurate encounter data not later than the 30th day after the last day of the month in which the managed care organization adjudicated the claim.

Sec. 531.905. STAGE ONE: ELECTRONIC PRESCRIBING. (a) In stage one of implementing the health information exchange system, the commission shall support and coordinate electronic prescribing tools used by health care providers and health care facilities

under the child health plan and Medicaid programs.

(b) The commission shall consult and collaborate with, and accept recommendations from, physicians and other stakeholders to ensure that the electronic prescribing tools described by Subsection (a):

(1) are integrated with existing electronic prescribing systems otherwise in use in the public and private sectors; and

(2) to the extent feasible:

(A) provide current payer formulary information at the time a health care provider writes a prescription; and

(B) support the electronic transmission of a prescription.

(c) The commission may take any reasonable action to comply with this section, including establishing information exchanges with national electronic prescribing networks or providing health care providers with access to an Internet-based prescribing tool developed by the commission.

(d) The commission shall apply for and actively pursue any waiver to the child health plan program or the state Medicaid plan from the federal Centers for Medicare and Medicaid Services or any other federal agency as necessary to remove an identified impediment to supporting and implementing electronic prescribing tools under this section, including the requirement for handwritten certification of certain drugs under 42 C.F.R. Section 447.512. If the commission with assistance from the Legislative Budget Board determines that the implementation of operational modifications in

accordance with a waiver obtained as required by this subsection has resulted in cost increases in the child health plan or Medicaid program, the commission shall take the necessary actions to reverse the operational modifications.

Sec. 531.906. STAGE TWO: EXPANSION. (a) Based on the recommendations of the advisory committee established under Section 531.903 and feedback provided by interested parties, the commission in stage two of implementing the health information exchange system may expand the system by:

(1) providing an electronic health record for each child enrolled in the child health plan program;

(2) including state laboratory results information in an electronic health record, including the results of newborn screenings and tests conducted under the Texas Health Steps program, based on the system developed for the health passport under Section 266.006, Family Code;

(3) improving data-gathering capabilities for an electronic health record so that the record may include basic health and clinical information in addition to available claims information, as determined by the executive commissioner;

(4) using evidence-based technology tools to create a unique health profile to alert health care providers regarding the need for additional care, education, counseling, or health management activities for specific patients; and

(5) continuing to enhance the electronic health record created under Section 531.904 as technology becomes available and interoperability capabilities improve.

(b) In expanding the system, the commission shall consult and collaborate with, and accept recommendations from, physicians and other stakeholders to ensure that electronic health records provided under this section support health information exchange with electronic medical records systems in use by physicians in the public and private sectors in a manner that:

(1) allows those physicians to exclusively use their own electronic medical records systems; and

(2) does not require the purchase of a new electronic medical records system.

Sec. 531.907. STAGE THREE: EXPANSION. In stage three of implementing the health information exchange system, the commission may expand the system by:

(1) developing evidence-based benchmarking tools that can be used by health care providers to evaluate their own performances on health care outcomes and overall quality of care as compared to aggregated performance data regarding peers; and

(2) expanding the system to include state agencies, additional health care providers, laboratories, diagnostic facilities, hospitals, and medical offices.

Sec. 531.908. INCENTIVES. The commission and the advisory committee established under Section 531.903 shall develop strategies to encourage health care providers to use the health information exchange system, including incentives, education, and outreach tools to increase usage.

Sec. 531.909. REPORTS. (a) The commission shall provide an initial report to the Senate Committee on Health and Human

Services or its successor, the House Committee on Human Services or its successor, and the House Committee on Public Health or its successor regarding the health information exchange system not later than January 1, 2011, and shall provide a subsequent report to those committees not later than January 1, 2013. Each report must:

(1) describe the status of the implementation of the system;

(2) specify utilization rates for each health information technology implemented as a component of the system; and

(3) identify goals for utilization rates described by Subdivision (2) and actions the commission intends to take to increase utilization rates.

(b) This section expires September 2, 2013.

Sec. 531.910. RULES. The executive commissioner may adopt rules to implement this subchapter.

