BILL ANALYSIS

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

BACKGROUND AND PURPOSE

Interested parties report that there is a need to improve the quality and efficiency of health care in Texas. C.S.S.B. 7 seeks to address this issue by amending current law relating to the administration, quality, and efficiency of health care, health and human services, and health benefits programs in Texas.

RULEMAKING AUTHORITY

It is the committee's opinion that rulemaking authority is expressly granted to the executive commissioner of the Health and Human Services Commission in SECTIONS 1.01, 1.02, 1.05, 1.09, 1.11, 1.12, 1.13, 1.17, 1.18, 5.01, 6.03, 6.04, 6.09, and 7.05; the commissioner of insurance in SECTION 4.01; the commissioner of insurance and the attorney general in SECTIONS 4.01 and 4.07; the appropriate rulemaking authority for each state agency that regulates a health care facility under the Health and Safety Code in SECTIONS 8.02 and 8.03; and the Texas Higher Education Coordinating Board in SECTIONS 9.01 and 9.02 of this bill.

ANALYSIS

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

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
C.S.S.B. 7 amends the Government Code to require 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. The bill requires HHSC to require that the assessment be conducted in a certain manner and that the process include certain assessments and documentation if HHSC develops an objective assessment process. The bill requires HHSC, if HHSC develops the objective assessment process, to implement the process within the Medicaid fee-for-service model and the primary care case management Medicaid managed care model and to take certain necessary actions to implement the process within the STAR and STAR + PLUS Medicaid managed care programs.

C.S.S.B. 7 requires an assessment of whether a recipient should be referred for additional therapy services to be waived if the recipient's need for therapy services has been established by

a recommendation from a therapist providing care before discharge of the recipient from a licensed hospital or nursing home. The bill 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. The bill requires the executive commissioner of HHSC to adopt rules providing for a process by which a provider of acute nursing services who disagrees with the results of an assessment of a Medicaid recipient's needs for acute nursing services may request and obtain a review of those results.

C.S.S.B. 7 requires HHSC, after implementing the objective assessment process for acute nursing services, 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. The bill authorizes HHSC, if the commission determines that implementing such assessment 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. The bill requires such an objective assessment process to include a process that allows a provider of therapy services to request and obtain a review of the results of an assessment that is comparable to the process for requesting and obtaining a review of the results of an assessment of a Medicaid recipient's needs for acute nursing services implemented under rules adopted by the executive commissioner.

C.S.S.B. 7 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 names of the provider and recipient and the date and time the provider begins and ends each service delivery visit. The bill requires HHSC, if the commission determines implementation to be cost-effective and feasible, to implement the electronic visit verification system not later than September 1, 2012. The bill defines "acute nursing services" and "therapy services."

Section 1.02

C.S.S.B. 7 amends the Government Code to require HHSC to determine the most cost-effective alignment of managed care service delivery areas and authorizes the executive 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. The bill removes a provision of law prohibiting HHSC from providing Medicaid using a health maintenance organization in Cameron County, Hidalgo County, or Maverick County.

C.S.S.B. 7 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. The bill 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 Medicaid and Medicare programs. The bill 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. The bill defines "patient-centered medical home." The bill 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 Medicaid recipients.

C.S.S.B. 7 requires HHSC, in awarding contracts to managed care organizations in the initial implementation of managed care in the South Texas service region, to give extra consideration to an organization that either is locally owned, managed, and operated, if one exists, or is in compliance with the requirements of a certain provision of law relating to mandatory contracts

between HHSC and a managed care organization in a health service region. The bill 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; adjudicated to have committed a breach of contract; or assessed a penalty or fine in the amount of $500,000 or more in a state or federal administrative proceeding.

C.S.S.B. 7 expands the components required in a contract between a managed care organization and HHSC for the organization to provide health care services to recipients to include the following:

- a requirement that the organization provide certain information for fraud control and otherwise comply and cooperate with the office of the attorney general, in addition to cooperating with HHSC's office of inspector general;
- a requirement that a medical doctor who is authorized to make medical necessity determinations is available to the region where the managed care organization provides health care services;
- 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;
- a requirement that the managed care organization provide special programs and materials for recipients with limited English proficiency or low literacy skills;
- 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;
- 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;
- 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; that 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 that 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;
- 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;
- a requirement that the managed care organization develop, implement, and maintain an outpatient pharmacy benefit plan for its enrolled recipients that exclusively employs the vendor drug program formulary and preserves the state's ability to

reduce waste, fraud, and abuse under the Medicaid program; that adheres to the applicable preferred drug list adopted by HHSC; that includes the prior authorization procedures and requirements prescribed by or implemented under state law for the vendor drug program; for purposes of which the managed care organization is prohibited from negotiating or collecting rebates associated with pharmacy products on the vendor drug program formulary and from receiving drug rebate or pricing information that is confidential; that complies with the prohibition against providing sexual performance enhancing medication under the Medicaid vendor drug program to a person required to register as a sex offender; under which the managed care organization is prohibited from prohibiting, limiting, or interfering 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; 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, with certain exceptions; under which the managed care organization is prohibited from preventing 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; under which the managed care organization is authorized to include mail-order pharmacies in its networks but is prohibited from requiring enrolled recipients to use those pharmacies and from charging an enrolled recipient who opts to use this service a fee, including postage and handling fees; and under which the managed care organization or pharmacy benefit manager, as applicable, is required to pay claims in accordance with Insurance Code provisions relating to the deadline for action on certain prescription claims; and

- 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, the office of the attorney general all discounts, incentives, rebates, fees, free goods, bundling arrangements, and other agreements affecting the net cost of goods or services provided under the plan.

The bill specifies that certain requirements for an outpatient pharmacy benefit plan developed, implemented, and maintained by a managed care organization relating to the vendor drug program do not apply and may not be enforced on and after August 31, 2013.

C.S.S.B. 7 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 preventative services exceeds minimum establishes standards. The bill includes the provision of a single portal through which providers in any managed care organization's provider network may submit claims among the ways in which HHSC is required, in improving the administration of contracts with managed care organizations, to decrease the administrative burdens of managed care for the state, the managed care organizations, and the providers under managed care networks.

C.S.S.B. 7 requires a person who serves as a medical director for a managed care plan to be a physician licensed to practice medicine in Texas under the Medical Practice Act. The bill prohibits a recipient enrolled in a Medicaid managed care plan, with certain exceptions and to the extent permitted by federal law, from disenrolling from a Medicaid managed care plan and enrolling in another managed care plan, rather than authorizing HHSC to prohibit a recipient from disenrolling in a Medicaid managed care plan and enrolling in another managed care plan, during the 12-month period after the date the recipient initially enrolls in the plan. The bill requires HHSC to allow a recipient who is enrolled in a Medicaid managed care plan to disenroll from that plan and enroll in another managed care plan once for any reason after the 12-month

period after the date the recipient initially enrolls in a plan and after the 91st day after the date of a recipient's initial enrollment in a managed care plan, in addition to at any time for cause in accordance with federal law.

C.S.S.B. 7 specifies that the information a managed care organization contracting with HHSC to implement a Medicaid managed care program is required to submit to HHSC for purposes of fraud control be submitted at no cost. The bill requires such an organization to provide the same information at no cost to the office of the attorney general on request and makes related conforming changes. The bill includes among such required information a description and breakdown of all funds paid by the managed care organization, in addition to a description and breakdown of all funds paid to the organization, and specifies that a managed care organization includes, for purposes of the description of funds, a pharmacy benefit manager.

