BILL ANALYSIS

Senate Research Center

S.B. 7
By: Nelson et al.
Finance
9/19/2011
Enrolled

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

S.B. 7 includes cost-containment measures necessary to achieve the savings assumed in the budget adopted by the 82nd Legislature. It also includes measures designed to improve patient outcomes in Medicaid and the Children's Health Insurance Program (CHIP) and across private health care.

S.B. 7 amends current law relating to the administration, quality, and efficiency of health care, health and human services, and health benefits programs in this state, creates an offense and provides penalties.

RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to the executive commissioner of the Health and Human Services Commission (executive commissioner; HHSC) in SECTION 1.01 (Section 531.02417, Government Code), SECTION 1.05 (Sections 242.033, 260A.008, and 260A.011, Health and Safety Code), SECTION 1.09 (Section 531.0861, Government Code), SECTION 1.11 (Section 531.508, Government Code), SECTION 1.12 (Sections 536.003 and 536.203, Government Code), SECTION 1.17 (Sections 531.024181 and 531.024182, Government Code), SECTION 1.18 (Section 32.0314, Human Resources Code), SECTION 5.01 (Section 311.004, Health and Safety Code), SECTION 6.03 (Section 98.103, Health and Safety Code), SECTION 6.04 (Section 98.1045, Health and Safety Code), and SECTION 6.09 (Section 98.108, Health and Safety Code) of this bill.

Rulemaking authority is expressly granted to the Department of Aging and Disability Services in SECTION 1.05 (Section 260A.007, Health and Safety Code) of this bill.

Rulemaking authority previously granted to HHSC is transferred to the executive commissioner in SECTION 1.02 (Section 32.046, Human Resources Code) of this bill.

Rulemaking authority previously granted to HHSC is rescinded in SECTION 1.05 (Section 48.003, Human Resources Code) of this bill.

Rulemaking authority previously granted to the Texas Health Care Information Council is transferred to the executive commissioner in SECTION 7.04 (Sections 108.013 and 108.0135, Health and Safety Code) of this bill.

Rulemaking authority previously granted to the executive commissioner is modified in SECTION 1.12 (Section 536.151, Government Code), SECTION 1.14 (Section 531.912, Government Code), and SECTION 6.06 (Section 98.105, Health and Safety Code) of this bill.

Rulemaking authority is expressly granted to the commissioner of insurance in SECTION 4.01 (Sections 848.054, 848.056, 848.108, 848.151, and 848.152, Insurance Code) of this bill.

Rulemaking authority is expressly granted to the attorney general in SECTION 4.01 (Section 848.151, Insurance Code) of this bill.

Rulemaking authority is expressly granted to the appropriate rulemaking authority for each regulatory authority in SECTION 8.02 (Section 224.005, Health and Safety Code) of this bill.

Rulemaking authority is expressly granted to the Texas Higher Education Coordinating Board in SECTION 9.01 (Sections 61.9802 and 61.9806, Education Code) of this bill.

SECTION BY SECTION ANALYSIS

ARTICLE 1. ADMINISTRATION OF AND EFFICIENCY, COST-SAVING, AND FRAUD PREVENTION MEASURES FOR CERTAIN HEALTH AND HUMAN SERVICES AND HEALTH BENEFITS PROGRAMS

SECTION 1.01. (a) Amends Subchapter B, Chapter 531, Government Code, by adding Sections 531.02417, 531.024171, and 531.024172, as follows:

Sec. 531.02417. MEDICAID NURSING SERVICES ASSESSMENTS. (a) Defines, in this section, "acute nursing services."

(b) Requires the Health and Human Services Commission (HHSC), if cost-effective, to develop an objective assessment process for use in assessing a Medicaid recipient's needs for acute nursing services. Requires HHSC, if HHSC develops an objective assessment process under this section, to require that:

(1) the assessment be conducted by a state employee or contractor who is a registered nurse who is licensed to practice in this state and who is not the person who will deliver any necessary services to the recipient and is not affiliated with the person who will deliver those services, and in a timely manner so as to protect the health and safety of the recipient by avoiding unnecessary delays in service delivery; and

(2) the process include an assessment of specified criteria and documentation of the assessment results on a standard form; an assessment of whether the recipient should be referred for additional assessments regarding the recipient's needs for therapy services, as defined by Section 531.024171, attendant care services, and durable medical equipment; and completion by the person conducting the assessment of any documents related to obtaining prior authorization for necessary nursing services.

(c) Requires HHSC, if HHSC develops the objective assessment process under Subsection (b), to:

(1) implement the process within the Medicaid fee-for-service model and the primary care case management Medicaid managed care model; and

(2) take necessary actions, including modifying contracts with managed care organizations under Chapter 533 (Implementation of Medicaid Managed Care Program) to the extent allowed by law, to implement the process within the STAR and STAR + PLUS Medicaid managed care programs.

(d) Requires that an assessment under Subsection (b)(2)(B) (relating to additional assessments) of whether a recipient should be referred for additional therapy services, unless HHSC determines that the assessment is feasible and beneficial, be waived if the recipient's need for therapy services has been established by a recommendation from a therapist providing care prior to discharge of the recipient from a licensed hospital or nursing home. Prohibits the assessment from being waived if the recommendation is made by a therapist who will deliver any services to

the recipient or is affiliated with a person who will deliver those services when the recipient is discharged from the licensed hospital or nursing home.

(e) Requires the executive commissioner of HHSC (executive commissioner) to adopt rules providing for a process by which a provider of acute nursing services who disagrees with the results of the assessment conducted under Subsection (b) may request and obtain a review of those results.

Sec. 531.024171. THERAPY SERVICES ASSESSMENTS. (a) Defines, in this section, "therapy services."

(b) Requires HHSC, after implementing the objective assessment process for acute nursing services in accordance with Section 531.02417, to consider whether implementing age- and diagnosis-appropriate objective assessment processes for assessing the needs of a Medicaid recipient for therapy services would be feasible and beneficial.

(c) Authorizes HHSC, if HHSC determines that implementing age- and diagnosis-appropriate processes with respect to one or more types of therapy services is feasible and would be beneficial, to implement the processes within the Medicaid fee-for-service model, the primary care case management Medicaid managed care model, and the STAR and STAR + PLUS Medicaid managed care programs.

(d) Requires that an objective assessment process implemented under this section include a process that allows a provider of therapy services to request and obtain a review of the results of an assessment conducted as provided by this section that is comparable to the process implemented under rules adopted under Section 531.02417(e).

Sec. 531.024172. ELECTRONIC VISIT VERIFICATION SYSTEM. (a) Defines, in this section, "acute nursing services."

(b) Requires HHSC, if it is cost-effective and feasible, to implement an electronic visit verification system to electronically verify and document, through a telephone or computer-based system, basic information relating to the delivery of Medicaid acute nursing services, including the provider's name, the recipient's name, and the date and time the provider begins and ends each service delivery visit.

(b) Requires HHSC, not later than September 1, 2012, to implement the electronic visit verification system required by Section 531.024172, Government Code, as added by this section, if HHSC determines that implementation of that system is cost-effective and feasible.

SECTION 1.02. (a) Amends Section 533.0025(e), Government Code, as follows:

(e) Requires HHSC to determine the most cost-effective alignment of managed care service delivery areas. Authorizes the commissioner to consider the number of lives impacted, the usual source of health care services for residents in an area, and other factors that impact the delivery of health care services in the area. Deletes existing text prohibiting HHSC, notwithstanding Subsection (b)(1) (relating to providing acute care using a health maintenance organization model), from providing medical assistance using a health maintenance organization in Cameron County, Hidalgo County, or Maverick County.

(b) Amends Subchapter A, Chapter 533, Government Code, by adding Sections 533.0027, 533.0028, and 533.0029, as follows:

Sec. 533.0027. PROCEDURES TO ENSURE CERTAIN RECIPIENTS ARE ENROLLED IN SAME MANAGED CARE PLAN. Requires HHSC to ensure that all recipients who are children and who reside in the same household may, at the family's election, be enrolled in the same managed care plan.

Sec. 533.0028. EVALUATION OF CERTAIN STAR + PLUS MEDICAID MANAGED CARE PROGRAM SERVICES. Requires the external quality review organization to periodically conduct studies and surveys to assess the quality of care and satisfaction with health care services provided to enrollees in the STAR + PLUS Medicaid managed care program who are eligible to receive health care benefits under both the Medicaid and Medicare programs.

Sec. 533.0029. PROMOTION AND PRINCIPLES OF PATIENT-CENTERED MEDICAL HOMES FOR RECIPIENTS. (a) Defines, for purposes of this section, "patient-centered medical home."

(b) Requires HHSC, to the extent possible, to work to ensure that managed care organizations promote the development of patient-centered medical homes for recipients, and provide payment incentives for providers that meet the requirements of a patient-centered medical home.

(c) Amends Section 533.003, Government Code, as follows:

Sec. 533.003. CONSIDERATIONS IN AWARDING CONTRACTS. (a) Creates this subsection from existing text. Requires HHSC, in awarding contracts to managed care organizations, to:

(1)-(4) Makes no changes to these subdivisions; and

(5) in the initial implementation of managed care in the South Texas service region, give extra consideration to an organization that either:

(A) is locally owned, managed, and operated, if one exists; or

(B) is in compliance with the requirements of Section 533.004 (Mandatory Contracts).

(b) Requires HHSC, in considering approval of a subcontract between a managed care organization and a pharmacy benefit manager for the provision of prescription drug benefits under the Medicaid program, to review and consider whether the pharmacy benefit manager has been in the preceding three years convicted of an offense involving a material misrepresentation or an act of fraud or of another violation of state or federal criminal law, has been adjudicated to have committed a breach of contract, or has been assessed a penalty or fine in the amount of $500,000 or more in a state or federal administrative proceeding.

(d) Amends Section 533.005, Government Code, by amending Subsection (a) and adding Subsection (a-1), as follows:

(a) Requires that a contract between a managed care organization and HHSC for the organization to provide health care services to recipients contain:

(1)-(9) Makes no changes to these subdivisions;

(10) a requirement that the managed care organization provide the information required by Section 533.012 (Information for Fraud Control)

and otherwise comply and cooperate with HHSC's office of inspector general and the Office of the Attorney General (OAG);

(11)-(15) Makes no changes to these subdivisions;

(16) a requirement that a medical director who is authorized to make medical necessity determinations is available to the region where the managed care organization provides health care services;

(17) a requirement that the managed care organization ensure that a medical director and patient care coordinators and provider and recipient support services personnel are located in the South Texas service region, if the managed care organization provides a managed care plan in that region;

(18) a requirement that the managed care organization provide special programs and materials for recipients with limited English proficiency or low literacy skills;

(19) a requirement that the managed care organization develop and establish a process for responding to provider appeals in the region where the organization provides health care services;

(20) a requirement that the managed care organization develop and submit to HHSC, before the organization begins to provide health care services to recipients, a comprehensive plan that describes how the organization's provider network will provide recipients sufficient access to preventive care, primary care, specialty care, after-hours urgent care, and chronic care;

(21) a requirement that the managed care organization demonstrate to HHSC, before the organization begins to provide health care services to recipients, that the organization's provider network has the capacity to serve the number of recipients expected to enroll in a managed care plan offered by the organization; the organization's provider network includes a sufficient number of primary care providers, a sufficient variety of provider types, and providers located throughout the region where the organization will provide health care services; and health care services will be accessible to recipients through the organization's provider network to a comparable extent that health care services would be available to recipients under a fee-for-service or primary care case management model of Medicaid managed care;

(22) a requirement that the managed care organization develop a monitoring program for measuring the quality of the health care services provided by the organization's provider network that incorporates the National Committee for Quality Assurance's Healthcare Effectiveness Data and Information Set (HEDIS) measures, focuses on measuring outcomes, and includes the collection and analysis of clinical data relating to prenatal care, preventive care, mental health care, and the treatment of acute and chronic health conditions and substance abuse;

(23) subject to Subsection (a-1), a requirement that the managed care organization develop, implement, and maintain an outpatient pharmacy benefit plan for its enrolled recipients:

(A) that exclusively employs the vendor drug program formulary and preserves the state's ability to reduce waste, fraud, and abuse under the Medicaid program;

(B) that adheres to the applicable preferred drug list adopted by HHSC under Section 531.072 (Preferred Drug Lists);

(C) that includes the prior authorization procedures and requirements prescribed by or implemented under Sections 531.073(b) (relating to establishing procedures for prior authorization for certain drug programs), (c) (relating to prior implementation of certain drug programs for the child health plan program), and (g) (relating to requiring HHSC to ensure that requests for prior authorization be submitted) for the vendor drug program;

(D) for purposes of which the managed care organization may not negotiate or collect rebates associated with pharmacy products on the vendor drug program formulary, and may not receive drug rebate or pricing information that is confidential under Section 531.071 (Confidentiality of Information Regarding Drug Rebates, Pricing, and Negotiations);

(E) that complies with the prohibition under Section 531.089;

(F) under which the managed care organization may not prohibit, limit, or interfere with a recipient's selection of a pharmacy or pharmacist of the recipient's choice for the provision of pharmaceutical services under the plan through the imposition of different copayments;

(G) that allows the managed care organization or any subcontracted pharmacy benefit manager to contract with a pharmacist or pharmacy providers separately for specialty pharmacy services, except that the managed care organization and pharmacy benefit manager are prohibited from allowing exclusive contracts with a specialty pharmacy owned wholly or partly by the pharmacy benefit manager responsible for the administration of the pharmacy benefit program, and the managed care organization and pharmacy benefit manager must adopt policies and procedures for reclassifying prescription drugs from retail to specialty drugs, and those policies and procedures must be consistent with rules adopted by the executive commissioner and include notice to network pharmacy providers from the managed care organization;

(H) under which the managed care organization may not prevent a pharmacy or pharmacist from participating as a provider if the pharmacy or pharmacist agrees to comply with the financial terms and conditions of the contract as well as other reasonable administrative and professional terms and conditions of the contract;

(I) under which the managed care organization may include mail-order pharmacies in its networks, but may not require enrolled recipients to use those pharmacies, and may not charge an enrolled recipient who opts to use this service a fee, including postage and handling fees; and

(J) under which the managed care organization or pharmacy benefit manager, as applicable, must pay claims in accordance with Section 843.339 (Deadline for Action on Certain Prescription Claims), Insurance Code; and

(24) a requirement that the managed care organization and any entity with which the managed care organization contracts for the performance of services under a managed care plan disclose, at no cost, to HHSC and, on request, OAG all discounts, incentives, rebates, fees, free goods, bundling arrangements, and other agreements affecting the net cost of goods or services provided under the plan.

(a-1) Provides that the requirements imposed by Subsections (a)(23)(A), (B), and (C) do not apply, and are prohibited from being enforced, on and after August 31, 2013.

(e) Amends Subchapter A, Chapter 533, Government Code, by adding Section 533.0066, as follows:

Sec. 533.0066. PROVIDER INCENTIVES. Requires HHSC, to the extent possible, to work to ensure that managed care organizations provide payment incentives to health care providers in the organizations' networks whose performance in promoting recipients' use of preventive services exceeds minimum established standards.

(f) Amends Section 533.0071, Government Code, as follows:

Sec. 533.0071. ADMINISTRATION OF CONTRACTS. Requires HHSC, to improve the administration of these contracts, to:

(1)-(3) Makes no changes to these subdivisions;

(4) decrease the administrative burdens of managed care for the state, the managed care organizations, and the providers under managed care networks to the extent that those changes are compatible with state law and existing Medicaid managed care contracts, including decreasing those burdens by:

(A)-(D) Makes no changes to these paragraphs; and

(E) providing a single portal through which providers in any managed care organization's provider network may submit claims; and

(5) Makes no changes to this subdivision.

(g) Amends Subchapter A, Chapter 533, Government Code, by adding Section 533.0073, as follows:

Sec. 533.0073. MEDICAL DIRECTOR QUALIFICATIONS. Requires a person who serves as a medical director for a managed care plan to be a physician licensed to practice medicine in this state under Subtitle B (Physicians), Title 3 (Health Professions), Occupations Code.

(h) Amends Sections 533.0076(a) and (c), Government Code, as follows:

(a) Prohibits a recipient enrolled in a managed care plan under this chapter, except as provided by Subsections (b) and (c), and to the extent permitted by federal law, from disenrolling from that plan and enrolling in another managed care plan during the 12-month period after the date the recipient initially enrolls in a plan. Deletes existing text authorizing HHSC, except as provided by Subsections (b) (relating to authorizing the recipient to disenroll in a managed care plan) and (c), and to the extent permitted by federal law, to prohibit a recipient from disenrolling in a managed care plan under this chapter and

enrolling in another managed care plan during the 12-month period after the date the recipient initially enrolls in a plan.

(c) Requires HHSC to allow a recipient who is enrolled in a managed care plan under this chapter to disenroll from that plan and enroll in another managed care plan at any time for cause in accordance with federal law, and once for any reason after the periods described by Subsections (a) and (b), rather than to disenroll in that plan at any time for cause in accordance with federal law.

(i) Amends Sections 533.012(a), (b), (c), and (e), Government Code, as follows:

(a) Requires each managed care organization contracting with HHSC under this chapter to submit the following, at no cost, to HHSC and, on request, the office of the attorney general:

(1) a description of any financial or other business relationship between the organization and any subcontractor providing health care services under the contract;

(2) a copy of each type of contract between the organization and a subcontractor relating to the delivery of or payment for health care services;

(3) a description of the fraud control program used by any subcontractor that delivers health care services; and

(4) a description and breakdown of all funds paid to or by the managed care organization, including a health maintenance organization, primary care case management provider, pharmacy benefit manager, and exclusive provider organization, necessary for HHSC to determine the actual cost of administering the managed care plan.

(b) Requires that the information submitted under this section be submitted in the form required by HHSC or OAG, as applicable, and be updated as required by HHSC or OAG, as applicable.

(c) Requires HHSC's office of investigations and enforcement or OAG, as applicable, to review the information submitted under this section as appropriate in the investigation of fraud in the Medicaid managed care program.

(e) Provides that information submitted to HHSC or OAG, as applicable, under Subsection (a)(1) is confidential and not subject to disclosure under Chapter 552 (Public Information), Government Code.

(j) Amends the heading to Section 32.046, Human Resources Code, to read as follows:

Sec. 32.046. SANCTIONS AND PENALTIES RELATED TO THE PROVISION OF PHARMACY PRODUCTS.

(k) Amends Section 32.046(a), Human Resources Code, to require the executive commissioner of HHSC, rather than HHSC or an agency operating part of the medical assistance program, to adopt rules governing sanctions and penalties that apply to a provider who participates in the vendor drug program or is enrolled as a network pharmacy provider of a managed care organization contracting with HHSC under Chapter 533, Government Code, or its subcontractor and who submits an improper claim for reimbursement under the program.

(l) Repealer: Section 533.012(d) (relating to fraud control information provided by certain providers), Government Code.

(m) Requires HHSC, not later than December 1, 2013, to submit a report to the legislature regarding HHSC's work to ensure that Medicaid managed care organizations promote the development of patient-centered medical homes for recipients of medical assistance as required under Section 533.0029, Government Code, as added by this section.

(n) Requires HHSC, in a contract between HHSC and a managed care organization under Chapter 533, Government Code, that is entered into or renewed on or after the effective date of this Act, to include the provisions required by Subsection (a), Section 533.005, Government Code, as amended by this section.

(o) Makes application of Section 533.0073, Government Code, as added by this section, prospective.

(p) Makes application of Sections 533.0076(a) and (c), Government Code, as amended by this section, prospective.

SECTION 1.03. (a) Amends Section 62.101, Health and Safety Code, by adding Subsection (a-1), to authorize a child who is the dependent of an employee of an agency of this state and who meets the requirements of Subsection (a) (relating to providing that a child is eligible for health benefits coverage under the child health plan if the child meets certain conditions) to be eligible for health benefits coverage in accordance with 42 U.S.C. Section 1397jj(b)(6) and any other applicable law or regulations.

(b) Repealers: Sections 1551.159 (Coverage for Certain Dependent Children of Employees) and 1551.312 (Amount of State Contribution for Certain Dependent Children), Insurance Code.

(c) Provides that the State Kids Insurance Program operated by the Employees Retirement System of Texas is abolished on the effective date of this Act. Requires HHSC to:

(1) establish a process in cooperation with the Employees Retirement System of Texas to facilitate the enrollment of eligible children in the child health plan program established under Chapter 62 (Child Health Plan for Certain Low-Income Children), Health and Safety Code, on or before the date those children are scheduled to stop receiving dependent child coverage under the State Kids Insurance Program; and

(2) modify any applicable administrative procedures to ensure that children described by this subsection maintain continuous health benefits coverage while transitioning from enrollment in the State Kids Insurance Program to enrollment in the child health plan program.

SECTION 1.04. (a) Amends Subchapter B, Chapter 31, Human Resources Code, by adding Section 31.0326, as follows:

Sec. 31.0326. VERIFICATION OF IDENTITY AND PREVENTION OF DUPLICATE PARTICIPATION. Requires HHSC to use appropriate technology to confirm the identity of applicants for benefits under the financial assistance program, and prevent duplicate participation in the program by a person.

(b) Amends Chapter 33, Human Resources Code, by adding Section 33.0231, as follows:

Sec. 33.0231. VERIFICATION OF IDENTITY AND PREVENTION OF DUPLICATE PARTICIPATION IN SNAP. Requires HHSC to use appropriate technology to confirm the identity of applicants for benefits under the supplemental nutrition assistance program, and prevent duplicate participation in the program by a person.

(c) Amends Section 531.109, Government Code, by adding Subsection (d) to authorize HHSC, absent an allegation of fraud, waste, or abuse, to conduct an annual review of claims under this section only after HHSC has completed the prior year's annual review of claims.

