BILL ANALYSIS

C.S.S.B. 7
By: Nelson
Public Health
Committee Report (Substituted)

BACKGROUND AND PURPOSE

The goal of C.S.S.B. 7 is to improve the quality, safety, and efficiency of Medicaid and the Children's Health Insurance Program in Texas. The bill achieves such improvements through improving health information technology, quality-based hospital payments, a standardized patient identification system, increased equity in uncompensated hospital care reporting and reimbursement, and the use of pilot programs designed to promote innovation in the delivery of health care. This legislation also ensures that stakeholders participate in an advisory role throughout the implementation process.

C.S.S.B. 7 lays the groundwork for changes in the way the state pays for health care. Currently, hospitals and providers are paid a "fee-for-service" based on the number of treatments, as opposed to the outcome of treatment, which can have the effect of de-incentivizing efficiency and quality. The bill aims to move toward a system that allows health care payments based on quality of care and outcomes, as opposed to quantity of services.

C.S.S.B. 7 relates 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.

RULEMAKING AUTHORITY

It is the committee's opinion that rulemaking authority is expressly granted to the executive commissioner of the Health and Human Services Commission in SECTIONS 1, 3-6 and 8-11 of this bill.

ANALYSIS

Section 531.0055, Government Code, as amended by Chapter 198 (H.B. 2292), Acts of the 78th Legislature, Regular Session, 2003, expressly grants to the executive commissioner of the Health and Human Services Commission all rulemaking authority for the operation of and provision of services by the health and human services agencies. Similarly, Sections 1.16-1.29, Chapter 198 (H.B. 2292), Acts of the 78th Legislature, Regular Session, 2003, provide for the transfer of a power, duty, function, program, or activity from a health and human services agency abolished by that act to the corresponding legacy agency. To the extent practicable, this bill analysis is written to reflect any transfer of rulemaking authority and to update references as necessary to an agency's authority with respect to a particular health and human services program.

Child Health Plan and Medicaid Pilot Programs

C.S.S.B. 7 amends the Government Code to require the Health and Human Services Commission (HHSC) and the Department of State Health Services (DSHS) to coordinate to establish an obesity prevention pilot program designed to decrease the rate of obesity in children's health insurance program enrollees and Medicaid recipients, improve the nutritional choices and increase physical activity levels of those enrollees and recipients, and achieve long-term cost

reductions in those programs incurred by the state as a result of obesity. The bill requires HHSC and DSHS to implement the pilot program for a period of at least 24 months in one or more health care service regions in the state, as selected by HHSC with consideration of the degree to which enrollees and recipients in the region are at higher than average risk of obesity.

C.S.S.B. 7 requires HHSC and DSHS in consultation with the Health Care Quality Advisory Committee, to identify measurable goals and specific strategies for achieving the goals in developing the program. The bill authorizes the specific strategies to be evidence based to the extent evidence-based strategies are available for the purposes of the program. The bill requires HHSC to 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 children's health insurance and Medicaid programs regarding the results of the pilot program. The bill requires HHSC to submit a final report to the committees regarding those results not later than three months after the conclusion of the pilot program, and prescribes contents of each report. The bill authorizes the executive commissioner of HHSC to adopt rules to implement the obesity prevention pilot program.

C.S.S.B. 7 requires HHSC to establish and operate for a period of at least 24 months a pilot program in one or more state health care service regions designed to establish a medical home for each children's health insurance program enrollee and Medicaid recipient participating in the pilot program. The bill authorizes a primary care provider participating in the program to designate a care coordinator to support the medical home concept. The bill requires HHSC, in consultation with the Health Care Quality Advisory Committee, to develop the pilot program in a manner that 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 allows for the examination of measureable wellness and prevention criteria, use of best practices, and outcomes based on type of primary care provider.

C.S.S.B. 7 requires HHSC to submit a report on or before each January 1 that occurs during the period the pilot program is operated regarding the status of the pilot program to the standing committees of the senate and house of representatives having primary jurisdiction over the children's health insurance and Medicaid programs and prescribes the contents of the report. The bill requires HHSC to submit a final report to the committees regarding the results of the pilot program not later than three months after the conclusion of the program, and prescribes contents of the report. The bill defines "medical home."