C.S.S.B. 7 repeals a certain provision of law relating to fraud control information required to be submitted by a managed care organization and the managed care provider for a subcontractor who reenrolled as a provider in the Medicaid program or who modified a contract.

C.S.S.B. 7 amends the Human Resources Code to require the executive commissioner of HHSC to adopt rules governing sanctions and penalties that apply to a provider who is enrolled as a network pharmacy provider of a managed care organization contracting with HHSC under the Medicaid managed care program or its subcontractor and who submits an improper claim for reimbursement under the program.

C.S.S.B. 7 requires HHSC, in a contract between HHSC and a managed care organization under provisions relating to the implementation of a Medicaid managed care program that is entered into or renewed on or after the bill's effective date, to include the contract provisions required by the provision of law setting out the components of such a contract, as amended by the bill.

Section 1.03

C.S.S.B. 7 abolishes the State Kids Insurance Program operated by the Employees Retirement System of Texas (ERS) on the bill's effective date and requires HHSC to establish a process in cooperation with ERS to facilitate the enrollment of eligible children in the child health plan program for certain low-income children on or before the date those children are scheduled to stop receiving dependent child coverage under the State Kids Insurance Program and to modify any applicable administrative procedures to ensure that affected children maintain continuous health benefits coverage while transitioning from enrollment in the State Kids Insurance Program to enrollment in the child health plan program.

C.S.S.B. 7 amends the Health and Safety Code to specify that a child who is the dependent of an employee of a Texas agency and who meets the eligibility requirements for the child health plan program may be eligible for health benefits coverage in accordance with certain specified federal law and any other law or regulations.

C.S.S.B. 7 repeals provisions of the Insurance Code relating to coverage for certain dependent children of employees and the amount of state contribution for certain dependent children to conform to the abolishment of the State Kids Insurance Program.

Section 1.04

C.S.S.B. 7 amends the Human Resources Code to require HHSC to use appropriate technology

to confirm the identity of applicants for benefits under the Temporary Assistance for Needy Families (TANF) program and to prevent duplicate participation in the program by a person. The bill provides that the bill provision establishing that requirement has no effect if H.B. 710, Acts of the 82nd Legislature, Regular Session, 2011, becomes law. The bill requires HHSC to use appropriate technology to confirm the identity of applicants for benefits under the Supplemental Nutrition Assistance Program (SNAP) and prevent duplicate participation in the program by a person and repeals a provision added by H.B. 710, Acts of the 82nd Legislature, Regular Session, 2011, if that Act becomes law, that establishes the same requirement regarding SNAP. The bill, if H.B. 710, Acts of the 82nd Legislature, Regular Session, 2011, does not become law, repeals a certain provision of law relating to the electronic fingerprint-imaging or photo-imaging program for adult and teen parent applicants for and recipients of financial assistance under the TANF program or food stamp benefits.

C.S.S.B. 7 amends the Government Code to authorize HHSC, absent an allegation of fraud, waste, or abuse, to conduct an annual review of claims for reimbursement under Medicaid only after HHSC has completed the prior year's annual review of claims.

Section 1.05

C.S.S.B. 7 amends the Health and Safety Code to extend the period in which a license for a convalescent or nursing home or a related institution is renewable from every two years to every three years following an inspection, if required, payment of the license fee, and Department of Aging and Disability Services (DADS) approval of the report required to be filed by the licensee for license renewal at the same interval as the renewal period. The bill requires the executive commissioner of HHSC, as soon as practicable after the bill's effective date but not later than December 1, 2012, to adopt by rule a system under which an appropriate number of licenses issued by DADS expire on staggered dates occurring in each three-year period. The bill requires DADS, if the expiration date of a license changes as a result of the system, to prorate the licensing fee relating to that license as appropriate. The bill postpones from September 1, 2012, to September 1, 2014, the date on which an institution is required to comply with certain automated external defibrillator requirements and postpones the expiration date of the provision relating to the requirements from January 1, 2013, to January 1, 2015.

Section 1.06

C.S.S.B. 7 amends Section 161.081, Human Resources Code, as effective September 1, 2011, to include among the initiatives the implementation of which DADS is authorized to consider in streamlining the administration of and delivery of services through Section 1915(c) waiver programs the following initiatives, 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. The bill 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 DADS and HHSC efforts to streamline and unify the administration and delivery of the program services.

C.S.S.B. 7 amends the Human Resources Code to require DADS to perform a utilization review of services in all Section 1915(c) waiver programs and requires the utilization review to 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. The bill provides for the meaning of "Section 1915(c) waiver program" by reference to the Government Code.

Section 1.07

C.S.S.B. 7 amends the Human Resources Code to require 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 names of the provider and the recipient, the date and time the provider begins and ends the delivery of services, and the location of service delivery.

Section 1.08

C.S.S.B. 7 amends the Health and Safety Code to include among the establishments included in the definition of "assisted living facility" an establishment that may provide skilled nursing services for the following limited purposes: coordination of resident care with outside home and community support services agencies and other health care professionals; provision or delegation of personal care services and medication administration; assessment of residents to determine the care required; and delivery of temporary skilled nursing treatment for a minor illness, injury, or emergency for periods as established by DADS rule.

C.S.S.B. 7 amends Section 247.004, Health and Safety Code, as effective September 1, 2011, to exempt from the Assisted Living Facility Licensing Act a facility that provides personal care services only to persons enrolled in a program that is funded in whole or in part by the Department of State Health Services (DSHS) and that is monitored by DSHS or by its designated local mental health authority in accordance with standards set by DADS.

C.S.S.B. 7 amends the Health and Safety Code to authorize the employment of a health care professional by an assisted living facility to provide at the facility to the facility's residents services that are authorized by the Assisted Living Facility Licensing Act and that are within the professional's scope of practice, unless otherwise prohibited by law, and removes language authorizing 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

C.S.S.B. 7 amends the Government Code to add temporary provisions requiring HHSC to conduct a study to evaluate physician incentive programs that attempt to reduce hospital emergency room use for non-emergent conditions by Medicaid recipients. The bill requires each physician incentive program evaluated in the study to be administered by a health maintenance organization participating in the STAR or STAR + PLUS Medicaid managed care program and to provide incentives to primary care providers who attempt to reduce emergency room use for non-emergent conditions by recipients. The bill requires the study to 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. The bill requires the executive commissioner, not later than August 31, 2013, to submit to the governor and the Legislative Budget Board a report summarizing the findings of the study and sets these provisions to expire September 1, 2014. The bill repeals a provision added by H.B. 2245, Acts of the 82nd Legislature, Regular Session, 2011, if that Act becomes law, requiring HHSC to conduct a study of physician incentive programs and to submit a report summarizing the findings of the study.

C.S.S.B. 7 requires the executive commissioner, if cost-effective, to establish by rule a physician incentive program designed to reduce the use of hospital emergency room services for non-

emergent conditions by Medicaid recipients and authorizes the executive commissioner, in establishing the program, to include only the program components identified as cost-effective in the HHSC's study evaluating physician incentive programs. The bill 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. The bill repeals a provision added by H.B. 2245, Acts of the 82nd Legislature, Regular Session, 2011, if that Act becomes law, establishing requirements for the executive commissioner regarding the establishment of a physician incentive program.