(d) Provides that if H.B. No. 710, Acts of the 82nd Legislature, Regular Session, 2011, does not become law, Section 31.0325 (Electronic Imaging Program), Human Resources, is repealed.

(e) Provides that if H.B. No. 710, Acts of the 82nd Legislature, Regular Session, 2011, becomes law, Section 31.0326, Human Resources Code, as added by this section, has no effect.

(f) Provides that if H.B. 710, Acts of the 82nd Legislature, Regular Session, 2011, becomes law, Section 33.0231, Human Resources Code, as added by this Act, is repealed.

SECTION 1.05. (a) Amends Section 242.033, Health and Safety Code, by amending Subsection (d) and adding Subsection (g), as follows:

(d) Provides that except as provided by Subsection (f) (relating to a probationary license issued to certain applicants), a license is renewable every three years, rather than two years, after an inspection, unless an inspection is not required as provided by Section 242.047 (Accreditation Review to Satisfy Inspection or Certification Requirements), payment of the license fee, and the Department of Aging and Disability Services (DADS) approval of the report filed every three years, rather than two years, by the licensee.

(g) Requires the executive commissioner by rule to adopt a system under which an appropriate number of licenses issued by DADS under this chapter expire on staggered dates occurring in each three-year period. Requires DADS, if the expiration date of a license changes as a result of this subsection, to prorate the licensing fee relating to that license as appropriate.

(b) Amends Section 242.159(e-1), Health and Safety Code, to provide that an institution is not required to comply with Subsections (a) (relating to an automated external defibrillator at an institution) and (e) (relating to a person trained in the proper use of an automated external defibrillator) until September 1, 2014, rather than September 1, 2012. Provides that this subsection expires January 1, 2015, rather than January 1, 2013.

(c) Amends Subtitle B, Title 4, Health and Safety Code, by adding Chapter 260A, as follows:

CHAPTER 260A. REPORTS OF ABUSE, NEGLECT, AND EXPLOITATION OF RESIDENTS OF CERTAIN FACILITIES

Sec. 260A.001. DEFINITIONS. Defines, in this chapter, "abuse," "department," "executive commissioner," "exploitation," "facility," "neglect," and "resident."

Sec. 260A.002. REPORTING OF ABUSE, NEGLECT, AND EXPLOITATION. (a) Requires a person, including an owner or employee of a facility, who has cause to believe that the physical or mental health or welfare of a resident has been or may be adversely affected by abuse, neglect, or exploitation caused by another person to report the abuse, neglect, or exploitation in accordance with this chapter.

(b) Requires that each facility require each employee of the facility, as a condition of employment with the facility, to sign a statement that the employee realizes that the employee may be criminally liable for failure to report those abuses.

(c) Requires a person to make an oral report immediately on learning of the abuse, neglect, or exploitation and to make a written report to DADS not later than the fifth day after the oral report is made.

Sec. 260A.003. CONTENTS OF REPORT. (a) Provides that a report of abuse, neglect, or exploitation is nonaccusatory and reflects the reporting person's belief that a resident has been or will be abused, neglected, or exploited or has died of abuse or neglect.

(b) Requires that the report contain the name and address of the resident; the name and address of the person responsible for the care of the resident, if available; and other relevant information.

(c) Provides that except for an anonymous report under Section 260A.004, a report of abuse, neglect, or exploitation under Section 260A.002 should also include the address or phone number of the person making the report so that an investigator can contact the person for any necessary additional information. Requires that the phone number, address, and name of the person making the report be deleted from any copy of any type of report that is released to the public, to the facility, or to an owner or agent of the facility.

Sec. 260A.004. ANONYMOUS REPORTS OF ABUSE, NEGLECT, OR EXPLOITATION. (a) Requires that an anonymous report of abuse, neglect, or exploitation, although not encouraged, be received and acted on in the same manner as an acknowledged report.

(b) Provides that an anonymous report about a specific individual that accuses the individual of abuse, neglect, or exploitation need not be investigated.

Sec. 260A.005. TELEPHONE HOTLINE; PROCESSING OF REPORTS. (a) Requires DADS to operate DADS' telephone hotline to receive reports of abuse, neglect, or exploitation; and dispatch investigators.

(b) Requires that a report of abuse, neglect, or exploitation be made to DADS' telephone hotline or to a local or state law enforcement agency. Requires that a report made relating to abuse, neglect, or exploitation or another complaint described by Section 260A.007(c)(1) be made to DADS' telephone hotline and to the law enforcement agency described by Section 260A.017(a).

(c) Requires a local or state law enforcement agency that receives a report of abuse, neglect, or exploitation, except as provided by Section 260A.017, to refer the report to DADS.

Sec. 260A.006. NOTICE. (a) Requires that each facility prominently and conspicuously post a sign for display in a public area of the facility that is readily available to residents, employees, and visitors.

(b) Sets forth required language to included on the sign.

(c) Requires that a facility provide the telephone hotline number to an immediate family member of a resident of the facility upon the resident's admission into the facility.

Sec. 260A.007. INVESTIGATION AND REPORT OF DEPARTMENT. (a) Requires DADS to make a thorough investigation after receiving an oral or

written report of abuse, neglect, or exploitation under Section 260A.002 or another complaint alleging abuse, neglect, or exploitation.

(b) Provides that the primary purpose of the investigation is the protection of the resident.

(c) Requires DADS to begin the investigation within 24 hours after receipt of the report or other allegation, if the report of abuse, neglect, exploitation, or other complaint alleges that a resident's health or safety is in imminent danger; a resident has recently died because of conduct alleged in the report of abuse, neglect, exploitation, or other complaint; a resident has been hospitalized or been treated in an emergency room because of conduct alleged in the report of abuse, neglect, exploitation, or other complaint; a resident has been a victim of any act or attempted act described by Section 21.02 (Continuous Sexual Abuse of Young Child or Children), 21.11 (Indecency With a Child), 22.011 (Sexual Assault), or 22.021 (Aggravated Sexual Assault), Penal Code; or a resident has suffered bodily injury, as that term is defined by Section 1.07 (Definitions), Penal Code, because of conduct alleged in the report of abuse, neglect, exploitation, or other complaint; or before the end of the next working day after the date of receipt of the report of abuse, neglect, exploitation, or other complaint, if the report or complaint alleges the existence of circumstances that could result in abuse, neglect, or exploitation and that could place a resident's health or safety in imminent danger.

(d) Requires DADS to adopt rules governing the conduct of investigations, including procedures to ensure that the complainant and the resident, the resident's next of kin, and any person designated to receive information concerning the resident receive periodic information regarding the investigation.

(e) Requires the investigator for DADS, in investigating the report of abuse, neglect, exploitation, or other complaint, to:

(1) make an unannounced visit to the facility to determine the nature and cause of the alleged abuse, neglect, or exploitation of the resident;

(2) interview each available witness, including the resident who suffered the alleged abuse, neglect, or exploitation if the resident is able to communicate or another resident or other witness identified by any source as having personal knowledge relevant to the report of abuse, neglect, exploitation, or other complaint;

(3) personally inspect any physical circumstance that is relevant and material to the report of abuse, neglect, exploitation, or other complaint and that may be objectively observed;

(4) make a photographic record of any injury to a resident, subject to Subsection (n); and

(5) write an investigation report that includes the investigator's personal observations; a review of relevant documents and records; a summary of each witness statement, including the statement of the resident that suffered the alleged abuse, neglect, or exploitation and any other resident interviewed in the investigation; and a statement of the factual basis for the findings for each incident or problem alleged in the report or other allegation.

(f) Requires an investigator for an investigating agency to conduct an interview under Subsection (e)(2) in private unless the witness expressly requests that the interview not be private.

(g) Requires the investigator, not later than the 30th day after the date the investigation is complete, to prepare the written report required by Subsection (e). Requires DADS to make the investigation report available to the public on request after the date DADS' letter of determination is complete. Requires DADS to delete from any copy made available to the public the name of any resident, unless DADS receives written authorization from a resident or the resident's legal representative requesting the resident's name be left in the report; the person making the report of abuse, neglect, exploitation, or other complaint; and an individual interviewed in the investigation; and photographs of any injury to the resident.

(h) Requires DADS, in the investigation, to determine:

(1) the nature, extent, and cause of the abuse, neglect, or exploitation;

(2) the identity of the person responsible for the abuse, neglect, or exploitation; (3) the names and conditions of the other residents;

(4) an evaluation of the persons responsible for the care of the residents;

(5) the adequacy of the facility environment; and

(6) any other information required by DADS.

(i) Requires a probate or county court, if DADS attempts to carry out an on-site investigation and it is shown that admission to the facility or any place where the resident is located cannot be obtained, to order the person responsible for the care of the resident or the person in charge of a place where the resident is located to allow entrance for the interview and investigation.

(j) Requires DADS, before the completion of the investigation, to file a petition for temporary care and protection of the resident if DADS determines that immediate removal is necessary to protect the resident from further abuse, neglect, or exploitation.

(k) Requires DADS to make a complete final written report of the investigation and submit the report and its recommendations to the district attorney and, if a law enforcement agency has not investigated the report of abuse, neglect, exploitation, or other complaint, to the appropriate law enforcement agency.

(l) Requires DADS, within 24 hours after receipt of a report of abuse, neglect, exploitation, or other complaint described by Subsection (c)(1), to report the report or complaint to the law enforcement agency described by Section 260A.017(a). Requires DADS to cooperate with that law enforcement agency in the investigation of the report or complaint as described by Section 260A.017.

(m) Provides that the inability or unwillingness of a local law enforcement agency to conduct a joint investigation under Section 260A.017 does not constitute grounds to prevent or prohibit DADS from performing its duties under this chapter. Requires DADS to document any

instance in which a law enforcement agency is unable or unwilling to conduct a joint investigation under Section 260A.017.

(n) Provides that if DADS determines that, before a photographic record of an injury to a resident may be made under Subsection (e), consent is required under state or federal law, the investigator:

(1) is required to seek to obtain any required consent; and

(2) is prohibited from making the photographic record unless the consent is obtained.

Sec. 260A.008. CONFIDENTIALITY. Provides that a report, record, or working paper used or developed in an investigation made under this chapter and the name, address, and phone number of any person making a report under this chapter are confidential and may be disclosed only for purposes consistent with rules adopted by the executive commissioner. Requires that the report, record, or working paper and the name, address, and phone number of the person making the report be disclosed to a law enforcement agency as necessary to permit the law enforcement agency to investigate a report of abuse, neglect, exploitation, or other complaint in accordance with Section 260A.017.

Sec. 260A.009. IMMUNITY. (a) Provides that a person who reports as provided by this chapter is immune from civil or criminal liability that, in the absence of the immunity, might result from making the report.

(b) Provides that the immunity provided by this section extends to participation in any judicial proceeding that results from the report.

(c) Provides that this section does not apply to a person who reports in bad faith or with malice.

Sec. 260A.010. PRIVILEGED COMMUNICATIONS. Prohibits evidence, in a proceeding regarding the abuse, neglect, or exploitation of a resident or the cause of any abuse, neglect, or exploitation, from being excluded on the ground of privileged communication except in the case of a communication between an attorney and client.

Sec. 260A.011. CENTRAL REGISTRY. (a) Requires DADS to maintain in the city of Austin a central registry of reported cases of resident abuse, neglect, or exploitation.

(b) Authorizes the executive commissioner to adopt rules necessary to carry out this section.

(c) Requires that the rules provide for cooperation with hospitals and clinics in the exchange of reports of resident abuse, neglect, or exploitation.

Sec. 260A.012. FAILURE TO REPORT; CRIMINAL PENALTY. (a) Provides that a person commits an offense if the person has cause to believe that a resident's physical or mental health or welfare has been or may be further adversely affected by abuse, neglect, or exploitation and knowingly fails to report in accordance with Section 260A.002.

(b) Provides that an offense under this section is a Class A misdemeanor.

Sec. 260A.013. BAD FAITH, MALICIOUS, OR RECKLESS REPORTING; CRIMINAL PENALTY. (a) Provides that a person commits an offense if the person reports under this chapter in bad faith, maliciously, or recklessly.

(b) Provides that an offense under this section is a Class A misdemeanor.

(c) Provides that the criminal penalty provided by this section is in addition to any civil penalties for which the person may be liable.

Sec. 260A.014. RETALIATION AGAINST EMPLOYEES PROHIBITED. (a) Defines, in this section, "employee."

(b) Provides that an employee has a cause of action against a facility, or the owner or another employee of the facility, that suspends or terminates the employment of the person or otherwise disciplines or discriminates or retaliates against the employee for reporting to the employee's supervisor, an administrator of the facility, a state regulatory agency, or a law enforcement agency a violation of law, including a violation of Chapter 242 (Convalescent and Nursing Homes and Related Institutions) or 247 (Assisted Living Facilities) or a rule adopted under Chapter 242 or 247, or for initiating or cooperating in any investigation or proceeding of a governmental entity relating to care, services, or conditions at the facility.

(c) Authorizes the petitioner to recover the greater of $1,000 or actual damages, including damages for mental anguish even if an injury other than mental anguish is not shown, and damages for lost wages if the petitioner's employment was suspended or terminated; exemplary damages; court costs; and reasonable attorney's fees.

(d) Entitles a person whose employment is suspended or terminated, in addition to the amounts that may be recovered under Subsection (c), to appropriate injunctive relief, including, if applicable:

(1) reinstatement in the person's former position; and

(2) reinstatement of lost fringe benefits or seniority rights.

(e) Requires the petitioner, not later than the 90th day after the date on which the person's employment is suspended or terminated, to bring suit or notify the Texas Workforce Commission (TWC) of the petitioner's intent to sue under this section. Requires a petitioner who notifies TWC under this subsection to bring suit not later than the 90th day after the date of the delivery of the notice to TWC. Requires TWC, on receipt of the notice, to notify the facility of the petitioner's intent to bring suit under this section.

(f) Provides that the petitioner has the burden of proof, except that there is a rebuttable presumption that the person's employment was suspended or terminated for reporting abuse, neglect, or exploitation if the person is suspended or terminated within 60 days after the date on which the person reported in good faith.

(g) Authorizes a suit under this section to be brought in the district court of the county in which the plaintiff resides; the plaintiff was employed by the defendant; or the defendant conducts business.

(h) Requires that each facility require each employee of the facility, as a condition of employment with the facility, to sign a statement that the employee understands the employee's rights under this section. Requires that the statement be part of the statement required under Section 260A.002. If a facility does not require an employee to read and sign the statement, the periods under Subsection (e) do not apply, and the

petitioner must bring suit not later than the second anniversary of the date on which the person's employment is suspended or terminated.

Sec. 260A.015. RETALIATION AGAINST VOLUNTEERS, RESIDENTS, OR FAMILY MEMBERS OR GUARDIANS OF RESIDENTS. (a) Prohibits a facility from retaliating or discriminating against a volunteer, resident, or family member or guardian of a resident because the volunteer, resident, resident's family member or guardian, or any other person:

(1) makes a complaint or files a grievance concerning the facility;

(2) reports a violation of law, including a violation of Chapter 242 or 247 or a rule adopted under Chapter 242 or 247; or

(3) initiates or cooperates in an investigation or proceeding of a governmental entity relating to care, services, or conditions at the facility.

(b) Entitles a volunteer, resident, or family member or guardian of a resident who is retaliated or discriminated against in violation of Subsection (a) to sue for:

(1) injunctive relief;

(2) the greater of $1,000 or actual damages, including damages for mental anguish even if an injury other than mental anguish is not shown;

(3) exemplary damages;

(4) court costs; and

(5) reasonable attorney's fees.

(c) Requires a volunteer, resident, or family member or guardian of a resident who seeks relief under this section to report the alleged violation not later than the 180th day after the date on which the alleged violation of this section occurred or was discovered by the volunteer, resident, or family member or guardian of the resident through reasonable diligence.

(d) Authorizes a suit under this section to be brought in the district court of the county in which the facility is located or in a district court of Travis County.

Sec. 260A.016. REPORTS RELATING TO DEATHS OF RESIDENTS OF AN INSTITUTION. (a) Defines, in this section, "institution."

(b) Requires an institution to submit a report to DADS concerning deaths of residents of the institution. Requires that the report be submitted not later than the 10th day after the last day of each month in which a resident of the institution dies. Requires that the report also include the death of a resident occurring within 24 hours after the resident is transferred from the institution to a hospital.

(c) Requires that the institution make the report on a form prescribed by DADS. Requires that the report contain the name and social security number of the deceased.

(d) Requires DADS to correlate reports under this section with death certificate information to develop data relating to the:

(1) name and age of the deceased;

(2) official cause of death listed on the death certificate;

(3) date, time, and place of death; and

(4) name and address of the institution in which the deceased resided.

(e) Provides that, except as provided by Subsection (f), a record under this section is confidential and not subject to the provisions of Chapter 552 (Public Information), Government Code.

(f) Requires DADS to develop statistical information on official causes of death to determine patterns and trends of incidents of death among residents and in specific institutions. Provides that information developed under this subsection is public.

(g) Requires a licensed institution to make available historical statistics on all required information on request of an applicant or applicant's representative.

Sec. 260A.017. DUTIES OF LAW ENFORCEMENT; JOINT INVESTIGATION. (a) Requires DADS to investigate a report of abuse, neglect, exploitation, or other complaint described by Section 260A.007(c)(1) jointly with:

(1) the municipal law enforcement agency, if the facility is located within the territorial boundaries of a municipality; or

(2) the sheriff's department of the county in which the facility is located, if the facility is not located within the territorial boundaries of a municipality.

(b) Requires the law enforcement agency described by Subsection (a) to acknowledge the report of abuse, neglect, exploitation, or other complaint and begin the joint investigation required by this section within 24 hours after receipt of the report or complaint. Requires the law enforcement agency to cooperate with DADS and report to DADS the results of the investigation.

(c) Provides that the requirement that the law enforcement agency and DADS conduct a joint investigation under this section does not require that a representative of each agency be physically present during all phases of the investigation or that each agency participate equally in each activity conducted in the course of the investigation.

Sec. 260A.018. CALL CENTER EVALUATION; REPORT. (a) Requires DADS, using existing resources, to test, evaluate, and determine the most effective and efficient staffing pattern for receiving and processing complaints by expanding customer service representatives' hours of availability at DADS' telephone hotline call center.

(b) Requires DADS to report the findings of the evaluation described by Subsection (a) to the House Committee on Human Services and the Senate Committee on Health and Human Services not later than September 1, 2012.

(c) Provides that this section expires October 31, 2012.

(d) Amends Chapter 2, Code of Criminal Procedure, by adding Article 2.271, as follows:

Art. 2.271. INVESTIGATION OF CERTAIN REPORTS ALLEGING ABUSE, NEGLECT, OR EXPLOITATION. Requires the appropriate local law enforcement agency, notwithstanding Article 2.27 (Investigation of Certain Reports Alleging Abuse), on receipt of a report of abuse, neglect, exploitation, or other complaint of a resident of a nursing home, convalescent home, or other related institution or an assisted living facility, under Section 260A.007(c)(1), Health and Safety Code, to investigate the report as required by Section 260A.017, Health and Safety Code.

(e) Amends Subchapter A, Chapter 242, Health and Safety Code, by adding Section 242.018, as follows:

Sec. 242.018. COMPLIANCE WITH CHAPTER 260A. (a) Requires an institution to comply with Chapter 260A and the rules adopted under that chapter.

(b) Requires a person, including an owner or employee of an institution, to comply with Chapter 260A and the rules adopted under that chapter.

(f) Amends Section 242.042(a), Health and Safety Code, as follows:

(a) Requires each institution to prominently and conspicuously post for display in a public area of the institution that is readily available to residents, employees, and visitors:

(1)-(8) Makes no changes to these subdivisions;

(9) notice that employees, other staff, residents, volunteers, and family members and guardians of residents are protected from discrimination or retaliation as provided by Sections 260A.014 and 260A.015, rather than Sections 242.133 and 242.1335; and

(10) a sign required to be posted under Section 260A.006(a).

(g) Amends Section 242.0665(b), Health and Safety Code, as follows:

(b) Provides that subsection (a) does not apply:

(1)-(2) Makes no changes to these subdivisions;

(3) to a violation of Section 260A.014 or 260A.015, rather than Section 242.133 or 242.1335; or

(4) Makes no changes to this subdivision.

(h) Amends Section 242.848(a) and (b), Health and Safety Code, as follows:

(a) Provides that for purposes of the duty to report abuse or neglect under Section 260A.002, rather than Section 242.122, and the criminal penalty for the failure to report abuse or neglect under Section 260A.012 rather than Section 242.131, a person who is conducting electronic monitoring on behalf of a resident under this subchapter is considered to have viewed or listened to a tape or recording made by the electronic monitoring device on or before the 14th day after the date the tape or recording is made.

(b) Makes conforming changes.

(i) Amends Subchapter A, Chapter 247, Health and Safety Code, by adding Section 247.007, as follows:

Sec. 247.007. COMPLIANCE WITH CHAPTER 260A. (a) Requires an assisted living facility to comply with Chapter 260A and the rules adopted under that chapter.

(b) Requires a person, including an owner or employee of an assisted living facility, to comply with Chapter 260A and the rules adopted under that chapter.

(j) Amends Section 247.043(a), Health and Safety Code, as follows:

(a) Requires DADS to conduct an investigation in accordance with Section 260A.007 after receiving a report of abuse, exploitation, or neglect of a resident of an assisted living facility. Deletes existing text requiring DADS to conduct a preliminary investigation of each allegation of abuse, exploitation, or neglect of a resident of an assisted living facility to determine if there is evidence to corroborate the allegation. Deletes existing text requires DADS, if DADS determines that there is evidence to corroborate the allegation, to conduct a thorough investigation of the allegation

(k) Amends Section 247.0452(b), Health and Safety Code, as follows:

(b) Provides that Subsection (a) does not apply:

(1) Makes no changes to this subdivision;

(2) to a violation described by Sections 247.0451(a)(2)-(7) or a violation of Section 260A.014 or 260A.015; or

(3)-(4) Makes no changes to these subdivisions.