(b) Subchapter B, Chapter 62, Health and Safety Code, is amended by adding Section 62.060 to read as follows:

Sec. 62.060. HEALTH INFORMATION TECHNOLOGY STANDARDS. (a) In this section, "health information technology" means information technology used to improve the quality, safety, or efficiency of clinical practice, including the core functionalities of an electronic health record, an electronic medical record, a computerized health care provider order entry, electronic prescribing, and clinical decision support technology.

(b) The commission shall ensure that any health information technology used by the commission or any entity acting on behalf of

the commission in the child health plan program conforms to standards required under federal law.

(c) Subchapter B, Chapter 32, Human Resources Code, is amended by adding Section 32.073 to read as follows:

Sec. 32.073. HEALTH INFORMATION TECHNOLOGY STANDARDS. (a) In this section, "health information technology" means information technology used to improve the quality, safety, or efficiency of clinical practice, including the core functionalities of an electronic health record, an electronic medical record, a computerized health care provider order entry, electronic prescribing, and clinical decision support technology.

(b) The Health and Human Services Commission shall ensure that any health information technology used by the commission or any entity acting on behalf of the commission in the medical assistance program conforms to standards required under federal law.

(d) As soon as practicable after the effective date of this Act, the executive commissioner of the Health and Human Services Commission shall adopt rules to implement the electronic health record and electronic prescribing system required by Subchapter V, Chapter 531, Government Code, as added by this section.

(e) The executive commissioner of the Health and Human Services Commission shall appoint the members of the Electronic Health Information Exchange System Advisory Committee established under Section 531.903, Government Code, as added by this section, as soon as practicable after the effective date of this Act.

SECTION 5. QUALITY-BASED PAYMENT INITIATIVES.

(a) Chapter 531, Government Code, is amended by adding Subchapter W to read as follows:

SUBCHAPTER W. QUALITY-BASED PAYMENT INITIATIVES PILOT PROGRAMS FOR PROVISION OF HEALTH CARE SERVICES

Sec. 531.951. DEFINITIONS. In this subchapter:

(1) "Pay-for-performance payment system" means a system for compensating a health care provider or facility for arranging for or providing health care services to child health plan program enrollees or Medicaid recipients, or both, that is based on the provider or facility meeting or exceeding certain defined performance measures. The compensation system may include sharing realized cost savings with the provider or facility.

(2) "Pilot program" means a quality-based payment initiatives pilot program established under this subchapter.

Sec. 531.952. PILOT PROGRAM PROPOSALS; DETERMINATION OF BENEFIT TO STATE. (a) Health care providers and facilities and disease or care management organizations may submit proposals to the commission for the implementation through pilot programs of quality-based payment initiatives that provide incentives to the providers and facilities, as applicable, to develop health care interventions for child health plan program enrollees or Medicaid recipients, or both, that are cost-effective to this state and will improve the quality of health care provided to the enrollees or recipients.

(b) The commission shall determine whether it is feasible and cost-effective to implement one or more of the proposed pilot programs. In addition, the commission shall examine alternative

payment methodologies used in the Medicare program and consider whether implementing one or more of the methodologies, modified as necessary to account for programmatic differences, through a pilot program under this subchapter would achieve cost savings in the Medicaid program while ensuring the use of best practices.

Sec. 531.953. PURPOSE AND IMPLEMENTATION OF PILOT PROGRAMS. (a) If the commission determines under Section 531.952 that implementation of one or more quality-based payment initiatives pilot programs is feasible and cost-effective for this state, the commission shall establish one or more programs as provided by this subchapter to test pay-for-performance payment system alternatives to traditional fee-for-service or other payments made to health care providers or facilities participating in the child health plan or Medicaid program, as applicable, that are based on best practices, outcomes, and efficiency, but ensure high-quality, effective health care services.

(b) The commission shall administer any pilot program established under this subchapter. The executive commissioner may adopt rules, plans, and procedures and enter into contracts and other agreements as the executive commissioner considers appropriate and necessary to administer this subchapter.

(c) The commission may limit a pilot program to:

(1) one or more regions in this state;

(2) one or more organized networks of health care facilities and providers; or

(3) specified types of services provided under the child health plan or Medicaid program, or specified types of

enrollees or recipients under those programs.

(d) A pilot program implemented under this subchapter must be operated for at least one state fiscal year.

