SENATE AMENDMENTS

2nd Printing

By: Howard of Travis H.B. No. 1218

A BILL TO BE ENTITLED

AN ACT

relating to a pilot project to exchange secure electronic health information between the Health and Human Services Commission and local or regional health information exchanges.

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

SECTION 1. Subchapter B, Chapter 531, Government Code, is amended by adding Section 531.02416 to read as follows:

Sec. 531.02416. ELECTRONIC HEALTH INFORMATION EXCHANGE PILOT PROJECT. (a) The commission shall establish a pilot project in at least one urban area of this state to determine the feasibility, costs, and benefits of exchanging secure electronic health information between the commission and local or regional health information exchanges. The pilot project must include the participation of at least two local or regional health information exchanges.

(b) A local or regional health information exchange selected for the pilot project under this section must possess a functioning health information exchange database that exchanges secure electronic health information among hospitals, clinics, physicians' offices, and other health care providers that are not each owned by a single entity or included in a single operational unit or network. The information exchanged by the local or regional health information exchange must include health information for patients receiving services from state and federal health and human

services programs administered by the commission.

(c) In developing the pilot project under this section, the commission shall:

(1) establish specific written guidelines, in conjunction with the health information exchanges participating in the pilot project, to:

(A) ensure that information exchanged through the pilot project is used only for the patient's benefit; and

(B) specify which health care providers will use which data elements obtained from the commission and for what purposes, including purposes related to reducing costs, improving access, and improving quality of care for patients; and

(2) ensure compliance with all state and federal laws and rules related to the transmission of health information, including state privacy laws and the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. Section 1320d et seq.) and rules adopted under that Act.

(d) The commission and the health information exchanges participating in the pilot project shall at a minimum exchange a patient's medication history under the pilot project. The pilot project may include additional health care information, either at the inception of the project or as part of a subsequent expansion of the scope of the project.

(e) The commission may accept gifts, grants, and donations from any public or private source for the operation of the pilot project.

SECTION 2. Not later than the 60th day after the effective

date of this Act, the Health and Human Services Commission shall begin implementing the pilot project established under Section 531.02416, Government Code, as added by this Act.

SECTION 3. Not later than December 1, 2010, the Health and Human Services Commission shall:

(1) assess, in conjunction with the health information exchanges selected for participation in the pilot project established under Section 531.02416, Government Code, as added by this Act, the benefits to the state, patients, and health care providers of exchanging secure health information with local or regional health information exchanges;

(2) include, as part of the assessment required by Subdivision (1) of this section, a return on investment analysis for the guidelines developed under Section 531.02416(c)(1), Government Code, as added by this Act; and

(3) report the commission's findings to the standing committees of the senate and house of representatives having primary jurisdiction over health and human services issues.

SECTION 4. 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 5. This Act takes effect immediately if it receives a vote of two-thirds of all the members elected to each house, as provided by Section 39, Article III, Texas Constitution. If this

Act does not receive the vote necessary for immediate effect, this Act takes effect September 1, 2009.

ADOPTED

MAY 2 6 2009

Secretary of the Senate

FLOOR AMENDMENT NO. 1 BY: [signature]

Amend H.B. No. 1218 (senate committee printing) as follows:

(1) In SECTION 1 of the bill, immediately following added Section 531.02416(d), Government Code (page 1, between lines 53 and 54), insert the following:

(e) The pilot project shall initially use the method of secure transmission that is available at the time implementation of the pilot project begins, and subsequently move toward full interoperability in conjunction with the health information exchange development plan administered by the commission.

(2) In SECTION 1 of the bill, in added Section 531.02416(e), Government Code (page 1, line 54), strike "(e)" and substitute "(f)".

(3) Strike SECTION 2 of the bill (page 1, lines 57-60) and substitute the following:

SECTION 2. The Health and Human Services Commission shall begin implementing the pilot project established under Section 531.02416, Government Code, as added by this Act, as soon as feasible after September 1, 2009, but not later than the 60th day after the effective date of this Act.

(4) In SECTION 3 of the bill (page 1, line 61), strike "December 1, 2010" and substitute "January 1, 2011".

ADOPTED

MAY 2 6 2009

Secretary of the Senate

FLOOR AMENDMENT NO. 2 BY: Whitmire

Amend H.B. No. 1218 by inserting the following language on page 1, line 50, between the period and "The":

If the commissioner determines that there will be no significant cost to the state, the commission shall apply for and actively pursue any waiver from the federal Centers for Medicare and Medicaid Services as may be necessary for the pilot project and shall actively pursue a waiver to use an electronic alternative to the requirement for handwritten certification under 42 C.F.R. Section 447.152.

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ADOPTED

MAY 2 6 2009

Secretary of the Senate

FLOOR AMENDMENT NO. 3 BY: _____

Amend H.B. 1218 by adding the appropriately numbered SECTIONS to read as follows:

SECTION __. Subchapter B, Chapter 7, Education Code, is amended by adding Section 7.029 to read as follows:

Sec. 7.029. MEMORANDUM OF UNDERSTANDING REGARDING EXCHANGE OF INFORMATION FOR STUDENTS IN FOSTER CARE. (a) The agency and the Department of Family and Protective Services shall enter into a memorandum of understanding regarding the exchange of information as appropriate to facilitate the department's evaluation of educational outcomes of students in foster care. The memorandum of understanding must require:

(1) the department to provide the agency each year with demographic information regarding individual students who during the preceding school year were in the conservatorship of the department following an adversarial hearing under Section 262.201, Family Code; and

(2) the agency, in a manner consistent with federal law, to provide the department with aggregate information regarding educational outcomes of students for whom the agency received demographic information under Subdivision (1).

(b) For purposes of Subsection (a)(2), information regarding educational outcomes includes information relating to student academic achievement, graduation rates, school attendance, disciplinary actions, and receipt of special education services.

(c) The department may authorize the agency to provide education research centers established under Section 1.005 with demographic information regarding individual students received by the agency in accordance with Subsection (a)(1), as

appropriate to allow the centers to perform additional analysis regarding educational outcomes of students in foster care. Any use of information regarding individual students provided to a center under this subsection must be approved by the department.

(d) Nothing in this section may be construed to:

(1) require the agency or the department to collect or maintain additional information regarding students in foster care; or

(2) allow the release of information regarding an individual student in a manner not permitted under the Family Educational Rights and Privacy Act of 1974 (20 U.S.C. Section 1232g) or another state or federal law.

SECTION __. The Texas Education Agency and the Department of Family and Protective Services shall enter into the memorandum of understanding required by Section 7.029, Education Code, as added by this Act, not later than January 1, 2010.

ADOPTED

MAY 26 2009

Secretary of the Senate

FLOOR AMENDMENT NO. 4 BY: Nelson

Amend H.B. No. 1218 (senate committee printing) by adding the following appropriately numbered SECTION to the bill and renumbering subsequent SECTIONS of the bill accordingly:

SECTION __. (a) Chapter 531, Government Code, is amended by adding Subchapter V to read as follows:

SUBCHAPTER V. ELECTRONIC HEALTH INFORMATION EXCHANGE PROGRAM

Sec. 531.901. DEFINITIONS. In this subchapter:

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

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

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

(4) "Local or regional health information exchange" means a health information exchange operating in this state that securely exchanges electronic health information, including information for patients receiving services under the child health plan or Medicaid program, among hospitals, clinics, physicians' offices, and other health care providers that are not owned by a single entity or included in a single operational unit or network.

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

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

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

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

(C) Chapter 552, Government Code;

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

(E) Section 12.003, Human Resources Code; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) The executive commissioner shall appoint to the advisory committee at least 12 and not more than 16 members who have an interest in health information technology and who have experience in serving persons receiving health care through the child health plan and Medicaid programs.

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

(1) Medicaid providers;

(2) child health plan program providers;

(3) fee-for-service providers;

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) presentation of data;

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

(4) federal and state laws regarding privacy and

management of private patient information;

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

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

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

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

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

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

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

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

(2) does not require the purchase of a new electronic

medical records system.

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

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

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

(3) an immunization record;

(4) a prescription history;

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

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

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

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

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

the 30th day after the last day of the month in which the managed care organization adjudicated the claim.

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

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

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

(2) to the extent feasible:

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

(B) support the electronic transmission of a prescription.

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

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

Section 447.512. If the commission with assistance from the Legislative Budget Board determines that the implementation of operational modifications in accordance with a waiver obtained as required by this subsection has resulted in cost increases in the child health plan or Medicaid program, the commission shall take the necessary actions to reverse the operational modifications.

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

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

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

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

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

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

(b) In expanding the system, the commission shall consult

and collaborate with, and accept recommendations from, physicians and other stakeholders to ensure that electronic health records provided under this section support health information exchange with electronic medical records systems in use by physicians in the public and private sectors in a manner that:

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

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

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

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

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

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

Sec. 531.909. REPORTS. (a) The commission shall provide an initial report to the Senate Committee on Health and Human Services or its successor, the House Committee on Human Services or its successor, and the House Committee on Public Health or its successor regarding the health information exchange system not later than January 1, 2011, and shall provide a subsequent

report to those committees not later than January 1, 2013. Each report must:

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

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

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

(b) This section expires September 2, 2013.

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

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

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

(b) The commission shall ensure that any health information technology used by the commission or any entity acting on behalf of the commission in the child health plan program conforms to standards required under federal law.

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

Sec. 32.073. HEALTH INFORMATION TECHNOLOGY STANDARDS. (a) In this section, "health information technology" means

information technology used to improve the quality, safety, or efficiency of clinical practice, including the core functionalities of an electronic health record, an electronic medical record, a computerized health care provider order entry, electronic prescribing, and clinical decision support technology.

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

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

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

ADOPTED

MAY 26 2009

Secretary of the Senate

Floor Amendment No. 5 By: Jane Nelson

Amend H.B. 1218 (Senate Committee Printing) by adding the following appropriately numbered SECTION to the bill:

SECTION _____. 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) must be:

(A) recognized by the executive commissioner as

valid indicators of the overall quality of care received by medical assistance recipients; and

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

(2) may include measures of:

(A) quality of life;

(B) direct-care staff retention and turnover;

(C) recipient satisfaction;

(D) employee satisfaction and engagement;

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

(F) regulatory compliance;

(G) level of person-centered care; and

(H) level of occupancy or of facility utilization.

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

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

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

(e) To be eligible for an incentive payment under the program, a nursing facility must meet or exceed applicable

performance thresholds in at least two of the performance measures adopted under Subsection (c), at least one of which is an indicator of quality of care.

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

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

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

(A) data collection;

(B) data analysis; and

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

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

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

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

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

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

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

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

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

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

(e) As soon as practicable after the effective date of this

Act, the executive commissioner of the Health and Human Services Commission shall adopt the rules required by Section 32.0283, Human Resources Code, as added by this section.

ADOPTED

MAY 2 6 2009

Secretary of the Senate

FLOOR AMENDMENT NO. 6 BY: Nelson

Amend H.B. No. 1218 (Senate committee printing) as follows:

(1) Add the following appropriately numbered SECTIONS to the bill and renumber subsequent SECTIONS of the bill accordingly:

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

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

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

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

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

(b) The commission and the Department of State Health Services shall implement the pilot program for a period of at least 24 months in one or more health care service regions in this state, as selected by the commission. In selecting the regions for participation, the commission shall consider the degree to which child health plan program enrollees and Medicaid recipients in the region are at higher than average risk of obesity.

(c) In developing the pilot program, the commission and the Department of State Health Services in consultation with the Health Care Quality Advisory Committee established under Section

531.0995 shall identify measurable goals and specific strategies for achieving those goals. The specific strategies may be evidence-based to the extent evidence-based strategies are available for the purposes of the program.

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

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

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

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

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

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

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

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

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

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

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

(d) The commission shall submit a report on or before each January 1 that occurs during the period the pilot program is operated to the standing committees of the senate and house of representatives having primary jurisdiction over the child health plan and Medicaid programs regarding the status of the pilot program. Each report must include:

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

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

recommendations.

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

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

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

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

Sec. 531.0995. HEALTH CARE QUALITY ADVISORY COMMITTEE. (a) The commission shall establish the Health Care Quality Advisory Committee to assist the commission as specified by Subsection (e) with defining best practices and quality performance with respect to health care services and setting standards for quality performance by health care providers and facilities for purposes of programs administered by the commission or a health and human services agency.

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

(1) the following types of health care providers:

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

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

(C) a nurse practitioner;

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

(A) a general acute care hospital; and

(B) a children's hospital;

(3) a representative from a care management organization;

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

(5) a representative of health care consumers.

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

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

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

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

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

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

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

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

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

as follows:

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

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

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

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

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

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

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

(a-2) The Department of State Health Services shall notify the commission of each hospital in this state that fails to submit complete and adequate data required by the department

under Subsection (a-1) on or before the date specified by the department. Notwithstanding any other law and to the extent allowed by federal law, the commission may withhold Medicaid program reimbursements owed to the hospital until the hospital complies with the requirement.