(l) Amends Section 48.003, Human Resources Code, as follows:

Sec. 48.003. New heading: INVESTIGATIONS IN NURSING HOMES, ASSISTED LIVING FACILITIES, AND SIMILAR FACILITIES. (a) Provides that this chapter does not apply if the alleged or suspected abuse, neglect, or exploitation occurs in a facility licensed under Chapter 242 (Convalescent and Nursing Homes and Related Institutions) or 247, Health and Safety Code.

(b) Provides that alleged or suspected abuse, neglect, or exploitation that occurs in a facility licensed under Chapter 242 or 247, Health and Safety Code, is governed by Chapter 260A, rather than Subchapter B (Licensing, Fees, and Inspections), Chapter 242, Health and Safety Code.

(m) Repealer: Subchapter E (Reports of Abuse and Neglect), Chapter 242, Health and Safety Code.

(n) Requires the executive commissioner of HHSC to adopt the rules required under Section 242.033(g), Health and Safety Code, as added by this section, as soon as practicable after the effective date of this Act, but not later than December 1, 2012.

(o) Provides that the repeal by this Act of Section 242.131, Health and Safety Code, does not apply to an offense committed under that section before the effective date of this Act. Provides that an offense committed before the effective date of this Act is governed by that section as it existed on the date the offense was committed, and the former law is continued in effect for that purpose. Provides that for purposes of this subsection, an offense was committed before the effective date of this Act if any element of the offense occurred before that date.

(p) Provides that the repeal by this Act of Sections 242.133 and 242.1335, Health and Safety Code, does not apply to a cause of action that accrues before the effective date of this Act. Provides that a cause of action that accrues before the effective date of this Act is governed by Section 242.133 or 242.1335, Health and Safety Code, as applicable, as the section existed at the time the cause of action accrued, and the former law is continued in effect for that purpose.

(q) Provides that the change in law made by this Act by the repeal of Subchapter E, Chapter 242, Health and Safety Code, does not apply to a disciplinary action under Subchapter C, Chapter 242, Health and Safety Code, for conduct that occurred before the effective date of this Act. Provides that conduct that occurs before the effective date of this Act is governed by the law as it existed on the date the conduct occurred, and the former law is continued in effect for that purpose.

(r) Requires DADS to implement Chapter 260A, Health and Safety Code, as added by this Act, using only existing resources and personnel.

(s) Requirses DADS to ensure that the services provided on the effective date of this Act are at least as comprehensive as the services provided on the day before the effective date of this Act.

SECTION 1.06. (a) Amends Section 161.081, Human Resources Code, as follows:

Sec. 161.081. New heading: LONG-TERM CARE MEDICAID WAIVER PROGRAMS: STREAMLINING AND UNIFORMITY. (a) Makes no changes to this subsection.

(b) Authorizes DADS, in implementing this subsection, subject to Subsection (c), to consider implementing certain streamlining initiatives, including, if feasible, concurrently conducting program certification and billing audit and review processes and other related audit and review processes, streamlining other billing and auditing requirements, eliminating duplicative responsibilities with respect to the coordination and oversight of individual care plans for persons receiving waiver services, and streamlining cost reports and other cost reporting processes. Make a nonsubstantive and conforming change.

(c) Requires DADS to ensure that actions taken under Subsection (b), rather than this section, do not conflict with any requirements of HHSC under Section 531.0218, Government Code.

(d) Requires DADS and HHSC to jointly explore the development of uniform licensing and contracting standards that would apply to all contracts for the delivery of Section 1915(c) waiver program services, promote competition among providers of those program services, and integrate with other department and commission efforts to streamline and unify the administration and delivery of the program services, including those required by this section or Section 531.0218, Government Code.

(b) Amends Subchapter D, Chapter 161, Human Resources Code, by adding Section 161.082, as follows:

Sec. 161.082. LONG-TERM CARE MEDICAID WAIVER PROGRAMS: UTILIZATION REVIEW. (a) Defines, in this section, "Section 1915(c) waiver program."

(b) Requires DADS to perform a utilization review of services in all Section 1915(c) waiver programs. Requires that the utilization review include, at a minimum, reviewing program recipients' levels of care and

any plans of care for those recipients that exceed service level thresholds established in the applicable waiver program guidelines.

SECTION 1.07. Amends Subchapter D, Chapter 161, Human Resources Code, by adding Section 161.086, as follows:

Sec. 161.086. ELECTRONIC VISIT VERIFICATION SYSTEM. Requires DADS, if it is cost-effective, to implement an electronic visit verification system under appropriate programs administered by DADS under the Medicaid program that allows providers to electronically verify and document basic information relating to the delivery of services, including the provider's name, the recipient's name, the date and time the provider begins and ends the delivery of services, and the location of service delivery.

SECTION 1.08. (a) Amends Section 247.002(1), Health and Safety Code, to redefine "assisted living facility."

(b) Amends Section 247.004, Health and Safety Code, effective September 1, 2011, as follows:

Sec. 247.004. EXEMPTIONS. Provides that this chapter does not apply to certain facilities, including a boarding home facility as defined by Section 260.001; or a facility that provides personal care services only to persons enrolled in a program that is funded in whole or in part by DADS and that is monitored by DADS or its designated local mental retardation authority in accordance with standards set by DADS, or is funded in whole or in part by the Department of State Health Services (DSHS) and that is monitored by that department, or by its designated local mental health authority in accordance with standards set by DSHS.

(c) Amends Section 247.067(b), Health and Safety Code, to authorize a health care professional, unless otherwise prohibited by law, to be employed by an assisted living facility to provide at the facility to the facility's residents services that are authorized by this chapter and that are within the professional's scope of practice, rather than authorizes a health care professional to provide services within the professional's scope of practice to a resident of an assisted living facility at the facility.

SECTION 1.09. (a) Amends Subchapter B, Chapter 531, Government Code, by adding Sections 531.086 and 531.0861, as follows:

Sec. 531.086. STUDY REGARDING PHYSICIAN INCENTIVE PROGRAMS TO REDUCE HOSPITAL EMERGENCY ROOM USE FOR NON-EMERGENT CONDITIONS. (a) Requires HHSC to conduct a study to evaluate physician incentive programs that attempt to reduce hospital emergency room use for non-emergent conditions by recipients under the medical assistance program. Requires that each physician incentive program evaluated in the study be administered by a health maintenance organization participating in the STAR or STAR + PLUS Medicaid managed care program, and provide incentives to primary care providers who attempt to reduce emergency room use for non-emergent conditions by recipients.

(b) Requires that the study conducted under Subsection (a) evaluate the cost-effectiveness of each component included in a physician incentive program, and any change in statute required to implement each component within the Medicaid fee-for-service payment model.

(c) Requires the executive commissioner, not later than August 31, 2013, to submit to the governor and the Legislative Budget Board (LBB) a report summarizing the findings of the study required by this section.

(d) Provides that this section expires September 1, 2014.

Sec. 531.0861. PHYSICIAN INCENTIVE PROGRAM TO REDUCE HOSPITAL EMERGENCY ROOM USE FOR NON-EMERGENT CONDITIONS. (a) Requires the executive commissioner, if cost-effective, by rule to establish a physician incentive program designed to reduce the use of hospital emergency room services for non-emergent conditions by recipients under the medical assistance program.

(b) Authorizes the executive commissioner, in establishing the physician incentive program under Subsection (a), to include only the program components identified as cost-effective in the study conducted under Section 531.086.

(c) Requires the executive commissioner, if the physician incentive program includes the payment of an enhanced reimbursement rate for routine after-hours appointments, to implement controls to ensure that the after-hours services billed are actually being provided outside of normal business hours.

(b) Amends Section 32.0641, Human Resources Code, as follows:

Sec. 32.0641. New heading: RECIPIENT ACCOUNTABILITY PROVISIONS; COST-SHARING REQUIREMENT TO IMPROVE APPROPRIATE UTILIZATION OF SERVICES. (a) Requires the executive commissioner, to the extent permitted under and in a manner that is consistent with Title XIX, Social Security Act (42 U.S.C. Section 1396 et seq.) and any other applicable law or regulation or under a federal waiver or other authorization, to adopt, after consulting with the Medicaid and CHIP Quality-Based Payment Advisory Committee established under Section 536.002, Government Code, cost-sharing provisions that encourage personal accountability and appropriate utilization of health care services, including a cost-sharing provision applicable to a recipient who chooses to receive a nonemergency medical service through a hospital emergency room. Deletes existing text requiring the executive commissioner, if DADS determines that it is feasible and cost-effective, and to the extent permitted under Title XIX, Social Security Act (42 U.S.C. Section 1396 et seq.) and any other applicable law or regulation or under a federal waiver or other authorization, to adopt cost-sharing provisions that require a recipient who chooses a high-cost medical service provided through a hospital emergency room to pay a copayment, premium payment, or other cost-sharing payment for the high-cost medical service if the hospital from which the recipient seeks service performs an appropriate medical screening and determines that the recipient does not have a condition requiring emergency medical services; informs the recipient that the recipient does not have a condition requiring emergency medical services, that, if the hospital provides the nonemergency service, the hospital may require payment of a copayment, premium payment, or other cost-sharing payment by the recipient in advance, and of the name and address of a nonemergency Medicaid provider who can provide the appropriate medical service without imposing a cost-sharing payment; and offers to provide the recipient with a referral to the nonemergency provider to facilitate scheduling of the service; and after receiving the information and assistance described by Subdivision (1) from the hospital, the recipient chooses to obtain emergency medical services despite having access to medically acceptable, lower-cost medical services.

(b) Prohibits DADS from seeking a federal waiver or other authorization under this section, rather than under Subsection (a), that would prevent a Medicaid recipient who has a condition requiring emergency medical services from receiving care through a hospital emergency room, or waive any provision under Section 1867, Social Security Act (42 U.S.C. Section 1395dd). Deletes existing Subsection (c), prohibiting HHSC, if the executive commissioner of HHSC adopts a copayment or other cost-

sharing payment under Subsection (a), from reducing hospital payments to reflect the potential receipt of a copayment or other payment from a recipient receiving medical services provided through a hospital emergency room.

(c) Provides that if H.B. No. 2245, Acts of the 82nd Legislature, Regular Session, 2011, becomes law, Sections 531.086 and 531.0861, Government Code, as added by that Act, are repealed.

SECTION 1.10. Amends Subchapter B, Chapter 531, Government Code, by adding Section 531.024131, as follows:

Sec. 531.024131. EXPANSION OF BILLING COORDINATION AND INFORMATION COLLECTION ACTIVITIES. (a) Authorizes HHSC, if cost-effective, to:

(1) contract to expand all or part of the billing coordination system established under Section 531.02413 (Billing Coordination System) to process claims for services provided through other benefits programs administered by HHSC or a health and human services agency;

(2) expand any other billing coordination tools and resources used to process claims for health care services provided through the Medicaid program to process claims for services provided through other benefits programs administered by HHSC or a health and human services agency; and

(3) expand the scope of persons about whom information is collected under Section 32.042 (Information Required from Health Insurers), Human Resources Code, to include recipients of services provided through other benefits programs administered by HHSC or a health and human services agency.

(b) Requires each health and human services agency, notwithstanding any other state law, to provide HHSC with any information necessary to allow HHSC or HHSC's designee to perform the billing coordination and information collection activities authorized by this section.

SECTION 1.11. (a) Amends Sections 531.502(b), (c), and (d), Government Code, as follows:

(b) Authorizes the executive commissioner to include the following federal money in the waiver:

(1) money provided under the disproportionate share hospitals or upper payment limit supplemental payment program, or both, rather than all money provided under the disproportionate share hospitals and upper payment limit supplemental payment programs;

(2) money provided by the federal government in lieu of some or all of the payments under one or both of those programs;

(3) any combination of funds authorized to be pooled by Subdivisions (1) and (2); and

(4) any other money available for that purpose, including federal money and money identified under Subsection (c); gifts, grants, or donations for that purpose; local funds received by this state through intergovernmental transfers; and if approved in the waiver, federal money obtained through the use of certified public expenditures.

(c) Requires HHSC to seek to optimize federal funding by taking certain actions, including identifying health care related state and local funds and program expenditures that, before September 1, 2011, rather than September 1, 2007, are not being matched with federal money.

(d) Requires that the terms of a waiver approved under this section:

(1) include safeguards to ensure that the total amount of federal money provided under the disproportionate share hospitals or upper payment limit supplemental payment program, rather than under the disproportionate share hospitals and upper payment limit supplemental payment programs, that is deposited as provided by Section 531.504 is, for a particular state fiscal year, at least equal to the greater of the annualized amount provided to this state under those supplemental payment programs during state fiscal year 2011, rather than state fiscal year 2007, excluding amounts provided during that state fiscal year that are retroactive payments, or the state fiscal years during which the waiver is in effect; and

(2) allow for the development by this state of a methodology for allocating money in the fund to be used to supplement Medicaid hospital reimbursements under a waiver that includes terms that are consistent with, or that produce revenues consistent with, disproportionate share hospital and upper payment limit principles, rather than to offset, in part, the uncompensated health care costs incurred by hospitals; reduce the number of persons in this state who do not have health benefits coverage, and maintain and enhance the community public health infrastructure provided by hospitals.

(b) Amends Section 531.504, Government Code, as follows:

Sec. 531.504. DEPOSITS TO FUND. (a) Requires the comptroller of public accounts (comptroller) to deposit in the fund federal money provided to this state under the disproportionate share hospitals supplemental payment program or the hospital upper payment limit supplemental payment program, or both, rather than all federal money provided to this state under the disproportionate share hospitals supplemental payment program and the hospital upper payment limit supplemental payment program, other than money provided under those programs to state-owned and operated hospitals, and all other non-supplemental payment program federal money provided to this state that is included in the waiver authorized by Section 531.502 (Direction to Obtain Federal Waiver), and state money appropriated to the fund.

(b) Authorizes HHSC and the comptroller to accept gifts, grants, and donations from any source, and receive intergovernmental transfers, for purposes consistent with this subchapter and the terms of the waiver. Requires that any intergovernmental transfer received, including associated federal matching funds, be used, if feasible, for the purposes intended by the transferring entity and in accordance with the terms of the waiver.

(c) Amends Section 531.508, Government Code, by adding Subsection (d) to prohibit money from the fund from being used to finance the construction, improvement, or renovation of a building or land unless the construction, improvement, or renovation is approved by HHSC, according to rules adopted by the executive commissioner for that purpose.

(d) Repealer: Section 531.502(g) (relating to certain advice regarding the terms and conditions of the negotiated waiver), Government Code.

SECTION 1.12. (a) Amends Subtitle I, Title 4, Government Code, by adding Chapter 536, and transfering Section 531.913, Government Code, to Subchapter D, Chapter 536, Government Code, redesignating it as Section 536.151, Government Code, and amending it as follows:

CHAPTER 536. MEDICAID AND CHILD HEALTH PLAN PROGRAMS: QUALITY-BASED OUTCOMES AND PAYMENTS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 536.001. DEFINITIONS. Defines, in this chapter, "advisory committee," "alternative payment system," "blended payment system," "child health plan program," "commission," "executive commissioner," "health and human services agencies," "episode-based bundled payment system," "exclusive provider benefit plan," "freestanding emergency medical care facility," "global payment system," "health care provider," "hospital," "managed care organization," "managed care plan," "Medicaid program," "physician," "potentially preventable admission," "potentially preventable ancillary service," "potentially preventable complication," "potentially preventable event," "potentially preventable emergency room visit," "potentially preventable readmission," and "quality-based payment system."

Sec. 536.002. MEDICAID AND CHIP QUALITY-BASED PAYMENT ADVISORY COMMITTEE. (a) Provides that the Medicaid and CHIP Quality-Based Payment Advisory Committee (advisory committee) is established to advise HHSC on establishing, for purposes of the child health plan and Medicaid programs administered by HHSC or a health and human services agency:

(1) reimbursement systems used to compensate physicians or other health care providers under those programs that reward the provision of high-quality, cost-effective health care and quality performance and quality of care outcomes with respect to health care services;

(2) standards and benchmarks for quality performance, quality of care outcomes, efficiency, and accountability by managed care organizations and physicians and other health care providers;

(3) programs and reimbursement policies that encourage high-quality, cost-effective health care delivery models that increase appropriate provider collaboration, promote wellness and prevention, and improve health outcomes; and

(4) outcome and process measures under Section 536.003.

(b) Requires the executive commissioner to appoint the members of the advisory committee. Requires the committee to consist of physicians and other health care providers, representatives of health care facilities, representatives of managed care organizations, and other stakeholders interested in health care services provided in this state, including:

(1) at least one member who is a physician with clinical practice experience in obstetrics and gynecology;

(2) at least one member who is a physician with clinical practice experience in pediatrics;

(3) at least one member who is a physician with clinical practice experience in internal medicine or family medicine;

(4) at least one member who is a physician with clinical practice experience in geriatric medicine;

(5) at least one member who is or who represents a health care provider that primarily provides long-term care services;

(6) at least one member who is a consumer representative; and

(7) at least one member who is 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.

(c) Requires the executive commissioner to appoint the presiding officer of the advisory committee.

Sec. 536.003. DEVELOPMENT OF QUALITY-BASED OUTCOME AND PROCESS MEASURES. (a) Requires HHSC, in consultation with the advisory committee, to develop quality-based outcome and process measures that promote the provision of efficient, quality health care and that can be used in the child health plan and Medicaid programs to implement quality-based payments for acute and long-term care services across all delivery models and payment systems, including fee-for-service and managed care payment systems. Requires HHSC, in developing outcome measures under this section, to consider measures addressing potentially preventable events.

(b) Requires HHSC, to the extent feasible, to develop outcome and process measures:

(1) consistently across all child health plan and Medicaid program delivery models and payment systems;

(2) in a manner that takes into account appropriate patient risk factors, including the burden of chronic illness on a patient and the severity of a patient's illness;

(3) that will have the greatest effect on improving quality of care and the efficient use of services; and

(4) that are similar to outcome and process measures used in the private sector, as appropriate.

(c) Requires HHSC, to the extent feasible, to align outcome and process measures developed under this section with measures required or recommended under reporting guidelines established by the federal Centers for Medicare and Medicaid Services, the Agency for Healthcare Research and Quality, or another federal agency.

(d) Authorizes the executive commissioner by rule to require managed care organizations and physicians and other health care providers participating in the child health plan and Medicaid programs to report to HHSC in a format specified by the executive commissioner information necessary to develop outcome and process measures under this section.

(e) Requires HHSC, if HHSC increases physician and other health care provider reimbursement rates under the child health plan or Medicaid program as a result of an increase in the amounts appropriated for the programs for a state fiscal biennium as compared to the preceding state fiscal biennium, to the extent permitted under federal law and to the extent otherwise possible considering other relevant factors, to correlate the

increased reimbursement rates with the quality-based outcome and process measures developed under this section.

Sec. 536.004. DEVELOPMENT OF QUALITY-BASED PAYMENT SYSTEMS. (a) Requires HHSC, after consulting with the advisory committee, using quality-based outcome and process measures developed under Section 536.003 and subject to this section, to develop quality-based payment systems for compensating a physician or other health care provider participating in the child health plan or Medicaid program that:

(1) align payment incentives with high-quality, cost-effective health care;

(2) reward the use of evidence-based best practices;

(3) promote the coordination of health care;

(4) encourage appropriate physician and other health care provider collaboration;

(5) promote effective health care delivery models; and

(6) take into account the specific needs of the child health plan program enrollee and Medicaid recipient populations.

(b) Requires HHSC to develop quality-based payment systems in the manner specified by this chapter. Requires HHSC, to the extent necessary, to coordinate the timeline for the development and implementation of a payment system with the implementation of other initiatives such as the Medicaid Information Technology Architecture (MITA) initiative of the Center for Medicaid and State Operations, the ICD-10 code sets initiative, or the ongoing Enterprise Data Warehouse (EDW) planning process in order to maximize the receipt of federal funds or reduce any administrative burden.

(c) Requires HHSC, in developing quality-based payment systems under this chapter, to examine and consider implementing:

(1) an alternative payment system;

(2) any existing performance-based payment system used under the Medicare program that meets the requirements of this chapter, modified as necessary to account for programmatic differences, if implementing the system would reduce unnecessary administrative burdens, and align quality-based payment incentives for physicians and other health care providers with the Medicare program; and

(3) alternative payment methodologies within the system that are used in the Medicare program, modified as necessary to account for programmatic differences, and that will achieve cost savings and improve quality of care in the child health plan and Medicaid programs.

(d) Requires HHSC, in developing quality-based payment systems under this chapter, to ensure that a managed care organization or physician or other health care provider will not be rewarded by the system for withholding or delaying the provision of medically necessary care.

(e) Authorizes HHSC to modify a quality-based payment system developed under this chapter to account for programmatic differences

between the child health plan and Medicaid programs and delivery systems under those programs.

Sec. 536.005. CONVERSION OF PAYMENT METHODOLOGY. (a) Requires HHSC, to the extent possible, to convert hospital reimbursement systems under the child health plan and Medicaid programs to a diagnosis-related groups (DRG) methodology that will allow HHSC to more accurately classify specific patient populations and account for severity of patient illness and mortality risk.

(b) Provides that Subsection (a) does not authorize HHSC to direct a managed care organization to compensate physicians and other health care providers providing services under the organization's managed care plan based on a diagnosis-related groups (DRG) methodology.