Sec. 531.954. STANDARDS; PROTOCOLS. (a) In consultation with the Health Care Quality Advisory Committee established under Section 531.0995, the executive commissioner shall approve quality of care standards, evidence-based protocols, and measurable goals for a pilot program to ensure high-quality and effective health care services.

(b) In addition to the standards approved under Subsection (a), the executive commissioner may approve efficiency performance standards that may include the sharing of realized cost savings with health care providers and facilities that provide health care services that exceed the efficiency performance standards. The efficiency performance standards may not create any financial incentive for or involve making a payment to a health care provider that directly or indirectly induces the limitation of medically necessary services.

Sec. 531.955. QUALITY-BASED PAYMENT INITIATIVES. (a) The executive commissioner may contract with appropriate entities, including qualified actuaries, to assist in determining appropriate payment rates for a pilot program implemented under this subchapter.

(b) The executive commissioner may increase a payment rate, including a capitation rate, adopted under this section as necessary to adjust the rate for inflation.

(c) The executive commissioner shall ensure that services

provided to a child health plan program enrollee or Medicaid recipient, as applicable, meet the quality of care standards required under this subchapter and are at least equivalent to the services provided under the child health plan or Medicaid program, as applicable, for which the enrollee or recipient is eligible.

Sec. 531.956. TERMINATION OF PILOT PROGRAM; EXPIRATION OF SUBCHAPTER. The pilot program terminates and this subchapter expires September 2, 2013.

(b) Not later than November 1, 2012, the Health and Human Services Commission shall present a report to the governor, the lieutenant governor, the speaker of the house of representatives, and the members of each legislative committee having jurisdiction over the child health plan and Medicaid programs. For each pilot program implemented under Subchapter W, Chapter 531, Government Code, as added by this section, the report must:

(1) describe the operation of the pilot program;

(2) analyze the quality of health care provided to patients under the pilot program;

(3) compare the per-patient cost under the pilot program to the per-patient cost of the traditional fee-for-service or other payments made under the child health plan and Medicaid programs; and

(4) make recommendations regarding the continuation or expansion of the pilot program.

SECTION 6. QUALITY-BASED HOSPITAL PAYMENTS. Chapter 531, Government Code, is amended by adding Subchapter X to read as follows:

SUBCHAPTER X. QUALITY-BASED HOSPITAL REIMBURSEMENT SYSTEM

Sec. 531.981. DEFINITIONS. In this subchapter:

(1) "DRG methodology" means a diagnoses-related groups methodology.

(2) "Potentially preventable complication" means a harmful event or negative outcome with respect to a person, including an infection or surgical complication, that:

(A) occurs after the person's admission to a hospital;

(B) results from the care or treatment provided during the hospital stay rather than from a natural progression of an underlying disease; and

(C) could reasonably have been prevented if care and treatment had been provided in accordance with accepted standards of care.

(3) "Potentially preventable readmission" means a return hospitalization of a person within a period specified by the commission that results from deficiencies in the care or treatment provided to the person during a previous hospital stay or from deficiencies in post-hospital discharge follow-up. The term does not include a hospital readmission necessitated by the occurrence of unrelated events after the discharge. The term includes the readmission of a person to a hospital for:

(A) the same condition or procedure for which the person was previously admitted;

(B) an infection or other complication resulting from care previously provided;

(C) a condition or procedure that indicates that a surgical intervention performed during a previous admission was unsuccessful in achieving the anticipated outcome; or

(D) another condition or procedure of a similar nature, as determined by the executive commissioner.

Sec. 531.982. DEVELOPMENT OF QUALITY-BASED HOSPITAL REIMBURSEMENT SYSTEM. (a) Subject to Subsection (b), the commission shall develop a quality-based hospital reimbursement system for paying Medicaid reimbursements to hospitals. The system is intended to align Medicaid provider payment incentives with improved quality of care, promote coordination of health care, and reduce potentially preventable complications and readmissions.

(b) The commission shall develop the quality-based hospital reimbursement system in phases as provided by this subchapter. To the extent possible, the commission shall coordinate the timeline for the development and implementation with the implementation of the Medicaid Information Technology Architecture (MITA) initiative of the Center for Medicaid and State Operations and the ICD-10 code sets initiative and with the ongoing Enterprise Data Warehouse (EDW) planning process to maximize receipt of federal funds.