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

(1) the seriousness of the violation;

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

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

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

(c) As soon as possible after the date the Department of

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

SECTION __. QUALITY-BASED PAYMENT INITIATIVES. (a) Chapter 531, Government Code, is amended by adding Subchapter W to read as follows:

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

Sec. 531.951. DEFINITIONS. In this subchapter:

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

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

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

state and will improve the quality of health care provided to the enrollees or recipients.

(b) The commission shall determine whether it is feasible and cost-effective to implement one or more of the proposed pilot programs. In addition, the commission shall examine alternative payment methodologies used in the Medicare program and consider whether implementing one or more of the methodologies, modified as necessary to account for programmatic differences, through a pilot program under this subchapter would achieve cost savings in the Medicaid program while ensuring the use of best practices.

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

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

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

(1) one or more regions in this state;

(2) one or more organized networks of health care

facilities and providers; or

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

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

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

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

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

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

(c) The executive commissioner shall ensure that services provided to a child health plan program enrollee or Medicaid

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

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

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

(1) describe the operation of the pilot program;

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

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

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

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

SUBCHAPTER X. QUALITY-BASED HOSPITAL REIMBURSEMENT SYSTEM

Sec. 531.981. DEFINITIONS. In this subchapter:

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

groups methodology.

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

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

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

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

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

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

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

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

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

Sec. 531.982. DEVELOPMENT OF QUALITY-BASED HOSPITAL REIMBURSEMENT SYSTEM. (a) Subject to Subsection (b), the

commission shall develop a quality-based hospital reimbursement system for paying Medicaid reimbursements to hospitals. The system is intended to align Medicaid provider payment incentives with improved quality of care, promote coordination of health care, and reduce potentially preventable complications and readmissions.

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

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

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

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

(d) After the commission provides the reports to hospitals as provided by Subsection (c), each hospital will be afforded a

period of two years during which the hospital may adjust its practices in an attempt to reduce its potentially preventable readmissions. During this period, reimbursements paid to the hospital may not be adjusted on the basis of potentially preventable readmissions.

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

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

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

(1) may not be applied to a hospital if the patient's readmission to that hospital is classified as a potentially preventable readmission, but that hospital is not the same

hospital to which the person was previously admitted; and

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

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

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

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

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

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

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

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

Sec. 32.0424. REQUIREMENTS OF THIRD-PARTY HEALTH INSURERS. (a) A third-party health insurer is required to provide to the

department, on the department's request, information in a form prescribed by the department necessary to determine:

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

(2) the nature of the coverage; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

establish one or more subcommittees to assist the advisory panel in addressing health care-associated infections and preventable adverse events relating to hospital care provided to children or other special patient populations.

(d) Subsection (a), Section 98.052, Health and Safety Code, as added by Chapter 359 (S.B. 288), Acts of the 80th Legislature, Regular Session, 2007, is amended to read as follows:

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

(1) two infection control professionals who:

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

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

(2) two infection control professionals who:

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

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

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

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

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

(C) have demonstrated expertise in quality

assessment and performance improvement or infection control in health care facilities;

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

(5) one officer of a general hospital;

(6) one officer of an ambulatory surgical center;

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

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

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

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

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

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

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

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

department; and

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

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

(1) avoid duplicate submission of records;

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

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

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

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

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

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

(b) The executive commissioner may exclude an adverse event described by Subsection (a)(2) from the reporting requirement of Subsection (a) if the executive commissioner, in consultation with the advisory panel, determines that the

adverse event is not an appropriate indicator of a preventable adverse event.

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

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

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

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

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

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

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

Sec. 98.108. FREQUENCY OF REPORTING. In consultation with the advisory panel, the executive commissioner by rule shall establish the frequency of reporting by health care facilities

required under Sections 98.103, [~~and~~] 98.104, and 98.1045. Facilities may not be required to report more frequently than quarterly.

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

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

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

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

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

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

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

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

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

Sec. 32.0312. REIMBURSEMENT FOR SERVICES ASSOCIATED WITH PREVENTABLE ADVERSE EVENTS. The executive commissioner of the Health and Human Services Commission shall adopt rules regarding the denial or reduction of reimbursement under the medical assistance program for preventable adverse events that occur in a hospital setting. In adopting the rules, the executive commissioner:

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

the federal Centers for Medicare and Medicaid Services;

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) Strike SECTION 5 of the bill (page 2, lines 18 through 22) and substitute the following appropriately numbered SECTION:

SECTION ___. This Act takes effect September 1, 2009.

ADOPTED

MAY 2 6 2009

Secretary of the Senate

FLOOR AMENDMENT NO. 1 BY: _____

Amend H.B. No. 1218 (Senate committee printing) by adding the following appropriately numbered SECTIONS to the bill and renumbering subsequent SECTIONS of the bill accordingly:

SECTION ___. Subsections (e) and (g), Section 531.102, Government Code, are amended to read as follows:

(e) The executive commissioner [~~commission~~], in consultation with the inspector general, by rule shall set specific claims criteria that, when met, require the office to begin an investigation. The claims criteria adopted under this subsection must be consistent with the criteria adopted under Section 32.0291(a-1), Human Resources Code.

(g)(1) Whenever the office learns or has reason to suspect that a provider's records are being withheld, concealed, destroyed, fabricated, or in any way falsified, the office shall immediately refer the case to the state's Medicaid fraud control unit. However, such criminal referral does not preclude the office from continuing its investigation of the provider, which investigation may lead to the imposition of appropriate administrative or civil sanctions.

(2) In addition to other instances authorized under state or federal law, the office shall impose without prior notice a hold on payment of claims for reimbursement submitted by a provider to compel production of records or when requested by the state's Medicaid fraud control unit, as applicable. The office must notify the provider of the hold on payment not later than the fifth working day after the date the payment hold is imposed. The notice to the provider must include:

(A) an information statement indicating the nature of a payment hold;

(B) a statement of the reason the payment hold is being imposed, the provider's suspected violation, and the evidence to support that suspicion; and

(C) a statement that the provider is entitled to request a hearing regarding the payment hold or an informal resolution of the identified issues, the time within which the request must be made, and the procedures and requirements for making the request, including that a request for a hearing must be in writing.

(3) On timely written request by a provider subject to a hold on payment under Subdivision (2), other than a hold requested by the state's Medicaid fraud control unit, the office shall file a request with the State Office of Administrative Hearings for an expedited administrative hearing regarding the hold. The provider must request an expedited hearing under this subdivision not later than the 10th day after the date the provider receives notice from the office under Subdivision (2). A provider who submits a timely request for a hearing under this subdivision must be given notice of the following not later than the 30th day before the date the hearing is scheduled:

(A) the date, time, and location of the hearing; and

(B) a list of the provider's rights at the hearing, including the right to present witnesses and other evidence.

(3-a) With respect to a provider who timely requests a hearing under Subdivision (3):

(A) if the hearing is not held on or before the 60th day after the date of the request, the payment hold is automatically terminated on the 60th day after the date of the request and may be reinstated only if prima facie evidence of

fraud, waste, or abuse is presented subsequently at the hearing;

(B) if the hearing is held on or before the 60th day after the date of the request, the payment hold may be continued after the hearing only if the hearing officer determines that prima facie evidence of fraud, waste, or abuse was presented at the hearing; and

(C) if the hearing is scheduled to be held on or before the 60th day after the date of the request, but a request for a continuance is made by the provider and granted by the State Office of Administrative Hearings, the period of the continuance is excluded in computing whether the hearing was held on or before the 60th day after the date of the request for purposes of this subdivision.

(4) The commission shall adopt rules that allow a provider subject to a hold on payment under Subdivision (2), other than a hold requested by the state's Medicaid fraud control unit, to seek an informal resolution of the issues identified by the office in the notice provided under that subdivision. A provider must seek an informal resolution under this subdivision not later than the deadline prescribed by Subdivision (3). A provider's decision to seek an informal resolution under this subdivision does not extend the time by which the provider must request an expedited administrative hearing under Subdivision (3). However, a hearing initiated under Subdivision (3) shall be stayed at the office's request until the informal resolution process is completed. The period during which the hearing is stayed under this subdivision is excluded in computing whether a hearing was scheduled or held not later than the 60th day after the hearing was requested for purposes of Subdivision (3-a).

(4-a) With respect to a provider who timely requests

an informal resolution under Subdivision (4):

(A) if the informal resolution is not completed on or before the 60th day after the date of the request, the payment hold is automatically terminated on the 60th day after the date of the request and may be reinstated only if prima facie evidence of fraud, waste, or abuse is subsequently presented at a hearing requested and held under Subdivision (3); and

(B) if the informal resolution is completed on or before the 60th day after the date of the request, the payment hold may be continued after the completion of the informal resolution only if the office determines that prima facie evidence of fraud, waste, or abuse was presented during the informal resolution process.

(5) The executive commissioner [~~office~~] shall, in consultation with the state's Medicaid fraud control unit, adopt rules for the office [~~establish guidelines~~] under which holds on payment or program exclusions:

(A) may permissively be imposed on a provider; or

(B) shall automatically be imposed on a provider.

(6) If a payment hold is terminated, either automatically or after a hearing or informal review, in accordance with Subdivision (3-a) or (4-a), the office shall inform all affected claims payors, including Medicaid managed care organizations, of the termination not later than the fifth day after the date of the termination.

(7) A provider in a case in which a payment hold was imposed under this subsection who ultimately prevails in a hearing or, if the case is appealed, on appeal, or with respect

to whom the office determines that prima facie evidence of fraud, waste, or abuse was not presented during an informal resolution process, is entitled to prompt payment of all payments held and interest on those payments at a rate equal to the prime rate, as published in The Wall Street Journal on the first day of each calendar year that is not a Saturday, Sunday, or legal holiday, plus one percent.

SECTION ___. Subsections (a) and (b), Section 531.103, Government Code, are amended to read as follows:

(a) The commission, acting through the commission's office of inspector general, and the office of the attorney general shall enter into a memorandum of understanding to develop and implement joint written procedures for processing cases of suspected fraud, waste, or abuse, as those terms are defined by state or federal law, or other violations of state or federal law under the state Medicaid program or other program administered by the commission or a health and human services agency, including the financial assistance program under Chapter 31, Human Resources Code, a nutritional assistance program under Chapter 33, Human Resources Code, and the child health plan program. The memorandum of understanding shall require:

(1) the office of inspector general and the office of the attorney general to set priorities and guidelines for referring cases to appropriate state agencies for investigation, prosecution, or other disposition to enhance deterrence of fraud, waste, abuse, or other violations of state or federal law, including a violation of Chapter 102, Occupations Code, in the programs and maximize the imposition of penalties, the recovery of money, and the successful prosecution of cases;

(1-a) the office of inspector general to refer each case of suspected provider fraud, waste, or abuse to the office

of the attorney general not later than the 20th business day after the date the office of inspector general determines that the existence of fraud, waste, or abuse is reasonably indicated;

(1-b) the office of the attorney general to take appropriate action in response to each case referred to the attorney general, which action may include direct initiation of prosecution, with the consent of the appropriate local district or county attorney, direct initiation of civil litigation, referral to an appropriate United States attorney, a district attorney, or a county attorney, or referral to a collections agency for initiation of civil litigation or other appropriate action;

(2) the office of inspector general to keep detailed records for cases processed by that office or the office of the attorney general, including information on the total number of cases processed and, for each case:

(A) the agency and division to which the case is referred for investigation;

(B) the date on which the case is referred; and

(C) the nature of the suspected fraud, waste, or abuse;

(3) the office of inspector general to notify each appropriate division of the office of the attorney general of each case referred by the office of inspector general;

(4) the office of the attorney general to ensure that information relating to each case investigated by that office is available to each division of the office with responsibility for investigating suspected fraud, waste, or abuse;

(5) the office of the attorney general to notify the office of inspector general of each case the attorney general declines to prosecute or prosecutes unsuccessfully;

(6) representatives of the office of inspector general and of the office of the attorney general to meet not less than quarterly to share case information and determine the appropriate agency and division to investigate each case; [~~and~~]

(7) the office of inspector general and the office of the attorney general to submit information requested by the comptroller about each resolved case for the comptroller's use in improving fraud detection; and

(8) the office of inspector general and the office of the attorney general to develop and implement joint written procedures for processing cases of suspected fraud, waste, or abuse, which must include:

(A) procedures for maintaining a chain of custody for any records obtained during an investigation and for maintaining the confidentiality of the records;

(B) a procedure by which a provider who is the subject of an investigation may make copies of any records taken from the provider during the course of the investigation before the records are taken or, in lieu of the opportunity to make copies, a requirement that the office of inspector general or the office of the attorney general, as applicable, make copies of the records taken during the course of the investigation and provide those copies to the provider not later than the 10th day after the date the records are taken; and

(C) a procedure for returning any original records obtained from a provider who is the subject of a case of suspected fraud, waste, or abuse not later than the 15th day after the final resolution of the case, including all hearings and appeals.

