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 nutritional choices by child health plan program enrollees and Medicaid recipients; and

(3) achieve 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 consider the degree to which child health plan program enrollees and Medicaid recipients in the region are at higher than average

risk of obesity.

(c) In developing the pilot program, the commission and the Department of State Health Services shall identify measurable goals and specific strategies for achieving those goals.

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

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

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

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

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

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

(b) The commission shall establish a pilot program in one or more health care service regions in this state designed to establish a medical home for each child health plan program

enrollee and Medicaid recipient participating in the pilot program. A primary care provider participating in the program may designate a care coordinator to support the medical home concept.

(c) Any physician practice group providing services to participants under the pilot program must meet the Physician Practice Connections--Patient-Centered Medical Home standards established by the National Committee for Quality Assurance, as those standards existed on January 1, 2009.

(d) The commission shall 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.

(e) Not later than November 1, 2011, the commission shall submit a report to the standing committees of the senate and house of representatives having primary jurisdiction over the child health plan and Medicaid programs regarding the results of the pilot program under this section. The report must include:

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

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

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

SECTION 2. UNCOMPENSATED HOSPITAL CARE DATA. (a) The heading to Section 531.551, Government Code, is amended to read as follows:

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

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

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

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

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

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

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

(a-2) The Department of State Health Services shall notify the commission of each hospital in this state that fails to submit complete and adequate data required by the department under Subsection (a-1) on or before the date specified by the department.

Notwithstanding any other law and to the extent allowed by federal law, the commission may withhold Medicaid program reimbursements owed to the hospital until the hospital complies with the requirement.

(d) If the commission determines through the procedures adopted under Subsection (b) that a hospital submitted a report described by Subsection (a)(3) with incomplete or inaccurate information, the commission shall notify the hospital of the specific information the hospital must submit and prescribe a date by which the hospital must provide that information. If the hospital fails to submit the specified information on or before the date prescribed by the commission, the commission shall notify the attorney general of that failure. On receipt of the notice, the attorney general shall impose an administrative penalty on the hospital in an amount not to exceed $10,000. In determining the amount of the penalty to be imposed, the attorney general shall consider:

(1) the seriousness of the violation;

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

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

(m) The commission may require each hospital that is required under 42 C.F.R. Section 455.304 to be audited to pay a fee in an amount equal to the costs incurred in conducting the audit.

(c) As soon as possible after the date the Department of State Health Services requires each hospital in this state to

initially submit uncompensated hospital care data under Section 531.551(a-1), Government Code, as added by this section, the executive commissioner of the Health and Human Services Commission shall adopt rules or amendments to existing rules that conform to the requirements of Section 531.551(a), Government Code, as amended by this section.

SECTION 3. MEDICAL TECHNOLOGY; ELECTRONIC HEALTH INFORMATION EXCHANGE PROGRAM. (a) Section 531.02411, Government Code, is amended to read as follows:

Sec. 531.02411. STREAMLINING ADMINISTRATIVE PROCESSES. (a) The commission shall make every effort using the commission's existing resources to reduce the paperwork and other administrative burdens placed on Medicaid recipients and providers and other participants in the Medicaid program and shall use technology and efficient business practices to decrease those burdens. In addition, the commission shall make every effort to improve the business practices associated with the administration of the Medicaid program by any method the commission determines is cost-effective, including:

(1) expanding the utilization of the electronic claims payment system;

(2) developing an Internet portal system for prior authorization requests;

(3) encouraging Medicaid providers to submit their program participation applications electronically;

(4) ensuring that the Medicaid provider application is easy to locate on the Internet so that providers may conveniently

apply to the program;

(5) working with federal partners to take advantage of every opportunity to maximize additional federal funding for technology in the Medicaid program; and

(6) encouraging the increased use of medical technology by providers, including increasing their use of:

(A) electronic communications between patients and their physicians or other health care providers;

(B) electronic prescribing tools that provide up-to-date payer formulary information at the time a physician or other health care practitioner writes a prescription and that support the electronic transmission of a prescription;

(C) ambulatory computerized order entry systems that facilitate physician and other health care practitioner orders at the point of care for medications and laboratory and radiological tests;

(D) inpatient computerized order entry systems to reduce errors, improve health care quality, and lower costs in a hospital setting;

(E) regional data-sharing to coordinate patient care across a community for patients who are treated by multiple providers; and

(F) electronic intensive care unit technology to allow physicians to fully monitor hospital patients remotely.