Health Care Quality Advisory Committee

C.S.S.B. 7 requires HHSC to establish the Health Care Quality Advisory Committee to assist HHSC 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 HHSC or a health and human services agency. The bill requires the executive commissioner of HHSC to appoint the members of the advisory committee, not later than November 1, 2009, and to appoint a presiding officer. The bill establishes the composition of the advisory committee and the issues about which the advisory committee is required to advise HHSC. The bill clarifies that the credentials of a single advisory committee member may satisfy more than one of the membership criteria prescribed by the bill's provisions.

Uncompensated Hospital Care Data

C.S.S.B. 7 requires DSHS, to assist the executive commissioner of HHSC in adopting and amending rules relating to uncompensated hospital care, to require each hospital in the state to provide to DSHS, not later than a date specified by DSHS, uncompensated hospital care data prescribed by HHSC. The bill specifies that each hospital is required to complete and submit adequate data by that date. The bill requires DSHS to notify HHSC of each hospital that fails to submit complete and adequate data as required by DSHS on or before the specified date. The

bill authorizes HHSC to withhold Medicaid program reimbursements owed to the hospital until the hospital complies with the reporting requirement to the extent allowed by federal law. The bill clarifies that the rules required to be adopted by the executive commissioner of HHSC are to be adopted using certain uncompensated hospital care data submitted to DSHS. The bill clarifies that the standard definition of "uncompensated hospital care" for which the executive commissioner of HHSC is required to adopt rules is one that reflects unpaid costs incurred by hospitals and accounts for actual hospital costs and hospital charges and revenue sources.

C.S.S.B. 7 authorizes HHSC to require each hospital that is required to be audited under federal regulations relating to conditions for federal financial participation in the Medicaid program to pay a fee to offset the cost of the audit in an amount determined by HHSC. The bill prohibits the total amount of fees imposed on hospitals from exceeding the total cost incurred by HHSC in conducting the required audits of the hospitals.

C.S.S.B. 7 requires the executive commissioner of HHSC, as soon as possible after the date DSHS requires each hospital to initially submit uncompensated hospital care data, to adopt rules or amendments to existing rules that conform to the requirements of the bill's provisions.

Medical Technology; Electronic Health Information Exchange Program

C.S.S.B. 7 requires HHSC to develop an electronic health information exchange system to improve the quality, safety, and efficiency of health care services provided under the children's health insurance and Medicaid programs. The bill requires HHSC, in developing the system, to ensure that the confidentiality of patients' health information is protected and the privacy of those patients is maintained in accordance with specified state and federal laws, rules, and regulations; appropriate information technology systems used by HHSC and health and human services agencies are interoperable; the system and external information technology systems are interoperable in receiving and exchanging appropriate electronic health information as necessary to enhance the comprehensive nature of the information contained in electronic health records and health care provider efficiency by supporting integration of the information into the electronic health record used by health care providers; the system and other health information systems and data warehousing initiatives are interoperable; and the system has elements required by the bill's provisions.

C.S.S.B. 7 prescribes the elements the health information exchange system is required to include relating to identity verification for access, data-sharing agreements, system access during a declared state emergency, sharing information with state and federal emergency responders, compatibility with certain national information networks and initiatives, patient identification across systems, and health care provider access. The bill requires HHSC to implement the system in stages as described by the bill's provisions, except that HHSC may deviate from the prescribed stages if technological advances make a deviation advisable or more efficient. The bill requires the system to be developed in accordance with the Medicaid Information Technology Architecture initiative of the Center for Medicaid and State Operations and conform to other standards required under federal law.

C.S.S.B. 7 requires HHSC to establish the Electronic Health Information Exchange System Advisory Committee to assist in the performance of HHSC duties in relation to the electronic health information exchange programs, requires the executive commissioner of HHSC to appoint to the advisory committee at least 12 and not more than 16 members who have appropriate interest and experience and the presiding officer. The bill establishes the composition of the advisory committee, requires the membership to represent the geographic and cultural diversity of the state, and prescribes the specific issues about which the advisory committee is required to advise HHSC. The bill requires the advisory committee to 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.

C.S.S.B. 7 establishes procedures for the three stages of implementation for the health information exchange system program. The bill requires HHSC, in stage one, to develop and establish an electronic health record for each person who receives medical assistance under the Medicaid program that is available through a browser-based format, and available to the patient through the Internet. The bill sets out procedures relating to physician and stakeholder involvement to meet certain system requirements and requires the executive commissioner of HHSC to adopt rules specifying the information to be included in the electronic health record, provides information authorized to be included as appropriate, and provides for the addition of information to the record and the exchange of that information.