(b) An exchange of information under this section between the office of the attorney general and the commission, the

office of inspector general, or a health and human services agency does not affect the confidentiality of the information or whether the information is subject to disclosure under Chapter 552.

SECTION ___. Section 32.0291, Human Resources Code, is amended to read as follows:

Sec. 32.0291. PREPAYMENT REVIEWS AND POSTPAYMENT HOLDS. (a) Notwithstanding any other law and subject to Subsections (a-1) and (a-2), the department may:

(1) perform a prepayment review of a claim for reimbursement under the medical assistance program to determine whether the claim involves fraud or abuse; and

(2) as necessary to perform that review, withhold payment of the claim for not more than five working days without notice to the person submitting the claim.

(a-1) The executive commissioner of the Health and Human Services Commission shall adopt rules governing the conduct of a prepayment review of a claim for reimbursement from a medical assistance provider authorized by Subsection (a). The rules must:

(1) specify actions that must be taken by the department, or an appropriate person with whom the department contracts, to educate the provider and remedy irregular coding or claims filing issues before conducting a prepayment review;

(2) outline the mechanism by which a specific provider is identified for a prepayment review;

(3) define the criteria, consistent with the criteria adopted under Section 531.102(e), Government Code, used to determine whether a prepayment review will be imposed, including the evidentiary threshold, such as prima facie evidence, that is required before imposition of that review;

(4) prescribe the maximum number of days a provider may be placed on prepayment review status;

(5) require periodic reevaluation of the necessity of continuing a prepayment review after the review action is initially imposed;

(6) establish procedures affording due process to a provider placed on prepayment review status, including notice requirements, an opportunity for a hearing, and an appeals process; and

(7) provide opportunities for provider education while providers are on prepayment review status.

(a-2) The department may not perform a random prepayment review of a claim for reimbursement under the medical assistance program to determine whether the claim involves fraud or abuse. The department may only perform a prepayment review of the claims of a provider who meets the criteria adopted under Subsection (a-1)(3) for imposition of a prepayment review.

(b) Notwithstanding any other law and subject to Section 531.102(g), Government Code, the department may impose a postpayment hold on payment of future claims submitted by a provider if the department has reliable evidence that the provider has committed fraud or wilful misrepresentation regarding a claim for reimbursement under the medical assistance program. [~~The department must notify the provider of the postpayment hold not later than the fifth working day after the date the hold is imposed.~~]

(c) A postpayment hold authorized by this section is governed by the requirements and procedures specified for payment holds under Section 531.102, Government Code [~~On timely written request by a provider subject to a postpayment hold under Subsection (b), the department shall file a request with~~

~~the State Office of Administrative Hearings for an expedited administrative hearing regarding the hold. The provider must request an expedited hearing under this subsection not later than the 10th day after the date the provider receives notice from the department under Subsection (b). The department shall discontinue the hold unless the department makes a prima facie showing at the hearing that the evidence relied on by the department in imposing the hold is relevant, credible, and material to the issue of fraud or wilful misrepresentation.~~

[~~(d) The department shall adopt rules that allow a provider subject to a postpayment hold under Subsection (b) to seek an informal resolution of the issues identified by the department in the notice provided under that subsection. A provider must seek an informal resolution under this subsection not later than the deadline prescribed by Subsection (c). A provider's decision to seek an informal resolution under this subsection does not extend the time by which the provider must request an expedited administrative hearing under Subsection (c). However, a hearing initiated under Subsection (c) shall be stayed at the department's request until the informal resolution process is completed~~].

SECTION ___. The executive commissioner of the Health and Human Services Commission shall adopt the rules required by Subsection (a-1), Section 32.0291, Human Resources Code, as added by this Act, not later than November 1, 2009.

ADOPTED

MAY 26 2009

Secretary of the Senate

FLOOR AMENDMENT NO. _____ BY: Patricia VandePutte

1218 Rotary Saw

Amend # B. No. 1238 by adding the following appropriately numbered SECTION to the bill and renumbering subsequent SECTIONS of the bill accordingly:

Subchapter B, Chapter 562, Occupations Code, is amended by adding Section 562.057 to read as follows:

Sec. 562.057. COMMERCIAL USE STUDY; CIVIL PENALTY. (a) The board shall conduct a study on the license, transfer, use, and sale of prescription information records containing patient-identifiable and practitioner-identifiable information by pharmacy benefit managers, insurers, electronic transmission intermediaries, pharmacies, and other similar entities for the purpose of advertising, marketing, or promoting pharmaceutical products.

(b) Not later than August 1, 2010, the board shall submit to the governor, the lieutenant governor, the speaker of the house of representatives, and the appropriate standing committees of the legislature a report regarding the results of the study conducted under Subsection (a), together with any recommendation for legislation.

(c) The report under this section must consist of aggregate information and may not identify by name any entity that provided information to the board. Information provided by an entity that is a trade secret is subject to Section 552.110, Government Code.

(d) An entity described by Subsection (a), other than a pharmacy, that fails to provide to the board the information requested by the board for the study conducted under this section before the 90th day after the date the board requests the information is liable to this state for a civil penalty not

to exceed $5,000 for each violation. Each day a violation continues constitutes a separate violation.

(e) The amount of the penalty shall be based on:

(1) the seriousness of the violation;

(2) the history of previous violations;

(3) the amount necessary to deter a future violation; and

(4) any other matter that justice may require.

(f) The board or the attorney general may sue to collect a civil penalty under this section. In the suit the state may recover the reasonable expenses incurred in obtaining the penalty, including investigation and court costs, reasonable attorney's fees, witness fees, and other expenses.

(g) A pharmacy that fails to provide to the board the information requested by the board for the study conducted under this section before the 90th day after the date the board requests the information is subject to appropriate administrative sanctions imposed by the board.

(h) This section expires October 1, 2010.

SECTION __ This Act takes effect immediately if it receives a vote of two-thirds of all the members elected to each house, as provided by Section 39, Article III, Texas Constitution. If this Act does not receive the vote necessary for immediate effect, this Act takes effect September 1, 2009.

ADOPTED

MAY 26 2009

Secretary of the Senate

FLOOR AMENDMENT NO. 9 BY: Van de Putte

Amend H.B. 128 by adding the following appropriately numbered SECTION to the bill and renumbering subsequent SECTIONS of the bill accordingly:

SECTION ____. (a) Title 12, Health and Safety Code, is amended by designating Chapter 1001, Health and Safety Code, as Subtitle A and adding a heading for Subtitle A to read as follows:

SUBTITLE A. ADMINISTRATION BY DEPARTMENT

(b) Title 12, Health and Safety Code, is amended by adding Subtitle B to read as follows:

SUBTITLE B. DEPARTMENT OF STATE HEALTH SERVICES PROGRAMS

CHAPTER 1022. SERVICES FOR SERVICEMEMBERS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1022.001. DEFINITIONS. In this chapter:

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

(2) "Post-traumatic stress disorder" means a psychiatric disorder that can occur in people who have experienced or witnessed life-threatening events, including natural disasters, serious accidents, terrorist incidents, war, or violent personal assaults.

(3) "Program" means the program established under this chapter.

(4) "Servicemember" has the meaning assigned by Section 161.551.

(5) "Traumatic brain injury" means an acquired injury to the brain, including brain injuries caused by anoxia due to near drowning. The term does not include brain dysfunction caused by congenital or degenerative disorders or birth trauma.

Sec. 1022.002. RULES. The executive commissioner of the

Health and Human Services Commission shall adopt rules to implement this chapter.

Sec. 1022.003. CREATION AND PURPOSE. The department shall establish a program under this chapter to promote the wellness of servicemembers and their families through the development, maintenance, and dissemination of clinical practice guidelines and other information for the effective treatment of psychological trauma and the reintegration of servicemembers into their communities, families, and workplaces, with emphasis on the trauma of war, including post-traumatic stress disorder, traumatic brain injury, and sexual trauma that occurs in military settings.

[Sections 1022.004-1022.050 reserved for expansion]

SUBCHAPTER B. CLINICAL PRACTICE GUIDELINES FOR TRAUMA

Sec. 1022.051. CLINICAL GUIDELINES. (a) The department shall develop evidence-based clinical practice guidelines containing recommendations to clinicians and other providers of mental health services for the management of trauma, including post-traumatic stress disorder, traumatic brain injury, and other trauma impacting behavioral health.

(b) In developing clinical practice guidelines, the department shall consider the recommendations and research of the National Center for Posttraumatic Stress Disorder of the federal Veterans Health Administration, the trauma registry and research database of the United States Army Institute of Surgical Research, and other appropriate and reputable sources of clinical research and information as determined by the department.

(c) The department shall provide for the ongoing maintenance and updating of the clinical practice guidelines in a manner that reflects current diagnostic and treatment best practices.

(d) Clinical practice guidelines established under this

subchapter do not constitute the sole source of guidance in the management of trauma. Guidelines are intended to assist clinicians by providing a framework for clinical decision making. These guidelines do not provide the only appropriate approach to the management of trauma or replace other clinical judgment.

Sec. 1022.052. DISSEMINATION OF GUIDELINES. (a) The department shall make the clinical practice guidelines and other information developed under this subchapter available to providers of physical and behavioral health services.

(b) The department shall provide the clinical practice guidelines and information to the appropriate professional associations to be used in continuing education and shall, to the extent feasible, enter into agreements or take other action to promote the use of the materials for continuing education purposes.

(c) The department or its designees shall provide training and continuing education to clinicians and shall recognize through certificates or other means the health care providers that have demonstrated knowledge and mastery of the clinical practice guidelines and other materials developed by the department for the program.

Sec. 1022.053. TRAINING AND EDUCATIONAL MATERIALS. In addition to clinical practice guidelines, the department shall develop, with the advice of and in consultation with the Texas Veterans Commission, training and educational materials for the use of the Texas Veterans Commission, veterans county service officers, and other service providers. The materials must promote the understanding and effective treatment of trauma affecting behavioral health and other health-related information pertaining to the reintegration of servicemembers into their communities, families, and workplaces.

[Sections 1022.054-1022.100 reserved for expansion]

SUBCHAPTER C. SERVICE COORDINATION FOR BEHAVIORAL HEALTH SERVICES

Sec. 1022.101. SERVICE COORDINATION. (a) The department, in consultation with the United States Department of Veterans Affairs, the Texas military forces, the Texas Information and Referral Network, the Texas Veterans Commission, and the General Land Office, shall provide service coordination for servicemembers and their families in all geographic regions of the state to connect them to behavioral health services that may be available through the United States Department of Veterans Affairs or available under this chapter.

(b) In geographic areas in this state in which services are not yet available or accessible through the United States Department of Veterans Affairs, the department shall negotiate contracts with the United States Department of Veterans Affairs for behavioral health services provided through community mental health centers or other community resources with which the department contracts until federal services are available.

(c) The department shall provide servicemembers and their families current, accurate, and complete information about behavioral health services and resources through existing Internet-based resource programs and through:

(1) the directory of services for military personnel and their families disseminated through the Texas Information and Referral Network under Subchapter U, Chapter 161; and

(2) the service referral program under Section 431.0291, Government Code, as added by Chapter 1381 (S.B. 1058), Acts of the 80th Legislature, Regular Session, 2007.

(d) The department shall seek reimbursement for the costs of services provided under this section from the United States Department of Veterans Affairs and from other governmental agencies

that may provide behavioral health services or payments for such services to servicemembers and their families.

(e) In order to enhance service coordination and assess the needs of servicemembers and their families, the department shall provide an opportunity for servicemembers to disclose military status when accessing local behavioral health services that receive funding from the department.

[Sections 1022.102-1022.150 reserved for expansion]

SUBCHAPTER D. BEHAVIORAL HEALTH SERVICES PILOT PROGRAMS

Sec. 1022.151. ESTABLISHMENT OF PILOT PROGRAMS. (a) The department shall establish pilot programs in El Paso and Bexar Counties to evaluate the effectiveness of a program to provide behavioral health services to eligible servicemembers.

(b) The department shall contract with the local mental health authorities in El Paso and Bexar Counties to administer the pilot programs.

Sec. 1022.152. ELIGIBILITY. (a) To qualify for behavioral health services under Section 1022.153, a servicemember must:

(1) reside in El Paso or Bexar County;

(2) be younger than 65 years of age;

(3) have served for at least 180 days of duty after the servicemember's initial training;

(4) not be an inmate of a public institution;

(5) not be a resident of a nursing facility;

(6) not have health care coverage that provides diagnostic review and treatment for post-traumatic stress disorder, traumatic brain injury, or other trauma occurring in a military setting that impacts behavioral health; and

(7) be ineligible for services from the United States Department of Veterans Affairs or be unable to access those services because:

(A) the servicemember does not have transportation to a service provider; or

(B) the servicemember must wait more than 30 days for an appointment with a service provider.