(b) The commission shall develop and implement a plan designed to encourage the increased use by Medicaid providers of the medical technology described by Subsection (a)(6)(B). The plan

must include a goal of achieving by September 1, 2014, a specified percentage increase in the use of electronic prescribing by Medicaid providers. Not later than January 1, 2010, the commission shall submit a report to the legislature describing the plan developed by the commission in accordance with this subsection. Not later than January 1, 2011, and January 1, 2013, the commission shall submit a report to the legislature regarding the implementation and results of the plan. This subsection expires September 1, 2014.

(b) 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) "Health care provider" means a person, other than a physician, who is licensed or otherwise authorized to provide a health care service in this state.

(2) "Health information exchange system" means the electronic health information exchange system created under this subchapter.

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) appropriate information technology systems used by the commission and health and human services agencies are

interoperable; and

(2) 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.

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

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

(1) Medicaid providers;

(2) child health plan program providers;

(3) fee-for-service providers;

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

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

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

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

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

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

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

(2) presentation of data;

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

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

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

Sec. 531.904. STAGE ONE: ELECTRONIC HEALTH RECORD. (a) In stage one of implementing the health information exchange system,

the commission shall develop and establish a claims-based electronic health record for each person who receives medical assistance under the Medicaid program. The electronic health record must be available through an Internet-based format.

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

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

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

(3) an immunization record;

(4) a prescription history;

(5) a list of pending and past due appointments based on Texas Health Steps program guidelines; and

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

(c) Information under Subsection (b) may be added to any existing electronic health record or health information technology.

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

Sec. 531.905. STAGE ONE: ELECTRONIC PRESCRIBING. (a) In stage one of implementing the health information exchange system, the commission shall develop and coordinate electronic prescribing

tools for use by physicians and health care providers under the child health plan and Medicaid programs.

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

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

(2) support the electronic transmission of a prescription.

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

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; or

(4) using predictive modeling techniques and medical profiling capabilities to create a unique health profile for a person to be included in the person's electronic health record to alert physicians and health care providers regarding the need for education, counseling, or health management activities.

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

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

(2) developing benchmarking tools that can be used to evaluate the performance of physicians and health care providers and overall health care quality; or

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

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

Sec. 531.909. RULES. The executive commissioner may adopt rules to implement this subchapter.

(c) Subchapter B, Chapter 62, Health and Safety Code, is

amended by adding Section 62.060 to read as follows:

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

(b) The commission shall ensure that any health information technology used in the child health plan program conforms to the standards adopted by the Healthcare Information Technology Standards Panel sponsored by the American National Standards Institute.

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

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

(b) The Health and Human Services Commission shall ensure that any health information technology used in the medical assistance program conforms to the standards adopted by the Healthcare Information Technology Standards Panel sponsored by the American National Standards Institute.

(e) 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.

(f) 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 4. 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 physician or health care provider for arranging for or providing health care services to child health plan program enrollees or Medicaid recipients, or both, that is based on the physician or health care provider meeting or exceeding certain defined performance measures. The compensation system may include sharing realized cost savings with the physician or other health care provider.

(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) Physicians and other health care providers may submit proposals to the commission for the implementation through pilot programs of quality-based payment initiatives that provide incentives to the physicians or other health care providers 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 the bundled payment system used in the Medicare program and consider whether implementing the system, 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 physicians and other health care providers participating in the child health plan or Medicaid program, as applicable, that are based on best practices, outcomes, and efficiency, but ensure high-quality, effective health care services.

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

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

(1) one or more regions in this state;

(2) one or more organized networks of physicians, hospitals, and other health care providers; or

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

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

Sec. 531.954. STANDARDS; PROTOCOLS. (a) The executive commissioner shall approve quality of care standards and evidence-based protocols for a pilot program to ensure high-quality and effective health care services.

(b) In addition to the standards approved under Subsection (a), the executive commissioner may approve efficiency performance standards that may include the sharing of realized cost savings with physicians and other health care providers who provide health care services that exceed the efficiency performance standards.

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

this subchapter.