Sec. 536.006. TRANSPARENCY. Requires HHSC and the advisory committee to:

(1) ensure transparency in the development and establishment of quality-based payment and reimbursement systems under Section 536.004 and Subchapters B, C, and D, including the development of outcome and process measures under Section 536.003; and quality-based payment initiatives under Subchapter E, including the development of quality of care and cost-efficiency benchmarks under Section 536.204(a) and efficiency performance standards under Section 536.204(b);

(2) develop guidelines establishing procedures for providing notice and information to, and receiving input from, managed care organizations, health care providers, including physicians and experts in the various medical specialty fields, and other stakeholders, as appropriate, for purposes of developing and establishing the quality-based payment and reimbursement systems and initiatives described under Subdivision (1); and

(3) in developing and establishing the quality-based payment and reimbursement systems and initiatives described under Subdivision (1), consider that as the performance of a managed care organization or physician or other health care provider improves with respect to an outcome or process measure, quality of care and cost-efficiency benchmark, or efficiency performance standard, as applicable, there will be a diminishing rate of improved performance over time.

Sec. 536.007. PERIODIC EVALUATION. (a) Requires HHSC, at least once each two-year period, to evaluate the outcomes and cost-effectiveness of any quality-based payment system or other payment initiative implemented under this chapter.

(b) Requires HHSC to present the results of its evaluation under Subsection (a) to the advisory committee for the committee's input and recommendations, and provide a process by which managed care organizations and physicians and other health care providers may comment and provide input into the committee's recommendations under Subdivision (1).

Sec. 536.008. ANNUAL REPORT. (a) Requires HHSC to submit an annual report to the legislature regarding the quality-based outcome and process measures developed under Section 536.003, and the progress of the implementation of quality-based payment systems and other payment initiatives implemented under this chapter.

(b) Requires HHSC to report outcome and process measures under Subsection (a)(1) by health care service region and service delivery model.

[Reserves Sections 536.009-536.050 for expansion.]

SUBCHAPTER B. QUALITY-BASED PAYMENTS RELATING TO MANAGED CARE ORGANIZATIONS

Sec. 536.051. DEVELOPMENT OF QUALITY-BASED PREMIUM PAYMENTS; PERFORMANCE REPORTING. (a) Requires HHSC, subject to Section 1903(m)(2)(A), Social Security Act (42 U.S.C. Section 1396b(m)(2)(A)), and other applicable federal law, to base a percentage of the premiums paid to a managed care organization participating in the child health plan or Medicaid program on the organization's performance with respect to outcome and process measures developed under Section 536.003, including outcome measures addressing potentially preventable events.

(b) Requires HHSC to make available information relating to the performance of a managed care organization with respect to outcome and process measures under this subchapter to child health plan program enrollees and Medicaid recipients before those enrollees and recipients choose their managed care plans.

Sec. 536.052. PAYMENT AND CONTRACT AWARD INCENTIVES FOR MANAGED CARE ORGANIZATIONS. (a) Authorizes HHSC to allow a managed care organization participating in the child health plan or Medicaid program increased flexibility to implement quality initiatives in a managed care plan offered by the organization, including flexibility with respect to financial arrangements, in order to achieve high-quality, cost-effective health care, increase the use of high-quality, cost-effective delivery models, and reduce potentially preventable events.

(b) Requires HHSC, after consulting with the advisory committee, to develop quality of care and cost-efficiency benchmarks, including benchmarks based on a managed care organization's performance with respect to reducing potentially preventable events and containing the growth rate of health care costs.

(c) Authorizes HHSC to include in a contract between a managed care organization and HHSC financial incentives that are based on the organization's successful implementation of quality initiatives under Subsection (a) or success in achieving quality of care and cost-efficiency benchmarks under Subsection (b).

(d) Requires HHSC, in awarding contracts to managed care organizations under the child health plan and Medicaid programs, in addition to considerations under Section 533.003 of this code and Section 62.155 (Health Plan Providers), Health and Safety Code, to give preference to an organization that offers a managed care plan that successfully implements quality initiatives under Subsection (a) as determined by HHSC based on data or other evidence provided by the organization or meets quality of care and cost-efficiency benchmarks under Subsection (b).

(e) Authorizes HHSC to implement financial incentives under this section only if implementing the incentives would be cost-effective.

[Reserves Sections 536.053-536.100 for expansion.]

SUBCHAPTER C. QUALITY-BASED HEALTH HOME PAYMENT SYSTEMS

Sec. 536.101. DEFINITIONS. Defines, in this subchapter, "health home" and "participating enrollee."

Sec. 536.102. QUALITY-BASED HEALTH HOME PAYMENTS. (a) Authorizes HHSC, subject to this subchapter, after consulting with the advisory committee, to develop and implement quality-based payment systems for health homes designed to improve quality of care and reduce the provision of unnecessary medical services. Requires that a quality-based payment system developed under this section base payments made to a participating enrollee's health home on quality and efficiency measures that may include measurable wellness and prevention criteria and use of evidence-based best practices, sharing a portion of any realized cost savings achieved by the health home, and ensuring quality of care outcomes, including a reduction in potentially preventable events; and allow for the examination of measurable wellness and prevention criteria, use of evidence-based best practices, and quality of care outcomes based on the type of primary or specialty care provider practice.

(b) Authorizes HHSC to develop a quality-based payment system for health homes under this subchapter only if implementing the system would be feasible and cost-effective.

Sec. 536.103. PROVIDER ELIGIBILITY. Requires a health home provider, to be eligible to receive reimbursement under a quality-based payment system under this subchapter, to provide participating enrollees, directly or indirectly, with access to health care services outside of regular business hours; educate participating enrollees about the availability of health care services outside of regular business hours; and provide evidence satisfactory to HHSC that the provider meets the requirement of Subdivision (1).

[Reserves Sections 536.104-536.150 for expansion.]

SUBCHAPTER D. QUALITY-BASED HOSPITAL REIMBURSEMENT SYSTEM

Sec. 536.151. New heading: COLLECTION AND REPORTING OF CERTAIN INFORMATION. Redesignates existing Section 531.913 as Section 536.151. (a) Redesignates existing Subsection (b) as Subsection (a). Requires the executive commissioner to adopt rules for identifying potentially preventable readmissions of child health plan program enrollees and Medicaid recipients and potentially preventable complications experienced by child health plan program enrollees and Medicaid recipients. Requires HHSC to collect data from hospitals, rather than to exchange data with hospitals, on present-on-admission indicators for purposes of this section. Deletes existing text of Subsection (a) defining, in this section, "potentially preventable readmission."

(b) Redesignates existing Subsection (c) as Subsection (b). Requires HHSC to establish a program to provide a confidential report to each hospital in this state that participates in the child health plan or Medicaid program regarding the hospital's performance with respect to potentially preventable readmissions and potentially preventable complications. Provides that to the extent possible, a report provided under this section should include potentially preventable readmissions and potentially preventable complications information across all child health plan and Medicaid program payment systems. Requires a hospital to distribute the information contained in the report to physicians and other health care providers providing services at the hospital. Deletes existing text requiring HHSC to establish a health information exchange program to exchange confidential information with each hospital in this state regarding the hospital's performance with respect to potentially preventable readmissions. Deletes existing text requiring a hospital to

distribute the information received from HHSC to health care providers providing services at the hospital.

(c) Provides that a report provided to a hospital under this section is confidential and is not subject to Chapter 552.

Sec. 536.152. REIMBURSEMENT ADJUSTMENTS. (a) Requires HHSC, after consulting with the advisory committee, subject to Subsection (b), using the data collected under Section 536.151 and the diagnosis-related groups (DRG) methodology implemented under Section 536.005, to the extent feasible adjust child health plan and Medicaid reimbursements to hospitals, including payments made under the disproportionate share hospitals and upper payment limit supplemental payment programs, in a manner that may reward or penalize a hospital based on the hospital's performance with respect to exceeding, or failing to achieve, outcome and process measures developed under Section 536.003 that address the rates of potentially preventable readmissions and potentially preventable complications.

(b) Requires HHSC to provide the report required under Section 536.151(b) to a hospital at least one year before HHSC adjusts child health plan and Medicaid reimbursements to the hospital under this section.

[Reserves Sections 536.153-536.200 for expansion.]

SUBCHAPTER E. QUALITY-BASED PAYMENT INITIATIVES

Sec. 536.201. DEFINITION. Defines, in this subchapter, "payment initiative."

Sec. 536.202. PAYMENT INITIATIVES; DETERMINATION OF BENEFIT TO STATE. (a) Requires HHSC, after consulting with the advisory committee, to establish payment initiatives to test the effectiveness of quality-based payment systems, alternative payment methodologies, and high-quality, cost-effective health care delivery models that provide incentives to physicians and other health care providers to develop health care interventions for child health plan program enrollees or Medicaid recipients, or both, that will improve the quality of health care provided to the enrollees or recipients, reduce potentially preventable events, promote prevention and wellness, increase the use of evidence-based best practices, increase appropriate physician and other health care provider collaboration, and contain costs.

(b) Requires HHSC to establish a process by which managed care organizations and physicians and other health care providers may submit proposals for payment initiatives described by Subsection (a), and determine whether it is feasible and cost-effective to implement one or more of the proposed payment initiatives.

Sec. 536.203. PURPOSE AND IMPLEMENTATION OF PAYMENT INITIATIVES. (a) Requires HHSC, if HHSC determines under Section 536.202 that implementation of one or more payment initiatives is feasible and cost-effective for this state, to establish one or more payment initiatives as provided by this subchapter.

(b) Requires HHSC to administer any payment initiative established under this subchapter. Authorizes the executive commissioner to 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) Authorizes HHSC to limit a payment initiative to one or more regions in this state, one or more organized networks of physicians and other

health care providers, or specified types of services provided under the child health plan or Medicaid program, or specified types of enrollees or recipients under those programs.

(d) Requires that a payment initiative implemented under this subchapter be operated for at least one calendar year.

Sec. 536.204. STANDARDS; PROTOCOLS. (a) Requires the executive commissioner to consult with the advisory committee to develop quality of care and cost-efficiency benchmarks and measurable goals that a payment initiative must meet to ensure high-quality and cost-effective health care services and healthy outcomes, and approve benchmarks and goals developed as provided by Subdivision (1).

(b) Authorizes the executive commissioner, in addition to the benchmarks and goals under Subsection (a), to approve efficiency performance standards that may include the sharing of realized cost savings with physicians and other health care providers who provide health care services that exceed the efficiency performance standards. Prohibits the efficiency performance standards from creating any financial incentive for or involving making a payment to a physician or other health care provider that directly or indirectly induces the limitation of medically necessary services.

Sec. 536.205. PAYMENT RATES UNDER PAYMENT INITIATIVES. Authorizes the executive commissioner to contract with appropriate entities, including qualified actuaries, to assist in determining appropriate payment rates for a payment initiative implemented under this subchapter.

(b) Requires HHSC to convert the hospital reimbursement systems used under the child health plan program under Chapter 62, Health and Safety Code, and medical assistance program under Chapter 32 (Medical Assistance Program), Human Resources Code, to the diagnosis-related groups (DRG) methodology to the extent possible as required by Section 536.005, Government Code, as added by this section, as soon as practicable after the effective date of this Act, but not later than September 1, 2013, for reimbursements paid to children's hospitals, and September 1, 2012, for reimbursements paid to other hospitals under those programs.

(c) Requires HHSC, not later than September 1, 2012, to begin providing performance reports to hospitals regarding the hospitals' performances with respect to potentially preventable complications as required by Section 536.151, Government Code, as designated and amended by this section.

(d) Requires HHSC, subject to Section 536.004(b), Government Code, as added by this section, to begin making adjustments to child health plan and Medicaid reimbursements to hospitals as required by Section 536.152, Government Code, as added by this section not later than September 1, 2012, based on the hospitals' performances with respect to reducing potentially preventable readmissions, and not later than September 1, 2013, based on the hospitals' performances with respect to reducing potentially preventable complications.

SECTION 1.13. (a) Amends the heading to Section 531.912, Government Code, to read as follows:

Sec. 531.912. COMMON PERFORMANCE MEASUREMENTS AND PAY-FOR-PERFORMANCE INCENTIVES FOR CERTAIN NURSING FACILITIES.

(b) Amends Sections 531.912(b), (c), and (f), Government Code, as follows:

(b) Requires, rather than authorizes, the executive commissioner, if feasible, by rule to establish an incentive payment program for nursing facilities that choose to participate, rather than to establish a quality of care health information exchange with nursing facilities that choose to participate. Requires that the program be designed to improve the quality of care and services provided to medical assistance recipients. Makes a nonsubstantive change.

(c) Requires the executive commissioner, in establishing an incentive payment program, rather than a quality of care health information exchange program, under this section, subject to Subsection (d), to adopt common performance measures to be used in evaluating nursing facilities that are related to structure, process, and outcomes that positively correlate to nursing facility quality and improvement, rather than to exchange information with participating nursing facilities regarding performance measures. Provides that the common performance measures:

(1) Makes no changes to this subdivision; and

(2) are authorized to include measures of:

(A) quality of care, as determined by clinical performance ratings published by the federal Centers for Medicare and Medicaid Services, the Agency for Healthcare Research and Quality, or another federal agency, rather than quality of life;

(B) Makes no changes to this paragraph;

(C) recipient satisfaction, including the satisfaction of recipients who are short-term and long-term residents of facilities, and family satisfaction, as determined by the Nursing Home Consumer Assessment of Health Providers and Systems survey relied upon by the federal Centers for Medicare and Medicaid Services;

(D)-(G) Makes no changes to these paragraphs; and

(H) direct-care staff training, including a facility's utilization of independent distance learning programs for the continuous training of direct-care staff, rather than level of occupancy or of facility utilization.

(f) Authorizes HHSC to make incentive payments under the program only if money is appropriated, rather than is specifically appropriated, for that purpose.

(c) Requires DADS to conduct a study to evaluate the feasibility of expanding any incentive payment program established for nursing facilities under Section 531.912, Government Code, as amended by this section, by providing incentive payments 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: intermediate care facilities for persons with mental retardation licensed under Chapter 252 (Intermediate Care Facilities for the Mentally Retarded), Health and Safety Code, and 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) Requires DADS, not later than September 1, 2012, to submit to the legislature a written report containing the findings of the study conducted under Subsection (c) of this section and DADS' recommendations.

SECTION 1.14. Amends Section 780.004, Health and Safety Code, by amending Subsection (a) and adding Subsection (j), as follows:

(a) Provides that the commissioner:

(1) with advice and counsel from the chairpersons of the trauma service area regional advisory councils, is required to use money appropriated from the account established under this chapter to fund designated trauma facilities, county and regional emergency medical services, and trauma care systems in accordance with this section; and

(2) after consulting with the executive commissioner, is authorized to transfer to an account in the general revenue fund money appropriated from the account established under this chapter to maximize the receipt of federal funds under the medical assistance program established under Chapter 32, Human Resources Code, and to fund provider reimbursement payments as provided by Subsection (j).

(j) Authorizes money in the account described by Subsection (a)(2) to be appropriated only to HHSC to fund provider reimbursement payments under the medical assistance program established under Chapter 32, Human Resources Code, including reimbursement enhancements to the statewide dollar amount (SDA) rate used to reimburse designated trauma hospitals under the program.

SECTION 1.15 Amends Subchapter B, Chapter 531, Government Code, by adding Sections 531.0696 and 531.0697, as follows:

Sec. 531.0696. CONSIDERATIONS IN AWARDING CERTAIN CONTRACTS. Prohibits HHSC from contracting with a managed care organization, including a health maintenance organization, or a pharmacy benefit manager if, in the preceding three years, the organization or pharmacy manager, in connection with a bid, proposal, or contract with HHSC, was subject to a final judgment by a court of competent jurisdiction resulting in a conviction for a criminal offense under state or federal law:

(1) related to the delivery of an item or service;

(2) related to neglect or abuse of patients in connection with the delivery of an item or service;

(3) consisting of a felony related to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct; or

(4) resulting in a penalty or fine in the amount of $500,000 or more in a state or federal administrative proceeding.

Sec. 531.0697. PRIOR APPROVAL AND PROVIDER ACCESS TO CERTAIN COMMUNICATIONS WITH CERTAIN RECIPIENTS. (a) Provides that this section applies to the vendor drug program for the Medicaid and child health plan programs, the kidney health care program, the children with special health care needs program, and any other state program administered by HHSC that provides prescription drug benefits.

(b) Requires a managed care organization, including a health maintenance organization, or a pharmacy benefit manager, that administers claims for prescription drug benefits under a program to which this section applies, at least 10 days before the date the organization or pharmacy benefit manager intends to deliver a communication to recipients collectively under a program, to submit a copy of the communication to HHSC for approval, and if applicable, allow the pharmacy providers of recipients who are to receive the communication access to the communication.

SECTION 1.16. (a) Amends Subchapter A, Chapter 61, Health and Safety Code, by adding Section 61.012, as follows:

Sec. 61.012. REIMBURSEMENT FOR SERVICES. (a) Defines, in this section, "sponsored alien."

(b) Authorizes a public hospital or hospital district that provides health care services to a sponsored alien under this chapter to recover from a person who executed an affidavit of support on behalf of the alien the costs of the health care services provided to the alien.

(c) Requires a public hospital or hospital district described by Subsection (b) to notify a sponsored alien and a person who executed an affidavit of support on behalf of the alien, at the time the alien applies for health care services, that a person who executed an affidavit of support on behalf of a sponsored alien is liable for the cost of health care services provided to the alien.

(b) Makes application of Section 61.012, Health and Safety Code, as added by this section, prospective.

SECTION 1.17. Amends Subchapter B, Chapter 531, Government Code, by adding Sections 531.024181 and 531.024182, as follows:

Sec. 531.024181. VERIFICATION OF IMMIGRATION STATUS OF APPLICANTS FOR CERTAIN BENEFITS WHO ARE QUALIFIED ALIENS. (a) Provides that this section applies only with respect to the child health plan program under Chapter 62, Health and Safety Code, the financial assistance program under Chapter 31 (Financial Assistance and Service Programs), Human Resources Code, the medical assistance program under Chapter 32, Human Resources Code, and the nutritional assistance program under Chapter 33 (Nutritional Assistance Programs), Human Resources Code.

(b) Requires HHSC, if, at the time of application for benefits under a program to which this section applies, a person states that the person is a qualified alien, as that term is defined by 8 U.S.C. Section 1641(b), to the extent allowed by federal law, to verify information regarding the immigration status of the person using an automated system or systems where available.

(c) Requires the executive commissioner to adopt rules necessary to implement this section.

(d) Provides that nothing in this section adds to or changes the eligibility requirements for any of the benefits programs to which this section applies.

Sec. 531.024182. VERIFICATION OF SPONSORSHIP INFORMATION FOR CERTAIN BENEFITS RECIPIENTS; REIMBURSEMENT. (a) Defines, in this section, "sponsored alien."

(b) Authorizes HHSC, if, at the time of application for benefits, a person stated that the person is a sponsored alien, to the extent allowed by federal law, to verify information relating to the sponsorship, using an automated system or systems where available, after the person is determined eligible for and begins receiving benefits under the child health plan program under Chapter 62, Health and Safety Code, the financial assistance program under Chapter 31, Human Resources Code, the medical assistance program under Chapter 32, Human Resources Code, or the nutritional assistance program under Chapter 33, Human Resources Code.

(c) Authorizes HHSC, if HHSC verifies that a person who receives benefits under a program listed in Subsection (b) is a sponsored alien, to seek reimbursement from the person's sponsor for benefits provided to the person under those programs to the extent allowed by federal law, provided HHSC determines that seeking reimbursement is cost-effective.

(d) Requires HHSC, if, at the time a person applies for benefits under a program listed in Subsection (b), the person states that the person is a sponsored alien, to make a reasonable effort to notify the person that HHSC may seek reimbursement from the person's sponsor for any benefits the person receives under those programs.

(e) Requires the executive commissioner to adopt rules necessary to implement this section, including rules that specify the most cost-effective procedures by which HHSC may seek reimbursement under Subsection (c).

(f) Provides that nothing in this section adds to or changes the eligibility requirements for any of the benefits programs listed in Subsection (b).

SECTION 1.18. Amends Subchapter B, Chapter 32, Human Resources Code, by adding Section 32.0314, as follows:

Sec. 32.0314. REIMBURSEMENT FOR DURABLE MEDICAL EQUIPMENT AND SUPPLIES. Requires the executive commissioner to adopt rules requiring the electronic submission of any claim for reimbursement for durable medical equipment and supplies under the medical assistance program.

SECTION 1.19. (a) Amends Subchapter A, Chapter 531, Government Code, by adding Section 531.0025, as follows:

Sec. 531.0025. RESTRICTIONS ON AWARDS TO FAMILY PLANNING SERVICE PROVIDERS. (a) Requires that money appropriated to DSHS for the purpose of providing family planning services, notwithstanding any other law, be awarded:

(1) to eligible entities in the following order of descending priority: public entities that provide family planning services, including state, county, and local community health clinics and federally qualified health centers; nonpublic entities that provide comprehensive primary and preventive care services in addition to family planning services; and nonpublic entities that provide family planning services but do not provide comprehensive primary and preventive care services; or

(2) as otherwise directed by the legislature in the General Appropriations Act.

(b) Requires DHSH, notwithstanding Subsection (a), in compliance with federal law, to ensure distribution of funds for family planning services in a manner that does not severely limit or eliminate access to those services in any region of the state.

(b) Amends Section 32.024, Human Resources Code, by adding Subsection (c-1), to require HHSC to ensure that money spent for purposes of the demonstration project for women's health care services under former Section 32.0248, Human Resources Code, or a similar successor program is not used to perform or promote elective abortions, or to contract with entities that perform or promote elective abortions or affiliate with entities that perform or promote elective abortions.

SECTION 1.20. Amends Subchapter B, Chapter 32, Human Resources, Code, by adding Section 32.074, as follows:

Sec. 32.074. ACCESS TO PERSONAL EMERGENCY RESPONSE SYSTEM. (a) Defines, in this section, "personal emergency response system."