(b) A servicemember who does not meet the eligibility requirements for services under this section shall be referred to an appropriate service provider for follow-up care.

(c) To receive behavioral health services under Section 1022.153, an eligible servicemember must enroll with the local mental health authority in the pilot program. Following expiration of the term of a servicemember's enrollment in the pilot program, the servicemember may reenroll for services under the pilot program if the local mental health authority determines that the servicemember continues to qualify for treatment for post-traumatic stress disorder, traumatic brain injury, or other trauma occurring in a military setting that impacts behavioral health.

(d) A family member of an enrolled servicemember may receive behavioral health services under the pilot program as described by Section 1022.153.

Sec. 1022.153. BEHAVIORAL HEALTH SERVICES PILOT PROGRAMS. (a) The department through contracts with the local mental health authorities in El Paso and Bexar Counties shall establish pilot programs to provide behavioral health services in accordance with this section for eligible servicemembers under Section 1022.152. The behavioral health services provided under this section may include:

(1) crisis services; and

(2) behavioral health services.

(b) The behavioral health services provided under Subsection (a)(2) must to the greatest extent possible be provided

in a peer-based treatment environment and may include:

(1) screening assessments;

(2) individual, family, and group therapy;

(3) substance abuse early intervention and detoxification services; and

(4) substance abuse medication-assisted treatment.

(c) The provision of services by the local mental health authority under this section must be based on medical necessity criteria established by department rule.

(d) The department shall seek reimbursement for the costs of services provided under this section from the United States Department of Veterans Affairs and from other governmental agencies that may provide behavioral health services or payments for such services to servicemembers and their families.

Sec. 1022.154. REPORT. Not later than December 1, 2010, the department shall submit a report to the governor, lieutenant governor, and speaker of the house of representatives that includes:

(1) an analysis of the effectiveness of the pilot program under this subchapter; and

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

Sec. 1022.155. EXPIRATION. This subchapter expires September 1, 2011.

[Sections 1022.156-1022.200 reserved for expansion]

SUBCHAPTER E. BEHAVIORAL HEALTH OUTREACH

Sec. 1022.201. OUTREACH ACTIVITIES. (a) Through a public outreach program, the department shall provide to servicemembers and their families information on accessing services through the Texas Information and Referral Network and through other organizations participating in memoranda of understanding

maintained by the Texas military forces.

(b) The department's outreach activities must describe programs administered by health and human services agencies that could be of interest to servicemembers and their families, including early childhood intervention services, state vocational rehabilitation services, and higher education benefits and support services.

(c) The department's outreach efforts must be:

(1) conducted on a statewide basis;

(2) conducted through a contract or contracts with statewide or local community-based organizations with experience in statewide outreach to the military; and

(3) staffed by individuals with demonstrated experience in working with the military and military service organizations.

(d) Outreach methods must include direct personal contacts with servicemembers and outreach using communications media and printed materials. As a component of the department's outreach activities, the department shall maintain or support an existing interactive Internet-based resource program that:

(1) allows individuals to access comprehensive information, advocacy resources, and other resources regarding public and private behavioral health services, crisis and emergency services, and early intervention and prevention programs; and

(2) enables the public and private health care communities to work together to address the problems related to obtaining access to behavioral health services and other reintegration services for servicemembers and their families.

(e) The interactive Internet-based program established under Subsection (d) shall be developed or maintained by the department with the advice of and in consultation with the Texas

military forces. The department shall collaborate with state agencies and the Texas military forces to develop strategies to use existing interactive Internet-based resources that serve servicemembers and their families.

(c) Subchapter A, Chapter 431, Government Code, is amended by adding Section 431.0186 to read as follows:

Sec. 431.0186. SCREENING FOR TRAUMATIC BRAIN INJURY. (a) The adjutant general shall require each member of the Texas National Guard who served during Operation Enduring Freedom or Operation Iraqi Freedom to be screened for traumatic brain injury.

(b) The adjutant general shall assist a member of the Texas National Guard who tests positive for traumatic brain injury in obtaining appropriate medical care.

(d) Section 434.007, Government Code, is amended to read as follows:

Sec. 434.007. DUTIES. (a) The commission shall:

(1) compile federal, state, and local laws enacted to benefit members of the armed forces, veterans, and their families and dependents;

(2) collect information relating to services and facilities available to veterans;

(3) cooperate with veterans service agencies in the state;

(4) inform members and veterans of the armed forces, their families and dependents, and military and civilian authorities about the existence or availability of:

(A) educational training and retraining facilities;

(B) health, medical, rehabilitation, and housing services and facilities;

(C) employment and reemployment services;

(D) provisions of federal, state, and local law affording rights, privileges, and benefits to members and veterans of the armed forces and their families and dependents; and

(E) other similar, related, or appropriate matters;

(5) assist veterans and their families and dependents in presenting, proving, and establishing claims, privileges, rights, and benefits they may have under federal, state, or local law, including establishing eligibility for health care services and treatments from the federal Veterans Health Administration and for services provided through the Department of State Health Services;

(6) cooperate with all government and private agencies securing services or benefits to veterans and their families and dependents;

(7) investigate, and if possible correct, abuses or exploitation of veterans or their families or dependents, and recommend necessary legislation for full correction;

(8) coordinate the services and activities of state departments and divisions having services and resources affecting veterans or their families or dependents;

(9) provide training and certification of veterans county service officers and assistant veterans county service officers in accordance with Section 434.038; and

(10) through surveys or other reasonable and accurate methods of estimation, collect and maintain for each county in the state the number of servicemembers and veterans residing in the county and annually update and publish the information on the commission's website.

(b) The commission shall enter into a memorandum of understanding with the Department of State Health Services to

develop training materials for veterans county service officers and veterans service organizations that promote the understanding and effective treatment of trauma affecting behavioral health and other health-related information that promotes the reintegration of members and veterans of the armed forces into their communities, families, and workplaces. The commission shall:

(1) disseminate training and educational materials for the development of clinical practice guidelines and other training and educational materials that it receives from the department;

(2) enter into a contract or other agreement for the development of the training and educational materials with the department;

(3) reimburse the department for costs of preparing the materials from appropriations or other amounts available to the commission; and

(4) enter into relationships with established training programs for the purpose of providing peer support training and certification for veterans county service officers.

(e) Subsection (a), Section 434.0078, Government Code, is amended to read as follows:

(a) The commission shall adopt procedures for administering claims assistance services under Section 434.007(5). Claims assistance services shall be provided for establishing eligibility for health care services and treatments from the federal Veterans Health Administration. The procedures shall include:

(1) criteria for determining when a veteran's initial claim is substantially complete and basic eligibility requirements are met as provided by federal law;

(2) a process for expediting a claim based on hardship, including whether the veteran:

(A) is in immediate need;

(B) is terminally ill;

(C) has a verifiable financial hardship; or

(D) has a disability that presents an undue burden;

(3) a procedure for counseling veterans on the potential merits or drawbacks of pursuing a claim;

(4) a process to ensure adequate documentation and development of a claim or appeal, including early client involvement, collection of needed evidence and records, and analysis of actions necessary to pursue and support a claim or appeal;

(5) criteria for evaluating whether a decision of the United States Department of Veterans Affairs contains sufficient cause for filing an appeal;

(6) a requirement that a claims counselor report to the United States Department of Veterans Affairs if the counselor has direct knowledge that a claim contains false or deceptive information; and

(7) a procedure for prioritizing a claim, when appropriate, or providing an alternative source for obtaining claims assistance services when it is not appropriate to prioritize.

(f) The Department of State Health Services shall conduct an immediate analysis of the behavioral health needs of servicemembers and their families and submit a preliminary report of its findings and recommendations to the legislature and the governor on or before December 1, 2009, and a final report of its findings and recommendations on or before December 1, 2010. The report shall:

(1) identify the gaps in behavioral health services available to servicemembers and their families;

(2) identify impediments to the ability of servicemembers and their families to access the behavioral health services that are available, particularly in the state's rural areas;

(3) evaluate collaboration among organizations and entities that provide behavioral health services to servicemembers and their families;

(4) make recommendations with respect to improving outreach to servicemembers and their families in need of behavioral health services;

(5) include a specific plan of action to promote federal and state collaboration to maximize funding and access to resources for the behavioral health needs of servicemembers and their families;

(6) make recommendations with respect to building provider capacity and increasing provider training to meet the behavioral health needs of servicemembers and their families through peer support treatment methodologies; and

(7) make recommendations with respect to improving the coordination of behavioral health services for servicemembers and their families.

(g) Not later than January 1, 2010, the executive commissioner of the Health and Human Services Commission shall adopt rules as necessary to administer Chapter 1022, Health and Safety Code, as added by this section.

(h) This section does not make an appropriation. This section takes effect only if a specific appropriation for the implementation of the section is provided in a general appropriations act of the 81st Legislature.

ADOPTED

MAY 2 6 2009

Secretary of the Senate

FLOOR AMENDMENT NO. 10 BY: Vande Putte

Amend H.B. No. 1218 by adding the following appropriately numbered SECTIONS to the bill and renumbering subsequent SECTIONS of the bill accordingly:

SECTION ____. Section 843.002, Insurance Code, is amended by adding Subdivision (9-a) to read as follows:

(9-a) "Extrapolation" means a mathematical process or technique used by a health maintenance organization or pharmacy benefit manager that administers pharmacy claims for a health maintenance organization in the audit of a pharmacy or pharmacist to estimate audit results or findings for a larger batch or group of claims not reviewed by the health maintenance organization or pharmacy benefit manager.

SECTION ____. Section 843.338, Insurance Code, is amended to read as follows:

Sec. 843.338. DEADLINE FOR ACTION ON CLEAN CLAIMS. Except as provided by Sections [~~Section~~] 843.3385 and 843.339, not later than the 45th day after the date on which a health maintenance organization receives a clean claim from a participating physician or provider in a nonelectronic format or the 30th day after the date the health maintenance organization receives a clean claim from a participating physician or provider that is electronically submitted, the health maintenance organization shall make a determination of whether the claim is payable and:

(1) if the health maintenance organization determines the entire claim is payable, pay the total amount of the claim in accordance with the contract between the physician or provider and the health maintenance organization;

(2) if the health maintenance organization determines a portion of the claim is payable, pay the portion of the claim that

is not in dispute and notify the physician or provider in writing why the remaining portion of the claim will not be paid; or

(3) if the health maintenance organization determines that the claim is not payable, notify the physician or provider in writing why the claim will not be paid.

SECTION ____. Section 843.339, Insurance Code, is amended to read as follows:

Sec. 843.339. DEADLINE FOR ACTION ON [~~CERTAIN~~] PRESCRIPTION CLAIMS; PAYMENT. (a) A [~~Not later than the 21st day after the date a~~] health maintenance organization, or a pharmacy benefit manager that administers pharmacy claims for the health maintenance organization, that affirmatively adjudicates a pharmacy claim that is electronically submitted[~~, the health maintenance organization~~] shall pay the total amount of the claim through electronic funds transfer not later than the 18th day after the date on which the claim was affirmatively adjudicated.

(b) A health maintenance organization, or a pharmacy benefit manager that administers pharmacy claims for the health maintenance organization, that affirmatively adjudicates a pharmacy claim that is not electronically submitted shall pay the total amount of the claim not later than the 21st day after the date on which the claim was affirmatively adjudicated.

SECTION ____. Section 843.340, Insurance Code, is amended by adding Subsections (f) and (g) to read as follows:

(f) A health maintenance organization or a pharmacy benefit manager that administers pharmacy claims for the health maintenance organization may not use extrapolation to complete the audit of a provider who is a pharmacist or pharmacy. A health maintenance organization or a pharmacy benefit manager that administers pharmacy claims for the health maintenance organization may not require extrapolation audits as a condition of participation in the

health maintenance organization's contract, network, or program for a provider who is a pharmacist or pharmacy.

(g) A health maintenance organization or a pharmacy benefit manager that administers pharmacy claims for the health maintenance organization that performs an on-site audit under this chapter of a provider who is a pharmacist or pharmacy shall provide the provider reasonable notice of the audit and accommodate the provider's schedule to the greatest extent possible. The notice required under this subsection must be in writing and must be sent by certified mail to the provider not later than the 15th day before the date on which the on-site audit is scheduled to occur.

SECTION ____. Section 843.344, Insurance Code, is amended to read as follows:

Sec. 843.344. APPLICABILITY OF SUBCHAPTER TO ENTITIES CONTRACTING WITH HEALTH MAINTENANCE ORGANIZATION. This subchapter applies to a person, including a pharmacy benefit manager, with whom a health maintenance organization contracts to:

(1) process or pay claims;

(2) obtain the services of physicians and providers to provide health care services to enrollees; or

(3) issue verifications or preauthorizations.