C.S.S.B. 7 amends the Human Resources Code to require the executive commissioner, to the extent permitted under and in a manner consistent with certain specified provisions of the federal Social Security Act and any other applicable law or regulation or under a federal waiver or other authorization and after consulting with the Medicaid and CHIP Quality-Based Payment Advisory Committee established under the bill's provisions, to adopt cost-sharing provisions that encourage personal accountability and appropriate utilization of health care services, including a cost-sharing provision applicable to a Medicaid recipient who chooses to receive a nonemergency medical service through a hospital emergency room. The bill removes language requiring the executive commissioner under certain conditions to adopt cost-sharing provisions that require a Medicaid 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 under certain conditions and makes a related conforming change.

Section 1.10

C.S.S.B. 7 amends the Government Code to authorize HHSC, if cost-effective, to contract to expand all or part of the acute care Medicaid billing coordination system to process claims for services provided through other benefits programs administered by HHSC or a health and human services agency; to 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 to expand the scope of persons about whom information is collected by health insurers to include recipients of services provided through other benefits programs administered by HHSC or a health and human services agency. The bill requires each health and human services agency to provide HHSC with any information necessary to allow HHSC or HHSC's designee to perform the billing coordination and information collection activities so authorized.

Section 1.11

C.S.S.B. 7 amends the Government Code to authorize the executive commissioner to include in the federal waiver to the state Medicaid plan, in order to defray costs associated with providing uncompensated health care, federal money provided under the disproportionate share hospitals program or upper payment limit supplemental payment program or both. The bill removes language authorizing the executive commissioner to include in the federal waiver all money provided under the disproportionate share hospitals program and upper payment limit supplemental payment programs and makes a conforming change. The bill expands the federal money authorized to be included in the waiver to include certain gifts, grants, or donations; local funds received by Texas through intergovernmental transfers; and, if approved in the waiver, federal money obtained through the use of certified public expenditures.

C.S.S.B. 7 requires HHSC to seek to optimize federal funding by identifying health care related state and local funds and program expenditures that, before September 1, 2011, rather than

before September 1, 2007, are not being matched with federal money. The bill requires the terms of the federal waiver to 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 the money appropriated under both programs, is at least equal to the greater of the annualized amount provide to the state under those programs during state fiscal year 2011, rather than during state fiscal year 2007. The bill requires the terms of the federal waiver to allow for the development by the 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. The bill removes language requiring the terms to allow for the development by the state of a methodology for allocating money in the fund to offset, in part, the uncompensated health care costs incurred by hospitals.

C.S.S.B. 7 requires the comptroller of public accounts to deposit in the Texas health opportunity pool trust fund federal money provided to Texas under the disproportionate share hospitals program or the hospital upper payment limit supplemental payment program or both, other than money provided under those programs to state-owned and operated hospitals and removes language requiring the comptroller to deposit all money provided under both programs. The bill authorizes HHSC and the comptroller to receive intergovernmental transfers for purposes consistent with state law governing the fund and with the terms of the federal waiver to the state Medicaid plan. The bill requires any governmental transfer received, including associated federal matching funds, to be used, if feasible, for the purposes intended by the transferring entity and in accordance with the terms of the waiver. The bill prohibits 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.

C.S.S.B. 7 repeals a provision requiring the executive commissioner to seek the advice of the Legislative Budget Board before finalizing the terms and conditions of the waiver.

Section 1.12

C.S.S.B. 7 amends the Government Code to establish the Medicaid and CHIP Quality-Based Payment Advisory Committee 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, the following: 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; standards and benchmarks for quality performance, quality of care outcomes, efficiency, and accountability by managed care organizations and physicians and other health care providers; 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 outcome and process measures under the bill's provisions.

C.S.S.B. 7 requires the executive commissioner to appoint the members and the presiding officer of the advisory committee and 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.

C.S.S.B. 7 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. The bill requires HHSC, in developing outcome measures, to consider measures addressing potentially preventable events.

C.S.S.B. 7 requires HHSC, to the extent feasible, to develop outcome and process measures consistently across all child health plan and Medicaid program delivery models and payment systems; 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; that will have the greatest effect on improving quality of care and the efficient use of services; and that are similar to outcome and process measures used in the private sector, as appropriate.

C.S.S.B. 7 requires HHSC, to the extent feasible, to align such outcome and process measures 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.

C.S.S.B. 7 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 the outcome and process measures.

C.S.S.B. 7 requires HHSC, to the extent permitted under federal law and to the extent otherwise possible considering other relevant factors, to correlate physician and other health care provider reimbursement rates increased under the child health plan or Medicaid program, if HHSC increases such rates 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 with the quality-based outcome and process measures.

C.S.S.B. 7 requires HHSC, after consulting with the advisory committee and using the quality-based outcome and process measures, 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 align payment incentives with high-quality, cost-effective health care; reward the use of evidence-based best practices; promote the coordination of health care; encourage appropriate physician and other health care provider collaboration; promote effective health care delivery models; and take into account the specific needs of the child health plan program enrollee and Medicaid recipient populations.

C.S.S.B. 7 requires HHSC to develop quality-based payment systems in the manner specified by provisions of the bill. The bill 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.S.S.B. 7 requires HHSC, in developing quality-based payment systems, to examine and consider implementing an alternative payment system; any existing performance-based payment system used under the Medicare program that meets certain statutory requirements, 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 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.

C.S.S.B. 7 requires HHSC, in developing such quality-based payment systems, 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.

C.S.S.B. 7 authorizes HHSC to modify such a quality-based payment system to account for programmatic differences between the child health plan and Medicaid programs and delivery systems under those programs.

C.S.S.B. 7 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 but specifies that such requirement 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 DRG methodology. The bill requires HHSC to convert the hospital reimbursement systems as soon as practicable after the bill's effective date but not later than September 1, 2013, for reimbursements paid to children's hospitals and not later than September 1, 2012, for reimbursements paid to other hospitals under those programs.

C.S.S.B. 7 requires HHSC and the advisory committee to ensure transparency in the development and establishment of quality-based payment and reimbursement systems and quality-based payment initiatives under certain of the bill's provisions; 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; and, in developing and establishing the quality-based payment and reimbursement systems and initiatives, 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.

C.S.S.B. 7 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 the bill's provisions. The bill requires HHSC to present the results of its evaluation 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 those recommendations. The bill requires HHSC to submit an annual report to the legislature regarding the quality-based outcome and process measures developed and the progress of the implementation of quality-based payment systems and other payment initiatives implemented under the bill's provisions. The bill requires HHSC to report outcome and process measures by health care service region and service delivery model.

C.S.S.B. 7 requires HHSC, subject to 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 the outcome and process measures developed under

the bill's provisions, including outcome measures addressing potentially preventable events. The bill requires HHSC to make available information relating to the performance of a managed care organization with respect to outcome and process measures to child health plan program enrollees and Medicaid recipients before those enrollees and recipients choose their managed care plans.