Sec. 531.983. PHASE ONE: COLLECTION AND REPORTING OF CERTAIN INFORMATION. (a) The first phase of the development of the quality-based hospital reimbursement system consists of the elements described by this section.

(b) The executive commissioner shall adopt rules for identifying potentially preventable readmissions of Medicaid recipients and the commission shall collect data on

present-on-admission indicators for purposes of this section.

(c) The commission shall establish a program to provide a confidential report to each hospital in this state regarding the hospital's performance with respect to potentially preventable readmissions. A hospital shall provide the information contained in the report provided to the hospital to health care providers providing services at the hospital.

(d) After the commission provides the reports to hospitals as provided by Subsection (c), each hospital will be afforded a period of two years during which the hospital may adjust its practices in an attempt to reduce its potentially preventable readmissions. During this period, reimbursements paid to the hospital may not be adjusted on the basis of potentially preventable readmissions.

(e) The commission shall convert hospitals that are reimbursed using a DRG methodology to a DRG methodology that will allow the commission to more accurately classify specific patient populations and account for severity of patient illness and mortality risk. For purposes of hospitals that are not reimbursed using a DRG methodology, the commission may modify data collection requirements to allow the commission to more accurately classify specific patient populations and account for severity of patient illness and mortality risk.

Sec. 531.984. PHASE TWO: REIMBURSEMENT ADJUSTMENTS. (a) The second phase of the development of the quality-based hospital reimbursement system consists of the elements described by this section and must be based on the information reported, data

collected, and DRG methodology implemented during phase one of the development.

(b) Using the information reported by hospitals that are not reimbursed using a DRG methodology during phase one of the development of the quality-based hospital reimbursement system, and using the DRG methodology for hospitals that are reimbursed using the DRG methodology implemented during that phase, the commission shall adjust Medicaid reimbursements to hospitals based on performance in reducing potentially preventable readmissions. An adjustment:

(1) may not be applied to a hospital if the patient's readmission to that hospital is classified as a potentially preventable readmission, but that hospital is not the same hospital to which the person was previously admitted; and

(2) must be focused on addressing potentially preventable readmissions that are continuing, significant problems, as determined by the commission.

Sec. 531.985. PHASE THREE: STUDY OF POTENTIALLY PREVENTABLE COMPLICATIONS. (a) In phase three of the development of the quality-based hospital reimbursement system, the executive commissioner shall adopt rules for identifying potentially preventable complications and the commission shall study the feasibility of:

(1) collecting data from hospitals concerning potentially preventable complications;

(2) adjusting Medicaid reimbursements based on performance in reducing those complications; and

(3) developing reconsideration review processes that provide basic due process in challenging a reimbursement adjustment described by Subdivision (2).

(b) The commission shall provide a report to the standing committees of the senate and house of representatives having primary jurisdiction over the Medicaid program concerning the results of the study conducted under this section when the study is completed.

(c) Rules adopted by the executive commissioner regarding potentially preventable complications are not admissible in a civil action for purposes of establishing a standard of care applicable to a physician.

SECTION 7. REQUIREMENTS OF THIRD-PARTY HEALTH INSURERS. Subchapter B, Chapter 32, Human Resources Code, is amended by adding Section 32.0424 to read as follows:

Sec. 32.0424. REQUIREMENTS OF THIRD-PARTY HEALTH INSURERS. (a) A third-party health insurer is required to provide to the department, on the department's request, information in a form prescribed by the department necessary to determine:

(1) the period during which an individual entitled to medical assistance, the individual's spouse, or the individual's dependents may be, or may have been, covered by coverage issued by the health insurer;

(2) the nature of the coverage; and

(3) the name, address, and identifying number of the health plan under which the person may be, or may have been, covered.

(b) A third-party health insurer shall accept the state's right of recovery and the assignment under Section 32.033 to the state of any right of an individual or other entity to payment from the third-party health insurer for an item or service for which payment was made under the medical assistance program.

(c) A third-party health insurer shall respond to any inquiry by the department regarding a claim for payment for any health care item or service reimbursed by the department under the medical assistance program not later than the third anniversary of the date the health care item or service was provided.