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

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

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

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

(1) describe the operation of the pilot program;

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

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

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

SECTION 5. QUALITY-BASED HOSPITAL PAYMENTS. Chapter 531, Government Code, is amended by adding Subchapter X to read as follows:

SUBCHAPTER X. QUALITY-BASED HOSPITAL REIMBURSEMENT SYSTEM

Sec. 531.981. DEFINITIONS. In this subchapter:

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

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

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

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

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

(A) the same condition or procedure for which the

person was previously admitted;

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

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

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

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

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

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

(b) The executive commissioner shall adopt rules requiring hospitals in this state to collect data with respect to Medicaid recipients regarding any indicators that are present at the time of a recipient's admission to the hospital that the recipient may experience potentially preventable complications on discharge from the hospital. The rules must:

(1) be consistent with policies established for the Medicare program for the collection of present-on-admission indicators; and

(2) require each hospital to report data on the indicators to the Texas Health Care Information Collection maintained by the Department of State Health Services.

(c) The commission shall establish a program to provide a confidential report to each hospital in this state regarding the hospital's performance with respect to potentially preventable readmissions of Medicaid recipients. The commission shall select a method for identifying potentially preventable readmissions for purposes of this subsection.

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

(e) The commission shall convert the hospital Medicaid reimbursement system to an all patient refined diagnoses related

groups (APR-DRG) payment system that will allow the commission to more accurately classify specific patient populations and account for severity of patient illness and mortality risk.

Sec. 531.984. PHASE TWO: REIMBURSEMENT ADJUSTMENTS. (a) The second phase of the development of the quality-based hospital reimbursement system consists of the elements described by this section and must be based on the information reported, and the all patient refined diagnoses related groups (APR-DRG) payment system implemented, during phase one of the development.

(b) Using the information reported and the all patient refined diagnoses related groups (APR-DRG) payment system implemented during phase one of the development of the quality-based hospital reimbursement system, the commission shall adjust Medicaid reimbursements to hospitals based on performance in reducing potentially preventable readmissions. The adjustment may be a partial reduction of the reimbursement, but may not entirely eliminate the reimbursement.

(c) The commission shall review present-on-admission indicator data reported by hospitals under Section 531.983(b) to determine the feasibility of establishing a program related to potentially preventable complications. If the program is determined feasible, the commission may establish a program to provide confidential reports to each hospital in this state regarding the hospital's performance with respect to potentially preventable complications experienced by Medicaid recipients. The commission shall select a method for identifying potentially preventable complications for purposes of this subsection.

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

Sec. 531.985. PHASE THREE: ADDITIONAL REIMBURSEMENT ADJUSTMENTS. (a) The third phase of the development of the quality-based hospital reimbursement system consists of the elements described by this section, and is based on the information reported during phase two of the development.

(b) The commission shall use the information reported during phase two of the development of the quality-based hospital reimbursement system to guide decision-making on the option of adjusting Medicaid reimbursements to hospitals based on performance in reducing potentially preventable complications. If the commission adjusts the reimbursements, the adjustment may be in the amount of a portion of the reimbursement, but may not entirely eliminate the reimbursement.

(c) The commission may expand the applicability of reimbursement adjustments to additional bases.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) avoid duplicate submission of records;

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

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

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

Sec. 98.1045. REPORTING OF PREVENTABLE ADVERSE EVENTS. (a) In this section:

(1) "Infant" means a child younger than one year of age.

(2) "Serious disability" means:

(A) a physical or mental impairment that substantially limits one or more major life activities of an individual such as seeing, hearing, speaking, walking, or breathing, or a loss of a bodily function, if the impairment or loss lasts more than seven days or is still present at the time of discharge from an inpatient health care facility; or

(B) loss of a body part.

(3) "Serious injury" means a bodily injury that results in:

(A) death;

(B) permanent and serious impairment of an important bodily function; or

(C) permanent and significant disfigurement.