C.S.S.B. 7 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. The bill 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. The bill 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 the quality initiatives or success in achieving the quality of care and cost-efficiency benchmarks. The bill requires HHSC, in awarding contracts to managed care organizations under the child health plan and Medicaid programs, and in addition to considerations under certain provisions of law, to give preference to an organization that offers a managed care plan that successfully implements the quality initiatives as determined by HHSC based on data or other evidence provided by the organization or meets the quality of care and cost-efficiency benchmarks. The bill authorizes HHSC to implement financial incentives only if implementing the incentives would be cost-effective.

C.S.S.B. 7 authorizes HHSC, 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. The bill requires such a quality-based payment system to 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 to 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. The bill authorizes HHSC to develop a quality-based payment system for health homes only if implementing the system would be feasible and cost-effective. The bill requires a health home provider, as a condition for eligibility for reimbursement under a quality-based payment system, 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 access requirement.

C.S.S.B. 7 transfers Section 531.913, Government Code, to Subchapter D, Chapter 536, Government Code, redesignates that provision as Section 536.151, Government Code, and amends that provision to require the executive commissioner to adopt rules for identifying potentially preventable readmissions of child health plan program enrollees, in addition to Medicaid recipients, and rules for identifying potentially preventable complications experienced by child health plan program enrollees and Medicaid recipients. The bill requires HHSC to collect data from hospitals, rather than to exchange data with hospitals, on present-on-admission indicators.

C.S.S.B. 7 requires HHSC to establish a program to provide a confidential report to each hospital

in Texas 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, rather than to establish a health information exchange program to exchange confidential information with each hospital in the state regarding the hospital's performance with respect to potentially preventable readmissions. The bill specifies that, to the extent possible, such a report should include potentially preventable readmissions and potentially preventable complications information across all child health plan and Medicaid program payment systems. The bill makes a conforming change relating to the distribution of information contained in the report and specifies that the requirement that a hospital distribute the information to health care providers providing services at the hospital applies to physicians providing services at the hospital. The bill makes such a report confidential and not subject to state public information law. The bill moves a provision defining "potentially preventable readmission" to a different portion of the code. The bill 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.

C.S.S.B. 7 amends the Government Code to require HHSC, using the present-on-admission indicators data collected and the DRG methodology implemented under the bill's provisions and after consulting with the advisory committee, to the extent feasible, to 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 the bill's provisions that address the rates of potentially preventable readmissions and potentially preventable complications. The bill requires HHSC to provide the report required regarding a hospital's performance with respect to potentially preventable readmissions and potentially preventable complications to a hospital at least one year before HHSC adjusts child health plan and Medicaid reimbursements to the hospital. The bill requires HHSC to begin making such adjustments, subject to the bill's provisions relating to the development of quality-based payment systems, 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.

C.S.S.B. 7 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. The bill requires HHSC to establish a process by which managed care organizations and physicians and other health care providers may submit proposals for such payment initiatives and determine whether it is feasible and cost-effective to implement one or more of the proposed payment initiatives.

C.S.S.B. 7 requires HHSC to establish one or more payment initiatives on a determination that implementation is feasible and cost-effective for the state. The bill requires HHSC to administer any payment initiative established under certain statutory provisions relating to quality-based payment initiatives and 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 its provisions relating to quality-based payment initiatives. The bill 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. The bill requires a payment initiative implemented under the bill's provisions to be operated for at least one calendar year.

C.S.S.B. 7 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 is required to meet to ensure high-quality and cost-effective health care services and healthy outcomes and to approve those developed benchmarks and goals. The bill authorizes the executive commissioner, in addition to approving the benchmarks and goals, 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. The bill 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.

C.S.S.B. 7 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 the bill's provisions.

C.S.S.B. 7 defines "advisory committee," "alternative payment system," "blended payment system," "episode-based bundled payment system," "exclusive provider benefit plan," "freestanding emergency medical care facility," "global payment system," "health care provider," "health home," "hospital," "managed care organization," "managed care plan," "Medicaid program," "participating enrollee," "payment initiative," "physician," "potentially preventable admission," "potentially preventable ancillary service," "potentially preventable complication," "potentially preventable event," "potentially preventable emergency room visit," and "quality-based payment system." The bill provides for the meanings of "child health plan program," "commission," "executive commissioner," and "health and human services agencies" by reference and moves the definition of "potentially preventable readmission" to a different portion of the code.

Section 1.13

C.S.S.B. 7 amends the Government Code to authorize the executive commissioner of HHSC, if feasible, to establish by rule an incentive payment program for nursing facilities that choose to participate, rather than requiring the executive commissioner to establish by rule a quality of care health information exchange with such nursing facilities. The bill requires the executive commissioner, in establishing the incentive program, 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. The bill removes a requirement that the executive commissioner, in establishing the quality of care health information exchange program, exchange information with participating nursing facilities regarding performance measures and makes a conforming change. The bill authorizes the common performance measures to include, among other measures, measures of 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, and measure of direct-care training, including a facility's utilization of independent distance learning programs for the continuous training of direct care staff. The bill includes in the measures of recipient satisfaction 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. The bill removes from the list of measures authorized for inclusion among the common performance measures measures of quality of life and level of occupancy or of

facility utilization. The bill removes the condition that money be specifically appropriated for incentive payment in order for HHSC to be authorized to make an incentive payment under the incentive payment program.

C.S.S.B. 7 requires DADS to conduct a study to evaluate the feasibility of expanding any incentive payment program established for nursing facilities for purposes of the incentive payment program, as amended by the bill's provisions, by providing incentive payments for licensed intermediate care facilities for persons with mental retardation and licensed or otherwise authorized providers of certain home and community-based services that provide long-term care services under the medical assistance program. The bill requires DADS, not later than September 1, 2012, to submit to the legislature a written report containing the findings of the study and the department's recommendations.

Section 1.14

C.S.S.B. 7 amends the Health and Safety Code to authorize the commissioner of state health services, after consulting with the executive commissioner of HHSC, to transfer to an account in the general revenue fund money appropriated from the trauma facility and emergency medical services account to maximize the receipt of federal funds under the Medicaid program and to fund provider reimbursement payments. The bill authorizes money that was transferred to the account under such conditions to be appropriated only to HHSC to fund provider reimbursement payments under the Medicaid program, including reimbursement enhancements to the statewide dollar amount (SDA) rate used to reimburse designated trauma hospitals under the program.

Section 1.15

C.S.S.B. 7 amends the Government Code to require a managed care organization, including a health maintenance organization, or a pharmacy benefit manager, that administers claims for prescription drug benefits under 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, to, at least 10 days before the date the organization or pharmacy benefit manager intends to deliver a communication to recipients collectively under a program, 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

C.S.S.B. 7 amends the Health and Safety Code to authorize a public hospital or hospital district that provides health care services to a sponsored alien under the Indigent Health Care and Treatment Act 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. The bill requires such a public hospital or hospital district 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. The bill defines "sponsored alien" for purposes of these provisions.

Section 1.17

C.S.S.B. 7 amends the Government Code to require HHSC, if, at the time of application for benefits under the child health plan program, the TANF program, Medicaid, or the nutritional assistance program, a person states that the person is a qualified alien, as that term is defined by federal law, to verify, to the extent allowed by federal law, information regarding the immigration status of the person using an automated system or systems where available. The bill requires the executive commissioner to adopt rules necessary to implement its provisions relating to qualified aliens.