C.S.S.B. 7 establishes stage one implementation procedures relating to the submission to HHSC of complete and accurate encounter data by Medicaid managed care organizations providing managed care services and services under the children's health insurance program and the support and coordination of electronic prescribing tools for use by health care providers and health care facilities under the children's health insurance and Medicaid programs. The bill sets out procedures relating to physician and stakeholder involvement and commission compliance with electronic prescribing provisions and requires HHSC to apply for and actively pursue a federal waiver to remove an identified impediment to supporting and implementing electronic prescribing tools. The bill requires HHSC to reverse any operational modifications made in accordance with a waiver determined to HHSC with assistance from the Legislative Budget Board to result in cost increases in the children's health insurance program or Medicaid program.

C.S.S.B. 7 prescribes actions HHSC is authorized to take in expanding the system in stages two and three of implementation with stage two's implementation based on the recommendations of the advisory committee and other feedback.

C.S.S.B. 7 requires HHSC and the advisory committee to develop strategies to encourage health care providers to use the system, including incentives, education, and outreach tools to increase usage.

C.S.S.B. 7 adds a temporary provision, set to expire September 2, 2013, to require HHSC to 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 system not later than January 1, 2011, and a subsequent report to those committees not later than January 1, 2013. The bill prescribes the information to be contained in the reports.

C.S.S.B. 7 authorizes the executive commissioner of HHSC to adopt rules to implement the electronic health information exchange program. The bill defines "electronic health record," "electronic medical record," "health information exchange system," and "local or regional health information exchange."

C.S.S.B. 7 amends the Health and Safety Code and Human Resources Code, respectively, to require HHSC to ensure that any health information technology used by HHSC or any entity acting on behalf of HHSC in the children's health insurance program or Medicaid program, respectively, conforms to standards required under federal law. The bill defines "health information technology" in each code.

C.S.S.B. 7 requires the executive commissioner of HHSC, as soon as practicable after the bill's effective date, to adopt rules to implement the electronic health record and electronic prescribing system, and to appoint the members of the Electronic Health Information Exchange System Advisory Committee.

Quality-Based Payment Initiatives

C.S.S.B. 7 amends the Government Code to add a temporary provision, set to expire September 2, 2013, to authorize health care providers and facilities and disease or care management organizations to submit proposals to HHSC 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 children's health insurance program enrollees or Medicaid recipients, or both, that are cost-effective to the state and will improve the quality of health care provided to the enrollees or recipients. The bill requires HHSC to determine whether it is feasible and cost-effective to implement one or more of the proposed pilot programs and to examine alternative payment methodologies used in the Medicare program and consider whether implementing one or more of the methodologies through a pilot program, modified as necessary to account for programmatic differences, would achieve cost savings in the Medicaid program while ensuring the use of best practices.

C.S.S.B. 7 requires HHSC, on determination that implementation of one or more quality-based payment initiatives pilot programs is feasible and cost-effective, to establish one or more such programs 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 children's health insurance program or Medicaid program, as applicable, that are based on best practices, outcomes, and efficiency, but ensure high-quality, effective health care services. The bill requires HHSC to administer any such pilot program and authorizes the executive commissioner of HHSC to adopt rules, plans, and procedures and enter into contracts and other agreements as the executive commissioner considers appropriate and necessary. The bill authorizes HHSC to limit a pilot program to one or more regions of the state, one or more organized networks of health care facilities and providers, or specified types of services or enrollees or recipients under the children's health insurance program or Medicaid program. The bill requires a pilot program to be operated for at least one state fiscal year.

C.S.S.B. 7 requires the executive commissioner of HHSC, in consultation with the Health Care Quality Advisory Committee, to approve quality of care standards, evidence-based protocols, and measurable goals for a pilot program to ensure high-quality and effective health care services. The bill authorizes the executive commissioner of HHSC additionally to 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 bill prohibits the efficiency performance standards from creating any financial incentive for or involving making a payment to a health care provider that directly or indirectly induces the limitation of medically necessary services. The bill authorizes the executive commissioner of HHSC to contract with appropriate entities, including qualified actuaries, to assist in determining appropriate payment rates for a pilot program and to increase a payment rate, including a capitation rate, as necessary to adjust the rate for inflation. The bill requires the executive commissioner of HHSC to ensure that services provided to a children's health insurance program enrollee or Medicaid recipient, as applicable, meet the required quality of care standards and are at least equivalent to the services provided under the applicable program for which the enrollee or recipient is eligible. The bill defines "pay-for-performance payment system" and "pilot program."