(b) Each health care facility shall report to the department the following preventable adverse events involving the facility's patient, if applicable:

(1) surgery performed on the wrong body part;

(2) surgery performed on the wrong person;

(3) the wrong surgical procedure performed on the patient;

(4) the unintended retention of a foreign object in the patient after surgery or another procedure;

(5) death during or immediately after surgery if the patient would be classified as a normal, healthy patient under

guidelines published by a national association of anesthesiologists;

(6) death or serious disability caused by the use of a contaminated drug, device, or biologic provided by a health care professional if the contamination was the result of a generally detectable contaminant in drugs, devices, or biologics regardless of the source of the contamination or product;

(7) death or serious disability caused by the use or function of a device during the patient's care in which the device was used for a function other than as intended;

(8) death or serious disability caused by an intravascular air embolism that occurred while the patient was receiving care, excluding a death associated with a neurological procedure known to present a high risk of intravascular air embolism;

(9) an infant being discharged to the wrong person;

(10) death or serious disability associated with the patient's disappearance for more than four hours, excluding the death or serious disability of an adult patient who has decision-making capacity;

(11) suicide or attempted suicide resulting in serious disability while the patient was receiving care at the facility if the suicide or attempted suicide was due to the patient's actions after admission to the facility, excluding a death resulting from a self-inflicted injury that was the reason for the patient's admission to the facility;

(12) death or serious disability caused by a

medication error, including an error involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration;

(13) death or serious disability caused by a hemolytic reaction resulting from the administration of ABO-incompatible blood or blood products;

(14) death or serious disability caused by labor or delivery in a low-risk pregnancy while the patient was receiving care at the facility, including death or serious disability occurring not later than 42 days after the delivery date;

(15) death or serious disability directly related to the following manifestations of poor glycemic control, the onset of which occurred while the patient was receiving care at the facility:

(A) diabetic ketoacidosis;

(B) nonketotic hyperosmolar coma;

(C) hypoglycemic coma;

(D) secondary diabetes with ketoacidosis; and

(E) secondary diabetes with hyperosmolarity;

(16) death or serious disability, including kernicterus, caused by failure to identify and treat hyperbilirubinemia in a neonate before discharge from the facility;

(17) stage three or four pressure ulcers acquired after admission to the facility;

(18) death or serious disability resulting from spinal manipulative therapy;

(19) death or serious disability caused by an electric

shock while the patient was receiving care at the facility, excluding an event involving a planned treatment such as electric countershock;

(20) an incident in which a line designated for oxygen or other gas to be delivered to the patient contained the wrong gas or was contaminated by a toxic substance;

(21) death or serious disability caused by a burn incurred from any source while the patient was receiving care at the facility;

(22) death or serious disability caused by a fall while the patient was receiving care at the facility;

(23) death or serious disability caused by the use of a restraint or bed rail while the patient was receiving care at the facility;

(24) an instance of care for the patient ordered or provided by an individual impersonating a physician, nurse, pharmacist, or other licensed health care professional;

(25) abduction of the patient from the facility;

(26) sexual assault of the patient within or on the grounds of the facility;

(27) death or serious injury resulting from a physical assault of the patient that occurred within or on the grounds of the facility;

(28) artificial insemination with the wrong donor sperm or implantation with the wrong donor egg;

(29) death or serious disability caused by a surgical site infection occurring as a result of the following procedures:

(A) a coronary artery bypass graft;

(B) bariatric surgery such as laparoscopic gastric bypass surgery, gastroenterostomy, and laparoscopic gastric restrictive surgery; and

(C) orthopedic procedures involving the spine, neck, shoulder, or elbow;

(30) death or serious disability caused by a pulmonary embolism or deep vein thrombosis that occurred while the patient was receiving care at the facility following a total knee arthroplasty or hip arthroplasty;

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

(32) any other preventable adverse event for which the facility is denied reimbursement under Section 32.0312, Human Resources Code.

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

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

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

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

(b) Information included in the [~~The~~] departmental summary

with respect to infections reported by facilities under Sections 98.103 and 98.104 must be risk adjusted and include a comparison of the risk-adjusted infection rates for each health care facility in this state that is required to submit a report under Sections 98.103 and 98.104.

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

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

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

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

(b-1) A state employee or officer may not be examined in a civil, criminal, or special proceeding, or any other proceeding, regarding the existence or contents of information or materials

obtained, compiled, or reported by the department under this chapter.

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

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

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

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

(j) 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 7. 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 LONG-TERM CARE PROVIDERS. (a) In this section, "long-term care provider" means a provider of long-term care services, as defined by Section 22.0011, to medical assistance recipients. The term includes:

(1) a convalescent or nursing home or related institution licensed under Chapter 242, Health and Safety Code;

(2) an intermediate care facility for persons with mental retardation licensed under Chapter 252, Health and Safety Code; and

(3) a provider of community-based long-term care services.