SECTION ____. Subchapter J, Chapter 843, Insurance Code, is amended by adding Sections 843.354, 843.355, and 843.356 to read as follows:

Sec. 843.354. DEPARTMENT ENFORCEMENT OF PHARMACY CLAIMS. (a) Notwithstanding any other provision of this subchapter, a dispute regarding payment of a claim to a provider who is a pharmacist or pharmacy shall be resolved as provided by this section.

(b) A provider who is a pharmacist or pharmacy may submit a complaint to the department alleging noncompliance with the

requirements of this subchapter by a health maintenance organization, a pharmacy benefit manager that administers pharmacy claims for the health maintenance organization, or another entity that contracts with the health maintenance organization as provided by Section 843.344. A complaint must be submitted in writing or by submitting a completed complaint form to the department by mail or through another delivery method. The department shall maintain a complaint form on the department's Internet website and at the department's offices for use by a complainant.

(c) After investigation of the complaint by the department, the commissioner shall determine the validity of the complaint and shall enter a written order. In the order, the commissioner shall provide the health maintenance organization and the complainant with:

(1) a summary of the investigation conducted by the department;

(2) written notice of the matters asserted, including a statement:

(A) of the legal authority, jurisdiction, and alleged conduct under which an enforcement action is imposed or denied, with a reference to the statutes and rules involved; and

(B) that, on request to the department, the health maintenance organization and the complainant are entitled to a hearing conducted by the State Office of Administrative Hearings in the manner prescribed by Section 843.355 regarding the determinations made in the order; and

(3) a determination of the denial of the allegations or the imposition of penalties against the health maintenance organization.

(d) An order issued under Subsection (c) is final in the absence of a request by the complainant or health maintenance

organization for a hearing under Section 843.355.

(e) If the department investigation substantiates the allegations of noncompliance made under Subsection (b), the commissioner, after notice and an opportunity for a hearing as described by Subsection (c), shall require the health maintenance organization to pay penalties as provided by Section 843.342.

Sec. 843.355. HEARING BY STATE OFFICE OF ADMINISTRATIVE HEARINGS; FINAL ORDER. (a) The State Office of Administrative Hearings shall conduct a hearing regarding a written order of the commissioner under Section 843.354 on the request of the department. A hearing under this section is subject to Chapter 2001, Government Code, and shall be conducted as a contested case hearing.

(b) After receipt of a proposal for decision issued by the State Office of Administrative Hearings after a hearing conducted under Subsection (a), the commissioner shall issue a final order.

(c) If it appears to the department, the complainant, or the health maintenance organization that a person or entity is engaging in or is about to engage in a violation of a final order issued under Subsection (b), the department, the complainant, or the health maintenance organization may bring an action for judicial review in district court in Travis County to enjoin or restrain the continuation or commencement of the violation or to compel compliance with the final order. The complainant or the health maintenance organization may also bring an action for judicial review of the final order.

Sec. 843.356. LEGISLATIVE DECLARATION. It is the intent of the legislature that the requirements contained in this subchapter regarding payment of claims to providers who are pharmacists or pharmacies apply to all health maintenance organizations and pharmacy benefit managers unless otherwise prohibited by federal

law.

SECTION ____. Section 1301.001, Insurance Code, is amended by amending Subdivision (1) and adding Subdivision (1-a) to read as follows:

(1) "Extrapolation" means a mathematical process or technique used by an insurer or pharmacy benefit manager that administers pharmacy claims for an insurer in the audit of a pharmacy or pharmacist to estimate audit results or findings for a larger batch or group of claims not reviewed by the insurer or pharmacy benefit manager.

(1-a) "Health care provider" means a practitioner, institutional provider, or other person or organization that furnishes health care services and that is licensed or otherwise authorized to practice in this state. The term includes a pharmacist and a pharmacy. The term does not include a physician.

SECTION ____. Section 1301.103, Insurance Code, is amended to read as follows:

Sec. 1301.103. DEADLINE FOR ACTION ON CLEAN CLAIMS. Except as provided by Sections 1301.104 and [~~Section~~] 1301.1054, not later than the 45th day after the date an insurer receives a clean claim from a preferred provider in a nonelectronic format or the 30th day after the date an insurer receives a clean claim from a preferred provider that is electronically submitted, the insurer shall make a determination of whether the claim is payable and:

(1) if the insurer determines the entire claim is payable, pay the total amount of the claim in accordance with the contract between the preferred provider and the insurer;

(2) if the insurer determines a portion of the claim is payable, pay the portion of the claim that is not in dispute and notify the preferred provider in writing why the remaining portion of the claim will not be paid; or

(3) if the insurer determines that the claim is not payable, notify the preferred provider in writing why the claim will not be paid.

SECTION ____. Section 1301.104, Insurance Code, is amended to read as follows:

Sec. 1301.104. DEADLINE FOR ACTION ON CERTAIN PHARMACY CLAIMS; PAYMENT. (a) An [~~Not later than the 21st day after the date an~~] insurer, or a pharmacy benefit manager that administers pharmacy claims for the insurer under a preferred provider benefit plan, that affirmatively adjudicates a pharmacy claim that is electronically submitted[~~, the insurer~~] shall pay the total amount of the claim through electronic funds transfer not later than the 18th day after the date on which the claim was affirmatively adjudicated.

(b) An insurer, or a pharmacy benefit manager that administers pharmacy claims for the insurer under a preferred provider benefit plan, that affirmatively adjudicates a pharmacy claim that is not electronically submitted shall pay the total amount of the claim not later than the 21st day after the date on which the claim was affirmatively adjudicated.

SECTION ____. Section 1301.105, Insurance Code, is amended by adding Subsections (e) and (f) to read as follows:

(e) An insurer or a pharmacy benefit manager that administers pharmacy claims for the insurer may not use extrapolation to complete the audit of a preferred provider that is a pharmacist or pharmacy. An insurer may not require extrapolation audits as a condition of participation in the insurer's contract, network, or program for a preferred provider that is a pharmacist or pharmacy.

(f) An insurer or a pharmacy benefit manager that administers pharmacy claims for the insurer that performs an

on-site audit of a preferred provider that is a pharmacist or pharmacy shall provide the provider reasonable notice of the audit and accommodate the provider's schedule to the greatest extent possible. The notice required under this subsection must be in writing and must be sent by certified mail to the preferred provider not later than the 15th day before the date on which the on-site audit is scheduled to occur.

SECTION ____. Section 1301.109, Insurance Code, is amended to read as follows:

Sec. 1301.109. APPLICABILITY TO ENTITIES CONTRACTING WITH INSURER. This subchapter applies to a person, including a pharmacy benefit manager, with whom an insurer contracts to:

(1) process or pay claims;

(2) obtain the services of physicians and health care providers to provide health care services to insureds; or

(3) issue verifications or preauthorizations.

SECTION ____. Subchapter C-1, Chapter 1301, Insurance Code, is amended by adding Sections 1301.139, 1301.140, and 1301.141 to read as follows:

Sec. 1301.139. DEPARTMENT ENFORCEMENT OF PHARMACY CLAIMS. (a) Notwithstanding any other provision of this subchapter, a dispute regarding payment of a claim to a preferred provider who is a pharmacist or pharmacy shall be resolved as provided by this section.

(b) A preferred provider who is a pharmacist or pharmacy may submit a complaint to the department alleging noncompliance with the requirements of this subchapter by an insurer, a pharmacy benefit manager that administers pharmacy claims for the insurer, or another entity that contracts with the insurer as provided by Section 1301.109. A complaint must be submitted in writing or by submitting a completed complaint form to the department by mail or

through another delivery method. The department shall maintain a complaint form on the department's Internet website and at the department's offices for use by a complainant.

(c) After investigation of the complaint by the department, the commissioner shall determine the validity of the complaint and shall enter a written order. In the order, the commissioner shall provide the insurer and the complainant with:

(1) a summary of the investigation conducted by the department;

(2) written notice of the matters asserted, including a statement:

(A) of the legal authority, jurisdiction, and alleged conduct under which an enforcement action is imposed or denied, with a reference to the statutes and rules involved; and

(B) that, on request to the department, the insurer and the complainant are entitled to a hearing conducted by the State Office of Administrative Hearings in the manner prescribed by Section 1301.140 regarding the determinations made in the order; and

(3) a determination of the denial of the allegations or the imposition of penalties against the insurer.

(d) An order issued under Subsection (c) is final in the absence of a request by the complainant or insurer for a hearing under Section 1301.140.

(e) If the department investigation substantiates the allegations of noncompliance made under Subsection (b), the commissioner, after notice and an opportunity for a hearing as described by Subsection (c), shall require the insurer to pay penalties as provided by Section 1301.137.

Sec. 1301.140. HEARING BY STATE OFFICE OF ADMINISTRATIVE HEARINGS; FINAL ORDER. (a) The State Office of Administrative

Hearings shall conduct a hearing regarding a written order of the commissioner under Section 1301.139 on the request of the department. A hearing under this section is subject to Chapter 2001, Government Code, and shall be conducted as a contested case hearing.

(b) After receipt of a proposal for decision issued by the State Office of Administrative Hearings after a hearing conducted under Subsection (a), the commissioner shall issue a final order.

(c) If it appears to the department, the complainant, or the insurer that a person or entity is engaging in or is about to engage in a violation of a final order issued under Subsection (b), the department, the complainant, or the insurer may bring an action for judicial review in district court in Travis County to enjoin or restrain the continuation or commencement of the violation or to compel compliance with the final order. The complainant or the insurer may also bring an action for judicial review of the final order.

Sec. 1301.141. LEGISLATIVE DECLARATION. It is the intent of the legislature that the requirements contained in this subchapter regarding payment of claims to preferred providers who are pharmacists or pharmacies apply to all insurers and pharmacy benefit managers unless otherwise prohibited by federal law.

SECTION _____. The change in law made by this Act to Chapters 843 and 1301, Insurance Code, applies only to a claim submitted by a provider to a health maintenance organization or an insurer on or after the effective date of this Act. A claim submitted before the effective date of this Act is governed by the law as it existed immediately before that date, and that law is continued in effect for that purpose.

SECTION _____. The change in law made by this Act to Chapters 843 and 1301, Insurance Code, applies only to a contract between a

pharmacy benefit manager and an insurer or health maintenance organization entered into or renewed on or after January 1, 2010. A contract entered into or renewed before January 1, 2010, is governed by the law as it existed immediately before the effective date of this Act, and that law is continued in effect for that purpose.

ADOPTED

MAY 26 2009

BY: Elliot Shapleigh

Secretary of the Senate

FLOOR AMENDMENT NO. 11

Amend H.B. No. 1218 (senate committee printing) by adding the following appropriately numbered SECTIONS to the bill and renumbering subsequent SECTIONS of the bill accordingly:

SECTION ___. Section 155.051, Occupations Code, is amended by adding Subsections (d) and (e) to read as follows:

(d) The time frame to pass each part of the examination does not apply to an applicant who:

(1) is licensed and in good standing as a physician in another state;

(2) has been licensed for at least five years;

(3) does not hold a medical license in the other state that has or has ever had any restrictions, disciplinary orders, or probation; and

(4) will practice in a medically underserved area or a health manpower shortage area, as those terms are defined by Section 157.052.

(e) The board may by rule establish a process to verify that a person, after meeting the requirements of Subsection (d), practices only in an area described by Subsection (d)(4).

SECTION ___. Section 155.056, Occupations Code, is amended by adding Subsections (e) and (f) to read as follows:

(e) The limitation on examination attempts by an applicant under Subsection (a) does not apply to an applicant who:

(1) is licensed and in good standing as a physician in another state;

(2) has been licensed for at least five years;

(3) does not hold a medical license in the other state that has or has ever had any restrictions, disciplinary orders, or probation; and

(4) will practice in a medically underserved area or a health manpower shortage area, as those terms are defined by Section 157.052.

(f) The board may by rule establish a process to verify that a person who, after meeting the requirements of Subsection (e), practices only in an area described by Subsection (e)(4).

ADOPTED

MAY 2 6 2009

Secretary of the Senate

FLOOR AMENDMENT NO. 12 BY: Leticia Vande Putte

Amend H.B. No. 1218 by adding the following appropriately numbered SECTION to the bill and renumbering subsequent SECTIONS of the bill accordingly:

Subchapter B, Chapter 562, Occupations Code, is amended by adding Section 562.057 to read as follows:

Sec. 562.057. COMMERCIAL USE STUDY; CIVIL PENALTY. (a) The board shall conduct a study on the license, transfer, use, and sale of prescription information records containing patient-identifiable and practitioner-identifiable information by pharmacy benefit managers, insurers, electronic transmission intermediaries, pharmacies, and other similar entities for the purpose of advertising, marketing, or promoting pharmaceutical products.