(d) A third-party health insurer may not deny a claim submitted by the department or the department's designee for which payment was made under the medical assistance program solely on the basis of the date of submission of the claim, the type or format of the claim form, or a failure to present proper documentation at the point of service that is the basis of the claim, if:

(1) the claim is submitted by the department or the department's designee not later than the third anniversary of the date the item or service was provided; and

(2) any action by the department or the department's designee to enforce the state's rights with respect to the claim is commenced not later than the sixth anniversary of the date the department or the department's designee submits the claim.

(e) This section does not limit the scope or amount of information required by Section 32.042.

SECTION 8. PREVENTABLE ADVERSE EVENT REPORTING. (a) The heading to Chapter 98, Health and Safety Code, as added by Chapter

359 (S.B. 288), Acts of the 80th Legislature, Regular Session, 2007, is amended to read as follows:

CHAPTER 98. REPORTING OF HEALTH CARE-ASSOCIATED INFECTIONS AND PREVENTABLE ADVERSE EVENTS

(b) Subdivisions (1) and (11), Section 98.001, Health and Safety Code, as added by Chapter 359 (S.B. 288), Acts of the 80th Legislature, Regular Session, 2007, are amended to read as follows:

(1) "Advisory panel" means the Advisory Panel on Health Care-Associated Infections and Preventable Adverse Events.

(11) "Reporting system" means the Texas Health Care-Associated Infection and Preventable Adverse Events Reporting System.

(c) Section 98.051, Health and Safety Code, as added by Chapter 359 (S.B. 288), Acts of the 80th Legislature, Regular Session, 2007, is amended to read as follows:

Sec. 98.051. ESTABLISHMENT. The commissioner shall establish the Advisory Panel on Health Care-Associated Infections and Preventable Adverse Events within [~~the infectious disease surveillance and epidemiology branch of~~] the department to guide the implementation, development, maintenance, and evaluation of the reporting system. The commissioner may establish one or more subcommittees to assist the advisory panel in addressing health care-associated infections and preventable adverse events relating to hospital care provided to children or other special patient populations.

(d) Subsection (a), Section 98.052, Health and Safety Code, as added by Chapter 359 (S.B. 288), Acts of the 80th Legislature,

Regular Session, 2007, is amended to read as follows:

(a) The advisory panel is composed of 18 [~~16~~] members as follows:

(1) two infection control professionals who:

(A) are certified by the Certification Board of Infection Control and Epidemiology; and

(B) are practicing in hospitals in this state, at least one of which must be a rural hospital;

(2) two infection control professionals who:

(A) are certified by the Certification Board of Infection Control and Epidemiology; and

(B) are nurses licensed to engage in professional nursing under Chapter 301, Occupations Code;

(3) three board-certified or board-eligible physicians who:

(A) are licensed to practice medicine in this state under Chapter 155, Occupations Code, at least two of whom have active medical staff privileges at a hospital in this state and at least one of whom is a pediatric infectious disease physician with expertise and experience in pediatric health care epidemiology;

(B) are active members of the Society for Healthcare Epidemiology of America; and

(C) have demonstrated expertise in quality assessment and performance improvement or infection control in health care facilities;

(4) four additional [~~two~~] professionals in quality assessment and performance improvement[~~, one of whom is employed by~~

~~a general hospital and one of whom is employed by an ambulatory surgical center~~];

(5) one officer of a general hospital;

(6) one officer of an ambulatory surgical center;

(7) three nonvoting members who are department employees representing the department in epidemiology and the licensing of hospitals or ambulatory surgical centers; and

(8) two members who represent the public as consumers.

(e) Subsections (a) and (c), Section 98.102, Health and Safety Code, as added by Chapter 359 (S.B. 288), Acts of the 80th Legislature, Regular Session, 2007, are amended to read as follows:

(a) The department shall establish the Texas Health Care-Associated Infection and Preventable Adverse Events Reporting System within the [~~infectious disease surveillance and epidemiology branch of the~~] department. The purpose of the reporting system is to provide for:

(1) the reporting of health care-associated infections by health care facilities to the department;

(2) the reporting of health care-associated preventable adverse events by health care facilities to the department;

(3) the public reporting of information regarding the health care-associated infections by the department;

(4) the public reporting of information regarding health care-associated preventable adverse events by the department; and

(5) [~~(3)~~] the education and training of health care

facility staff by the department regarding this chapter.