(b) If feasible, the executive commissioner of the Health and Human Services Commission by rule shall establish an incentive payment program for long-term care providers that is designed to improve the quality of care provided to medical assistance recipients. The program must provide additional reimbursement payments in accordance with this section to the providers that exceed performance standards established by the executive commissioner.

(c) In establishing an incentive payment program under this

section, the executive commissioner of the Health and Human Services Commission shall, subject to Subsection (d), adopt outcome-based performance measures. The performance measures:

(1) must be indicators of:

(A) whether a long-term care provider is providing evidence-based care; and

(B) the overall quality of care received by medical assistance recipients; and

(2) may include measures of:

(A) quality of life;

(B) direct-care staff stability;

(C) recipient satisfaction;

(D) regulatory compliance;

(E) level of person-centered care; and

(F) level of occupancy.

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

(1) limit the number of performance measures adopted under Subsection (c) to avoid an unreasonable administrative burden on long-term care providers; and

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

(e) To be eligible for an incentive payment under the program, a long-term care provider must exceed applicable performance thresholds in at least two of the performance measures adopted under Subsection (c), at least one of which is an indicator

of quality of care.

(f) The amount of an incentive payment under the program must be based on a long-term care provider's ability to achieve each performance measure, with greater weight given to performance measures that are strong indicators of quality of care.

(g) The executive commissioner of the Health and Human Services Commission may enter into a contract with a person for the following services related to the program:

(1) data collection;

(2) data analysis; and

(3) reporting of long-term care provider performance on the performance measures.

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

SECTION 8. NEVER 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 PROHIBITED FOR SERVICES ASSOCIATED WITH PREVENTABLE ADVERSE EVENTS. (a) In this section, "health care provider" means a person or facility licensed, certified, or otherwise authorized by the laws of this state to administer health care, for profit or otherwise, in the ordinary course of business or professional practice.

(b) The department may not provide reimbursement under the medical assistance program to a health care provider for a health

care service provided in association with a preventable adverse event involving a recipient of medical assistance while in the provider's care, including a health care service provided as a result of or to correct the consequences of a preventable adverse event.

(c) The executive commissioner of the Health and Human Services Commission shall adopt rules necessary to implement this section, including rules defining a preventable adverse event for purposes of Subsection (b). In adopting rules under this subsection, the executive commissioner shall:

(1) ensure that the department does not provide reimbursement for health care services provided in association with the same types of health care-associated adverse conditions for which the Medicare program will not provide additional payment under a policy adopted by the Centers for Medicare and Medicaid Services;

(2) consider the list of adverse events identified by the National Quality Forum; and

(3) consult with health care providers, including hospitals, physicians, and nurses, and representatives of health benefit plan issuers to obtain the recommendations of those providers and representatives regarding denial of reimbursement claims for any other preventable adverse events that cause patient death or serious disability in health care settings.

(b) Not later than November 1, 2009, the executive commissioner of the Health and Human Services Commission shall adopt rules necessary to implement Section 32.0312, Human Resources

Code, as added by this section.

(c) Notwithstanding Section 32.0312, Human Resources Code, as added by this section, Section 32.0312 applies only to a preventable adverse event occurring on or after the effective date of the rules adopted by the executive commissioner of the Health and Human Services Commission under Subsection (b) of this section.

SECTION 9. PATIENT WRISTBANDS. Subchapter A, Chapter 311, Health and Safety Code, is amended by adding Section 311.004 to read as follows:

Sec. 311.004. STANDARDIZED PATIENT WRISTBANDS. (a) In this section:

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

(2) "Hospital" means a hospital licensed under Chapter 241.

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

(c) The department shall require each hospital to implement and enforce the statewide standardized patient wristband identification system developed under Subsection (b).

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

SECTION 10. FEDERAL AUTHORIZATION. If before implementing any provision of this Act a state agency determines that a waiver or authorization from a federal agency is necessary for implementation of that provision, the agency affected by the provision shall request the waiver or authorization and may delay implementing that provision until the waiver or authorization is granted.

SECTION 11. EFFECTIVE DATE. This Act takes effect September 1, 2009.