C.S.S.B. 7 authorizes HHSC, if, at the time of application for benefits, a person stated that the person is a sponsored alien, to, verify, to the extent allowed by federal law, 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, the TANF program, Medicaid, or the nutritional assistance program. The bill authorizes HHSC, if HHSC verifies that a person who receives benefits under an applicable program 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. The bill requires HHSC, if, at the time a person applies for benefits under an applicable program, 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. The bill requires the executive commissioner to adopt rules necessary to implement its provisions relating to sponsored aliens, including rules that specify the most cost-effective procedures by which HHSC may seek reimbursement. The bill defines "sponsored alien" for purposes of these provisions.

C.S.S.B. 7 specifies that its provisions relating to qualified and sponsored aliens do not add to or change the eligibility requirements for any applicable benefits program.

Section 1.18
C.S.S.B. 7 amends the Human Resources Code to require the executive commissioner of HHSC to adopt rules requiring the electronic submission of any claim for reimbursement for durable medical equipment and supplies under the Medicaid program.

Section 1.19
C.S.S.B. 7 amends the Government Code to require money appropriated to DSHS for the purpose of providing family planning services to be awarded to the following eligible entities, in order of descending priority: public entities that provide family planning services, including state, county, and local community health clinics; 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 to be awarded as otherwise directed by the legislature in the General Appropriations Act. The bill requires DSHS, 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.

C.S.S.B. 7 amends the Human Resources Code to require HHSC to ensure that money spent for purposes of the demonstration project for women's health care services under Medicaid 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
C.S.S.B. 7 requires a state agency that is affected by a provision of this article to request a federal waiver or authorization if the agency determines that a waiver or authorization is necessary for the implementation of the provision, and it authorizes the agency to delay implementation until the federal waiver or authorization is obtained.

Article 2. Legislative Findings and Intent; Compliance with Antitrust Laws

Section 2.01
C.S.S.B. 7 states legislative findings and intent relating to compliance with antitrust laws, certified health care collaboratives, alternative payment mechanisms, and the improvement of the quality and efficiency of health care in Texas.

Article 3. Texas Institute of Health Care Quality and Efficiency

Section 3.01

C.S.S.B. 7 amends the Health and Safety Code to establish the Texas Institute of Health Care Quality and Efficiency to improve health care quality, accountability, education, and cost containment in Texas by encouraging health care provider collaboration, effective health care delivery models, and coordination of health care services. The bill makes the institute subject to the Texas Sunset Act and provides that the institute is abolished and the bill's provisions relating to the institute expire September 1, 2017, unless continued in existence as provided by that act.

C.S.S.B. 7 sets out provisions relating to the composition of the board of directors of the institute, which includes 15 voting members appointed by the governor and a number of nonvoting ex officio members as specified. The bill sets out provisions relating to the terms of office of the appointed board members. The bill specifies that the institute is administratively attached to the Health and Human Services Commission (HHSC) and requires HHSC to coordinate administrative responsibilities with the institute to streamline and integrate the institute's administrative operations and avoid unnecessary duplication of effort and costs. The bill authorizes the institute 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 the institute.

C.S.S.B. 7 sets out provisions relating to the compensation and reimbursement of board members, subjects information relating to the billing and payment of member expenses to public information laws, and provides for the designation of a presiding officer of the board. The bill sets out requirements for a board member or member of a committee formed by the board relating to conflicts of interest, including provisions relating to a conflict of interest statement and statement of ownership interests required to be filed with the board that is subject to public information laws, and prohibits the board from compensating, employing, or contracting with certain individuals. The bill sets out provisions relating to the board meeting schedule and board member immunity from civil liability for certain acts or omissions.

C.S.S.B. 7 establishes that protected health information and individually identifiable health information collected, assembled, or maintained by the institute is confidential and not subject to disclosure under state public information law. The bill requires the institute to comply with all state and federal laws and rules relating to the protection, confidentiality, and transmission of health information, including the federal Health Insurance Portability and Accountability Act of 1996 and rules adopted under that act and certain other federal law. The bill prohibits such confidential information from being disclosed by the commission, department, or institute or an officer or employee of the commission, department, or institute, including a board member; establishes that confidential information, documents, and records are not subject to subpoena or discovery and are prohibited from being introduced into evidence in any civil or criminal proceeding; and prohibits an officer or employee of HHSC, the Department of State Health Services (DSHS), or the institute, including a board member, from being examined in a civil, criminal, special, administrative, or other proceeding as to such confidential information.

C.S.S.B. 7 authorizes funding of the institute through the General Appropriations Act and authorizes the institute to request, accept, and use gifts, grants, and donations as necessary to implement its functions. The bill authorizes the institute to participate in other revenue-generating activity that is consistent with the institute's purposes. The bill requires each state agency represented on the board as a nonvoting member, except as otherwise provided by law, to provide funds to support the institute and to implement related bill provisions. The bill requires HHSC to establish a funding formula to determine the level of support each state agency is required to provide. The bill specifies that its provisions relating to the funding of the institute do not permit the sale of confidential health information collected, assembled, or maintained by the institute.

C.S.S.B. 7 requires the institute to make certain recommendations to the legislature relating to improving quality and efficiency of health care delivery; improving reporting, consolidation, and transparency of health care information; and implementing and supporting innovative health care collaborative payment and delivery systems.

C.S.S.B. 7 requires the institute to study and develop recommendations to improve the quality and efficiency of health care delivery in Texas, including quality-based payment systems that align payment incentives with high-quality, cost-effective health care; alternative health care delivery systems that promote health care coordination and provider collaboration; quality of care and efficiency outcome measurements that are effective measures of prevention, wellness, coordination, provider collaboration, and cost-effective health care; and meaningful use of electronic health records by providers and electronic exchange of health information among providers. The bill requires the institute to study and develop recommendations for measuring quality of care and efficiency across all state employee and state retiree benefit plans, employee and retiree benefit plans provided through the Teacher Retirement System of Texas, the state Medicaid program, and the child health plan. The bill requires the institute, in developing such recommendations, to use nationally accredited measures or, if no nationally accredited measures exist, measures based on expert consensus. The bill authorizes the institute to study and develop recommendations for measuring the quality of care and efficiency in state or federally funded health care delivery systems other than the state employee and state retiree benefit plans, employee and retiree benefit plans provided through the Teacher Retirement System of Texas, the state Medicaid program, and the child health plan. The bill prohibits the institute from basing its recommendations relating to the quality and efficiency of health care solely on actuarial data and requires the institute to use the studies described by these provisions to develop recommendations for a statewide plan for quality and efficiency of the delivery of health care.

C.S.S.B. 7 requires the institute to study and make recommendations for alternative health care payment and delivery systems and to recommend methods to evaluate a health care collaborative's effectiveness, including methods to evaluate the efficiency and effectiveness of cost-containment methods used by the collaborative, alternative health care payment and delivery systems used by the collaborative, the quality of care, health care provider collaboration and coordination, the protection of patients, patient satisfaction, and the meaningful use of electronic health records by providers and electronic exchange of health information among providers.

C.S.S.B. 7 requires the institute, 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. The bill requires the institute to develop a plan 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; for improving health care transparency to the public and health care providers by making information available in the most effective format; and 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.