(c) The data reported by health care facilities to the department must contain sufficient patient identifying information to:

(1) avoid duplicate submission of records;

(2) allow the department to verify the accuracy and completeness of the data reported; and

(3) for data reported under Section 98.103 or 98.104, allow the department to risk adjust the facilities' infection rates.

(f) Subchapter C, Chapter 98, Health and Safety Code, as added by Chapter 359 (S.B. 288), Acts of the 80th Legislature, Regular Session, 2007, is amended by adding Section 98.1045 to read as follows:

Sec. 98.1045. REPORTING OF PREVENTABLE ADVERSE EVENTS. (a) Each health care facility shall report to the department the occurrence of any of the following preventable adverse events involving the facility's patient:

(1) a health care-associated adverse condition or event for which the Medicare program will not provide additional payment to the facility under a policy adopted by the federal Centers for Medicare and Medicaid Services; and

(2) subject to Subsection (b), an event included in the list of adverse events identified by the National Quality Forum that is not included under Subdivision (1).

(b) The executive commissioner may exclude an adverse event described by Subsection (a)(2) from the reporting requirement of

Subsection (a) if the executive commissioner, in consultation with the advisory panel, determines that the adverse event is not an appropriate indicator of a preventable adverse event.

(g) Subsections (a), (b), and (g), Section 98.106, Health and Safety Code, as added by Chapter 359 (S.B. 288), Acts of the 80th Legislature, Regular Session, 2007, are amended to read as follows:

(a) The department shall compile and make available to the public a summary, by health care facility, of:

(1) the infections reported by facilities under Sections 98.103 and 98.104; and

(2) the preventable adverse events reported by facilities under Section 98.1045.

(b) Information included in the [~~The~~] departmental summary with respect to infections reported by facilities under Sections 98.103 and 98.104 must be risk adjusted and include a comparison of the risk-adjusted infection rates for each health care facility in this state that is required to submit a report under Sections 98.103 and 98.104.

(g) The department shall make the departmental summary available on an Internet website administered by the department and may make the summary available through other formats accessible to the public. The website must contain a statement informing the public of the option to report suspected health care-associated infections and preventable adverse events to the department.

(h) Section 98.108, Health and Safety Code, as added by Chapter 359 (S.B. 288), Acts of the 80th Legislature, Regular

Session, 2007, is amended to read as follows:

Sec. 98.108. FREQUENCY OF REPORTING. In consultation with the advisory panel, the executive commissioner by rule shall establish the frequency of reporting by health care facilities required under Sections 98.103, [~~and~~] 98.104, and 98.1045. Facilities may not be required to report more frequently than quarterly.

(i) Section 98.109, Health and Safety Code, as added by Chapter 359 (S.B. 288), Acts of the 80th Legislature, Regular Session, 2007, is amended by adding Subsection (b-1) and amending Subsection (e) to read as follows:

(b-1) A state employee or officer may not be examined in a civil, criminal, or special proceeding, or any other proceeding, regarding the existence or contents of information or materials obtained, compiled, or reported by the department under this chapter.

(e) A department summary or disclosure may not contain information identifying a [~~facility~~] patient, employee, contractor, volunteer, consultant, health care professional, student, or trainee in connection with a specific [~~infection~~] incident.

(j) Sections 98.110 and 98.111, Health and Safety Code, as added by Chapter 359 (S.B. 288), Acts of the 80th Legislature, Regular Session, 2007, are amended to read as follows:

Sec. 98.110. DISCLOSURE AMONG CERTAIN AGENCIES [~~WITHIN DEPARTMENT~~]. Notwithstanding any other law, the department may disclose information reported by health care facilities under

Section 98.103, [~~or~~] 98.104, or 98.1045 to other programs within the department, to the Health and Human Services Commission, and to other health and human services agencies, as defined by Section 531.001, Government Code, for public health research or analysis purposes only, provided that the research or analysis relates to health care-associated infections or preventable adverse events. The privilege and confidentiality provisions contained in this chapter apply to such disclosures.

