

By: Nelson

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 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

1 consider the degree to which child health plan program enrollees
2 and Medicaid recipients in the region are at higher than average
3 risk of obesity.

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

11 (d) Not later than November 1, 2011, the Health and Human
12 Services Commission shall submit a report to the standing
13 committees of the senate and house of representatives having
14 primary jurisdiction over the child health plan and Medicaid
15 programs regarding the results of the pilot program under this
16 section. The report must include:

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

19 (2) an analysis of the data collected in the program
20 and the capability of the data to measure achievement of the
21 identified goals;

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

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

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

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

7 (b) The commission shall establish a pilot program in one or
8 more health care service regions in this state designed to
9 establish a medical home for each child health plan program
10 enrollee and Medicaid recipient participating in the pilot program.
11 A primary care provider participating in the program may designate
12 a care coordinator to support the medical home concept.

13 (c) The commission shall develop in consultation with the
14 Health Care Quality Advisory Committee established under Section
15 531.0995 the pilot program in a manner that bases payments made, or
16 incentives provided, to a participant's medical home on factors
17 that include measurable wellness and prevention criteria, use of
18 best practices, and outcomes.

19 (d) Not later than January 1, 2011, the commission shall
20 submit a report to the standing committees of the senate and house
21 of representatives having primary jurisdiction over the child
22 health plan and Medicaid programs regarding the status of the pilot
23 program under this section. The report must include:

24 (1) recommendations regarding the continued operation
25 of the pilot program or whether the program should be implemented
26 statewide; or

27 (2) if the commission cannot make the recommendations

1 described by Subdivision (1) due to an insufficient amount of data
2 having been collected at the time of the report, statements
3 regarding the time frames within which the commission anticipates
4 collecting sufficient data and making those recommendations.

5 SECTION 2. HEALTH CARE QUALITY ADVISORY COMMITTEE.

6 (a) Subchapter B, Chapter 531, Government Code, is amended by
7 adding Section 531.0995 to read as follows:

8 Sec. 531.0995. HEALTH CARE QUALITY ADVISORY COMMITTEE.

9 (a) The commission shall establish the Health Care Quality
10 Advisory Committee to assist the commission as specified by
11 Subsection (d) with defining best practices and quality performance
12 with respect to health care services and setting standards for
13 quality performance by health care providers and facilities for
14 purposes of programs administered by the commission or a health and
15 human services agency.

16 (b) The executive commissioner shall appoint the members of
17 the advisory committee. The committee must consist of health care
18 providers, representatives of health care facilities, and other
19 stakeholders interested in health care services provided in this
20 state. At least one member must be a physician who has clinical
21 practice expertise, and at least one member must be a member of the
22 Advisory Panel on Health Care-Associated Infections and
23 Preventable Adverse Events who meets the qualifications prescribed
24 by Section 98.052(a)(4), Health and Safety Code.

25 (c) The executive commissioner shall appoint the presiding
26 officer of the advisory committee.

27 (d) The advisory committee shall advise the commission on:

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

3 (2) measurable wellness and prevention criteria and
4 best practices for the medical home pilot program under Section
5 531.0994;

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

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

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

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

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

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

24 (a) Using data submitted to the Department of State Health
25 Services under Subsection (a-1), the ~~[The]~~ executive commissioner
26 shall adopt rules providing for:

27 (1) a standard definition of "uncompensated hospital

1 care" that reflects unpaid costs incurred by hospitals and accounts
2 for actual hospital costs and hospital charges and revenue sources;

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

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

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

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

23 (d) If the commission determines through the procedures
24 adopted under Subsection (b) that a hospital submitted a report
25 described by Subsection (a)(3) with incomplete or inaccurate
26 information, the commission shall notify the hospital of the
27 specific information the hospital must submit and prescribe a date

1 by which the hospital must provide that information. If the
2 hospital fails to submit the specified information on or before the
3 date prescribed by the commission, the commission shall notify the
4 attorney general of that failure. On receipt of the notice, the
5 attorney general shall impose an administrative penalty on the
6 hospital in an amount not to exceed \$10,000. In determining the
7 amount of the penalty to be imposed, the attorney general shall
8 consider:

- 9 (1) the seriousness of the violation;
- 10 (2) whether the hospital had previously committed a
11 violation; and
- 12 (3) the amount necessary to deter the hospital from
13 committing future violations.

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

21 (c) As soon as possible after the date the Department of
22 State Health Services requires each hospital in this state to
23 initially submit uncompensated hospital care data under Subsection
24 (a-1), Section 531.551, Government Code, as added by this section,
25 the executive commissioner of the Health and Human Services
26 Commission shall adopt rules or amendments to existing rules that
27 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 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.