C.S.S.B. 7 requires the institute to study the feasibility and desirability of establishing a centralized database for health care claims information across all payors and establishes criteria for the study. The bill requires the institute to consult with DSHS and the Texas Department of Insurance to develop recommendations to submit to the legislature on the establishment of such a centralized claims database.

C.S.S.B. 7 defines "board," "commission," "department," "executive commissioner," "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" for purposes of the bill's provisions relating to the Texas Institute of Health Care Quality and Efficiency. The bill provides for the meaning of "health care collaborative" for such purposes by reference to the Insurance Code.

Section 3.02
C.S.S.B. 7 repeals provisions of law relating to the Texas Health Care Policy Council.

Section 3.03
C.S.S.B. 7, on the bill's effective date, abolishes the Texas Health Care Policy Council and establishes that any unexpended and unobligated balance of money appropriated by the legislature to the council as it existed immediately before the bill's effective date is transferred to the Texas Institute of Health Care Quality and Efficiency.

Section 3.04
C.S.S.B. 7 requires the governor to appoint the voting members of the board of directors of the Texas Institute of Health Care Quality and Efficiency to specified staggered terms as soon as practicable after the bill's effective date.

Section 3.05
C.S.S.B. 7 requires the Texas Institute of Health Care Quality and Efficiency, not later than December 1, 2012, to submit a report regarding recommendations for improved health care reporting and 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. The bill specifies the information required to be outlined in each report.

Section 3.06
C.S.S.B. 7 adds a temporary provision, set to expire September 1, 2013, requiring the institute, with the assistance of and in coordination with the Texas Department of Insurance, to conduct a study 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; 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 certain specified subjects relating to the amounts accepted as payment in full for health care services or supplies. The bill requires the institute to submit a report to the legislature outlining the results of that study and any recommendations for potential legislation not later than January 1, 2013.

Article 4. Health Care Collaboratives

Section 4.01
C.S.S.B. 7 amends the Insurance Code to set out provisions relating to health care collaboratives and makes an entity, other than a health maintenance organization, that, 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 that accepts responsibility for performing required functions under specified provisions of the Insurance Code subject to certain provisions of law relating to delegation by a health maintenance organization and establishes that such an entity is not required to obtain a certificate of authority or determination of approval under the applicable bill provisions.

C.S.S.B. 7 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 that are descriptive of the insurance, casualty, surety, or health maintenance organization business or that

are deceptively similar to the name or description of an insurer, surety corporation, or health maintenance organization engaging in business in Texas. The bill 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, unless the organization as an insurer or health maintenance organization holds the appropriate certificate of authority issued under other Insurance Code provisions. The bill makes certain Insurance Code provisions applicable 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, except that the remedies available under the bill's provisions in the manner provided by provisions of law relating to unfair methods of competition and unfair or deceptive acts or practices do not include a private cause of action or a class action under such provisions of law.

C.S.S.B. 7 establishes that an application, filing, or report required under the bill's provisions relating to health care collaboratives is public information subject to disclosure under state public information law. The bill makes certain specified information relating to a health care collaborative confidential and provides that such confidential information is not subject to disclosure under state public information law.

C.S.S.B. 7 prohibits an individual, subject to the Texas Health Maintenance Organization Act and certain bill provisions, from being required to obtain or maintain coverage under an individual health insurance policy written through a health care collaborative or under any plan or program for health care services provided on an individual basis through a health care collaborative and prohibits a fine or penalty from being imposed on an individual if the individual chooses not to obtain such coverage. The bill makes the prohibition against requiring an individual to obtain or maintain such coverage inapplicable to an individual who is required to obtain or maintain health benefit plan coverage written by an institution of higher education at which the individual is or will be enrolled as a student or under an order requiring medical support for a child or an individual who voluntarily applies for benefits under certain state administered programs under the federal Social Security Act and makes the prohibition against the imposition of a fine or penalty inapplicable to a fine or penalty imposed on such an individual for the individual's failure to obtain or maintain health benefit plan coverage. The bill specifies that its provisions relating to health care collaboratives do not require an individual to obtain or maintain health insurance coverage.

C.S.S.B. 7 authorizes a health care collaborative that is certified by DSHS under the bill's provisions to provide or arrange to provide health care services under contract with a governmental or private entity. The bill sets out provisions relating to the formation and governance of a health care collaborative. The bill 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 and sets out requirements regarding the composition of the committee. The bill 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.S.S.B. 7 prohibits an organization from organizing or operating a health care collaborative in Texas unless the organization holds a certificate of authority issued under applicable bill provisions and requires the commissioner of insurance to adopt rules governing the application for a certificate of authority for a health care collaborative. The bill exempts an organization from certification requirements if the organization holds an appropriate certificate of authority issued under another provision of the Insurance Code and exempts a person from such requirements to the extent that the person is a physician engaged in the delivery of medical care or 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. The bill exempts a medical school, medical and dental unit, or health science center from such certification requirements 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 and makes the bill's provisions relating to health care collaboratives otherwise applicable to a medical school, medical and dental unit, or health science center. The bill exempts an entity licensed under the Health and Safety Code that employs a physician under a specific statutory authority from such certification requirements to the extent that the entity contracts to deliver medical care services and health care services within a health care collaborative and makes the bill's provisions relating to health care collaboratives otherwise applicable to the entity.

C.S.S.B. 7 authorizes an organization to apply to the commissioner of insurance for and obtain a certificate of authority to organize and operate a health care collaborative, establishes the requirements of such an application, and requires the commissioner to approve or deny the application not later than the 190th day after the date an applicant submits an application. The bill authorizes the commissioner, by rule, to extend the date by which such an application is due and to require the disclosure of any additional information necessary to implement and administer the bill's provisions relating to health care collaborative, including information necessary to antitrust review and oversight. The bill requires the commissioner to issue a certificate of authority on payment of the application fee if the commissioner is satisfied that the applicant and the proposed health care collaborative meet certain specified criteria. The bill provides that such a certificate of authority is effective for a period of one year, subject to bill provisions relating to the expiration date of a renewal application on which the commissioner does not timely act. The bill 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 prescribed requirements and, if the commissioner denies an application, requires the commissioner to notify such an applicant that the plan is deficient and to specify the deficiencies.

C.S.S.B. 7, except as otherwise provided, requires the commissioner to forward an application for a certificate of authority to the attorney general if the commissioner determines that an application complies with the prescribed requirements and to include with the application all data, documents, and analysis considered by the commissioner in making the determination. The bill sets out procedures by which the attorney general is required to review the forwarded application, data, documents, and analysis to determine whether the attorney general concurs with the commissioner's determination and requires the commissioner to deny an application if the attorney general notifies the commissioner that the attorney general does not concur with the commissioner's determination. The bill 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.

C.S.S.B. 7 requires a health care collaborative, not later than the 180th day before the one-year anniversary of the date on which the collaborative's certificate of authority was issued or most recently renewed, to file with the commissioner an application to renew the certificate. The bill establishes requirements for an application for renewal and procedures for the renewal or denial of renewal of a certificate of authority by the commissioner and the attorney general, as applicable, and provides that, if the commissioner does not act on a renewal application before the one-year anniversary, a certificate of authority expires on the 90th day after the date of the one-year anniversary unless the renewal or determination of approval is approved before that date. The bill requires a health care collaborative to report to DSHS a material change in the size or composition of the collaborative and authorizes DSHS, on receipt of such a report, to require the collaborative to file an application for renewal before the deadline set by the bill's provisions.