(b) Requires HHSC to ensure that each Medicaid recipient enrolled in a home and community-based services waiver program that includes a personal emergency response system as a service has access to a personal emergency response system, if necessary, without regard to the recipient's access to a landline telephone.

SECTION 1.21. Amends Chapter 33, Human Resources Code, by adding Section 33.029, as follows:

Sec. 33.029. CERTAIN ELIGIBILITY RESTRICTIONS. Provides that, notwithstanding any other provision of this chapter, an applicant for or recipient of benefits under the supplemental nutrition assistance program is not entitled to and is prohibited from receiving or continuing to receive any benefit under the program if he applicant or recipient is not legally present in the United States.

SECTION 1.22. Provides that if before implementing any provision of this article 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.

ARTICLE 2. LEGISLATIVE FINDINGS AND INTENT; COMPLIANCE WITH ANTITRUST LAWS

SECTION 2.01. (a)-(b) Sets forth legislative findings.

(c) Provides that the legislature intends to exempt from antitrust laws and provide immunity from federal antitrust laws through the state action doctrine a health care collaborative that holds a certificate of authority certified under Chapter 848, Insurance Code, as added by Article 4 of this Act, and that collaborative's negotiations of contracts with payors. Provides that the legislature does not intend or authorize any person or entity to engage in activities or to conspire to engage in activities that would constitute per se violations of federal antitrust laws.

(d) Provides that the legislature intends to permit the use of alternative payment mechanisms, including bundled or global payments and quality-based payments, among physicians and other health care providers participating in a health care collaborative that holds a certificate of authority under Chapter 848, Insurance Code, as added by Article 4 of this Act. Provides that the legislature intends to authorize a health care collaborative to contract for and accept payments from governmental and private payors based on alternative payment mechanisms, and intends that the receipt and distribution of payments to participating physicians and health care providers is not a violation of any existing state law.

ARTICLE 3. TEXAS INSTITUTE OF HEALTH CARE QUALITY AND EFFICIENCY

SECTION 3.01. Amends Title 12, Health and Safety Code, by adding Chapter 1002, as follows:

CHAPTER 1002. TEXAS INSTITUTE OF HEALTH CARE QUALITY AND EFFICIENCY

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1002.001. DEFINITIONS. Defines, in this chapter, "board," "commission," "department," "executive commissioner," "health care collaborative," "health care facility," "institute," "potentially preventable admission," "potentially preventable ancillary service," "potentially preventable complication," "potentially preventable event," "potentially preventable emergency room visit," and "potentially preventable readmission."

Sec. 1002.002. ESTABLISHMENT; PURPOSE. Establishes and sets forth the purpose of the Texas Institute of Health Care Quality and Efficiency (TIHCQE).

[Reserves Sections 1002.003-1002.050 for expansion.]

SUBCHAPTER B. ADMINISTRATION

Sec. 1002.051. APPLICATION OF SUNSET ACT. Provides that TIHCQE is subject to Chapter 325 (Texas Sunset Act), Government Code. Provides that, unless continued in existence as provided by that chapter, TIHCQE is abolished and this chapter expires September 1, 2017.

Sec. 1002.052. COMPOSITION OF BOARD OF DIRECTORS. (a) Provides that TIHCQE is governed by a board of 15 directors appointed by the governor.

(b) Provides that certain ex officio, nonvoting members as set forth in this subsection also serve on the board.

(c) Requires the governor to appoint as board members health care providers, payors, consumers, and health care quality experts or persons who possess expertise in any other area the governor finds necessary for the successful operation of TIHCQE.

(d) Prohibits a person from serving as a voting member of the board if the person serves on or advises another board or advisory board of a state agency.

Sec. 1002.053. TERMS OF OFFICE. (a) Provides that appointed members of the board serve staggered terms of four years, with the terms of as close to one-half of the members as possible expiring January 31 of each odd-numbered year.

(b) Authorizes board members to serve consecutive terms.

Sec. 1002.054. ADMINISTRATIVE SUPPORT. (a) Provides that TIHCQE is administratively attached to HHSC.

(b) Requires HHSC to coordinate administrative responsibilities with TIHCQE to streamline and integrate TIHCQE's administrative operations and avoid unnecessary duplication of effort and costs.

(c) Authorizes TIHCQE to collaborate with, and coordinate its administrative functions, including functions related to research and reporting activities with, other public or private entities, including academic institutions and nonprofit organizations, that perform research on health care issues or other topics consistent with the purpose of TIHCQE.

Sec. 1002.055. EXPENSES. (a) Provides that members of the board serve without compensation but, subject to the availability of appropriated funds, may receive reimbursement for actual and necessary expenses incurred in attending meetings of the board.

(b) Provides that information relating to the billing and payment of expenses under this section is subject to Chapter 552 (Public Information), Government Code.

Sec. 1002.056. OFFICER; CONFLICT OF INTEREST. (a) Requires the governor to designate a member of the board as presiding officer to serve in that capacity at the pleasure of the governor.

(b) Requires any board member or a member of a committee formed by the board with direct interest, personally or through an employer, in a matter before the board to abstain from deliberations and actions on the matter in which the conflict

of interest arises and to further abstain on any vote on the matter, and prohibits the member from otherwise participating in a decision on the matter.

(c) Requires each board member to:

(1) file a conflict of interest statement and a statement of ownership interests with the board to ensure disclosure of all existing and potential personal interests related to board business; and

(2) update the statements described by Subdivision (1) at least annually.

(d) Provides that a statement filed under Subsection (c) is subject to Chapter 552, Government Code.

Sec. 1002.057. PROHIBITION ON CERTAIN CONTRACTS AND EMPLOYMENT. (a) Prohibits the board from compensating, employing, or contracting with any individual who serves as a member of the board of, or on an advisory board or advisory committee for, any other governmental body, including any agency, council, or committee, in this state.

(b) Prohibits the board from compensating, employing, or contracting with any person that provides financial support to the board, including a person who provides a gift, grant, or donation to the board.

Sec. 1002.058. MEETINGS. (a) Authorizes the board to meet as often as necessary, but requires the board to meet at least once each calendar quarter.

(b) Requires the board to develop and implement policies that provide the public with a reasonable opportunity to appear before the board and to speak on any issue under the authority of TIHCQE.

Sec. 1002.059. BOARD MEMBER IMMUNITY. (a) Prohibits a board member from being held civilly liable for an act performed, or omission made, in good faith in the performance of the members' powers and duties under this chapter.

(b) Provides that a cause of action does not arise against a member of the board for an act or omission described by Subsection (a).

Sec. 1002.060. PRIVACY OF INFORMATION. (a) Provides that protected health information and individually identifiable health information collected, assembled, or maintained by TIHCQE is confidential and is not subject to disclosure under Chapter 552, Government Code.

(b) Requires TIHCQE to comply with all state and federal laws and rules relating to the protection, confidentiality, and transmission of health information, including the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191) and rules adopted under that Act, 42 U.S.C. Section 290dd-2, and 42 C.F.R. Part 2.

(c) Prohibits HHSC, DSHS, or TIHCQE or an officer or employee of HHSC, DSHS, or TIHCQE, including a board member, from disclosing any information that is confidential under this section.

(d) Provides that information, documents, and records that are confidential as provided by this section are not subject to subpoena or discovery and may not be introduced into evidence in any civil or criminal proceeding.

(e) Prohibits an officer or employee of HHSC, DSHS, or TIHCQE, including a board member, from being examined in a civil, criminal, special, administrative, or other proceeding as to information that is confidential under this section.

Sec. 1002.061. FUNDING. (a) Authorizes TIHCQE to be funded through the General Appropriations Act and to request, accept, and use gifts, grants, and donations as necessary to implement its functions.

(b) Authorizes TIHCQE to participate in other revenue-generating activity that is consistent with TIHCQE's purposes.

(c) Requires each state agency represented on the board as a nonvoting member to provide funds to support TIHCQE and implement this chapter, except as otherwise provided by law. Requires HHSC to establish a funding formula to determine the level of support each state agency is required to provide.

(d) Provides that this section does not permit the sale of information that is confidential under Section 1002.060.

[Reserves Sections 1002.062-1002.100 for expansion.]

SUBCHAPTER C. POWERS AND DUTIES

Sec. 1002.101. GENERAL POWERS AND DUTIES. Requires TIHCQE to make recommendations to the legislature on:

(1) improving quality and efficiency of health care delivery by:

(A) providing a forum for regulators, payors, and providers to discuss and make recommendations for initiatives that promote the use of best practices, increase health care provider collaboration, improve health care outcomes, and contain health care costs;

(B) researching, developing, supporting, and promoting strategies to improve the quality and efficiency of health care in this state;

(C) determining the outcome measures that are the most effective measures of quality and efficiency:

(i) using nationally accredited measures; or

(ii) if no nationally accredited measures exist, using measures based on expert concensus;

(D) reducing the incidence of potentially preventable events; and

(E) creating a state plan that takes into consideration the regional differences of the state to encourage the improvement of the quality and efficiency of health care services;

(2) improving reporting, consolidation, and transparency of health care information; and

(3) implementing and supporting innovative health care collaborative payment and delivery systems under Chapter 848, Insurance Code.

Sec. 1002.102. GOALS FOR QUALITY AND EFFICIENCY OF HEALTH CARE; STATEWIDE PLAN. (a) Requires TIHCQE to study and develop recommendations to improve the quality and efficiency of health care delivery in this state, including:

(1) quality-based payment systems that align payment incentives with high-quality, cost-effective health care;

(2) alternative health care delivery systems that promote health care coordination and provider collaboration;

(3) quality of care and efficiency outcome measurements that are effective measures of prevention, wellness, coordination, provider collaboration, and cost-effective health care; and

(4) meaningful use of electronic health records by providers and electronic exchange of health information among providers.

(b) Requires TIHCQE to study and develop recommendations for measuring quality of care and efficiency across:

(1) all state employee and state retiree benefit plans;

(2) employee and retiree benefit plans provided through the Teacher Retirement System of Texas;

(3) the state medical assistance program under Chapter 32 (Medical Assistance Program), Human Resources Code; and

(4) the child health plan under Chapter 62 (Child Health Plan for Certain Low-Income Children), Health and Safety Code.

(c) Requires TIHCQE, in developing recommendations under Subsection (b), to use nationally accredited measures or, if no nationally accredited measures exist, measures based on expert consensus.

(d) Authorizes TIHCQE to study and develop recommendations for measuring the quality of care and efficiency in state or federally funded health care delivery systems other than those described by Subsection (b).

(e) Prohibits TIHCQE, in developing recommendations under Subsections (a) and (b), from basing its recommendations solely on actuarial data.

(f) Requires TIHCQE, using the studies described by Subsections (a) and (b), to develop recommendations for a statewide plan for quality and efficiency of the delivery of health care.

[Reserves Sections 1002.103-1002.150 for expansion.]

SUBCHAPTER D. HEALTH CARE COLLABORATIVE GUIDELINES AND SUPPORT

Sec. 1002.151. INSTITUTE STUDIES AND RECOMMENDATIONS REGARDING HEALTH CARE PAYMENT AND DELIVERY SYSTEMS. (a) Requires TIHCQE to study and make recommendations for alternative health care payment and delivery systems.

(b) Requires TIHCQE to recommend methods to evaluate a health care collaborative's effectiveness, including methods to evaluate:

(1) the efficiency and effectiveness of cost-containment methods used by the collaborative;

(2) alternative health care payment and delivery systems used by the collaborative;

(3) the quality of care;

(4) health care provider collaboration and coordination;

(5) the protection of patients; and

(6) patient satisfaction; and

(7) the meaningful use of electronic health records by providers and electronic exchange of health information among providers.

[Reserves Sections 1002.152-1002.200 for expansion.]

SUBCHAPTER E. IMPROVED TRANSPARENCY

Sec. 1002.201. HEALTH CARE ACCOUNTABILITY; IMPROVED TRANSPARENCY. (a) Requires TIHCQE, with the assistance of DSHS, to complete an assessment of all health-related data collected by the state, what information is available to the public, and how the public and health care providers currently benefit and could potentially benefit from this information, including health care cost and quality information.

(b) Requires TIHCQE to develop a plan:

(1) for consolidating reports of health-related data from various sources to reduce administrative costs to the state and reduce the administrative burden to health care providers and payors;

(2) for improving health care transparency to the public and health care providers by making information available in the most effective format; and

(3) providing recommendations to the legislature on enhancing existing health-related information available to health care providers and the public, including provider reporting of additional information not currently required to be reported under existing law, to improve quality of care.

Sec. 1002.202. ALL PAYOR CLAIMS DATABASE. (a) Requires TIHCQE to study the feasibility and desirability of establishing a centralized database for health care claims information across all payors.

(b) Requires that the study described by Subsection (a):

(1) use the assessment described by Section 1002.201 to develop recommendations relating to the adequacy of existing data sources for carrying out the state's purposes under this chapter and Chapter 848, Insurance Code;

(2) determine whether the establishment of an all payor claims database would reduce the need for some data submissions provided by payors;

(3) identify the best available sources of data necessary for the state's purposes under this chapter and Chapter 848, Insurance Code, that are not collected by the state under existing law;

(4) describe how an all payor claims database may facilitate carrying out the state's purposes under this chapter and Chapter 848, Insurance Code;

(5) identify national standards for claims data collection and use, including standardized data sets, standardized methodology, and standard outcome measures of health care quality and efficiency; and

(6) estimate the costs of implementing an all payor claims database, including:

(A) the costs to the state for collecting and processing data;

(B) the cost to the payors for supplying the data; and

(C) the available funding mechanisms that might support an all payor claims database.

(c) Requires TIHCQE to consult with DSHS and the Texas Department of Insurance (TDI) to develop recommendations to submit to the legislature on the establishment of the centralized claims database described by Subsection (a).

SECTION 3.02. Repealer: Chapter 109 (Texas Health Care Policy Council), Health and Safety Code.

SECTION 3.03. Provides that, on the effective date of this Act:

(1) the Texas Health Care Policy Council established under Chapter 109, Health and Safety Code, is abolished; and

(2) any unexpended and unobligated balance of money appropriated by the legislature to the Texas Health Care Policy Council established under Chapter 109, Health and Safety Code, as it existed immediately before the effective date of this Act, is transferred to TIHCQE created by Chapter 1002, Health and Safety Code, as added by this Act.

SECTION 3.04. (a) Requires the governor to appoint voting members of the board of directors of TIHCQE under Section 1002.052, Health and Safety Code, as added by this Act, as soon as practicable after the effective date of this Act.

(b) Requires the governor, in making the initial appointments under this section, to designate seven members to terms expiring January 31, 2013, and eight members to terms expiring January 31, 2015.

SECTION 3.05. (a) Requires TIHCQE, not later than December 1, 2012, to submit a report regarding recommendations for improved health care reporting to the governor, the lieutenant governor, the speaker of the house of representatives, and the chairs of the appropriate standing committees of the legislature outlining:

(1) the initial assessment conducted under Section 1002.201(a), Health and Safety Code, as added by this Act;

(2) the plans initially developed under Section 1002.201(b), Health and Safety Code, as added by this Act;

(3) the changes in existing law that would be necessary to implement the assessment and plans described by Subdivisions (1) and (2) of this subsection; and

(4) the cost implications to state agencies, small businesses, micro businesses, payors, and health care providers to implement the assessment and plans described by Subdivisions (1) and (2) of this subsection.

(b) Requires TIHCQE, not later than December 1, 2012, to submit a report regarding recommendations for an all payor claims database to the governor, the lieutenant governor, the speaker of the house of representatives, and the chairs of the appropriate standing committees of the legislature outlining:

(1) the feasibility and desirability of establishing a centralized database for health care claims;

(2) the recommendations developed under Section 1002.202(c), Health and Safety Code, as added by this Act;

(3) the changes in existing law that would be necessary to implement the recommendations described by Subdivision (2) of this subsection; and

(4) the cost implications to state agencies, small businesses, micro businesses, payors, and health care providers to implement the recommendations described by Subdivision (2) of this subsection.

SECTION 3.06. (a) Requires TIHCQE, under Chapter 1002, Health and Safety Code, as added by this Act, with the assistance of and in coordination with TDI, to conduct a study:

(1) evaluating how the legislature may promote a consumer-driven health care system, including by increasing the adoption of high-deductible insurance products with health savings accounts by consumers and employers to lower health care costs and increase personal responsibility for health care; and

(2) examining the issue of differing amounts of payment in full accepted by a provider for the same or similar health care services or supplies, including bundled health care services and supplies, and addressing:

(A) the extent of the differences in the amounts accepted as payment in full for a service or supply;

(B) the reasons that amounts accepted as payment in full differ for the same or similar services or supplies;

(C) the availability of information to the consumer regarding the amount accepted as payment in full for a service or supply;

(D) the effects on consumers of differing amounts accepted as payment in full; and

(E) potential methods for improving consumers' access to information in relation to the amounts accepted as payment in full for health care services or supplies, including the feasibility and desirability of requiring providers to:

(i) publicly post the amount that is accepted as payment in full for a service or supply; and

(ii) adhere to the posted amount.

(b) Requires TIHCQE to submit a report to the legislature outlining the results of the study conducted under this section and any recommendations for potential legislation not later than January 1, 2013.

(c) Provides that this section expires September 1, 2013.

ARTICLE 4. HEALTH CARE COLLABORATIVES

SECTION 4.01. Amends Subtitle C, Title 6, Insurance Code, by adding Chapter 848, as follows:

CHAPTER 848. HEALTH CARE COLLABORATIVES

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 848.001. DEFINITIONS. Defines, in this chapter, "affiliate," "health care collaborative," "health care services," "health care provider," "health maintenance organization," "hospital," "institute," "physician," and "potentially preventable event."

Sec. 848.002. EXCEPTION: DELEGATED ENTITIES. (a) Provides that this section applies only to an entity, other than a health maintenance organization, that:

(1) by itself or through a subcontract with another entity, undertakes to arrange for or provide medical care or health care services to enrollees in exchange for predetermined payments on a prospective basis; and

(2) accepts responsibility for performing functions that are required by:

(A) Chapter 222 (Life, Health, and Accident Insurance Premium Tax), 251 (General Provisions), 258 (Health Maintenance Organizations), or 1272 (Delegation of Certain Functions by Health Maintenance Organization), as applicable, to a health maintenance organization; or

(B) Chapter 843 (Health Maintenance Organizations), Chapter 1271 (Benefits Provided by Health Maintenance Organizations; Evidence of Coverage; Charges), Section 1367.053 (Coverage Required), Subchapter A (Credentialing of Physicians and Providers by Health Maintenance Organization), Chapter 1452 (Physician and Provider Credentials), or Subchapter B (Consumer Choice of Benefits Health Maintenance Organization Plans), Chapter 1507 (Consumer Choice of Benefits Plans), as applicable, solely on behalf of health maintenance organizations.

(b) Provides that an entity described by Subsection (a) is subject to Chapter 1272 and is not required to obtain a certificate of authority or determination of approval under this chapter.

Sec. 848.003. USE OF INSURANCE-RELATED TERMS BY HEALTH CARE COLLABORATIVE. Prohibits a health care collaborative that is not an insurer or health maintenance organization from using in its name, contracts, or literature certain words or initials, or any other words or initials that meet certain criteria.

Sec. 848.004. APPLICABILITY OF INSURANCE LAWS. (a) Prohibits an organization from arranging for or providing health care services to enrollees on a prepaid or indemnity basis through health insurance or a health benefit plan, including a health care plan, as defined by Section 843.002 (Definitions), unless the organization as an insurer or health maintenance organization holds the appropriate certificate of authority issued under another chapter of this code.

(b) Provides that except as provided by Subsection (c), the following provisions of this code apply to a health care collaborative in the same manner and to the same extent as they apply to an individual or entity otherwise subject to the provision:

(1) Section 38.001 (Inquiries);

(2) Subchapter A (Unfair Claim Settlement Practices), Chapter 542 (Processing and Settlement of Claims);

(3) Chapter 541 (Unfair Methods of Competition and Unfair or Deceptive Acts or Practices);

(4) Chapter 543 (Prohibited Practices Related to Policy or Certificate of Membership);

(5) Chapter 602 (Privacy of Health Information);

(6) Chapter 701 (Insurance Fraud Investigations);

(7) Chapter 803 (Location of Books, Records, Accounts, and Offices Outside of this State); and

(8) Chapter 804 (Service of Process).

(c) Provides that the remedies available under this chapter in the manner provided by Chapter 541 do not include:

(1) a private cause of action under Subchapter D (Private Action for Damages), Chapter 541; or

(2) a class action under Subchapter F (Class Actions by Attorney General or Private Individual), Chapter 541.

Sec. 848.005. CERTAIN INFORMATION CONFIDENTIAL. (a) Provides that, except as provided by Subsection (b), an application, filing, or report required under this chapter is public information subject to disclosure under Chapter 552, Government Code.

(b) Provides that the following information is confidential and is not subject to disclosure under Chapter 552, Government Code:

(1) a contract, agreement, or document that establishes another arrangement:

(A) between a health care collaborative and a governmental or private entity for all or part of health care services provided or arranged for by the health care collaborative; or

(B) between a health care collaborative and participating physicians and health care providers;

(2) a written description of a contract, agreement, or other arrangement described by Subdivision (1);

(3) information relating to bidding, pricing, or other trade secrets submitted to:

(A) TDI under Sections 848.057(a)(5) and (6); or

(B) the attorney general under Section 848.059;

(4) information relating to the diagnosis, treatment, or health of a patient who receives health care services from a health care collaborative under a contract for services; and

(5) information relating to quality improvement or peer review activities of a health care collaborative.