(2) "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.

(3) "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;

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

(3) 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.

(b) 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.

(c) 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.

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 15 members who have

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

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

6 (1) Medicaid providers;
7 (2) child health plan program providers;
8 (3) fee-for-service providers;
9 (4) at least one representative of the Texas Health
10 Services Authority established under Chapter 182, Health and Safety
11 Code;

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

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

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

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

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

22 (10) at least one representative of a local or
23 regional health information exchange.

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

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

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

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

7 (2) presentation of data;

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

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

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

15 (6) data exchange with local or regional health
16 information exchanges to enhance the comprehensive nature of the
17 information contained in electronic health records.

18 (g) The advisory committee shall collaborate with the Texas
19 Health Services Authority to ensure that the health information
20 exchange system is interoperable with, and not an impediment to,
21 the electronic health information infrastructure that the
22 authority assists in developing.

23 Sec. 531.904. STAGE ONE: ELECTRONIC HEALTH RECORD.

24 (a) In stage one of implementing the health information exchange
25 system, the commission shall develop and establish a claims-based
26 electronic health record for each person who receives medical
27 assistance under the Medicaid program. The electronic health

1 record must be available through a browser-based format.

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

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

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

10 (3) an immunization record;

11 (4) a prescription history;

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

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

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

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

23 Sec. 531.9041. STAGE ONE: ENCOUNTER DATA. In stage one of
24 implementing the health information exchange system, the
25 commission shall require for purposes of the implementation each
26 managed care organization with which the commission contracts under
27 Chapter 533 for the provision of Medicaid managed care services to

1 submit to the commission complete encounter data for each month
2 that includes all paid and processed claims for the month not later
3 than the 30th day after the last day of the month to which the data
4 relates.

5 Sec. 531.905. STAGE ONE: ELECTRONIC PRESCRIBING. (a) In
6 stage one of implementing the health information exchange system,
7 the commission shall develop and coordinate electronic prescribing
8 tools for use by health care providers and health care facilities
9 under the child health plan and Medicaid programs.

10 (b) To the extent feasible, the electronic prescribing
11 tools must:

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

14 (2) support the electronic transmission of a
15 prescription.

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

21 (d) The commission shall apply for and actively pursue any
22 waiver to the child health plan program or the state Medicaid plan
23 from the federal Centers for Medicare and Medicaid Services or any
24 other federal agency as necessary to remove an identified
25 impediment to the implementation of electronic prescribing tools
26 under this section. If the commission with assistance from the
27 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. 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.

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

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

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

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

16 Sec. 531.909. REPORTS. (a) The commission shall provide
17 an initial report to the Senate Committee on Health and Human
18 Services or its successor, the House Committee on Human Services or
19 its successor, and the House Committee on Public Health or its
20 successor regarding the health information exchange system not
21 later than January 1, 2011, and shall provide a subsequent report to
22 those committees not later than January 1, 2013. Each report must:

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

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

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

4 (b) This section expires September 2, 2013.

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

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

9 Sec. 62.060. HEALTH INFORMATION TECHNOLOGY STANDARDS.

10 (a) In this section, "health information technology" means
11 information technology used to improve the quality, safety, or
12 efficiency of clinical practice, including the core
13 functionalities of an electronic health record, an electronic
14 medical record, a computerized health care provider order entry,
15 electronic prescribing, and clinical decision support technology.

16 (b) The commission shall ensure that any health information
17 technology used in the child health plan program conforms to
18 nationally recognized standards.

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

21 Sec. 32.073. HEALTH INFORMATION TECHNOLOGY STANDARDS.

22 (a) In this section, "health information technology" means
23 information technology used to improve the quality, safety, or
24 efficiency of clinical practice, including the core
25 functionalities of an electronic health record, an electronic
26 medical record, a computerized health care provider order entry,
27 electronic prescribing, and clinical decision support technology.

(b) The Health and Human Services Commission shall ensure that any health information technology used in the medical assistance program conforms to nationally recognized standards.

(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 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

1 practices, outcomes, and efficiency, but ensure high-quality,
2 effective health care services.

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

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

9 (1) one or more regions in this state;

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

12 (3) specified types of services provided under the
13 child health plan or Medicaid program, or specified types of
14 enrollees or recipients under those programs.

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

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

23 (b) In addition to the standards approved under Subsection
24 (a), the executive commissioner may approve efficiency performance
25 standards that may include the sharing of realized cost savings
26 with health care providers and facilities that provide health care
27 services that exceed the efficiency performance standards.