C.S.S.B. 7 requires HHSC, not later than November 1, 2012, to 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 children's health insurance program and Medicaid program and prescribes the required contents of the report.

Quality-Based Hospital Payments

C.S.S.B. 7 requires HHSC to develop a quality-based hospital reimbursement system for paying Medicaid reimbursements to hospitals. The bill specifies that 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. The bill

requires HHSC to develop such a system in phases as provided by the bill's provisions. The bill requires HHSC, to the extent possible, to coordinate the timeline for the development and implementation with the implementation of the Medicaid Information Technology Architecture initiative of the Center for Medicaid and State Operations and the ICD-10 code sets initiative and with the ongoing Enterprise Data Warehouse planning process to maximize receipt of federal funds.

C.S.S.B. 7 establishes procedures for the three phases of development of the quality-based hospital reimbursement system. The bill requires the executive commissioner of HHSC to adopt rules for identifying potentially preventable readmissions of Medicaid recipients and requires HHSC to collect data on present-on-admission indicators for purposes of the collection and reporting of certain information during phase one. The bill requires HHSC to establish a program to provide a confidential report to each hospital in the state regarding the hospital's performance with respect to potentially preventable readmissions, and requires a hospital to provide such information contained in the report to health care providers serving the hospital. The bill sets a two-year period during which a hospital may adjust its practices in response to the report in an attempt to reduce those readmissions, and prohibits reimbursements paid to the hospital from being adjusted on the basis of potentially preventable readmissions during that period. The bill requires HHSC to convert hospitals that are reimbursed using a diagnosis-related groups (DRG) methodology to a DRG methodology that will allow HHSC to more accurately classify specific patient populations and account for severity of patient illness and mortality risk. The bill authorizes HHSC, for purposes of hospitals that are not reimbursed using a DRG methodology, to modify data collection requirements to allow HHSC to more accurately classify specific patient populations and account for severity of patient illness and mortality risk.

C.S.S.B. 7 clarifies that phase two of the development of the quality-based hospital reimbursement system is required to be based on the information reported, the data collected, and the DRG methodology implemented during phase one. The bill prescribes the method by which HHSC is required to adjust Medicaid reimbursements to hospitals based on performance in reducing potentially preventable readmissions. The bill requires the executive commissioner of HHSC, in phase three of development, to adopt rules for identifying potentially preventable complications and requires HHSC to study the feasibility of collecting data from hospitals concerning potentially preventable complications, adjusting Medicaid reimbursements based on performance in reducing those complications, and developing reconsideration review processes that provide basic due process in challenging such a reimbursement adjustment. The bill requires HHSC to 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 feasibility study on its completion. The bill clarifies that rules adopted by the executive commissioner of HHSC regarding potentially preventable complications are not admissible in a civil action for purposes of establishing a standard of care applicable to a physician.

C.S.S.B. 7 defines "DRG methodology," "potentially preventable complication," and "potentially preventable readmission."

Requirements of Third-Party Health Insurers

C.S.S.B 7 amends the Human Resources Code to require a third-party health insurer to provide to HHSC, on request, information in a form prescribed by HHSC necessary to determine the period during which an individual entitled to medical assistance under the Medicaid program, the individual's spouse, or the individual's dependents may be, or may have been, covered by coverage issued by the health insurer; the nature of the coverage; and the name, address, and identifying number of the health plan under which the person may be, or may have been, covered. The bill requires a third-party health insurer to accept the state's right of recovery and the assignment 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 Mediciad program.

C.S.S.B. 7 requires a third-party health insurer to respond to any inquiry by HHSC regarding a claim for payment for any health care item or service reimbursed by HHSC under the Medicaid program not later than the third anniversary of the date the health care item or service was provided. The bill prohibits a third-party health insurer from denying a claim submitted by HHSC or an HHSC designee for which payment was made under the Medicaid 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 certain conditions apply. The bill specifies that requirements relating to such requests for information do not limit the scope or amount of information otherwise required from insurers under third-party recovery provisions.