Sec. 848.006. COVERAGE BY HEALTH CARE COLLABORATIVE NOT REQUIRED. (a) Prohibits an individual, except as provided by Subsection (b) and subject to Chapter 843 (Health Maintenance Organizations) and Section 1301.0625, from being required to obtain or maintain coverage under:

(1) an individual health insurance policy written through a health care collaborative; or

(2) any plan or program for health care services provided on an individual basis through a health care collaborative.

(b) Provides that this chapter does not require an individual to obtain or maintain health insurance coverage.

(c) Provides that Subsection (a) does not apply to an individual:

(1) who is required to obtain or maintain health benefit plan coverage:

(A) written by an institution of higher education at which the individual is or will be enrolled as a student; or

(B) under an order requiring medical support for a child; or

(2) who voluntarily applies for benefits under a state administered program under Title XIX of the Social Security Act (42 U.S.C. Section 1396 et seq.), or Title XXI of the Social Security Act (42 U.S.C. Section 1397aa et seq.).

(d) Prohibits a fine or penalty from being imposed on an individual if the individual chooses not to obtain or maintain coverage described by Subsection (a), except as provided by Subsection (e).

(e) Provides that Subsection (d) does not apply to a fine or penalty imposed on an individual described in Subsection (c) for the individual's failure to obtain or maintain health benefit plan coverage.

[Reserves Sections 848.007-848.050 for expansion.]

SUBCHAPTER B. AUTHORITY TO ENGAGE IN BUSINESS

Sec. 848.051. OPERATION OF HEALTH CARE COLLABORATIVE. Authorizes a health care collaborative that is certified by TDI under this chapter to provide or arrange to provide health care services under a contract with a governmental or private entity.

Sec. 848.052. FORMATION AND GOVERNANCE OF HEALTH CARE COLLABORATIVE. (a) Provides that a health care collaborative is governed by a board of directors.

(b) Requires the person who establishes a health care collaborative to appoint an initial board of directors. Provides that each member of the initial board serves a term of not more than 18 months. Requires subsequent members of the board to be elected to serve two-year terms by physicians and health care providers who participate in the health care collaborative as provided by this section. Requires the board to elect a chair from among its members.

(c) Requires each member of the board of directors, if the participants in a health care collaborative are all physicians, to be an individual physician who is a participant in the health care collaborative.

(d) Requires the board of directors, if the participants in a health care collaborative are both physicians and other health care providers, to consist of:

(1) an even number of members who are individual physicians, selected by physicians who participate in the health care collaborative;

(2) a number of members equal to the number of members under Subdivision (1) who represent health care providers, one of whom is an

individual physician, selected by health care providers who participate in the health care collaborative; and

(3) one individual member with business expertise, selected by unanimous vote of the members described by Subdivisions (1) and (2).

(d-1) Requires that one member of the board of directors, if a health care collaborative includes hospital-based physicians, to be a hospital-based physician.

(e) Requires the board of directors to include at least three nonvoting ex officio members who represent the community in which the health care collaborative operates.

(f) Prohibits an individual from serving on the board of directors of a health care collaborative if the individual has an ownership interest in, serves on the board of directors of, or maintains an officer position with:

(1) another health care collaborative that provides health care services in the same service area as the health care collaborative; or

(2) a physician or health care provider that:

(A) does not participate in the health care collaborative; and

(B) provides health care services in the same service area as the health care collaborative.

(g) Requires the board of directors of a health care collaborative, in addition to the requirements of Subsection (f), to adopt a conflict of interest policy to be followed by members.

(h) Authorizes the board of directors to remove a member for cause. Prohibits a member from being removed from the board without cause.

(i) Prohibits the organizational documents of a health care collaborative from conflicting with any provision of this chapter, including this section.

Sec. 848.053. COMPENSATION ADVISORY COMMITTEE; SHARING OF CERTAIN DATA. (a) Requires the board of directors of a health care collaborative to establish a compensation advisory committee to develop and make recommendations to the board regarding charges, fees, payments, distributions, or other compensation assessed for health care services provided by physicians or health care providers who participate in the health care collaborative. Requires the compensation advisory committee to include:

(1) two members of the board of directors, of which one member is the hospital-based physician member, if the health care collaborative includes hospital-based physicians; and

(2) if the health care collaborative consists of physicians and other health care providers:

(A) a physician who is not a participant in the health care collaborative, selected by the physicians who are participants in the collaborative; and

(B) a member selected by the other health care providers who participate in the collaborative.

(b) Requires a health care collaborative to establish and enforce policies to prevent the sharing of charge, fee, and payment data among nonparticipating physicians and health care providers.

(c) Requires the compensation advisory committee to make recommendations to the board of directors regarding all charges, fees, payments, distributions, or other compensation assessed for health care services provided by a physician or health care provider who participates in the health care collaborative.

(d) Prohibits the board of directors and the compensation advisory committee, except as provided by Subsections (e) and (f), from using or considering a government payor's payment rates in setting the charges or fees for health care services provided by a physician or health care provider who participates in the health care collaborative.

(e) Authorizes the board of directors or the compensation advisory committee to use or consider a government payor's payment rates when setting the charges or fees for health care services paid by a government payor.

(f) Provides that this section does not prohibit a reference to a government payor's payment rates in agreements with health maintenance organizations, insurers, or other payors.

(g) Requires the board, after the compensation advisory committee submits a recommendation to the board of directors, to formally approve or refuse the recommendation.

(h) Defines, for purpose of this section, "government payor."

Sec. 848.054. CERTIFICATE OF AUTHORITY AND DETERMINATION OF APPROVAL REQUIRED. (a) Prohibits an organization from organizing or operating a health care collaborative in this state unless the organization holds a certificate of authority issued under this chapter.

(b) Requires the commissioner of insurance (commissioner) to adopt rules governing the application for a certificate of authority under this subchapter.

Sec. 848.055. EXCEPTIONS. (a) Provides that an organization is not required to obtain a certificate of authority under this chapter if the organization holds an appropriate certificate of authority issued under another chapter of this code.

(b) Provides that a person is not required to obtain a certificate of authority under this chapter to the extent that the person is:

(1) a physician engaged in the delivery of medical care; or

(2) a health care provider engaged in the delivery of health care services other than medical care as part of a health maintenance organization delivery network.

(c) Provides that a medical school, medical and dental unit, or health science center as described by Section 61.003 (Definitions), 61.501 (Definitions), or 74.601 (Use and Control), Education Code, is not required to obtain a certificate of authority under this chapter to the extent that the medical school, medical and dental unit, or health science center contracts to deliver medical care services within a health care collaborative. Provides that this chapter is otherwise applicable to a medical school, medical and dental unit, or health science center.

(d) Provides that an entity licensed under the Health and Safety Code that employs a physician under a specific statutory authority is not required to obtain a

certificate of authority under this chapter to the extent that the entity contracts to deliver medical care services and health care services within a health care collaborative. Provides that this chapter is otherwise applicable to the entity.

Sec. 848.056. APPLICATION FOR CERTIFICATE OF AUTHORITY. (a) Authorizes an organization to apply to the commissioner for and obtain a certificate of authority to organize and operate a health care collaborative.

(b) Requires that an application for a certificate of authority:

(1) comply with all rules adopted by the commissioner;

(2) be verified under oath by the applicant or an officer or other authorized representative of the applicant;

(3) be reviewed by the division within OAG that is primarily responsible for enforcing the antitrust laws of this state and of the United States under Section 848.059;

(4) demonstrate that the health care collaborative contracts with a sufficient number of primary care physicians in the health care collaborative's service area;

(5) state that enrollees may obtain care from any physician or health care provider in the health care collaborative; and

(6) identify a service area within which medical services are available and accessible to enrollees.

(c) Requires the commissioner, not later than the 190th day after the date an applicant submits an application to the commissioner under this section, to approve or deny the application.

(d) Authorizes the commissioner by rule to:

(1) extend the date by which an application is due under this section; and

(2) require the disclosure of any additional information necessary to implement and administer this chapter, including information necessary to antitrust review and oversight.

Sec. 848.057. REQUIREMENTS FOR APPROVAL OF APPLICATION. (a) Requires the commissioner to issue a certificate of authority on payment of the application fee prescribed by Section 848.152 if the commissioner is satisfied that:

(1) the applicant meets the requirements of Section 848.056;

(2) with respect to health care services to be provided, the applicant:

(A) has demonstrated the willingness and potential ability to ensure that the health care services will be provided in a manner that:

(i) increases collaboration among health care providers and integrates health care services;

(ii) promotes improvement in quality-based health care outcomes, patient safety, patient engagement, and coordination of services; and

(iii) reduces the occurrence of potentially preventable events;

(B) has processes that contain health care costs without jeopardizing the quality of patient care;

(C) has processes to develop, compile, evaluate, and report statistics of performance measures relating to the quality and cost of health care services, the pattern of utilization of services, and the availability and accessibility of services; and

(D) has processes to address complaints made by patients receiving services provided through the organization;

(3) the applicant is in compliance with all rules adopted by the commissioner under Section 848.151;

(4) the applicant has working capital and reserves sufficient to operate and maintain the health care collaborative and to arrange for services and expenses incurred by the health care collaborative;

(5) the applicant's proposed health care collaborative is not likely to reduce competition in any market for physician, hospital, or ancillary health care services due to:

(A) the size of the health care collaborative; or

(B) the composition of the collaborative, including the distribution of physicians by specialty within the collaborative in relation to the number of competing health care providers in the health care collaborative's geographic market; and

(6) the pro-competitive benefits of the applicant's proposed health care collaborative are likely to substantially outweigh the anticompetitive effects of any increase in market power.

(b) Provides that, subject to Section 848.060(d), a certificate of authority is effective for a period of one year.

Sec. 848.058. DENIAL OF CERTIFICATE OF AUTHORITY. (a) Prohibits the commissioner from issuing a certificate of authority if the commissioner determines that the applicant's proposed plan of operation does not meet the requirements of Section 848.057.

(b) Requires the commissioner, if the commissioner denies an application for a certificate of authority under Subsection (a), to notify the applicant that the plan is deficient and to specify the deficiencies.

Sec. 848.059. CONCURRENCE OF ATTORNEY GENERAL. (a) Requires the commissioner, if the commissioner determines that an application for a certificate of authority filed under Section 848.056 complies with the requirements of Section 848.057, to forward the application, and all data, documents, and analysis considered by the commissioner in making the determination, to the attorney general. Requires the attorney general to review the application and the data, documents, and analysis and, if the attorney general concurs with the commissioner's determination under Sections 848.057(a)(5) and (6), requires the attorney general to notify the commissioner.

(b) Requires the attorney general to notify the commissioner if the attorney general does not concur with the commissioner's determination under Sections 848.057(a)(5) and (6).

(c) Requires that a determination under this section be made not later than the 60th day after the date the attorney general receives the application and the data, documents, and analysis from the commissioner.

(d) Requires the attorney general, if the attorney general lacks sufficient information to make a determination under Sections 848.057(a)(5) and (6), within 60 days of the attorney general's receipt of the application and the data, documents, and analysis, to inform the commissioner that the attorney general lacks sufficient information as well as what information the attorney general requires. Requires the commissioner to then either provide the additional information to the attorney general or request the additional information from the applicant. Requires the commissioner promptly to deliver any such additional information to the attorney general. Requires the attorney general to then have 30 days from receipt of the additional information to make a determination under Subsection (a) or (b).

(e) Requires the commissioner, if the attorney general notifies the commissioner that the attorney general does not concur with the commissioner's review under Sections 848.057(5) and (6), notwithstanding any other provision of this subchapter, to, then, deny the application.

(f) Requires the attorney general, in reviewing the commissioner's determination, to consider the findings, conclusions, or analyses contained in any other governmental entity's evaluation of the health care collaborative.

(g) Authorizes the attorney general at any time to request from the commissioner additional time to consider an application under this section. Requires the commissioner to grant the request and notify the applicant of the request. Provides that a request by the attorney general or an order by the commissioner granting a request under this section is not subject to administrative or judicial review.

Sec. 848.060. RENEWAL OF CERTIFICATE OF AUTHORITY AND DETERMINATION OF APPROVAL. (a) Requires a health collaborative, not later than the 180th day before the one-year anniversary of the date on which the health care collaborative's certificate of authority was issued or most recently renewed, to file with the commissioner an application to renew the certificate.

(b) Requires that an application for renewal:

(1) be verified by at least two principal officers of the health care collaborative; and

(2) include:

(A) a financial statement of the health care collaborative, including a balance sheet and receipts and disbursements for the preceding calendar year, certified by an independent certified public accountant;

(B) a description of the service area of the health care collaborative;

(C) a description of the number and types of physicians and health care providers participating in the health care collaborative;

(D) an evaluation of the quality and cost of health care services provided by the health care collaborative;

(E) an evaluation of the health care collaborative's processes to promote evidence-based medicine, patient engagement, and coordination of health care services provided by the health care collaborative;

(F) the number, nature, and disposition of any complaints filed with the health care collaborative under Section 848.107; and

(G) any other information required by the commissioner.

(c) Provides that, if a completed application for renewal is filed under this section:

(1) the commissioner is required to conduct a review under Section 848.057 as if the application for renewal were a new application, and, on approval by the commissioner, the attorney general is required to review the application under Section 848.059 as if the application for renewal were a new application; and

(2) the commissioner is required to renew or deny the renewal of a certificate of authority at least 20 days before the one-year anniversary of the date on which a health care collaborative's certificate of authority was issued.

(d) Provides that, if the commissioner does not act on a renewal application before the one-year anniversary of the date on which a health care collaborative's certificate of authority was issued or renewed, the health care collaborative's certificate of authority expires on the 90th day after the date of the one-year anniversary unless the renewal of the certificate of authority or determination of approval, as applicable, is approved before that date.

(e) Requires a health care collaborative to report to TDI a material change in the size or composition of the collaborative. Authorizes TDI, on receipt of a report under this subsection, to require the collaborative to file an application for renewal before the date required by Subsection (a).

[Reserves Sections 848.061-848.100 for expansion.]

SUBCHAPTER C. GENERAL POWERS AND DUTIES OF HEALTH CARE COLLABORATIVE

Sec. 848.101. PROVIDING OR ARRANGING FOR SERVICES. (a) Authorizes a health care collaborative to provide or arrange for health care services through contracts with physicians and health care providers or with entities contracting on behalf of participating physicians and health care providers.

(b) Prohibits a health care collaborative from prohibiting a physician or other health care provider, as a condition of participating in the health care collaborative, from participating in another health care collaborative.

(c) Prohibits a health care collaborative from using a covenant not to compete to prohibit a physician from providing medical services or participating in another health care collaborative in the same service area.

(d) Requires a health care collaborative, except as provided by Subsection (f), on written consent of a patient who was treated by a physician participating in the health care collaborative, to provide the physician with the medical records of the patient, regardless of whether the physician is participating in the health care collaborative at the time the request for the records is made.

(e) Requires that records provided under Subsection (d) be made available to the physician in the format in which the records are maintained by the health care collaborative. Authorizes the health care collaborative to charge the physician a fee for copies of the records, as established by the Texas Medical Board.

(f) Provides that if a physician requests a patient's records from a health care collaborative under Subsection (d) for the purpose of providing emergency treatment to the patient:

(1) the health care collaborative is prohibited from charging a fee to the physician under Subsection (e); and

(2) the health care collaborative is required to provide the records to the physician regardless of whether the patient has provided written consent.

Sec. 848.102. INSURANCE, REINSURANCE, INDEMNITY, AND REIMBURSEMENT. Authorizes a health care collaborative to contract with an insurer authorized to engage in business in this state to provide insurance, reinsurance, indemnification, or reimbursement against the cost of health care and medical care services provided by the health care collaborative. Provides that this section does not affect the requirement that the health care collaborative maintain sufficient working capital and reserves.

Sec. 848.103. PAYMENT BY GOVERNMENTAL OR PRIVATE ENTITY. (a) Authorizes a health care collaborative to:

(1) contract for and accept payments from a governmental or private entity for all or part of the cost of services provided or arranged for by the health care collaborative; and

(2) distribute payments to participating physicians and health care providers.

(b) Authorizes a health care collaborative that is in compliance with this code, including Chapters 841 (Life, Health, or Accident Insurance Companies), 842 (Group Hospital Service Corporations), and 843, as applicable, notwithstanding any other law, to contract for, accept, and distribute payments from governmental or private payors based on fee-for-service or alternative payment mechanisms, including:

(1) episode-based or condition-based bundled payments;

(2) capitation or global payments; or

(3) pay-for-performance or quality-based payments.

(c) Prohibits a health care collaborative, except as provided by Subsection (d), from contracting for and accepting payment from a governmental or private entity on a prepaid, capitation, or indemnity basis unless the health care collaborative is licensed as a health maintenance organization or insurer. Requires TDI to review a health care collaborative's proposed payment methodology in contracts with governmental or private entities to ensure compliance with this section.

(d) Authorizes a health care collaborative to contract for and accept compensation on a prepaid or capitation basis from a health maintenance organization or insurer.

Sec. 848.104. CONTRACTS FOR ADMINISTRATIVE OR MANAGEMENT SERVICES. Authorizes a health care collaborative to contract with any person, including an affiliated entity, to perform administrative, management, or any other required business functions on behalf of the health care collaborative.

Sec. 848.105. CORPORATION, PARTNERSHIP, OR ASSOCIATION POWERS. Provides that a health care collaborative has all powers of a partnership, association, corporation, or limited liability company, including a professional association or corporation, as appropriate under the organizational documents of the health care collaborative, that are not in conflict with this chapter or other applicable law.

Sec. 848.106. QUALITY AND COST OF HEALTH CARE SERVICES. (a) Requires a health care collaborative to establish policies to improve the quality and control the cost of health care services provided by participating physicians and health care providers that are consistent with prevailing professionally recognized standards of medical practice. Requires that the policies include standards and procedures relating to:

(1) the selection and credentialing of participating physicians and health care providers;

(2) the development, implementation, monitoring, and evaluation of evidence-based best practices and other processes to improve the quality and control the cost of health care services provided by participating physicians and health care providers, including practices or processes to reduce the occurrence of potentially preventable events;

(3) the development, implementation, monitoring, and evaluation of processes to improve patient engagement and coordination of health care services provided by participating physicians and health care providers; and

(4) complaints initiated by participating physicians and health care providers, and patients under Section 848.107.

(b) Requires the governing body of a health care collaborative to establish a procedure for the periodic review of quality improvement and cost control measures.

Sec. 848.107. COMPLAINT SYSTEMS. (a) Requires a health care collaborative to implement and maintain complaint systems that provide reasonable procedures to resolve an oral or written complaint initiated by:

(1) a patient who received health care services provided by a participating physician or health care provider; or

(2) a participating physician or health care provider.

(b) Requires that the complaint system for complaints initiated by patients include a process for the notice and appeal of a complaint.

(c) Prohibits a health care collaborative from taking a retaliatory or adverse action against a physician or health care provider who files a complaint with a regulatory authority regarding an action of the health care collaborative.

Sec. 848.108. DELEGATION AGREEMENTS. (a) Provides that, except as provided by Subsection (b), a health care collaborative that enters into a delegation agreement described by Section 1272.001 (Definitions) is subject to the requirements of Chapter 1272 in the same manner as a health maintenance organization.

(b) Provides that Section 1272.301 (Access to Out-of-Network Services) does not apply to a delegation agreement entered into by a health care collaborative.

(c) Authorizes a health care collaborative to enter into a delegation agreement with an entity licensed under Chapter 841 (Life, Health, or Accident Insurance

Companies), 842 (Group Hospital Service Corporations), or 883 (Mutual Insurance Companies Other than Mutual Life Insurance Companies) if the delegation agreement assigns to the entity responsibility for:

(1) a function regulated by:

(A) Chapter 222;

(B) Chapter 841;

(C) Chapter 842;

(D) Chapter 883;

(E) Chapter 1272;

(F) Chapter 1301 (Preferred Provider Benefit Plans);

(G) Chapter 4201 (Utilization Review Agents);

(H) Section 1367.053; or

(I) Subchapter A (Consumer Choice of Benefits Health Insurance Plans), Chapter 1507 (Consumer Choice of Benefit Plans); or

(2) another function specified by commissioner rule.

(d) Requires that a health care collaborative that enters into a delegation agreement under this section to maintain reserves and capital in addition to the amounts required under Chapter 1272, in an amount and form determined by rule of the commissioner to be necessary for the liabilities and risks assumed by the health care collaborative.

(e) Provides that a health care collaborative that enters into a delegation agreement under this section is subject to Chapters 404 (Financial Condition), 441 (Supervision and Conservatorship), and 443 (Insurer Receivership Act) and is considered to be an insurer for purposes of those chapters.

Sec. 848.109. VALIDITY OF OPERATIONS AND TRADE PRACTICES OF HEALTH CARE COLLABORATIVES. Provides that the operations and trade practices of a health care collaborative that are consistent with the provisions of this chapter, the rules adopted under this chapter, and applicable federal antitrust laws are presumed to be consistent with Chapter 15 (Monopolies, Trust and Conspiracies in Restraint of Trade), Business & Commerce Code, or any other applicable provision of law.

Sec. 848.110. RIGHTS OF PHYSICIANS; LIMITATIONS ON PARTICIPATION. (a) Entitles a physician, before a complaint against the physician under Section 848.107 is resolved, or before a physician's association with a health care collaborative is terminated, to an opportunity to dispute the complaint or termination through a process that includes:

(1) written notice of the complaint or basis of the termination;

(2) an opportunity for a hearing not earlier than the 30th day after receiving notice under Subdivision (1);

(3) the right to provide information at the hearing, including testimony and a written statement; and

(4) a written decision that includes the specific facts and reasons for the decision.

(b) Authorizes a health care collaborative to limit a physician or group of physicians from participating in the health care collaborative if the limitation is based on an established development plan approved by the board of directors. Requires that each applicant physician or group be provided with a copy of the development plan.

[Reserves Sections 848.111-848.150 for expansion.]