C.S.S.B. 7 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. The bill 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. The bill 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.

C.S.S.B. 7 requires, with exception, a health care collaborative, on written consent of a patient who was treated by a physician participating in the collaborative, to provide the physician with the medical records of the patient, regardless of whether the physician is participating in the collaborative at the time the request for the records is made. The bill requires such records to be made available to the physician in the format in which the records are maintained by the health care collaborative and authorizes the health care collaborative to charge the physician a fee for copies of the records, as established by the Texas Medical Board. The bill prohibits the health care collaborative from charging a fee to a physician if the physician requests a patient's records for the purpose of providing emergency treatment to the patient and requires the health care collaborative to provide the records to such a physician regardless of whether the patient has provided written consent.

C.S.S.B. 7 authorizes a health care collaborative to contract with an insurer authorized to engage in business in Texas to provide insurance, reinsurance, indemnification, or reimbursement against the cost of health care and medical care services provided by the health care collaborative and specifies that such authorization does not affect the requirement that the health care collaborative maintain sufficient working capital and reserves. The bill authorizes a health care collaborative to 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 to distribute payments to participating physicians and health care providers. The bill authorizes a health care collaborative that is in compliance with the Insurance Code, including specified provisions as applicable, to contract for, accept, and distribute payments from governmental or private payors based on fee-for-service or alternative payment mechanisms, including episode-based or condition-based bundled payments, capitation or global payments, or pay-for-performance or quality-based payments. The bill prohibits a health care collaborative from contracting for and accepting from a governmental or private entity payments on a prospective basis, including bundled or global payments, unless the health care collaborative is licensed under the Texas Health Maintenance Organization Act, except that a health care collaborative is authorized to contract for and accept from an insurance company or a health maintenance organization payments on a prospective basis, including bundled or global payments. The bill 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.

C.S.S.B. 7 grants a health care collaborative 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 applicable bill provisions or other applicable law. The bill 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 and requires the policies to include certain specified standards and procedures. The bill requires the governing body of a health care collaborative to establish a procedure for the periodic review of quality improvement and cost control measures.

C.S.S.B. 7 requires a health care collaborative to implement and maintain complaint systems that provide reasonable procedures to resolve an oral or written complaint initiated by a patient who received health care services provided by a participating physician or health care provider or initiated by a participating physician or health care provider. The bill requires the complaint system for complaints initiated by patients to include a process for the notice and appeal of a complaint. The bill 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.

C.S.S.B. 7 authorizes a health care collaborative to enter into certain delegation agreements with a licensed life, health, or accident insurance company, group hospital service corporation, or health maintenance organization under certain conditions. The bill requires a health care collaborative that enters into such a delegation agreement to maintain reserves and capital in addition to the amounts required by provisions of law relating to the delegation of certain functions by health maintenance organizations 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. The bill establishes that a health care collaborative that enters into a delegation agreement is subject to provisions of law regulating solvency relating to financial condition, supervision and conservatorship, and the Insurer Receivership Act and is considered to be an insurer for those purposes.

C.S.S.B. 7 establishes that the operations and trade practices of a health care collaborative that are consistent with the bill's provisions relating to health care collaboratives, rules adopted under those provisions, and applicable federal antitrust laws are presumed to be consistent with the Texas Free Enterprise and Antitrust Act of 1983 or any other applicable provision of law. The bill sets out procedures by which a physician is entitled to an opportunity to dispute a complaint received by a health care collaborative regarding the physician or to dispute the termination of the physician's association with a health care collaboration before the complaint is resolved or before the physician's association is terminated. The bill 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 and requires each applicant physician or group to be provided with a copy of the development plan.

C.S.S.B. 7 authorizes the commissioner and the attorney general to adopt reasonable rules as necessary and proper to implement the requirements established by the bill's provisions relating to health care collaboratives. The bill requires a health care collaborative to pay to DSHS an application fee in an amount determined by commissioner rule and an annual assessment in an amount determined by commissioner rule. The bill requires the commissioner to set such fees and assessments in an amount sufficient to pay the reasonable expenses of DSHS and the attorney general in administering the bill's provisions relating to health care collaboratives, including the direct and indirect expenses incurred by DSHS and the attorney general in examining and reviewing health care collaboratives. The bill requires such fees and assessments to be deposited to the credit of the Texas Department of Insurance operating account and to be allocated among health care collaboratives on a pro rata basis to the extent that the allocation is feasible.

C.S.S.B. 7 authorizes the commissioner to examine the financial affairs and operations of any health care collaborative or applicant for a certificate of authority for a health care collaborative and sets out provisions requiring a health care collaborative to make certain financial books and records available for an examination and to provide certain documents relating to the health care collaborative to the commissioner or attorney general for purposes of such an examination. The bill specifies that documentation provided to the commissioner or attorney general for such examination purposes is confidential and not subject to disclosure under state public information law. The bill authorizes the commissioner or attorney general to disclose the results of such an examination or documentation provided for such examination purposes to a governmental agency that contracts with a health care collaborative for the purpose of determining financial stability, readiness, or other contractual compliance needs.

C.S.S.B. 7 authorizes the commissioner, after notice and opportunity for a hearing, to suspend or revoke a certificate of authority issued to the health care collaborative, impose sanctions, issue a cease and desist order, or impose administrative penalties and establishes the conditions under which the commissioner is authorized to take such enforcement action against a health care collaborative. The bill prohibits a health care collaborative whose certificate of authority is

suspended from entering into a new contract with a governmental or private entity or advertising or soliciting in any way during the period the certificate is suspended. The bill requires a health care collaborative, after its certificate of authority is revoked, to proceed, immediately following the effective date of the order of revocation, to conclude its affairs and prohibits the collaborative from conducting further business except as essential to the orderly conclusion of its affairs and from advertising or soliciting in any way. The bill authorizes the commissioner, 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.

C.S.S.B. 7 authorizes the attorney general, at the request of the commissioner and if the commissioner believes that a health care collaborative or another person is violating or has violated the bill's provisions relating to health care collaboratives or a rule adopted under those provisions, to bring an action in a Travis County district court to enjoin the violation and obtain other relief the court considers appropriate. The bill requires the commissioner to report any enforcement action taken against a health care collaborative under the bill's provisions to the relevant state licensing or certifying agency or board and the United States Department of Health and Human Services National Practitioner Data Bank and to post notice of the action on DSHS's Internet website.

C.S.S.B. 7 authorizes the attorney general to investigate a health care collaborative with respect to anticompetitive behavior that is contrary to the goals and requirements of the bill's provisions relating to health care collaboratives and request that the commissioner impose a penalty or sanction, issue a cease and desist order, or suspend or revoke the health care collaborative's certificate of authority. The bill specifies that such authorization does not limit any other authority or power of the attorney general.

C.S.S.B. 7 defines, for purposes of the bill's provisions relating to health care collaboratives, "affiliate," "health care collaborative," "health care services," "health care provider," "health maintenance organization," "hospital," "institute," and "physician" and provides for the meaning of "potentially preventable event" by reference to the Health and Safety Code.