Preventable Adverse Event Reporting

C.S.S.B. 7 amends Chapter 98, Health and Safety Code, as added by Chapter 359 (S.B. 288), Acts of the 80th Legislature, Regular Session, 2007, to establish the Advisory Panel on Health Care-Associated Infections and Preventable Adverse Events within DSHS, in place of the Advisory Panel on Health Care-Associated Infections within the infectious disease surveillance and epidemiology branch of DSHS. The bill authorizes the commissioner of state health services to 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. The bill increases the membership on the advisory panel from 16 to 18 members, clarifies that the three board-certified or board-eligible physicians, among other qualifications, have demonstrated expertise in quality assessment and performance improvement in health care facilities as an alternative to expertise in infection control, increases from two to four the required members who are professionals in quality assessment and performance improvement, and removes the conditions that one of those professionals be employed by a general hospital and one be employed by an ambulatory surgical center.

C.S.S.B. 7 adds to the purposes of the Texas Health Care-Associated Infection and Preventable Adverse Events Reporting System the reporting of health care-associated preventable adverse events by health care facilities to DSHS and the public reporting of information regarding health care-associated preventable adverse events by DSHS. The bill clarifies that the requirement that data reported by health care facilities contain sufficient patient identifying information to allow DSHS to risk adjust the facilities' infection rates applies to data reported relating to reportable infections and surgical site infections.

C.S.S.B. 7 requires each health care facility to report to DSHS the occurrence of certain preventable adverse events involving the facility's patient. The bill authorizes the executive commissioner of HHSC to exclude a specified adverse event from the reporting requirement 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. The bill adds the preventable adverse events report to the information DSHS is required to make available to the public in summary form. The bill adds the report of preventable adverse events to the statement required to be included on an Internet website administered by DSHS informing the public of the option to report certain information to the department.

C.S.S.B. 7 prohibits a state employee or officer from being 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 DSHS under provisions relating to the reporting of health care-associated infections. The bill clarifies that DSHS is authorized to disclose certain information reported by health care facilities to the Health and Human Services Commission and to other health and human services agencies. The bill specifies that the prohibition against certain published information being used in a civil action to establish a standard of care applicable to a health care facility applies also extends to preventable adverse events. The bill defines "advisory panel" and "reporting system."

C.S.S.B. 7 requires the commissioner of state health services, as soon as possible after the bill's effective date to appoint two additional members to the advisory panel who meet the prescribed qualifications as amended by the bill. The bill requires the executive commissioner of HHSC, not later than February 1, 2010, to adopt rules and procedures necessary to implement the reporting of health care-associated preventable adverse events.

Long-Term Care Incentives

C.S.S.B. 7 amends the Human Resources Code to require the executive commissioner of HHSC by rule, if feasible, to establish an incentive payment program for nursing facilities designed to improve the quality of care and services provided to Medicaid recipients. The bill requires the program to provide additional payments to the facilities that meet or exceed performance standards established by the executive commissioner. The bill requires the executive commissioner, in establishing the incentive payment program, to adopt outcome-based performance measures, and prescribes the performance measures.

C.S.S.B. 7 requires the executive commissioner of HHSC to maximize the use of available information technology and limit the number of performance measures adopted to achieve administrative cost efficiency and avoid an unreasonable administrative burden on nursing facilities and, for each performance measure adopted, establish a performance threshold for purposes of determining eligibility for an incentive payment under the program. The bill requires a nursing facility, to be eligible for an incentive payment under the program, to meet or exceed applicable performance thresholds in at least two of the adopted performance measures, at least one of which is an indicator of quality of care. The bill authorizes the executive commissioner of HHSC to determine the amount of an incentive payment under the program based on a specified performance index and to enter into a contract with a qualified person for certain services related to the program. The bill authorizes HHSC to make incentive payments under the program only if money is specifically appropriated for that purpose. The bill defines "nursing facility."

C.S.S.B 7 amends Section 32.060(a), Human Resources Code, as added by Section 16.01, Chapter 204 (H.B. 4), Acts of the 78th Legislature, Regular Session, 2003, to add any information obtained or used by DSHS to determine the eligibility of a nursing facility for an incentive payment, or to determine the facility's performance rating under the incentive payment program, to the information that is not admissible as evidence in a civil action.

C.S.S.B. 7 requires HHSC to conduct a study to evaluate the feasibility of providing an incentive payment program for certain types of providers of long-term care services under the Medicaid program similar to the incentive payment program for nursing facilities, and not later than September 1, 2010, to submit a written report of the study's findings to the legislature. The bill requires the executive commissioner of HHSC, as soon as practicable after the bill's effective date, to adopt rules for the incentive payment program for nursing facilities.