SUBCHAPTER D. REGULATION OF HEALTH CARE COLLABORATIVES

Sec. 848.151. RULES. Authorizes the commissioner and attorney general to adopt reasonable rules as necessary and proper to implement the requirements of this chapter.

Sec. 848.152. FEES AND ASSESSMENTS. (a) Requires the commissioner, within the limits prescribed by this section, to prescribe the fees to be charged and the assessments to be imposed under this section.

(b) Requires that amounts collected under this section be deposited to the credit of the TDI operating account.

(c) Requires a health care collaborative to pay to TDI:

(1) an application fee in an amount determined by commissioner rule; and

(2) an annual assessment in an amount determined by commissioner rule.

(d) Requires the commissioner to set fees and assessments under this section in an amount sufficient to pay the reasonable expenses of TDI and the attorney general in administering this chapter, including the direct and indirect expenses incurred by TDI and the attorney general in examining and reviewing health care collaboratives. Requires that fees and assessments imposed under this section be allocated among health care collaboratives on a pro rata basis to the extent that the allocation is feasible.

Sec. 848.153. EXAMINATIONS. (a) Authorizes the commissioner to examine the financial affairs and operations of any health care collaborative or applicant for a certificate of authority under this chapter.

(b) Requires a health care collaborative to make its books and records relating to its financial affairs and operations available for an examination by the commissioner or attorney general.

(c) Requires a health care collaborative, on request of the commissioner or attorney general, to provide to the commissioner or attorney general, as applicable:

(1) a copy of any contract, agreement, or other arrangement between the health care collaborative and a physician or health care provider; and

(2) a general description of the fee arrangements between the health care collaborative and the physician or health care provider.

(d) Provides that documentation provided to the commissioner or attorney under this section is confidential and is not subject to disclosure under Chapter 552, Government Code.

(e) Authorizes the commissioner or attorney general to disclose the results of an examination conducted under this section or documentation provided under this section to a governmental agency that contracts with a health care collaborative for the purpose of determining financial stability, readiness, or other contractual compliance needs.

[Reserves Sections 848.154-848.200 for expansion.]

SUBCHAPTER E. ENFORCEMENT

Sec. 848.201. ENFORCEMENT ACTIONS. (a) Authorizes the commissioner, after notice and opportunity for a hearing, to:

(1) suspend or revoke a certificate of authority issued to a health care collaborative under this chapter;

(2) impose sanctions under Chapter 82 (Sanctions);

(3) issue a cease and desist order under Chapter 83 (Emergency Cease and Desist Orders); or

(4) impose administrative penalties under Chapter 84 (Administrative Penalties).

(b) Authorizes the commissioner to take an enforcement action listed in Subsection (a) against a health care collaborative if the commissioner finds that the health care collaborative:

(1) is operating in a manner that is:

(A) significantly contrary to its basic organizational documents; or

(B) contrary to the manner described in and reasonably inferred from other information submitted under Section 848.057;

(2) does not meet the requirements of Section 848.057;

(3) cannot fulfill its obligation to provide health care services as required under its contracts with governmental or private entities;

(4) does not meet the requirements of Chapter 1272, if applicable;

(5) has not implemented the complaint system required by Section 848.107 in a manner to resolve reasonably valid complaints;

(6) has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive, or unfair manner or a person on behalf of the health care collaborative has advertised or merchandised the health care collaborative's services in an untrue, misrepresentative, misleading, deceptive, or untrue manner;

(7) has not complied substantially with this chapter or a rule adopted under this chapter;

(8) has not taken corrective action the commissioner considers necessary to correct a failure to comply with this chapter, any applicable provision of this code, or any applicable rule or order of the commissioner not later than the 30th day after the date of notice of the failure or within any longer period specified in the notice and determined by the commissioner to be reasonable; or

(9) has or is utilizing market power in an anticompetitive manner, in accordance with established antitrust principles of market power analysis.

Sec. 848.202. OPERATIONS DURING SUSPENSION OR AFTER REVOCATION OF CERTIFICATE OF AUTHORITY. (a) Prohibits the health care collaborative, during the period a certificate of authority of a health care collaborative is suspended, from:

(1) entering into a new contract with a governmental or private entity; or

(2) advertising or soliciting in any way.

(b) Provides that after a certificate of authority of a health care collaborative is revoked:

(1) the health care collaborative, immediately following the effective date of the order of revocation, is required to conclude its affairs;

(2) the health care collaborative is prohibited from conducting further business except as essential to the orderly conclusion of its affairs; and

(3) the health care collaborative is prohibited from advertising or soliciting in any way.

(c) Authorizes the commissioner, notwithstanding Subsection (b), by written order, to permit the further operation of the health care collaborative to the extent that the commissioner finds necessary to serve the best interest of governmental or private entities that have entered into contracts with the health care collaborative.

Sec. 848.203. INJUNCTIONS. Authorizes the attorney general, if the commissioner believes that a health care collaborative or another person is violating or has violated this chapter or a rule adopted under this chapter, at the request of the commissioner to bring an action in a Travis County district court to enjoin the violation and obtain other relief the court considers appropriate.

Sec. 848.204. NOTICE. Requires the commissioner to:

(1) report any action taken under this subchapter to:

(A) the relevant state licensing or certifying agency or board; and

(B) the United States Department of Health and Human Services National Practitioner Data Bank; and

(2) post notice of the action on TDI's Internet website.

Sec. 848.205. INDEPENDENT AUTHORITY OF ATTORNEY GENERAL. (a) Authorizes the attorney general to:

(1) investigate a health care collaborative with respect to anticompetitive behavior that is contrary to the goals and requirements of this chapter; and

(2) request that the commissioner:

(A) impose a penalty or sanction;

(B) issue a cease and desist order; or

(C) suspend or revoke the health care collaborative's certificate of authority.

(b) Provides that this section does not limit any other authority or power of the attorney general.

SECTION 4.02. Amends Section 74.001(a)(12)(A), Civil Practice and Remedies Code, to redefine "health care provider."

SECTION 4.03. Amends Subchapter B, Chapter 1301, Insurance Code, by adding Section 1301.0625, as follows:

Sec. 1301.0625. HEALTH CARE COLLABORATIVES. (a) Authorizes a health care collaborative to be designated as a preferred provider under a preferred provider benefit plan and to offer enhanced benefits for care provided by the health care collaborative, subject to the requirements of this chapter.

(b) Authorizes a preferred provider contract between an insurer and a health care collaborative to use a payment methodology other than a fee-for-service or discounted fee methodology. Provides that a reimbursement methodology used in a contract under this subsection is not subject to Chapter 843.

(c) Requires that a contract authorized by Subsection (b) specify that the health care collaborative and the physicians or providers providing health care services on behalf of the collaborative will hold an insured harmless for payment of the cost of covered health care services if the insurer or the health care collaborative do not pay the physician or health care provider for the services.

(d) Authorizes an insurer issuing an exclusive provider benefit plan authorized by another law of this state to limit access to only preferred providers participating in a health care collaborative if the limitation is consistent with all requirements applicable to exclusive provider benefit plans.

SECTION 4.04. Amends Subtitle F, Title 4, Health and Safety Code, by adding Chapter 316, as follows:

CHAPTER 316. ESTABLISHMENT OF HEALTH CARE COLLABORATIVES

Sec. 316.001. AUTHORITY TO ESTABLISH HEALTH CARE COLLABORATIVE. Authorizes a public hospital created under Subtitle C (Local Hospitals) or D (Hospital Districts) or a hospital district created under general or special law to form and sponsor a nonprofit health care collaborative that is certified under Chapter 848, Insurance Code.

SECTION 4.05. Amends Section 102.005, Occupations Code, to provide that Section 102.001 does not apply, in addition to certain other individuals and entities, to a health care collaborative certified under Chapter 848, Insurance Code.

SECTION 4.06. Amends Section 151.002(a)(5), Occupations Code, to redefine "health care entity."

SECTION 4.07. Requires the commissioner and the attorney general, not later than September 1, 2012, to adopt rules as necessary to implement this article.

SECTION 4.08. Requires the commissioner to designate or employ staff with antitrust expertise sufficient to carry out the duties required by this Act as soon as practicable after the effective date of this Act.

ARTICLE 5. PATIENT IDENTIFICATION

SECTION 5.01. Amends Subchapter A, Chapter 311, Health and Safety Code, by adding Section 311.004, as follows:

Sec. 311.004. STANDARDIZED PATIENT RISK IDENTIFICATION SYSTEM. (a) Defines "department" and "hospital" in this section.

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

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

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

(e) Requires DSHS to modify the statewide standardized patient risk identification system in accordance with evidence-based medicine as necessary.

(f) Authorizes the executive commissioner to adopt rules to implement this section.

ARTICLE 6. REPORTING OF HEALTH CARE-ASSOCIATED INFECTIONS

SECTION 6.01. Amends Section 98.001, Health and Safety Code, as added by Chapter 359 (S.B. 288), Acts of the 80th Legislature, Regular Session, 2007, by adding Subdivisions (8-a) and (10-a), to define "health care professional," "potentially preventable complication," and "potentially preventable readmission."

SECTION 6.02. Amends Section 98.102(c), Health and Safety Code, as added by Chapter 359 (S.B. 288), Acts of the 80th Legislature, Regular Session, 2007, to require that the data reported by health care facilities to DSHS contain sufficient patient identifying information to, in addition to certain provisions, allow DSHS, for data reported under Section 98.103 (Reportable Infections), rather than under Section 98.103 or 98.104 (Alternative for Reportable Surgical Site Infections), risk adjust the facilities' infection rates.

SECTION 6.03. Amends Section 98.103, Health and Safety Code, as added by Chapter 359 (S.B. 288), Acts of the 80th Legislature, Regular Session, 2007, by amending Subsection (b) and adding Subsection (d-1), as follows:

(b) Requires a pediatric and adolescent hospital to report the incidence of surgical site infections, including the causative pathogen if the infection is laboratory-confirmed, occurring in, in addition to certain other procedures, ventricular shunt procedures, rather than ventriculoperitoneal shunt procedures, to DSHS.

(d-1) Authorizes the executive commissioner by rule to designate the federal Centers for Disease Control and Prevention's National Healthcare Safety Network, or its successor, to receive reports of health care-associated infections from health care facilities on behalf of DSHS. Requires a health care facility to file a report required in accordance with a designation made under this subsection in accordance with the National Healthcare Safety Network's definitions, methods, requirements, and procedures. Requires a health care facility to authorize DSHS to have access to facility-specific data contained in a

report filed with the National Healthcare Safety Network in accordance with a designation made under this subsection.

SECTION 6.04. Amends Section 98.1045, Health and Safety Code, as added by Chapter 359 (S.B. 288), Acts of the 80th Legislature, Regular Session, 2007, by adding Subsection (c), as follows:

(c) Authorizes the executive commissioner by rule to designate an agency of the United States Department of Health and Human Services to receive reports of preventable adverse events by health care facilities on behalf of DSHS. Requires a health care facility to authorize DSHS to have access to facility-specific data contained in a report made in accordance with a designation made under this subsection.

SECTION 6.05. Amends Subchapter C, Chapter 98, Health and Safety Code, as added by Chapter 359 (S.B. 288), Acts of the 80th Legislature, Regular Session, 2007, by adding Sections 98.1046 and 98.1047, as follows:

Sec. 98.1046. PUBLIC REPORTING OF CERTAIN POTENTIALLY PREVENTABLE EVENTS FOR HOSPITALS. (a) Requires DSHS, in consultation with TIHCQE under Chapter 1002, using data submitted under Chapter 108, to publicly report for hospitals in this state risk-adjusted outcome rates for those potentially preventable complications and potentially preventable readmissions that DSHS, in consultation with TIHCQE, has determined to be the most effective measures of quality and efficiency.

(b) Requires DSHS to make the reports compiled under Subsection (a) available to the public on DSHS's Internet website.

(c) Prohibits DSHS from disclosing the identity of a patient or health care professional in the reports authorized in this section.

Sec. 98.1047. STUDIES ON LONG-TERM CARE FACILITY REPORTING OF ADVERSE HEALTH CONDITIONS. (a) Requires DSHS, in consultation with TIHCQE under Chapter 1002, to study which adverse health conditions commonly occur in long-term care facilities and, of those health conditions, which are potentially preventable.

(b) Requires DSHS to develop recommendations for reporting adverse health conditions identified under Subsection (a).

SECTION 6.06. Amends Section 98.105, Health and Safety Code, as added by Chapter 359 (S.B. 288), Acts of the 80th Legislature, Regular Session, 2007, as follows:

Sec. 98.105. REPORTING SYSTEM MODIFICATIONS. Authorizes the executive commissioner by rule, based on the recommendations of the advisory panel, to modify in accordance with this chapter the list of procedures that are reportable under Section 98.103 (Reportable Infections), rather than under Section 98.103 or 98.104. Requires that the modifications be based on changes in reporting guidelines and in definitions established by the federal Centers for Disease Control and Prevention.

SECTION 6.07. Amends Sections 98.106(a), (b), and (d), Health and Safety Code, as added by Chapter 359 (S.B. 288), Acts of the 80th Legislature, Regular Session, 2007, as follows:

(a) Requires DSHS to compile and make available to the public a summary, by health care facility, of, in addition to certain events, the infections reported by facilities under Section 98.103, rather than under Sections 98.103 and 98.104.

(b) Requires that information included in the departmental summary with respect to infections reported by facilities under Section 98.103, rather than under Sections 98.103 and 98.104, 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 Section 98.103, rather than under Sections 98.103 and 98.104.

(d) Requires DSHS to publish the departmental summary at least annually and may publish the summary more frequently as DSHS considers appropriate. Requires that data made available to the public include aggregate data covering a period of at least a full calendar quarter.

SECTION 6.08. Amends Subchapter C, Chapter 98, Health and Safety Code, as added by Chapter 359 (S.B. 288), Acts of the 80th Legislature, Regular Session, 2007, by adding Section 98.1065, as follows:

Sec. 98.1065. STUDY OF INCENTIVES AND RECOGNITION FOR HEALTH CARE QUALITY. Requires DSHS, in consultation with TIHCQE under Chapter 1002, to conduct a study on developing a recognition program to recognize exemplary health care facilities for superior quality of health care and make recommendations based on that study.

SECTION 6.09. Amends Section 98.108, Health and Safety Code, as added by Chapter 359 (S.B. 288), Acts of the 80th Legislature, Regular Session, 2007, as follows:

Sec. 98.108. FREQUENCY OF REPORTING. (a) Creates this subsection from existing text. Requires the executive commissioner by rule, in consultation with the advisory panel, to establish the frequency of reporting by health care facilities required under Sections 98.103 and 98.1045 (Reporting of Preventable Adverse Events), rather than under Sections 98.103, 98.104, and 98.1045.

(b) Prohibits facilities, except as provided by Subsection (c), from being required to report more frequently than quarterly. Makes a nonsubstantive change.

(c) Authorizes the executive commissioner to adopt rules requiring reporting more frequently than quarterly if more frequent reporting is necessary to meet the requirements for participation in the federal Centers for Disease Control and Prevention's National Healthcare Safety Network.

SECTION 6.10. Amends Section 98.109(a), Health and Safety Code, as added by Chapter 359 (S.B. 288), Acts of the 80th Legislature, Regular Session, 2007, to provide that except as provided by Sections 98.1046, 98.106, and 98.110, all information and materials obtained or compiled or reported by the DSHS under this chapter or compiled or reported by a health care facility under this chapter, and all related information and materials, are confidential and are not subject to disclosure under Chapter 552, Government Code, or discovery, subpoena, or other means of legal compulsion for release to any person; and are prohibited from being admitted as evidence or otherwise disclosed in any civil, criminal, or administrative proceeding.

SECTION 6.11. Amends Section 98.110, Health and Safety Code, as added by Chapter 359 (S.B. 288), Acts of the 80th Legislature, Regular Session, 2007, as follows:

Sec. 98.110. DISCLOSURE AMONG CERTAIN AGENCIES. (a) Creates this subsection from existing text. Authorizes DSHS, notwithstanding any other law, to disclose information reported by health care facilities under Section 98.103 (Reportable Infections) or 98.1045 (Reporting of Preventable Adverse Events), rather than Section 98.103, 98.104, or 98.1045, to other programs within DSHS, to HHSC, to other health and human services agencies, as defined by Section 531.001 (Definitions), Government Code, and to the federal Centers for Disease Control and Prevention, or any other agency of the United States Department of Health and Human Services, for public health research or analysis purposes only, provided that the research or analysis relates to health care-associated infections or preventable adverse events. Makes a nonsubstantive change.

(b) Authorizes an agency of the United States Department of Health and Human Services, if the executive commissioner designates that agency to receive reports of health care-associated infections or preventable adverse events, to use the information submitted for purposes allowed by federal law.

SECTION 6.12. Repealer: Section 98.104 (Alternative for Reportable Surgical Site Infections), Health and Safety Code, as added by Chapter 359 (S.B. 288), Acts of the 80th Legislature, Regular Session, 2007.

SECTION 6.13. Requires DSHS, not later than December 1, 2012, to submit a report regarding recommendations for improved health care reporting to the governor, the lieutenant governor, the speaker of the house of representatives, and the chairs of the appropriate standing committees of the legislature outlining:

(1) the initial assessment in the study conducted under Section 98.1065, Health and Safety Code, as added by this Act;

(2) based on the study described by Subdivision (1) of this subsection, the feasibility and desirability of establishing a recognition program to recognize exemplary health care facilities for superior quality of health care;

(3) the recommendations developed under Section 98.1065, Health and Safety Code, as added by this Act; and

(4) the changes in existing law that would be necessary to implement the recommendations described by Subdivision (3) of this subsection.

ARTICLE 7. INFORMATION MAINTAINED BY DEPARTMENT OF STATE HEALTH SERVICES

SECTION 7.01. Amends Section 108.002, Health and Safety Code, by adding Subdivisions (4-a) and (8-a) and amending Subdivision (7), to define "commission" and "executive commissioner" and redefine "department."

SECTION 7.02. Amends Chapter 108, Health and Safety Code, by adding Section 108.0026, as follows:

Sec. 108.0026. TRANSFER OF DUTIES; REFERENCE TO COUNCIL. (a) Provides that the powers and duties of the Texas Health Care Information Council (council) under this chapter were transferred to DSHS in accordance with Section 1.19, Chapter 198 (H.B. 2292), Acts of the 78th Legislature, Regular Session, 2003.

(b) Provides that in this chapter or other law, a reference to the council means DSHS.

SECTION 7.03. Amends Section 108.009(h), Health and Safety Code, as follows:

(h) Requires DSHS, rather than the council, to coordinate data collection with the data submission formats used by hospitals and other providers. Requires DSHS, rather than the council, to accept data in the format developed by the American National Standards Institute or its successor or other nationally accepted standardized forms that hospitals and other providers use for other complementary purposes, rather than developed by the National Uniform Billing Committee (Uniform Hospital Billing Form UB 92) and HCFA-1500 or their successors or other universally accepted standardized forms that hospitals and other providers use for other complementary purposes.

SECTION 7.04. Amends Section 108.013, Health and Safety Code, by amending Subsections (a) through (d), (g), (i), and (j) and adding Subsections (k) through (n), as follows:

(a) Requires that the data received by DSHS under this chapter, rather than by the council, be used by DSHS and HHSC, rather than by the council, for the benefit of the public. Requires DSHS, rather than the council, subject to specific limitations established by this chapter and executive commissioner rule, rather than council rule, to make determinations on requests for information in favor of access.

(b) Requires the executive commissioner, rather than the council, by rule to designate the characters to be used as uniform patient identifiers.

(c) Prohibits DSHS, rather than the council, unless specifically authorized by this chapter, from releasing and a person or entity from gaining access to any data obtained under this chapter:

(1) that could reasonably be expected to reveal the identity of a patient;

(2) that could reasonably be expected to reveal the identity of a physician;

(3) disclosing provider discounts or differentials between payments and billed charges;

(4) relating to actual payments to an identified provider made by a payer; or

(5) submitted to DSHS, rather than to the council, in a uniform submission format that is not included in the public use data set established under Sections 108.006(f) (relating to a public use data file minimum data set) and (g) (relating to an annual review of a public use data file minimum data set), except in accordance with Section 108.0135 (Scientific Review Panel).

(d) Provides that except as provided by this section, all data collected and used by DSHS, rather than by DSHS and the council, under this chapter is subject to the confidentiality provisions and criminal penalties of Section 311.037 (Confidential Data; Criminal Penalty), Section 81.103 (Confidentiality; Criminal Penalty), and Section 159.002 (Confidential Communications), Occupations Code.

(g) Prohibits DSHS, rather than the council, unless specifically authorized by this chapter, from releasing data elements in a manner that will reveal the identity of a patient. Makes a conforming change.

(i) Prohibits DSHS, rather than the council and DSHS, notwithstanding any other law and except as provided by this section, from providing information made confidential by this section to any other agency of this state.

(j) Requires the executive commissioner by rule to develop and implement a mechanism to comply with Subsections (c)(1) and (2), rather than requires the council by rule, with the assistance of the advisory committee under Section 108.003(g)(5), to develop and implement a mechanism to comply with Subsections (c)(1) and (2).

(k) Authorizes DSHS to disclose data collected under this chapter that is not included in public use data to any department or commission program if the disclosure is reviewed and approved by the institutional review board under Section 108.0135.

(l) Provides that confidential data collected under this chapter that is disclosed to a DSHS or HHSC program remains subject to the confidentiality provisions of this chapter and other applicable law. Requires DSHS to identify the confidential data that is disclosed to a program under Subsection (k). Requires that the program maintain the confidentiality of the disclosed confidential data.