(b) Not later than August 1, 2010, the board shall submit to the governor, the lieutenant governor, the speaker of the house of representatives, and the appropriate standing committees of the legislature a report regarding the results of the study conducted under Subsection (a), together with any recommendation for legislation.

(c) The report under this section must consist of aggregate information and may not identify by name any entity that provided information to the board. Information provided by an entity that is a trade secret is subject to Section 552.110, Government Code.

(d) An entity described by Subsection (a), other than a pharmacy, that fails to provide to the board the information requested by the board for the study conducted under this section before the 90th day after the date the board requests the information is liable to this state for a civil penalty not

to exceed $5,000 for each violation. Each day a violation continues constitutes a separate violation.

(e) The amount of the penalty shall be based on:

(1) the seriousness of the violation;

(2) the history of previous violations;

(3) the amount necessary to deter a future violation; and

(4) any other matter that justice may require.

(f) The board or the attorney general may sue to collect a civil penalty under this section. In the suit the state may recover the reasonable expenses incurred in obtaining the penalty, including investigation and court costs, reasonable attorney's fees, witness fees, and other expenses.

(g) A pharmacy that fails to provide to the board the information requested by the board for the study conducted under this section before the 90th day after the date the board requests the information is subject to appropriate administrative sanctions imposed by the board.

(h) This section expires October 1, 2010.

SECTION __ This Act takes effect immediately if it receives a vote of two-thirds of all the members elected to each house, as provided by Section 39, Article III, Texas Constitution. If this Act does not receive the vote necessary for immediate effect, this Act takes effect September 1, 2009.

LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 81ST LEGISLATIVE REGULAR SESSION

May 28, 2009

TO: Honorable Joe Straus, Speaker of the House, House of Representatives

FROM: John S. O'Brien, Director, Legislative Budget Board

IN RE: **HB1218** by Howard, Donna (Relating to a pilot project to exchange secure electronic health information between the Health and Human Services Commission and local or regional health information exchanges.), **As Passed 2nd House**

Estimated Two-year Net Impact to General Revenue Related Funds for HB1218, As Passed 2nd House: a positive impact of $889,741 through the biennium ending August 31, 2011.

The bill would make no appropriation but could provide the legal basis for an appropriation of funds to implement the provisions of the bill.

General Revenue-Related Funds, Five-Year Impact:

Fiscal Year	Probable Net Positive/(Negative) Impact to General Revenue Related Funds
2010	$225,861
2011	$663,880
2012	$4,762,833
2013	$4,816,457
2014	$4,851,357

All Funds, Five-Year Impact:

Fiscal Year	Probable Savings/ (Cost) from *GR Match For Medicaid* 758	Probable Savings/ (Cost) from *Federal Funds* 555	Probable Savings/ (Cost) from *New Other: AR Match for Medicaid Administrative*	Probable Savings/ (Cost) from *Medicaid Program Income* 705
2010	($5,319,257)	($11,882,757)	($2,186,000)	($7,500,000)
2011	($4,880,858)	($7,066,858)	($2,186,000)	($7,500,000)
2012	($2,376,147)	($4,562,147)	($2,186,000)	($7,500,000)
2013	($2,355,776)	($4,541,776)	($2,186,000)	($7,500,000)
2014	($2,355,776)	($4,541,776)	($2,186,000)	($7,500,000)

Fiscal Year	Probable Savings from *GR Match For Medicaid* 758	Probable Revenue Gain from *New Other: AR Match for Medicaid Administrative*	Probable Revenue Gain from *Medicaid Program Income* 705	Probable Revenue Gain from *Insurance Maint Tax Fees* 8042
2010	$7,500,000	$2,186,000	$7,500,000	$237,619
2011	$8,007,873	$2,186,000	$7,500,000	$223,795
2012	$8,041,130	$2,186,000	$7,500,000	$223,795
2013	$8,076,303	$2,186,000	$7,500,000	$223,795
2014	$8,113,187	$2,186,000	$7,500,000	$223,795

Fiscal Year	Probable (Cost) from *Insurance Maint Tax Fees* 8042	Probable Revenue Gain from *General Revenue Fund* 1	Probable (Cost) from *General Revenue Fund* 1	Change in Number of State Employees from FY 2009
2010	($237,619)	$10,000	($1,964,882)	15.8
2011	($223,795)	$0	($2,463,135)	19.0
2012	($223,795)	$0	($902,150)	16.5
2013	($223,795)	$0	($904,070)	16.0
2014	($223,795)	$0	($906,054)	16.0

Fiscal Analysis

AMENDMENTS 1 and 2: The bill would amend Subchapter B, Chapter 531, Government Code, to establish an electronic health information exchange pilot project in at least one urban area of the state with the participation of at least two local or regional health information exchanges.

The bill would require, at a minimum, the exchange of a patient's medication history between the Health and Human Services Commission (HHSC) and the selected health information exchanges under the pilot project. The pilot may include additional health care information either at inception or in a subsequent expansion. The bill would require HHSC to begin implementation of the pilot after September 1, 2009, but not later than the 60th day after the effective date of the bill. The agency could accept gifts, grants and donations for the pilot project.

The bill would require HHSC to assess the pilot project benefits to the state, the patients, and the health care providers of exchanging secure health information with local or regional health information exchanges. HHSC would be required to complete the pilot assessment, including analysis of return on investment, and report the findings by January 1, 2011.

AMENDMENT 3: The Texas Education Agency estimates that costs to provide the Department of Family and Protective Services (DFPS) with aggregated educational outcomes for students who were in conservatorship could be met with existing resources. Assuming that students placed in foster care refers only to children in DFPS conservatorship and not to all children in residential care, the DFPS indicates that workload associated with compiling and sharing information could be accommodated using existing resources.

AMENDMENTS 4, 5 and 6: The bill would amend the Government Code, Health and Safety Code, and Human Resources Code as it relates to strategies for and improvements in quality of health care and care management provided through health care facilities and through the Children's Health Insurance Program (CHIP) and Medicaid designed to improve health outcomes.

Original section 1 requires the HHSC and the Department of State Health Services (DSHS) to establish an obesity prevention pilot program for a period of at least 24 months in one or more health care service regions. HHSC would also be required to establish and operate for a period of at least 24 months a pilot program, in one or more health care service regions, designed to establish a medical home for participating CHIP and Medicaid recipients.

Original section 2 requires HHSC to establish the Health Care Quality Advisory Committee.

Original section 3 requires each hospital in the state to provide uncompensated hospital care data to DSHS; using this data, the executive commissioner of HHSC would be required to adopt or amend rules to provide for a standard definition of "uncompensated hospital care." Hospitals failing to report could, to the extent allowed by federal law, have Medicaid program reimbursements owed them withheld until they comply with the requirement. Hospitals submitting incomplete or inaccurate information would be subject to an administrative penalty not to exceed $10,000. This section also authorizes HHSC to charge hospitals receiving Disproportionate Share Hospital (DSH) payments a fee to offset the cost of an audit required by federal law and regulations; the total amount of fees imposed on hospitals may not exceed the total cost incurred by HHSC in conducting the required audits.

Original section 4 requires HHSC to develop an electronic health information exchange system to be implemented in stages and in accordance with federal Medicaid Information Technology Architecture

requirements. This section also requires HHSC to establish the Electronic Health Information Exchange System Advisory Committee and to ensure health information technology used in CHIP or Medicaid by HHSC or any entity acting on their behalf conforms to nationally recognized standards.

Original section 5 requires HHSC to determine whether it is feasible and cost-effective to implement one or more quality-based payment initiatives pilot programs and to examine the bundled payment system used in the Medicare program and consider whether its implementation as a pilot program would achieve Medicaid cost savings. If HHSC determines that implementation of one or more quality-based payment initiatives pilot programs is feasible and cost-effective, HHSC would be required to establish one or more of the pilot programs to test pay-for-performance payment system alternatives to traditional fee-for-service or other payments made to health care providers or facilities participating in CHIP or Medicaid. Pilot programs would terminate on September 2, 2013.

Original section 6 requires HHSC to develop, in phases, a quality-based hospital reimbursement system for the Medicaid program.

Phase One requires the executive commissioner of HHSC to adopt rules for identifying potentially preventable readmissions of Medicaid recipients and HHSC would be required to collect present-on-admission (POA) indicator data. The bill requires HHSC to establish a program to provide each hospital with a confidential report on the hospital's performance with respect to potentially preventable readmissions. Each hospital would be provided a two-year period to adjust its practices in order to reduce potentially preventable readmissions. HHSC would be required to convert hospitals that are reimbursed using a diagnoses-related groups (DRG) methodology to a DRG methodology that will allow the commission to more accurately classify specific patient populations and account for severity of patient illness and mortality risk. The bill authorizes HHSC to modify data collection requirements to allow HHCS to classify specific patient populations and account for severity of patient illness and mortality risk for hospitals not reimbursed using a DRG methodology.

Phase Two requires HHSC to adjust Medicaid reimbursement to hospitals based on performance in reducing potentially preventable readmissions.

Phase Three requires the executive commissioner to adopt rules to identify potentially preventable complications. The bill requires HHSC to study the feasibility of collecting data from hospitals concerning potentially preventable complications, adjusting Medicaid reimbursements based on performance in reducing those complications, and developing reconsideration review processes to provide basic due process.

Original section 7 outlines requirements of third-party health insurers with regard to Medicaid enrollees and documents other administrative requirements related to Medicaid reclamation activities.

Original section 8 expands the Advisory Panel on Health Care-Associated Infections to include Preventable Adverse Events; the commissioner is authorized to establish subcommittees to assist the panel in addressing health care-associated infections and preventable adverse events relating to hospital care provided to certain populations. This section also expands the Texas Health Care-Associated Infection Reporting System to include reporting to DSHS of 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 (CMS) and an event included on the list of adverse events identified by National Quality Forum not included in the CMS list, unless the executive commissioner excludes the event; DSHS is required to report the information publicly.

Original section 9 requires the executive commissioner, if feasible, to establish an incentive payment program for nursing facilities designed to improve the quality of care provided to Medicaid recipients. The program would provide additional payments to facilities that meet or exceed established performance standards. The bill would allow the executive commissioner to contract for data collection, data analysis, and reporting of provider performance. The bill requires HHSC to conduct a study to evaluate the feasibility of providing an incentive payment program for intermediate care facilities for persons with mental retardation and providers of home and community-based services and submit a report to the legislature.

Original section 10 requires HHSC to adopt rules regarding the denial or reduction of reimbursement under the Medicaid program for preventable adverse events that occur in a hospital setting.

Original section 11 requires DSHS to coordinate with hospitals to develop a statewide standardized patient risk identification system; hospitals would be required to implement and enforce the system unless an exemption is authorized.

AMENDMENT 7: The bill would amend Section 531.102(e) and (g), Government Code, relating to the imposition of payment holds and pre-payment review actions involving Medicaid providers. The bill would require the executive commissioner of the Health and Human Services Commission to adopt rules, in consultation with the state's Medicaid fraud control unit, regarding holds on payment and pre-payment reviews.

A provider in a case in which a payment hold was imposed who ultimately prevails in a hearing or, if the case is appealed, on appeal, or with respect to whom the Office of Inspector General determines that prima facie evidence of fraud, waste, or abuse was not presented during an informal resolution process, would be entitled to prompt payment of all payments held and interest on those payments at a rate equal to the prime rate, as published in The Wall Street Journal on the first day of each calendar year that is not a Saturday, Sunday, or legal holiday, plus one percent.

AMENDMENT 8 (same as Amendment 12): The bill would require the Board of Pharmacy to conduct a study on the license, transfer, use, and sale of prescription information records containing patient-identifiable and practitioner-identifiable information by pharmacy benefit managers, insurers, electronic transmission intermediaries, pharmacies, and other similar entities for the purpose of advertising, marketing, or promoting pharmaceutical products. The bill would require the Board of Pharmacy to submit a report regarding the results of the study to the governor, the lieutenant governor, the speaker of the house of representatives, and the appropriate standing committees. The bill would authorize a civil penalty not to exceed $5,000 for each violation when an entity other than a pharmacy subject to the study fails to provide the board the requested information within 90 days. The bill authorizes the Board of Pharmacy to take appropriate administrative action against a pharmacy that fails to provide the requested information within 90 days. The bill authorizes the Board of Pharmacy or the Attorney General to sue to collect a civil penalty.

AMENDMENT 9: The bill would require the Department of State Health Services (DSHS) to establish a program to promote the wellness of servicemembers and their families through the development, maintenance, and dissemination of clinical practice guidelines for the effective treatment of psychological trauma and the reintegration of servicemembers into their communities, families, and workplaces, with emphasis on the trauma of war, including post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), and sexual trauma that occurs in military settings. The bill would require DSHS to make the clinical practice guidelines available to providers of physical and behavioral health services. The bill would require DSHS to provide the clinical practice guidelines to the appropriate professional associations to be used in continuing education, and, to the extent feasible, enter into agreements or take other action to promote the use of the materials for continuing education purposes. The bill would require DSHS, or its designees, to provide training and continuing education to clinicians and to recognize, through certificates or other means, the health care providers that have demonstrated knowledge and mastery of the clinical practice guidelines and other materials developed by DSHS for the program.