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

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

9 (c) The executive commissioner shall ensure that services
10 provided to a child health plan program enrollee or Medicaid
11 recipient, as applicable, meet the quality of care standards
12 required under this subchapter and are at least equivalent to the
13 services provided under the child health plan or Medicaid program,
14 as applicable, for which the enrollee or recipient is eligible.

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

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

- 25 (1) describe the operation of the pilot program;
26 (2) analyze the quality of health care provided to
27 patients under the pilot program;

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

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

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

10 SUBCHAPTER X. QUALITY-BASED HOSPITAL REIMBURSEMENT SYSTEM

11 Sec. 531.981. DEFINITIONS. In this subchapter:

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

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

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

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

23 (2) "Potentially preventable readmission" means a
24 return hospitalization of a person within a period specified by the
25 commission that results from deficiencies in the care or treatment
26 provided to the person during a previous hospital stay or from
27 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.

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

5 (b) The executive commissioner shall adopt rules for
6 identifying potentially preventable readmissions of Medicaid
7 recipients and the commission shall collect data on
8 present-on-admission indicators for purposes of this section.

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

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

22 (e) The commission shall convert the hospital Medicaid
23 reimbursement system to a diagnoses-related groups (DRG)
24 methodology that will allow the commission to more accurately
25 classify specific patient populations and account for severity of
26 patient illness and mortality risk.

27 Sec. 531.984. PHASE TWO: REIMBURSEMENT ADJUSTMENTS.

1 (a) The second phase of the development of the quality-based
2 hospital reimbursement system consists of the elements described by
3 this section and must be based on the information reported, and the
4 diagnoses-related groups (DRG) methodology implemented, during
5 phase one of the development.

6 (b) Using the information reported and the
7 diagnoses-related groups (DRG) methodology implemented during
8 phase one of the development of the quality-based hospital
9 reimbursement system, the commission shall adjust Medicaid
10 reimbursements to hospitals based on performance in reducing
11 potentially preventable readmissions. An adjustment:

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

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

19 Sec. 531.985. PHASE THREE: STUDY OF POTENTIALLY
20 PREVENTABLE COMPLICATIONS. (a) In phase three of the development
21 of the quality-based hospital reimbursement system, the commission
22 shall study the feasibility of:

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

25 (2) adjusting Medicaid reimbursements based on
26 performance in reducing those complications.

27 (b) The commission shall provide a report to the standing

1 committees of the senate and house of representatives having
2 primary jurisdiction over the Medicaid program concerning the
3 results of the study conducted under this section when the study is
4 completed.

5 SECTION 7. PREVENTABLE ADVERSE EVENT REPORTING. (a) The
6 heading to Chapter 98, Health and Safety Code, as added by Chapter
7 359 (S.B. 288), Acts of the 80th Legislature, Regular Session,
8 2007, is amended to read as follows:

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

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

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

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

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

22 Sec. 98.051. ESTABLISHMENT. The commissioner shall
23 establish the Advisory Panel on Health Care-Associated Infections
24 and Preventable Adverse Events within [~~the infectious disease~~
25 ~~surveillance and epidemiology branch of~~] the department to guide
26 the implementation, development, maintenance, and evaluation of
27 the reporting system.

(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 an ~~[a pediatric infectious disease physician with expertise and experience in pediatric health care epidemiology,~~

~~[(B) are]~~ active member ~~[members]~~ of the Society for Healthcare Epidemiology of America; and

(B) [(C)] have demonstrated expertise in quality assessment and performance improvement or infection control in

1 health care facilities;

2 (4) four additional ~~[two]~~ professionals in quality
3 assessment and performance improvement~~[, one of whom is employed by~~
4 ~~a general hospital and one of whom is employed by an ambulatory~~
5 ~~surgical center]~~;

6 (5) one officer of a general hospital;

7 (6) one officer of an ambulatory surgical center;

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

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

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

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

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

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

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

27 (4) the public reporting of information regarding

1 health care-associated preventable adverse events by the
2 department; and

3 (5) [~~43~~] the education and training of health care
4 facility staff by the department regarding this chapter.

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

8 (1) avoid duplicate submission of records;

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

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

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

18 Sec. 98.1045. REPORTING OF PREVENTABLE ADVERSE EVENTS.

19 (a) Each health care facility shall report to the department the
20 occurrence of any of the following preventable adverse events
21 involving the facility's patient:

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

26 (2) subject to Subsection (b), an event included in
27 the list of adverse events identified by the National Quality Forum

1 that is not included under Subdivision (1).

2 (b) The executive commissioner may exclude an adverse event
3 described by Subsection (a)(2) from the reporting requirement of
4 Subsection (a) if the executive commissioner, in consultation with
5 the advisory panel, determines that the adverse event is not an
6 appropriate indicator of a preventable adverse event.