(m) Provides that the following provisions do not apply to the disclosure of data to a DSHS or HHSC program: Section 81.103, Sections 108.010(g) (relating to the release of provider quality data) and (h) (relating to limitations on a provider quality data

report), Sections 108.011(e) (relating to public use data regarding a specific provider) and (f) (relating to a reasonable review and comment period included in a report), Section 311.037, and Section 159.002, Occupations Code.

(n) Provides that nothing in this section authorizes the disclosure of physician identifying data.

SECTION 7.05. Amends Section 108.0135, Health and Safety Code, as follows:

Sec. 108.0135. New heading: INSTITUTIONAL REVIEW BOARD. (a) Requires DSHS to establish an institutional review board to review and approve requests for access to data not contained in public use data, rather than requires the council to establish a scientific review panel to review and approve requests for information other than public use data. Makes a conforming change.

(b) Requires the executive commissioner, rather than the council, to assist the institutional review board in determining whether to approve a request for information, to adopt rules similar to the federal Centers for Medicare and Medicaid Services' guidelines, rather than the federal Health Care Financing Administration's guidelines, on releasing data.

(c) Requires that a request for information other than public use data be made on the form prescribed by DSHS, rather than created by the council.

(d) Requires that any approval to release information under this section require that the confidentiality provisions of this chapter be maintained and that any subsequent use of the information conform to the confidentiality provisions of this chapter.

SECTION 7.06 Amends Chapter 108, Health and Safety Code, by adding Section 108.0131, to require DSHS to post on DSHS's Internet website a list of each entity that purchases or receives data collected under this chapter.

SECTION 7.07. (a) Provides that if S.B. No. 156, Acts of the 82nd Legislature, Regular Session, 2011, does not become law, effective September 1, 2014, Section 108.002(5) (defining "council") and (18) (defining "rural provider"), and Section 108.0025 (Rural Provider), and Section 108.009(c) (relating to certain data not required but authorized to be submitted by certain providers), Health and Safety Code, are repealed.

(b) Provides that if S.B. 156, Acts of the 82nd Legislature, Regular Session, 2011, becomes law, effective 1, 2014, Section 108.002(18) (defining "rural provider"), and Section 108.0025 (Rural Provider), and Section 108.009(c) (relating to certain data not required but authorized to be submitted by certain providers), Health and Safety Code, are repealed.

ARTICLE 8. ADOPTION OF VACCINE PREVENTABLE DISEASES POLICY BY HEALTH CARE FACILITIES

SECTION 8.01. Amends the heading to Subtitle A, Title 4, Health and Safety Code, to read as follows:

SUBTITLE A. FINANCING, CONSTRUCTING, REGULATING, AND INSPECTING HEALTH FACILITIES

SECTION 8.02. Amends Subtitle A, Title 4, Health and Safety Code, by adding Chapter 224, as follows:

CHAPTER 224. POLICY ON VACCINE PREVENTABLE DISEASES

Sec. 224.001. DEFINITIONS. Defines, in this chapter, "covered individual," "health care facility," "regulatory authority," and "vaccine preventable diseases."

Sec. 224.002. VACCINE PREVENTABLE DISEASES POLICY REQUIRED. (a) Requires each health care facility to develop and implement a policy to protect its patients from vaccine preventable diseases.

(b) Requires that the policy:

(1) require covered individuals to receive vaccines for the vaccine preventable diseases specified by the facility based on the level of risk the individual presents to patients by the individual's routine and direct exposure to patients;

(2) specify the vaccines a covered individual is required to receive based on the level of risk the individual presents to patients by the individual's routine and direct exposure to patients;

(3) include procedures for verifying whether a covered individual has complied with the policy;

(4) include procedures for a covered individual to be exempt from the required vaccines for the medical conditions identified as contraindications or precautions by the Centers for Disease Control and Prevention;

(5) for a covered individual who is exempt from the required vaccines, include procedures the individual must follow to protect facility patients from exposure to disease, such as the use of protective medical equipment, such as gloves and masks, based on the level of risk the individual presents to patients by the individual's routine and direct exposure to patients;

(6) prohibit discrimination or retaliatory action against a covered individual who is exempt from the required vaccines for the medical conditions identified as contraindications or precautions by the Centers for Disease Control and Prevention, except that required use of protective medical equipment, such as gloves and masks, may not be considered retaliatory action for purposes of this subdivision;

(7) require the health care facility to maintain a written or electronic record of each covered individual's compliance with or exemption from the policy; and

(8) include disciplinary actions the health care facility is authorized to take against a covered individual who fails to comply with the policy.

(c) Authorizes the policy to include procedures for a covered individual to be exempt from the required vaccines based on reasons of conscience, including a religious belief.

Sec. 224.003. DISASTER EXEMPTION. (a) Defines, in this section, "public health disaster."

(b) Authorizes a health care facility, during a public health disaster, to prohibit a covered individual who is exempt from the vaccines required in the policy developed by the facility under Section 224.002 from having contact with facility patients.

Sec. 224.004. DISCIPLINARY ACTION. Provides that a health care facility that violates this chapter is subject to an administrative or civil penalty in the same manner, and subject to the same procedures, as if the facility had violated a provision of this code that specifically governs the facility.

Sec. 224.005. RULES. Requires the appropriate rulemaking authority for each regulatory authority to adopt rules necessary to implement this chapter.

SECTION 8.03. Requires a state agency that regulates a health care facility subject to Chapter 224, Health and Safety Code, as added by this Act, not later than June 1, 2012, to adopt the rules necessary to implement that chapter.

SECTION 8.04. Provides that, notwithstanding Chapter 224, Health and Safety Code, as added by this Act, a health care facility subject to that chapter is not required to have a policy on vaccine preventable diseases in effect until September 1, 2012.

ARTICLE 9. TEXAS EMERGENCY AND TRAUMA CARE EDUCATION PARTNERSHIP PROGRAM

SECTION 9.01. Amends Chapter 61, Education Code, by adding Subchapter HH, as follows:

SUBCHAPTER HH. TEXAS EMERGENCY AND TRAUMA CARE EDUCATION PARTNERSHIP PROGRAM

Sec. 61.9801. DEFINITIONS. Defines, in this subchapter, "emergency and trauma care education partnership" and "participating education program."

Sec. 61.9802. PROGRAM: ESTABLISHMENT; ADMINISTRATION; PURPOSE. (a) Provides that the Texas emergency and trauma care education partnership program is established.

(b) Requires the Texas Higher Education Coordinating Board (THECB) to administer the program in accordance with this subchapter and rules adopted under this subchapter.

(c) Requires THECB, under the program, to the extent funds are available under Section 61.9805, to make grants to emergency and trauma care education partnerships to assist those partnerships to meet the state's needs for doctors and registered nurses with training in emergency and trauma care by offering one-year or two-year fellowships to students enrolled in graduate professional nursing or graduate medical education programs through collaboration between hospitals and graduate professional nursing or graduate medical education programs and the use of the existing expertise and facilities of those hospitals and programs.

Sec. 61.9803. GRANTS: CONDITIONS; LIMITATIONS. (a) Authorizes THECB to make a grant under this subchapter to an emergency and trauma care education partnership only if THECB determines that:

(1) the partnership will meet applicable standards for instruction and student competency for each program offered by each participating education program;

(2) each participating education program will, as a result of the partnership, enroll in the education program a sufficient number of additional students as established by THECB;

(3) each hospital participating in an emergency and trauma care education partnership will provide to students enrolled in a participating education program clinical placements that:

(A) allow the students to take part in providing or to observe, as appropriate, emergency and trauma care services offered by the hospital; and

(B) meet the clinical education needs of the students; and

(4) the partnership will satisfy any other requirement established by THECB rule.

(b) Authorizes a grant under this subchapter to be spent only on costs related to the development or operation of an emergency and trauma care education partnership that prepares a student to complete a graduate professional nursing program with a specialty focus on emergency and trauma care or earn board certification by the American Board of Medical Specialties.

Sec. 61.9804. PRIORITY FOR FUNDING. Requires THECB, in awarding a grant under this subchapter, to give priority to an emergency and trauma care education partnership that submits a proposal that:

(1) provides for collaborative educational models between one or more participating hospitals and one or more participating education programs that have signed a memorandum of understanding or other written agreement under which the participants agree to comply with standards established by THECB, including any standards THECB may establish that:

(A) provide for program management that offers a centralized decision-making process allowing for inclusion of each entity participating in the partnership;

(B) provide for access to clinical training positions for students in graduate professional nursing and graduate medical education programs that are not participating in the partnership; and

(C) specify the details of any requirement relating to a student in a participating education program being employed after graduation in a hospital participating in the partnership, including any details relating to the employment of students who do not complete the program, are not offered a position at the hospital, or choose to pursue other employment;

(2) includes a demonstrable education model to:

(A) increase the number of students enrolled in, the number of students graduating from, and the number of faculty employed by each participating education program; and

(B) improve student or resident retention in each participating education program;

(3) indicates the availability of money to match a portion of the grant money, including matching money or in-kind services approved by THECB from a hospital, private or nonprofit entity, or institution of higher education;

(4) can be replicated by other emergency and trauma care education partnerships or other graduate professional nursing or graduate medical education programs; and

(5) includes plans for sustainability of the partnership.

Sec. 61.9805. GRANTS, GIFTS, AND DONATIONS. Authorizes THECB, in addition to money appropriated by the legislature, to solicit, accept, and spend grants, gifts, and donations from any public or private source for the purposes of this subchapter.

Sec. 61.9806. RULES. Requires THECB to adopt rules for the administration of the Texas emergency and trauma care education partnership program. Requires that the rules include provisions relating to applying for a grant under this subchapter, and standards of accountability consistent with other graduate professional nursing and graduate medical education programs to be met by any emergency and trauma care education partnership awarded a grant under this subchapter.

Sec. 61.9807. ADMINISTRATIVE COSTS. Authorizes a reasonable amount, not to exceed three percent, of any money appropriated for purposes of this subchapter to be used to pay the costs of administering this subchapter.

SECTION 9.02. Requires THECB, as soon as practicable after the effective date of this article, to adopt rules for the implementation and administration of the Texas emergency and trauma care education partnership program established under Subchapter HH, Chapter 61, Education Code, as added by this Act. Authorizes THECB to adopt the initial rules in the manner provided by law for emergency rules.

ARTICLE 10. INSURER CONTRACTS REGARDING CERTAIN BENEFIT PLANS

SECTION 10.01. Amends Section 1301.006, Insurance Code, as follows:

Sec. 1301.006. AVAILABILITY OF AND ACCESSIBILITY TO HEALTH CARE SERVICES. (a) Creates this subsection from existing text. Makes no further changes.

(b) Prohibits a contract between an insurer that markets a plan regulated under this chapter and an institutional provider, as a condition of staff membership or privileges, require a physician or other practitioner from entering into a preferred provider contract.

ARTICLE 11. COVERED SERVICES OF CERTAIN HEALTH CARE PRACTITIONERS

SECTION 11.01. Amends Section 1451.109, Insurance Code, as follows:

Sec. 1451.109. SELECTION OF CHIROPRACTOR. (a) Creates this subsection from existing text. Makes no further changes.

(b) Prohibits a health insurance policy issuer, if physical modalities and procedures are covered services under a health insurance policy and within the scope of the license of a chiropractor and one or more other type of practitioner, from:

(1) denying payment or reimbursement for physical modalities and procedures provided by a chiropractor if the chiropractor provides the modalities and procedures in strict compliance with state law; and the health insurance policy issuer allows payment or reimbursement for the same physical modalities and procedures performed by another type of practitioner that an insured may select under this subchapter;

(2) making payment or reimbursement for particular covered physical modalities and procedures within the scope of a chiropractor's license contingent on treatment or examination by a practitioner that is not a chiropractor; or

(3) establishing other limitations on the provision of covered physical modalities and procedures that would prohibit an insured from seeking the covered physical modalities and procedures from a chiropractor to the

same extent that the insured may obtain covered physical modalities and procedures from another type of practitioner.

(c) Provides that nothing in this section requires a health insurance policy issuer to cover particular services or affects the ability of a health insurance policy issuer to determine whether specific procedures for which payment or reimbursement is requested are medically necessary.

(d) Provides that this section does not apply to workers' compensation insurance coverage as defined by Section 401.011 (General Definitions), Labor Code; a self-insured employee welfare benefit plan subject to the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.); the child health plan program under Chapter 62, Health and Safety Code, or the health benefits plan for children under Chapter 63, Health and Safety Code; or a Medicaid managed care program operated under Chapter 533, Government Code, or a Medicaid program operated under Chapter 32, Human Resources Code.

SECTION 11.02. Makes application of Section 1451.109, Insurance Code, prospective.

ARTICLE 12. INTERSTATE HEALTH CARE COMPACT

SECTION 12.01. Amends Title 15, Insurance Code, by adding Chapter 5002, as follows:

CHAPTER 5002. INTERSTATE HEALTH CARE COMPACT

Sec. 5002.001. EXECUTION OF COMPACT. Enacts the Interstate Health Care Compact and enters into the compact with all other states legally joining in the compact in substantially the same form as set forth.

SECTION 12.02. Effective date, this article: upon passage or the 91st day after the last day of the legislative session.

ARTICLE 13. MEDICAID PROGRAM AND ALTERNATE METHODS OF PROVIDING HEALTH SERVICES TO LOW-INCOME PERSONS

SECTION 13.01. Amends Subtitle I, Title 4, Government Code, by adding Chapter 537, as follows:

CHAPTER 537. MEDICAID REFORM WAIVER

Sec. 537.001. DEFINITIONS. Defines, in this chapter, "commission" and "executive commissioner."

Sec. 537.002. FEDERAL AUTHORIZATION FOR MEDICAID REFORM. (a) Requires the executive commissioner to seek a waiver under Section 1115 of the federal Social Security Act (42 U.S.C. Section 1315) to the state Medicaid plan.

(b) Requires that the waiver under this section be designed to achieve the following objectives regarding the Medicaid program and alternatives to the program:

(1) provide flexibility to determine Medicaid eligibility categories and income levels;

(2) provide flexibility to design Medicaid benefits that meet the demographic, public health, clinical, and cultural needs of this state or regions within this state;

(3) encourage use of the private health benefits coverage market rather than public benefits systems;

(4) encourage people who have access to private employer-based health benefits to obtain or maintain those benefits;

(5) create a culture of shared financial responsibility, accountability, and participation in the Medicaid program by establishing and enforcing copayment requirements similar to private sector principles for all eligibility groups; promoting the use of health savings accounts to influence a culture of individual responsibility; and promoting the use of vouchers for consumer-directed services in which consumers manage and pay for health-related services provided to them using program vouchers;

(6) consolidate federal funding streams, including funds from the disproportionate share hospitals and upper payment limit supplemental payment programs and other federal Medicaid funds, to ensure the most effective and efficient use of those funding streams;

(7) allow flexibility in the use of state funds used to obtain federal matching funds, including allowing the use of intergovernmental transfers, certified public expenditures, costs not otherwise matchable, or other funds and funding mechanisms to obtain federal matching funds;

(8) empower individuals who are uninsured to acquire health benefits coverage through the promotion of cost-effective coverage models that provide access to affordable primary, preventive, and other health care on a sliding scale, with fees paid at the point of service; and

(9) allow for the redesign of long-term care services and supports to increase access to patient-centered care in the most cost-effective manner.

SECTION 13.02. (a) Defines, in this section, "commission," "FMAP," "illegal immigrant," and "medicaid program."

(b) Requires HHSC to actively pursue a modification to the formula prescribed by federal law for determining this state's federal medical assistance percentage by which state expenditures under the Medicaid program are matched with federal funds (FMAP) to achieve a formula that would produce an FMAP that accounts for and is periodically adjusted to reflect changes in the following factors in this state: the total population; the population growth rate; and the percentage of the population with household incomes below the federal poverty level.

(c) Requires HHSC to pursue the modification as required by Subsection (b) of this section by providing to the Texas delegation to the United States Congress and the federal Centers for Medicare and Medicaid Services and other appropriate federal agencies data regarding the factors listed in that subsection and information indicating the effects of those factors on the Medicaid program that are unique to this state.

(d) Requires HHSC, in addition to the modification to the FMAP described by Subsection (b) of this section, to make efforts to obtain additional federal Medicaid funding for Medicaid services required to be provided to illegal immigrants in this state. Require HHSC, as part of that effort, to provide to the Texas delegation to the United States Congress and the federal Centers for Medicare and Medicaid Services and other appropriate federal agencies data regarding the costs to this state of providing those services.

(e) Provides that this section expires September 1, 2013.

SECTION 13.03. (a) Provides that the Medicaid Reform Waiver Legislative Oversight Committee (committee) is created to facilitate the reform waiver efforts with respect to Medicaid.

(b) Provides that the committee is composed of eight members, as follows:

(1) four members of the senate, appointed by the lieutenant governor not later than October 1, 2011; and

(2) four members of the house of representatives, appointed by the speaker of the house of representatives not later than October 1, 2011.

(c) Provides that a member of the committee serves at the pleasure of the appointing official.

(d) Requires the governor shall designate a member of the committee as the presiding officer.

(e) Prohibits a member of the committee from receiving compensation for serving on the committee but entitles the member to reimbursement for travel expenses incurred by the member while conducting the business of the committee as provided by the General Appropriations Act.

(f) Requires the committee to facilitate the design and development of the Medicaid reform waiver required by Chapter 537, Government Code, as added by this article; facilitate a smooth transition from existing Medicaid payment systems and benefit designs to a new model of Medicaid enabled by the waiver described by Subdivision (1) of this subsection; meet at the call of the presiding officer; and research, take public testimony, and issue reports requested by the lieutenant governor or speaker of the house of representatives.

(g) Authorizes the committee to request reports and other information from HHSC.

(h) Requires the committee to use existing staff of the senate, the house of representatives, and the Texas Legislative Council to assist the committee in performing its duties under this section.

(i) Provides that Chapter 551 (Open Meetings), Government Code, applies to the committee.

(j) Requires the committee to report to the lieutenant governor and speaker of the house of representatives not later than November 15, 2012. Requires that the report include:

(1) identification of significant issues that impede the transition to a more effective Medicaid program;

(2) the measures of effectiveness associated with changes to the Medicaid program;

(3) the impact of Medicaid changes on safety net hospitals and other significant traditional providers; and

(4) the impact on the uninsured in Texas.

(k) Provides that this section expires September 1, 2013, and the committee is abolished on that date.

SECTION 13.04. Effective date, this article: upon passage or on the 91st day after the last day of the legislative session.

ARTICLE 14. AUTOLOGOUS STEM CELL BANK FOR RECIPIENTS OF BLOOD AND TISSUE COMPONENTS WHO ARE THE LIVE HUMAN DONORS OF THE ADULT STEM CELLS

SECTION 14.01. Amends Title 12, Health and Safety Code, by adding Chapter 1003, as follows:

CHAPTER 1003. AUTOLOGOUS STEM CELL BANK FOR RECIPIENTS OF BLOOD AND TISSUE COMPONENTS WHO ARE THE LIVE HUMAN DONORS OF THE ADULT STEM CELLS

Sec. 1003.001. ESTABLISHMENT OF ADULT STEM CELL BANK. (a) Requires the executive commission, if the executive commissioner determines that it will be cost-effective and increase the efficiency or quality of health care, health and human services, and health benefits programs in this state, by rule to establish eligibility criteria for the creation and operation of an autologous adult stem cell bank.

(b) Requires the executive commissioner, in adopting the rules under Subsection (a), to consider the ability of the applicant to establish, operate, and maintain an autologous adult stem cell bank and to provide related services; and the demonstrated experience of the applicant in operating similar facilities in this state.

(c) Provides that this section does not affect the application of or apply to Chapter 162 (Blood Banks and Donation of Blood).

ARTICLE 15. STATE FUNDING FOR CERTAIN MEDICAL PROCEDURES

SECTION 15.01. Amends the heading to Subchapter M, Chapter 285, Health and Safety Code, to read as follows:

SUBCHAPTER M. REGULATION OF SERVICES

SECTION 15.02. Amends Subchapter M, Chapter 285, Health and Safety Code, by adding Section 285.202, as follows:

Sec. 285.202. USE OF TAX REVENUE FOR ABORTIONS; EXCEPTION FOR MEDICAL EMERGENCY. (a) Defines, in this section, "medical emergency."

(a-1) Defines, in Subsection (a), a "severe fetal abnormality."

(a-2) Defines, in Subsection (a-1), "reasonable medical judgment."

(b) Prohibits a hospital district created under general or special law that uses tax revenue of the district to finance the performance of an abortion, except in the case of a medical emergency, from receiving state funding.

(c) Requires a physician who performs an abortion in a medical emergency at a hospital or other health care facility owned or operated by a hospital district that receives state funds to:

(1) include in the patient's medical records a statement signed by the physician certifying the nature of the medical emergency; and

(2) not later than the 30th day after the date the abortion is performed, certify to DSHS the specific medical condition that constituted the emergency.

(d) Requires that the statement required under Subsection (c)(1) be placed in the patient's medical records and is required to be kept by the hospital or other health care facility where the abortion is performed until:

(1) the seventh anniversary of the date the abortion is performed; or

(2) if the pregnant woman is a minor, the later of the seventh anniversary of the date the abortion is performed; or the woman's 21st birthday.

ARTICLE 16. IMPLEMENTATION; EFFECTIVE DATE

SECTION 16.01. Provides that it is the intent of the legislature that HHSC take any action HHSC determines is necessary and appropriate, including expedited and emergency action, to ensure the timely implementation of the relevant provisions of this bill and the corresponding assumptions reflected in H.B. No. 1, 82nd Legislature, Regular Session, 2011 (General Appropriations Act), by September 1, 2011, or the effective date of this Act, whichever is later, including the adoption of administrative rules, the preparation and submission of any required waivers or state plan amendments, and the preparation and execution of any necessary contract changes or amendments.

SECTION 16.02. Effective date, except as otherwise provided by this Act: on the 91st day after the last day of the legislative session.