The bill would require DSHS to develop training and educational materials for the use of the TVC, veterans county service officers, and other service providers. The bill would require DSHS to provide, in consultation with the United States Department of Veterans Affairs (USDVA), the Texas military forces, The Texas Information and Referral Network (TIRN), the TVC, and the General Land Office (GLO), service coordination for servicemembers and their families in all geographic regions of the state to connect them to behavioral health services that may be available through the USDVA or under the provisions of the bill.

The bill would require DSHS to negotiate contracts, in geographic areas in which services are not yet available or accessible through USDVA, with the USDVA for behavioral health services provided

through community mental health centers or other community resources with which DSHS contracts until federal services are available. The bill would require DSHS to provide servicemembers and their families information about behavioral health services and resources through specified means. The bill would require DSHS to seek reimbursement for the costs of those services from USDVA and from other governmental agencies. The bill would require DSHS to establish pilot programs in El Paso and Bexar Counties to evaluate the effectiveness of a program to provide behavioral health services for eligible servicemembers. The bill would require DSHS to contract with local mental health authorities (LMHAs) in El Paso and Bexar Counties to administer the pilot programs, and sets forth the eligibility for participation in the pilot programs.

The bill would authorize the behavioral health services provided to include crisis services and behavioral health services. The bill would require that behavioral health services be provided, to the greatest extent possible, in a peer-based treatment environment and that the services may include screening; therapy; and substance abuse early intervention, detoxification, and medication-assisted treatment; and that the provision of services by LMHAs must be based on medical necessity criteria established by DSHS rule. The bill would require DSHS to seek reimbursement for the cost of services provided under the bill from USDVA and other government agencies that may provide behavioral health services or payments for such. The bill would authorize a family member of an enrolled servicemember to receive behavioral health services under the program. The bill would require DSHS to submit a report, not later than December 1, 2010, to the governor, lieutenant governor, and speaker of the house of representatives. The bill provides that the provisions relating to the pilot programs expires September 1, 2011.

The bill would require DSHS to provide to servicemembers and their families information, through a public outreach program, about accessing services through the TIRN and through other organizations participating in memoranda of understanding maintained by the Texas military forces. The bill would require that the outreach effort be conducted on a statewide basis, conducted through contract or contracts with community-based organizations with experience in statewide outreach to the military, and staffed by individuals with demonstrated experience in working with the military and military service organizations. The bill would require that outreach methods include direct personal contacts with military servicemembers and veterans, outreach using communications media and printed material, and the maintenance or support by DSHS of an existing interactive internet-based resource program that meets certain criteria.

The bill would require the adjutant general to require each member of the Texas National Guard who served during Operation Enduring Freedom or Operation Iraqi Freedom to be screened for traumatic brain injury, and require the adjutant general to assist those who test positive in obtaining appropriate medical care.

The bill would add the establishment of eligibility for health care services and treatments from the federal Veterans Health Administration and DSHS to the assistance the TVC is required to provide to veterans and their families and dependents. The bill would require TVC to enter into a memorandum of understanding with DSHS to develop training materials for veterans county service officers and veterans service organizations that promote the understanding and effective treatment of trauma affecting behavioral health and other health-related information that promotes reintegration.

The bill would require TVC to disseminate training and educational materials, enter into contract or other agreement for the development of training and educational materials, reimburse DSHS for costs of preparing the materials, and enter into relationships with established training programs for the purpose of providing peer support training and certification for veterans county service officers. The bill would require that claims assistance services be provided for establishing eligibility for health care services and treatments from the federal Veterans Health Administration.

The bill would require DSHS to conduct an immediate analysis of the behavioral health needs of servicemembers and their families and submit a preliminary report of its findings and recommendations to the legislature and the governor on or before December 1, 2009, and a final report of its findings and recommendations on or before December 1, 2010.

AMENDMENT 10: The bill would amend the Insurance Code to change the requirements of a

pharmacy audit and to decrease the time frame for insurance companies to pay pharmacies for claims. Additionally, the bill would create a dispute resolution process for the Texas Department of Insurance (TDI) to resolve disputes regarding claim payments by health maintenance organizations or insurers under preferred provider benefit plans. The bill would require that a complainant may appeal TDI's written order by requesting a hearing on the matter before the State Office of Administrative Hearings (SOAH). The bill would only apply to claims submitted on or after September 1, 2009 and to contracts between a pharmacy benefit manager and an insurer or health maintenance organization entered into or renewed on or after January 1, 2010.

The bill would take effect immediately if it receives a vote of two-thirds of the members elected to each house; if not, it would take effect September 1, 2009.

Methodology

AMENDMENTS 1, 2: HHSC indicates that the two pilot areas of the state would likely be central Texas and south central Texas. Information would likely be used primarily by the local or regional entity to assist in providing health care to their patients. HHSC assumes that costs related to amending the THMP (Medicaid claims) contract and the vendor drug contract, as well as contracted costs for pilot assessment, can be absorbed within existing resources.

AMENDMENT 3: Workload can be absorbed within existing resources.

AMENDMENTS 4, 5, and 6: *Many of the bill's provisions have the potential to produce significant long-term cost savings or avoidance for the Medicaid and CHIP programs. Most of these savings cannot be estimated and are not reflected here.*

Original section 1: According to HHSC, a two-year pilot program for obesity would start in fiscal year 2010 and award grants totaling $2.1 million for the 2010-11 biennium. It is estimated that 1 FTE would be hired through November 2011 to oversee the project and complete reporting at a cost of $86,696 in fiscal year 2010, $81,369 in fiscal year 2011, and $20,371 in fiscal year 2012. HHSC also assumed a $3.1 million biennial cost for the implementation of a health care system for the target population defined in the bill and a $2.8 million biennial cost for care coordination for the medical home pilot. It is estimated that 1 FTE would be hired through November 2011 to oversee the project and complete reporting at a cost of $86,696 in fiscal year 2010, $81,369 in fiscal year 2011, and $20,371 in fiscal year 2012. It is assumed that costs of both pilots would qualify for 50 percent federal participation.

Original section 2: It is assumed establishment of the Health Care Quality Advisory Committee can be accomplished with existing resources and that the committee members would not receive reimbursement for travel expenses.

Original section 3: It is assumed that the creation in the reporting system of a definition for uncompensated care can be absorbed by DSHS. HHSC states that the agency would contract with an entity to conduct the DSH audits. The costs of the audits would be matched with Medicaid Federal Funds at a rate of 50 percent. The majority of the cost ($2.3 million in fiscal year 2010 and $2.2 million in fiscal year 2011 and subsequent years) will be paid by the non-state owned hospitals and received by HHSC as Appropriated Receipts Match for Medicaid-Administrative (Other Funds). Costs for state-owned hospital audits will be paid for with General Revenue appropriated to each facility and would represent a cost to the state ($0.6 million in General Revenue Funds for the 2010-11 biennium for 15 state-owned hospitals). HHSC assumes the costs of the audits would vary by size of hospital and range from $25,000 to $36,000 each. It is assumed that contract management oversight would require 1 FTE at HHSC at a cost of $0.1 million in each fiscal year.

Original section 4: It is assumed that any cost associated with developing and implementing electronic medical records and e-prescribing in Medicaid and CHIP can be absorbed within existing resources because HHSC has already implemented or begun to implement many of the provisions.

Original section 5: HHSC assumes that it would establish multiple provider-submitted quality-based payment initiatives pilot programs in the CHIP and Medicaid programs beginning in fiscal year 2011.

It is assumed review of proposals and pilot design could be accomplished with existing resources. HHSC assumes incentive payments would be absorbed within existing costs for client services. HHSC cannot estimate cost savings associated with any pilot(s) and any amount that would be shared with providers as the bill allows. Although the bill authorizes HHSC to increase payment rates to adjust for inflation, HHSC assumes that the existing contract for this activity would be utilized at no additional cost. HHSC assumes it could complete the report with existing resources.

Original section 6: Phase One: To collect POA data for Medicaid hospitalizations, HHSC indicates a one-time cost of $1,664,000 for system development, hardware, and software in fiscal year 2010; the system will be fully operational in fiscal year 2011. HHSC assumes the Medicaid claims administrator would design and administer the POA reporting system. HHSC would be required to provide confidential reports to each hospital, and the agency indicates this can be accomplished within existing resources. HHSC assumes design of an all patient refined diagnoses related groups (APR-DRG) payment system would be required to assist in denying reimbursement for adverse events and would involve a one-time cost of $6,899,000 in fiscal year 2010; HHSC does not have sufficient information to determine other costs to implement this system. Costs for both systems are assumed to qualify for 75 percent federal participation.

Phase Two: HHSC would be required to adjust Medicaid reimbursement to hospitals based on performance in reducing potentially preventable readmissions. HHSC assumes payments will not be adjusted until fiscal year 2013, based on the start of operation of the reporting system in fiscal year 2011 and the two-year adjustment period for hospitals. HHSC assumes adjustments in payment would be accomplished within existing client services costs, with some payment adjustments resulting in an increase in payment and some in a decrease in payment. HHSC indicates these adjustments can be accomplished by existing staff.

Phase Three: HHSC indicates the feasibility study and report can be accomplished with existing staff.

Original section 7: According to HHSC, states are required to aggressively pursue third-party sources of payment for Medicaid recipients. HHSC indicates that if states comply with the Deficit Reduction Act, they are permitted to retain 10 percent more of fraudulent claims than they can retain currently. HHSC estimates additional collections of $7.5 million each year of Medicaid Program Income; it is assumed this additional revenue would be expended for Medicaid client services, resulting in an equal savings to General Revenue Match for Medicaid.

Original section 8: HHSC assumes the cost to expand the Advisory Panel on Health Care-Associated Infections, including potential creation of new subcommittees, would not result in a significant fiscal impact to DSHS. It is assumed that expansion of the Health-Care Associated Infections Reporting System to include Preventable Adverse Events would not result in a significant fiscal impact to DSHS. There is a potential for cost reduction in state programs that provide hospital services, including Medicaid, CHIP, and the health plans that administer benefits to retired and current state employees, if required reporting of preventable adverse events encourages facilities to reduce their incidence.

Original section 9: It is assumed that the executive commissioner would be able to establish rules for an incentive payment program for nursing facilities within existing resources. HHSC assumes the Department of Aging and Disability Services (DADS) would administer the long-term-care incentive payment program. HHSC assumes payment adjustments would be accomplished within existing client services costs, with some adjustments resulting in an increase in payment and some in a decrease in payment. HHSC indicates DADS would contract for data collection, analysis, and measure reporting at an annual cost of $2.5 million, which would qualify for 50 percent federal participation. HHSC assumes it can complete the required study within existing resources.

Original section 10: It is assumed that the executive commissioner would be able to establish rules within existing resources to ensure the agency does not provide reimbursement for health care-associated adverse events. HHSC assumes a savings from client services will begin in fiscal year 2011 based on time needed for rule-making, obtaining a federal waiver, and completing automation. HHSC estimates savings in Medicaid fee-for-service and managed care would be $1,236,905 in fiscal year 2011; $1,318,542 in fiscal year 2012; $1,404,248 in fiscal year 2013; and $1,494,119 in fiscal year 2014. Savings are assumed to be matched at the Federal Medical Assistance Percentage (FMAP).

State General Revenue savings for the 2010-11 biennium could be lower to the extent that federal stimulus improves the federal match for Medicaid client services.

It is assumed that the claims engine used by the Medicaid claims administrator would need to be modified to identify and prohibit reimbursement of preventable adverse events. HHSC indicates a one-time hardware and software cost of $192,000 would be incurred in fiscal year 2010, with 75 percent federal participation. HHSC also indicates annual operational costs would be incurred by the Medicaid claims administrator to perform claims review. HHSC estimates three percent of claims would be identified and approximately ten percent of these claims would be reviewed annually by nurse reviewers at the Medicaid claims administrator for a total cost of $1,647,000 beginning in fiscal year 2011, which would qualify for 50 percent federal participation.

Original section 11: According to DSHS, there is no significant fiscal impact for development, coordination, and enforcement of a statewide standardized patient risk identification system.

AMENDMENT 7: It is likely that General Revenue would be needed for these interest payments, as federal matching funds may not be available for state penalty payments. However, HHSC anticipates incurring little or no interest costs because it does not impose payment holds very often or for very long. It anticipates no more than 20 per year, of which none would last longer than 60 days absent the provider's agreement. Additionally, the State Office of Administrative Hearings states that it could absorb any additional costs within existing resources. Therefore, the bill would not have a significant fiscal impact.