7 (g) Subsections (a), (b), and (g), Section 98.106, Health
8 and Safety Code, as added by Chapter 359 (S.B. 288), Acts of the
9 80th Legislature, Regular Session, 2007, are amended to read as
10 follows:

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

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

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

17 (b) Information included in the [The] departmental summary
18 with respect to infections reported by facilities under Sections
19 98.103 and 98.104 must be risk adjusted and include a comparison of
20 the risk-adjusted infection rates for each health care facility in
21 this state that is required to submit a report under Sections 98.103
22 and 98.104.

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

1 infections and preventable adverse events to the department.

2 (h) Section 98.108, Health and Safety Code, as added by
3 Chapter 359 (S.B. 288), Acts of the 80th Legislature, Regular
4 Session, 2007, is amended to read as follows:

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

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

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

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

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

1 Sec. 98.110. DISCLOSURE AMONG CERTAIN AGENCIES [~~WITHIN~~
2 ~~DEPARTMENT~~]. Notwithstanding any other law, the department may
3 disclose information reported by health care facilities under
4 Section 98.103, ~~[or]~~ 98.104, or 98.1045 to other programs within
5 the department, to the Health and Human Services Commission, and to
6 other health and human services agencies, as defined by Section
7 531.001, Government Code, for public health research or analysis
8 purposes only, provided that the research or analysis relates to
9 health care-associated infections or preventable adverse events.
10 The privilege and confidentiality provisions contained in this
11 chapter apply to such disclosures.

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

15 (k) The commissioner of state health services shall appoint
16 a person who meets the qualifications prescribed by Subdivision
17 (3), Subsection (a), Section 98.052, Health and Safety Code, as
18 amended by this section, to serve as a member of the advisory panel
19 established under Section 98.051, Health and Safety Code, on each
20 expiration date of the term of a member serving on that panel who
21 met the qualifications prescribed by Subdivision (3), Subsection
22 (a), Section 98.052, Health and Safety Code, as that section
23 existed immediately preceding the effective date of this Act, and
24 who was appointed before that date. In addition, as soon as
25 possible after the effective date of this Act, the commissioner
26 shall appoint two additional members to the advisory panel who meet
27 the qualifications prescribed by Subdivision (4), Subsection (a),

Section 98.052, Health and Safety Code, as amended by this section.

(1) 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 8. 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. 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 (1) must be:

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

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

7 (2) may include measures of:

8 (A) quality of life;

9 (B) direct-care staff retention and turnover;

10 (C) recipient satisfaction;

11 (D) employee satisfaction and engagement;

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

14 (F) regulatory compliance;

15 (G) level of person-centered care; and

16 (H) level of occupancy or of facility
17 utilization.

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

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

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

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

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

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

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

15 (A) data collection;

16 (B) data analysis; and

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

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

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

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

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

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

8 (c) The Health and Human Services Commission shall conduct a
9 study to evaluate the feasibility of providing an incentive payment
10 program for the following types of providers of long-term care
11 services, as defined by Section 22.0011, Human Resources Code,
12 under the medical assistance program similar to the incentive
13 payment program established for nursing facilities under Section
14 32.0283, Human Resources Code, as added by this section:

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

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

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

26 (e) As soon as practicable after the effective date of this
27 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 9. 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

1 Subdivision (2).

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

6 (c) Rules adopted by the executive commissioner of the
7 Health and Human Services Commission under Section 32.0312, Human
8 Resources Code, as added by this section, may apply only to a
9 preventable adverse event occurring on or after the effective date
10 of the rules.

11 SECTION 10. PATIENT RISK IDENTIFICATION SYSTEM. Subchapter
12 A, Chapter 311, Health and Safety Code, is amended by adding Section
13 311.004 to read as follows:

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

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

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

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

1 the department in developing the statewide system.

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

6 (d) The department may exempt from the statewide
7 standardized patient risk identification system a hospital that
8 seeks to adopt another patient risk identification methodology
9 supported by evidence-based protocols for the practice of medicine.

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

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

15 SECTION 11. FEDERAL AUTHORIZATION. If before implementing
16 any provision of this Act a state agency determines that a waiver or
17 authorization from a federal agency is necessary for implementation
18 of that provision, the agency affected by the provision shall
19 request the waiver or authorization and may delay implementing that
20 provision until the waiver or authorization is granted.

21 SECTION 12. NO APPROPRIATION. This Act does not make an
22 appropriation. This Act takes effect only if a specific
23 appropriation for the implementation of the Act is provided in a
24 general appropriations act of the 81st Legislature.

25 SECTION 13. EFFECTIVE DATE. This Act takes effect
26 September 1, 2009.