Preventable Adverse Event Reimbursement

C.S.S.B. 7 amends the Human Resources Code to require the executive commissioner of HHSC, not later than September 1, 2010, to adopt rules regarding the denial or reduction of reimbursement under the Medicaid program for preventable adverse events that occur in a hospital setting. The bill sets forth certain requirements and authorizations relating to the adoption of such rules by the executive commissioner.

Patient Risk Identification System

C.S.S.B. 7 amends the Health and Safety Code to require DSHS to 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 bill requires the executive commissioner of HHSC to appoint an ad hoc committee of hospital representatives to assist DSHS in developing the statewide system. The bill requires DSHS to require each hospital to implement and enforce the statewide standardized patient risk identification system unless DSHS authorizes an exemption. The bill authorizes DSHS to 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. The bill requires DSHS to modify the statewide standardized patient risk identification system in accordance with evidence-based medicine as necessary. The bill authorizes the executive commissioner of HHSC to adopt rules to implement the statewide standardized patient risk identification system. The bill defines "department" and "hospital."

C.S.S.B. 7 requires a state agency that is affected by a provision of the bill to request a federal waiver or authorization if the agency determines that a waiver or authorization is necessary for the implementation of the provision, and it authorizes the agency to delay implementation until the federal waiver or authorization is obtained. The bill clarifies that its provisions do not make an appropriation and take effect only if a specific appropriation for implementation is provided in a general appropriations act of the 81st Legislature.

EFFECTIVE DATE

September 1, 2009.

COMPARISON OF ORIGINAL AND SUBSTITUTE

C.S.S.B. 7 adds provisions not included in the original to establish a minimum duration of 24 months during which the obesity prevention and the medical home for children's health insurance program enrollees and Medicaid recipients pilot programs are required to operate. The substitute differs from the original by conforming the reporting requirements to the duration of the pilot programs to require the Health and Human Services Commission (HHSC) to submit annual reports during the period each pilot program is operated, rather than requiring HHSC to submit a single report for each program by a date certain as in the original. The substitute adds provisions not included in the original requiring HHSC to submit a final report for each pilot program regarding the results of each program not later than three months after the conclusion of the program.

C.S.S.B. 7 adds a provision not included in the original specifying that the medical home pilot program must be developed in a manner that allows for the examination of measurable wellness and prevention criteria, use of best practices, and outcomes based on type of primary care provider. The substitute differs from the original by requiring the Health Care Quality Advisory Committee to consist of a physician from an urban area who has clinical practice expertise and who may be a pediatrician, a physician from a rural area who has clinical practice expertise and who may be a pediatrician, and a nurse practitioner, whereas the original requires the committee to consist of health care providers at least one of whom is a physician who has clinical practice expertise. The substitute differs from the original by specifying the types of health care facilities required to be represented on the committee and by adding a representative from a care management organization and a representative of health care consumers. The substitute adds a provision not included in the original to clarify that the credentials of a single member of the advisory committee may satisfy more than one criteria required by the bill's provisions.

C.S.S.B. 7 differs from the original by defining "electronic health record" as an electronic record of certain aggregated health-related information that can be created, managed, and consulted by providers across two or more health care organizations, whereas the original does not specify that the term refers to aggregated information and does not include the condition that it be created, managed, and consulted across organizations. The substitute adds a provision not

included in the original defining "electronic medical record." The substitute adds provisions not included in the original requiring patient health information under the electronic health information exchange system to be maintained in accordance with specified state and federal laws and expanding the criteria HHSC must ensure are met when developing the electronic health information exchange system relating to supporting integration of information into the electronic health record used by health care providers, the interoperability of systems not specifically identified by the bill and data warehousing initiatives, and specified elements required to be included in the system. The substitute adds provisions not included in the original prescribing elements required to be included in the system, and clarifying that the system is required to conform to standards required under federal law other than the Medicaid Information Technology Architecture initiative.