Sec. 98.111. CIVIL ACTION. Published infection rates or preventable adverse events may not be used in a civil action to establish a standard of care applicable to a health care facility.

(k) As soon as possible after the effective date of this Act, the commissioner of state health services shall appoint two additional members to the advisory panel who meet the qualifications prescribed by Subdivision (4), Subsection (a), Section 98.052, Health and Safety Code, as amended by this section.

(l) Not later than February 1, 2010, the executive commissioner of the Health and Human Services Commission shall adopt rules and procedures necessary to implement the reporting of health care-associated preventable adverse events as required under Chapter 98, Health and Safety Code, as amended by this section.

SECTION 9. LONG-TERM CARE INCENTIVES. (a) Subchapter B, Chapter 32, Human Resources Code, is amended by adding Section 32.0283 to read as follows:

Sec. 32.0283. PAY-FOR-PERFORMANCE INCENTIVES FOR CERTAIN NURSING FACILITIES. (a) In this section, "nursing facility" means

a convalescent or nursing home or related institution licensed under Chapter 242, Health and Safety Code, that provides long-term care services, as defined by Section 22.0011, to medical assistance recipients.

(b) If feasible, the executive commissioner of the Health and Human Services Commission by rule shall establish an incentive payment program for nursing facilities that is designed to improve the quality of care and services provided to medical assistance recipients. Subject to Subsection (g), the program must provide additional payments in accordance with this section to the facilities that meet or exceed performance standards established by the executive commissioner.

(c) In establishing an incentive payment program under this section, the executive commissioner of the Health and Human Services Commission shall, subject to Subsection (d), adopt outcome-based performance measures. The performance measures:

(1) must be:

(A) recognized by the executive commissioner as valid indicators of the overall quality of care received by medical assistance recipients; and

(B) designed to encourage and reward evidence-based practices among nursing facilities; and

(2) may include measures of:

(A) quality of life;

(B) direct-care staff retention and turnover;

(C) recipient satisfaction;

(D) employee satisfaction and engagement;

(E) the incidence of preventable acute care emergency room services use;

(F) regulatory compliance;

(G) level of person-centered care; and

(H) level of occupancy or of facility utilization.

(d) The executive commissioner of the Health and Human Services Commission shall:

(1) maximize the use of available information technology and limit the number of performance measures adopted under Subsection (c) to achieve administrative cost efficiency and avoid an unreasonable administrative burden on nursing facilities; and

(2) for each performance measure adopted under Subsection (c), establish a performance threshold for purposes of determining eligibility for an incentive payment under the program.

(e) To be eligible for an incentive payment under the program, a nursing facility must meet or exceed applicable performance thresholds in at least two of the performance measures adopted under Subsection (c), at least one of which is an indicator of quality of care.

(f) The executive commissioner of the Health and Human Services Commission may:

(1) determine the amount of an incentive payment under the program based on a performance index that gives greater weight to performance measures that are shown to be stronger indicators of a nursing facility's overall performance quality; and

(2) enter into a contract with a qualified person, as determined by the executive commissioner, for the following services related to the program:

(A) data collection;

(B) data analysis; and

(C) reporting of nursing facility performance on the performance measures adopted under Subsection (c).

(g) The Health and Human Services Commission may make incentive payments under the program only if money is specifically appropriated for that purpose.

(b) Subsection (a), Section 32.060, Human Resources Code, as added by Section 16.01, Chapter 204 (H.B. 4), Acts of the 78th Legislature, Regular Session, 2003, is amended to read as follows:

(a) The following are not admissible as evidence in a civil action:

(1) any finding by the department that an institution licensed under Chapter 242, Health and Safety Code, has violated a standard for participation in the medical assistance program under this chapter; [~~or~~]

(2) the fact of the assessment of a monetary penalty against an institution under Section 32.021 or the payment of the penalty by an institution; or

(3) any information obtained or used by the department to determine the eligibility of a nursing facility for an incentive payment, or to determine the facility's performance rating, under Section 32.028(g) or 32.0283(f).