AMENDMENT 8: Based on the analysis of the Board of Pharmacy, it is assumed that the board would contract with an independent entity to conduct the study at a cost of $10,000 in Fiscal Year 2010. This analysis also assumes that any increased costs to the agency, which is statutorily required to generate sufficient revenue to cover its costs of operation, would be offset by an increase in fee generated revenue. The Office of the Attorney General indicates that any costs associated with the bill could be absorbed within the agency's existing resources.

AMENDMENT 9: DSHS assumes that they will enter into contracts with local mental health authorities (LMHAs) to provide behavioral health services, as required by the bill.
The agency estimates a one-time cost of $0.5 million in fiscal year 2010 for the establishment of a 24-hour toll-free hotline for outreach, and an annual cost of $0.1 million for each subsequent year.

It is assumed that it would take six months to develop and implement the pilot program in Bexar and El Paso counties and that client services would be provided beginning in March 2010. DSHS estimates that there are 230,000 veterans in Texas who have been on active duty since September 2001 and that 10 percent, or 23,000, would meet the criteria set forth in the bill, statewide. Based on the proportion of persons aged 18 to 64 in Bexar and El Paso counties relative to total state population of persons aged 18 to 64, it is assumed that 9.5 percent, or 2,185 of those would reside in those counties and be eligible for services. Based on a RAND Corporation study, *Invisible Wounds of War*, the agency estimates that the prevalence rate of mental health conditions (PTSD or depression) among returning servicemembers is 18.5 percent, corresponding to an estimated 404 individuals eligible for the program in Bexar and El Paso counties. DSHS estimates 10 percent, or 219, of the 2,185 servicemembers meeting the eligibility criteria would require substance abuse services. These estimates do not include any servicemembers potentially eligible who may have served prior to September 2001 and who would meet the eligibility requirements set forth in the bill. It is assumed that the most likely candidates for participation are those servicemembers serving during Operation Enduring Freedom or Operation Iraqi Freedom; serving additional servicemembers would increase the estimated cost of the bill.

The agency estimates that one peer-to-peer service coordinator would be needed at each of the two LMHAs in Bexar and El Paso Counties for the provision of peer-to-peer counseling at an annual cost of $0.1 million. The agency estimates that the average cost to serve an adult mental health patient in an LMHA is $415 per month with an additional monthly cost of $52.05 for medications. An average length of service of six months is assumed. It is assumed that the 404 servicemembers meeting the criteria would be phased into the program over its first 12 months (34 clients entering per month) and that an additional 17 clients would present each month thereafter as more servicemembers return to

Texas or present with symptoms. The total estimated cost to provide services to these clients is $0.3 million in fiscal year 2010 and $0.9 million in fiscal year 2011.

The agency estimates that approximately 50 percent or 211 servicemembers would have family members that are eligible and likely to request services available to them through the program. The agency estimates 11 sessions per family at the standard rate for family therapy of $60.14 per session. The resulting cost for family services offered through the program is estimated to be $0.1 million in fiscal year 2010 and 2011.

The agency estimates that the average cost to provide substance abuse services is $875.10. An average length of service of two months is assumed. It is assumed that the 219 servicemembers meeting the criteria would be phased into the program over its first 12 months (18 clients entering per month) and that an additional 9 clients would present each month thereafter as more servicemembers return to Texas or present with symptoms. The total estimated cost to provide services to these clients is $0.2 million in fiscal year 2010 and $0.3 million in fiscal year 2011. The bill would extend behavioral health services to family members of enrolled servicemembers. It is not known how many family members would seek services or what behavioral health services would be made available, but this provision would likely result in significant additional cost. Because they cannot be estimated, these costs are not reflected in this estimate.

The adjutant general assumes no cost for screening and related assistance because screening is currently required at demobilization.

It is assumed that 12 full-time-equivalent positions (FTEs) would be necessary at DSHS for administration of the program in fiscal years 2010 and 2011; 11 FTEs are assumed in fiscal years 2012 and beyond. TVC estimates that one FTE would be required for the duties of coordination and consulting with DSHS on training and educational materials. The total estimated staffing costs are $0.7 million in fiscal year 2010 and $0.8 million in fiscal year 2011 and subsequent years. The total cost of the bill is estimated to be $2.0 million in fiscal year 2010, $2.5 million in fiscal year 2011, and $0.9 million in fiscal year 2012 and beyond.

It is assumed that the costs of the bill would be funded with General Revenue. It is unknown whether DSHS would be able to successfully contract with the USDVA for services being provided through community mental health centers in certain areas of the state, or if federal reimbursement would be obtained for those services and for services provided through the pilot programs in Bexar and El Paso counties. To the extent that reimbursement from Federal Funds is obtained, there could be a reduction to General Revenue costs.

AMENDMENT 10: Based on the analysis by TDI, it is anticipated that implementing the bill would require an additional 3 full-time-equivalent positions (FTE) each fiscal year to administer the complaint and investigation process. For each fiscal year from 2010 to 2014, the 3 FTEs would cost $163,390 for salaries with an associated benefit cost of $46,680; $7,500 for travel costs; and $6,225 for telephone, consumable supplies, and other operating expenses. In fiscal year 2010, the agency estimates $13,824 in one-time equipment costs.

Since TDI is required to generate revenues equivalent to its costs of operation under current law, this analysis assumes that all costs incurred would be paid from either existing fund balances or insurance maintenance tax revenues. Additionally, there would be a slight revenue increase in General Revenue – Dedicated Fund 36 due to form filings caused by the changes in statute. Since General Revenue – Dedicated Account Fund 36 is a self-leveling account, this analysis assumes all general revenue would go toward fund balances or the maintenance tax would be set to recover a lower level of revenue in the following year.

Based on the analysis by the Employee Retirement System, the bill would have no significant fiscal impact on the agency. SOAH indicates that any costs associated with the bill could be absorbed within current resources.

AMENDMENT 11: No fiscal impact is anticipated to the state.

Technology

HHSC indicates that there will be one-time costs of $1,664,000 for system development, hardware, and software and $6,899,000 to implement the APR-DRG payment system and one-time costs of $192,000 in fiscal year 2010 for Medicaid claims engine modifications.

Local Government Impact

No significant fiscal implication to units of local government is anticipated.

Source Agencies: 302 Office of the Attorney General, 304 Comptroller of Public Accounts, 305 General Land Office and Veterans' Land Board, 327 Employees Retirement System, 360 State Office of Administrative Hearings, 454 Department of Insurance, 515 Board of Pharmacy, 529 Health and Human Services Commission, 530 Family and Protective Services, Department of, 537 State Health Services, Department of, 539 Aging and Disability Services, Department of, 701 Central Education Agency, 720 The University of Texas System Administration

LBB Staff: JOB, CL, PP, MB, SJ, LL, LR

LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 81ST LEGISLATIVE REGULAR SESSION

May 18, 2009

TO: Honorable Jane Nelson, Chair, Senate Committee on Health & Human Services

FROM: John S. O'Brien, Director, Legislative Budget Board

IN RE: **HB1218** by Howard, Donna (Relating to a pilot project to exchange secure electronic health information between the Health and Human Services Commission and local or regional health information exchanges.), **As Engrossed**

No significant fiscal implication to the State is anticipated.

The bill would amend Subchapter B, Chapter 531, Government Code, to establish an electronic health information exchange pilot project in at least one urban area of the state with the participation of at least two local or regional health information exchanges.

The bill would require, at a minimum, the exchange of a patient's medication history between the Health and Human Services Commission (HHSC) and the selected health information exchanges under the pilot project. The pilot may include additional health care information either at inception or in a subsequent expansion. The bill would require HHSC to begin implementation of the pilot not later than the 60th day after the effective date of the bill. The agency could accept gifts, grants and donations for the pilot project.

The bill would require HHSC to assess the pilot project benefits to the state, the patients, and the health care providers of exchanging secure health information with local or regional health information exchanges. HHSC would be required to complete the pilot assessment, including analysis of return on investment, and report the findings to the standing committees of the Senate and the House having primary jurisdiction over health and human services, by December 1, 2010.

The bill would take effect immediately if it receives a vote of two-thirds of the members elected to each house; if not, it would take effect September 1, 2009.

HHSC indicates that the two pilot areas of the state would likely be central Texas and south central Texas. Information would likely be used primarily by the local or regional entity to assist in providing health care to their patients. HHSC assumes that costs related to amending the THMP (Medicaid claims) contract and the vendor drug contract, as well as contracted costs for pilot assessment, can be absorbed within existing resources.

Local Government Impact

Because the bill would not have statewide impact on units of local government of the same type or class, no comment from this office is required by the rules of the House/Senate as to its probable fiscal implication on units of local government.

Source Agencies: 529 Health and Human Services Commission, 537 State Health Services, Department of

LBB Staff: JOB, CL, MB, LR

LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 81ST LEGISLATIVE REGULAR SESSION

April 23, 2009

TO: Honorable Lois W. Kolkhorst, Chair, House Committee on Public Health

FROM: John S. O'Brien, Director, Legislative Budget Board

IN RE: **HB1218** by Howard, Donna (Relating to a pilot project to exchange secure electronic health information between the Health and Human Services Commission and local or regaional health information exchanges.), **Committee Report 1st House, Substituted**

No significant fiscal implication to the State is anticipated.

The bill would amend Subchapter B, Chapter 531, Government Code, to establish an electronic health information exchange pilot project in at least one urban area of the state with the participation of at least two local or regional health information exchanges.

The bill would require, at a minimum, the exchange of a patient's medication history between the Health and Human Services Commission (HHSC) and the selected health information exchanges under the pilot project. The pilot may include additional health care information either at inception or in a subsequent expansion. The bill would require HHSC to begin implementation of the pilot not later than the 60th day after the effective date of the bill. The agency could accept gifts, grants and donations for the pilot project.

The bill would require HHSC to assess the pilot project benefits to the state, the patients, and the health care providers of exchanging secure health information with local or regional health information exchanges. HHSC would be required to complete the pilot assessment, including analysis of return on investment, and report the findings to the standing committees of the Senate and the House having primary jurisdiction over health and human services, by December 1, 2010.

The bill would take effect immediately if it receives a vote of two-thirds of the members elected to each house; if not, it would take effect September 1, 2009.

HHSC indicates that the two pilot areas of the state would likely be central Texas and south central Texas. Information would likely be used primarily by the local or regional entity to assist in providing health care to their patients. HHSC assumes that costs related to amending the THMP (Medicaid claims) contract and the vendor drug contract, as well as contracted costs for pilot assessment, can be absorbed within existing resources.

Local Government Impact

Because the bill would not have statewide impact on units of local government of the same type or class, no comment from this office is required by the rules of the House/Senate as to its probable fiscal implication on units of local government.

Source Agencies: 529 Health and Human Services Commission, 537 State Health Services, Department of

LBB Staff: JOB, CL, MB, LR

LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 81ST LEGISLATIVE REGULAR SESSION

April 7, 2009

TO: Honorable Lois W. Kolkhorst, Chair, House Committee on Public Health

FROM: John S. O'Brien, Director, Legislative Budget Board

IN RE: **HB1218** by Howard, Donna (Relating to a pilot project to exchange secure electronic health information between the Health and Human Services Commission and local or regional health information exchanges.), **As Introduced**

No significant fiscal implication to the State is anticipated.

The bill would amend Subchapter B, Chapter 531, Government Code, to establish an electronic health information exchange pilot project in at least one urban area of the state with the participation of at least two local or regional health information exchanges.

The bill would require, at a minimum, the exchange of a patient's medication history between the Health and Human Services Commission (HHSC) and the selected health information exchanges under the pilot project. The pilot may include additional health care information either at inception or in a subsequent expansion. The bill would require HHSC to begin implementation of the pilot not later than the 60th day after the effective date of the bill.

The bill would require HHSC to assess the pilot project benefits to the state, the patients, and the health care providers of exchanging secure health information with local or regional health information exchanges. HHSC would be required to complete the pilot assessment, including analysis of return on investment, and report the findings to the standing committees of the Senate and the House having primary jurisdiction over health and human services, by December 1, 2010.

The bill would take effect immediately if it receives a vote of two-thirds of the members elected to each house; if not, it would take effect September 1, 2009.

HHSC indicates that the two pilot areas of the state would likely be central Texas and south central Texas. Information would likely be used primarily by the local or regional entity to assist in providing health care to their patients. HHSC assumes that costs related to amending the THMP (Medicaid claims) contract and the vendor drug contract, as well as contracted costs for pilot assessment, can be absorbed within existing resources.

Local Government Impact

Because the bill would not have statewide impact on units of local government of the same type or class, no comment from this office is required by the rules of the House/Senate as to its probable fiscal implication on units of local government.

Source Agencies: 529 Health and Human Services Commission, 537 State Health Services, Department of

LBB Staff: JOB, CL, MB, LR