C.S.S.B. 7 differs from the original by increasing the maximum number of members on the Electronic Health Information Exchange System Advisory Committee to 16 members, rather than 15 as in the original. The substitute adds provisions not included in the original to add at least one representative of Medicaid recipients and children's health insurance program enrollees, and at least one representative who is skilled in pediatric medical informatics to the required members of the advisory committee. The substitute adds a provision not included in the original to expand the prescribed issues about which the advisory committee is required to advise HHSC to include the exchange of data to enhance health care provider efficiency by supporting integration of the information into electronic health records used by providers. The substitute differs from the original by requiring HHSC to develop and establish an electronic health record for each person who receives medical assistance under the Medicaid program, rather than requiring HHSC to develop and establish a claims-based electronic health record as in the original. The substitute adds provisions not included in the original requiring HHSC to consult and collaborate with, and accept recommendations from, physicians and other stakeholders to ensure that electronic health records established under the health information exchange system support health information exchange with electronic medical records systems in use by physicians and does not require the purchase of new systems. The substitute differs from the original by requiring each managed care organization with which HHSC contracts for the provision of children's health insurance program services, in addition to managed care organizations that contract for the provision of Medicaid managed care services, to submit encounter data to the commission for stage one implementation of the health information exchange system, whereas the original only requires organizations that contract for Medicaid managed care services to submit the data. The substitute omits a provision included in the original specifying that the encounter data submitted is required to be data for each month that includes all paid and processed claims for the month. The substitute differs from the original by requiring the encounter data to be submitted not later than the 30th day after the last day of the month in which the managed care organization adjudicated the claim, whereas the original requires the data to be submitted not later than the 30th day after the last day of the month to which the data relates.

C.S.S.B. 7 differs from the original by requiring HHSC to consult and collaborate with, and accept recommendations from, physicians and other stakeholders with regard to the support and coordination of electronic prescribing tools to ensure that the tools meet certain conditions. The substitute differs from the original by conforming those conditions to include the requirement that the electronic prescribing tools are integrated with existing electronic prescribing systems in use by physicians. The substitute adds provisions not included in the original including the requirement for handwritten certification of certain drugs under federal law among the impediments to supporting and implementing electronic prescribing tools for which HHSC is required to actively pursue federal waivers. The substitute differs from the original by specifying that HHSC is required to ensure that any health information technology used by HHSC or any entity acting on behalf of HHSC in the children's health insurance program and Medicaid program conforms to standards required under federal law, rather than requiring HHSC to ensure that any health information technology conforms to nationally recognized standards as in the original.

C.S.S.B. 7 adds a provision not included in the original including disease or care management organizations among the entities authorized to submit proposals to HHSC for the implementation of pilot programs of quality-based payment initiatives. The substitute adds a provision not included in the original prohibiting certain efficiency performance standards approved by the executive commissioner of HHSC from creating any financial incentive for or involving making a payment to a health care provider that induces the limitation of medically necessary services.

C.S.S.B 7 adds a provision not included in the original defining "DRG methodology." The substitute adds provisions not included in the original authorizing HHSC to modify data collection under phase one of the quality-based hospital reimbursement system for hospitals that are not reimbursed using a DRG methodology for purposes of more accurately classifying and accounting for certain information and making related conforming changes.

C.S.S.B. 7 adds provisions not included in the original requiring the executive commissioner of HHSC to adopt rules for identifying potentially preventable complications and including developing reconsideration review processes that provide basic due process in challenging a reimbursement adjustment among the issues for which HHSC is required to study the feasibility under phase three of the quality-based hospital reimbursement system, and specifying that the rules adopted by the executive commissioner are not admissible in a civil action for the specified purposes. The substitute adds provisions not included in the original authorizing the commissioner of state health services to establish one or more subcommittees to assist the Advisory Panel on Health Care-Associated Infections and Preventable Adverse Events on issues relating to children or other special patient populations. The substitute differs from the original by restoring statutory language struck in the original requiring at least one of the board-certified or board-eligible physicians serving on the advisory panel to be a pediatric infectious disease physician with expertise in pediatric health care epidemiology. The substitute differs from the original by retaining existing statutory language requiring all three of the board-certified or board-eligible physicians serving on the advisory panel to be active members of the Society for Healthcare Epidemiology of America, whereas the original amended that language to require one of those physicians to be an active member. The substitute omits provisions included in the original relating to the appointment by the commissioner of state health services of a person to the advisory panel on each expiration date of the term of a member serving on the panel and appointed to the panel before the bill's effective date and instead requires the commissioner to appoint two additional members as soon as possible after the effective date.

C.S.S.B. 7 adds provisions not included in the original relating to information required to be provided to HHSC by third-party health insurers. The substitute adds a provision not included in the original authorizing HHSC to make incentive payments under the incentive payment program only if money is specifically appropriated for that purpose. The substitute makes nonsubstantive conforming and clarifying changes not included in the original.