(c) The Health and Human Services Commission shall conduct a

study to evaluate the feasibility of providing an incentive payment program for the following types of providers of long-term care services, as defined by Section 22.0011, Human Resources Code, under the medical assistance program similar to the incentive payment program established for nursing facilities under Section 32.0283, Human Resources Code, as added by this section:

(1) intermediate care facilities for persons with mental retardation licensed under Chapter 252, Health and Safety Code; and

(2) providers of home and community-based services, as described by 42 U.S.C. Section 1396n(c), who are licensed or otherwise authorized to provide those services in this state.

(d) Not later than September 1, 2010, the Health and Human Services Commission shall submit to the legislature a written report containing the findings of the study conducted under Subsection (c) of this section and the commission's recommendations.

(e) As soon as practicable after the effective date of this Act, the executive commissioner of the Health and Human Services Commission shall adopt the rules required by Section 32.0283, Human Resources Code, as added by this section.

SECTION 10. PREVENTABLE ADVERSE EVENT REIMBURSEMENT. (a) Subchapter B, Chapter 32, Human Resources Code, is amended by adding Section 32.0312 to read as follows:

Sec. 32.0312. REIMBURSEMENT FOR SERVICES ASSOCIATED WITH PREVENTABLE ADVERSE EVENTS. The executive commissioner of the Health and Human Services Commission shall adopt rules regarding

the denial or reduction of reimbursement under the medical assistance program for preventable adverse events that occur in a hospital setting. In adopting the rules, the executive commissioner:

(1) shall ensure that the commission imposes the same reimbursement denials or reductions for preventable adverse events as the Medicare program imposes for the same types of health care-associated adverse conditions and the same types of health care providers and facilities under a policy adopted by the federal Centers for Medicare and Medicaid Services;

(2) shall consult with the Health Care Quality Advisory Committee established under Section 531.0995, Government Code, to obtain the advice of that committee regarding denial or reduction of reimbursement claims for any other preventable adverse events that cause patient death or serious disability in health care settings, including events on the list of adverse events identified by the National Quality Forum; and

(3) may allow the commission to impose reimbursement denials or reductions for preventable adverse events described by Subdivision (2).

(b) Not later than September 1, 2010, the executive commissioner of the Health and Human Services Commission shall adopt the rules required by Section 32.0312, Human Resources Code, as added by this section.

(c) Rules adopted by the executive commissioner of the Health and Human Services Commission under Section 32.0312, Human Resources Code, as added by this section, may apply only to a

preventable adverse event occurring on or after the effective date of the rules.

SECTION 11. PATIENT RISK IDENTIFICATION SYSTEM. Subchapter A, Chapter 311, Health and Safety Code, is amended by adding Section 311.004 to read as follows:

Sec. 311.004. STANDARDIZED PATIENT RISK IDENTIFICATION SYSTEM. (a) In this section:

(1) "Department" means the Department of State Health Services.

(2) "Hospital" means a general or special hospital as defined by Section 241.003. The term includes a hospital maintained or operated by this state.

(b) The department shall coordinate with hospitals to develop a statewide standardized patient risk identification system under which a patient with a specific medical risk may be readily identified through the use of a system that communicates to hospital personnel the existence of that risk. The executive commissioner of the Health and Human Services Commission shall appoint an ad hoc committee of hospital representatives to assist the department in developing the statewide system.

(c) The department shall require each hospital to implement and enforce the statewide standardized patient risk identification system developed under Subsection (b) unless the department authorizes an exemption for the reason stated in Subsection (d).

(d) The department may exempt from the statewide standardized patient risk identification system a hospital that seeks to adopt another patient risk identification methodology

supported by evidence-based protocols for the practice of medicine.

(e) The department shall modify the statewide standardized patient risk identification system in accordance with evidence-based medicine as necessary.

(f) The executive commissioner of the Health and Human Services Commission may adopt rules to implement this section.

SECTION 12. FEDERAL AUTHORIZATION. If before implementing any provision of this Act 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 shall request the waiver or authorization and may delay implementing that provision until the waiver or authorization is granted.

SECTION 13. NO APPROPRIATION. This Act does not make an appropriation. This Act takes effect only if a specific appropriation for the implementation of the Act is provided in a general appropriations act of the 81st Legislature.

SECTION 14. EFFECTIVE DATE. This Act takes effect September 1, 2009.