Section 4.02
C.S.S.B. 7 amends the Civil Practice and Remedies Code to redefine "health care provider," for purposes of provisions relating to medical liability, to include a certified health care collaborative certified under applicable bill provisions.

Section 4.03
C.S.S.B. 7 amends the Insurance Code to authorize the designation of a health care collaborative as a preferred provider under a preferred provider benefit plan and to authorize a health care collaborative to offer enhanced benefits for care provided by the health care collaborative, subject to the requirements of provisions of law relating to preferred provider benefit plans. The bill 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 and specifies that a reimbursement methodology used in such a contract is not subject to the Texas Health Maintenance Organization Act. The bill requires such a contract to 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. The bill 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
C.S.S.B. 7 amends the Health and Safety Code to authorize a public hospital created under specified Health and Safety Code provisions or a hospital district created under general or special law to form and sponsor a nonprofit health care collaborative that is certified under applicable bill provisions.

Section 4.05
C.S.S.B. 7 amends the Occupations Code to make provisions of law relating to the offense of soliciting patients inapplicable to a health care collaborative certified under applicable bill provisions.

Section 4.06
C.S.S.B. 7 amends the Occupations Code to redefine "health care entity," for purposes of the Medical Practice Act, to include a health care collaborative certified under applicable bill provisions.

Section 4.07
C.S.S.B. 7 requires the commissioner of insurance and the attorney general, not later than September 1, 2012, to adopt rules as necessary to implement this article.

Section 4.08
C.S.S.B. 7 requires the commissioner of insurance, as soon as practicable after the bill's effective date, to designate or employ staff with antitrust expertise sufficient to carry out the duties required by the bill's provisions.

Article 5. Patient Identification

Section 5.01
C.S.S.B. 7 amends the Health and Safety Code to require DSHS to coordinate with hospitals to develop a statewide standardized patient risk identification system under which a patient with a specific medical risk may be readily identified through the use of a system that communicates to hospital personnel the existence of that risk. The bill requires the executive commissioner of HHSC to appoint an ad hoc committee of hospital representatives to assist DSHS in developing the statewide system.

C.S.S.B. 7 requires DSHS to require each hospital to implement and enforce the statewide standardized patient risk identification system unless DSHS authorizes and exempts from the system a hospital that seeks to adopt another patient risk identification methodology supported by evidence-based protocols for the practice of medicine. The bill requires DSHS to modify the statewide system in accordance with evidence-based medicine as necessary. The bill authorizes the executive commissioner of HHSC to adopt rules to implement this section and defines "department" and "hospital" for purposes of this section.

Article 6. Reporting of Health Care-Associated Infections

Section 6.01
C.S.S.B. 7 amends Section 98.001, Health and Safety Code, as added by Chapter 359 (S.B. 288), Acts of the 80th Legislature, Regular Session, 2007, for purposes of provisions relating to reporting of health care-associated infections and preventable adverse events, to define "health care professional" and to provide for the meanings of "potentially preventable complication" and "potentially preventable readmission" by reference.

Section 6.02
C.S.S.B. 7 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 make a conforming change.

Section 6.03
C.S.S.B. 7 amends Section 98.103, Health and Safety Code, as added by Chapter 359 (S.B. 288), Acts of the 80th Legislature, Regular Session, 2007, to specify that a pediatric and adolescent hospital is required to report to DSHS the incidence of surgical site infections occurring in ventricular, rather than ventriculoperitoneal, shunt procedures. The bill authorizes the executive commissioner of HHSC, 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. The bill requires a health care facility to file a report required in accordance with such a designation in accordance with the National Healthcare Safety Network's definitions, methods, requirements, and procedures. The bill requires a health care facility to authorize DSHS to have access to facility-specific data contained in a report filed with the network in accordance with such a designation.

Section 6.04
C.S.S.B. 7 amends Section 98.1045, Health and Safety Code, as added by Chapter 359 (S.B. 288), Acts of the 80th Legislature, Regular Session, 2007, to authorize the executive commissioner of HHSC, 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. The bill requires a health care facility to authorize DSHS to have access to facility-specific data contained in a report made in accordance with such a designation.

Section 6.05
C.S.S.B. 7 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, to require DSHS, in consultation with the Texas Institute of Health Care Quality and Efficiency, using data submitted under certain statutory provisions relating to the Texas Health Care Information Council, to publicly report for hospitals in Texas risk-adjusted outcome rates for those potentially preventable complications and potentially preventable readmissions that DSHS, in consultation with the institute, has determined to be the most effective measures of quality and efficiency. The bill requires DSHS to make such reports available to the public on the DSHS's Internet website and prohibits DSHS from disclosing the identity of a patient or health care professional in the reports. The bill requires DSHS, in consultation with the institute, to study which adverse health conditions commonly occur in long-term care facilities and, of those health conditions, which are potentially preventable. The bill requires DSHS to develop recommendations for reporting adverse health conditions identified in that study.

Section 6.06
C.S.S.B. 7 amends Section 98.105, Health and Safety Code, as added by Chapter 359 (S.B. 288), Acts of the 80th Legislature, Regular Session, 2007, to make a conforming change.

Section 6.07
C.S.S.B. 7 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, to require data made available to the public in the department's summary of reportable infections and preventable adverse events to include aggregate data covering a period of at least a full calendar quarter and to make conforming changes.

Section 6.08
C.S.S.B. 7 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, to require DSHS, in consultation with the Texas Institute of Health Care Quality and Efficiency, to conduct a study on developing a recognition program to recognize exemplary health care facilities for superior quality of health care and to make recommendations based on that study.

Section 6.09
C.S.S.B. 7 amends Section 98.108, Health and Safety Code, as added by Chapter 359 (S.B. 288),

Acts of the 80th Legislature, Regular Session, 2007, to make conforming changes and to authorize the executive commissioner of HHSC to adopt rules requiring health care facilities to report to DSHS the occurrence of reportable infections and preventable adverse events 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
C.S.S.B. 7 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 make a conforming change.

Section 6.11
C.S.S.B. 7 amends Section 98.110, Health and Safety Code, as added by Chapter 359 (S.B. 288), Acts of the 80th Legislature, Regular Session, 2007, to make a conforming change and to authorize DSHS to disclose information regarding reported health care-associated infections and preventable adverse events to the federal Centers for Disease Control and Prevention or any other agency of the United States Department of Health and Human Services, in addition to certain health and human services agencies, for related public health research or analysis purposes only. The bill authorizes an agency of the United States Department of Health and Human Services that is designated by the executive commissioner of HHSC 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
C.S.S.B. 7 repeals a certain provision of law relating to alternative surgical site infection reporting requirements for a health care facility that does not perform at least an average of 50 applicable procedures per month.

Section 6.13
C.S.S.B. 7 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 the initial assessment in the study on developing a recognition program to recognize exemplary health care facilities for superior quality of health care conducted under the bill's provisions, the feasibility and desirability of establishing such a recognition program based on that study, the recommendations developed by DSHS, and the changes in existing law that would be necessary to implement those recommendations.

Article 7. Information Maintained by Department of State Health Services

Section 7.01
C.S.S.B. 7 amends the Health and Safety Code to define "commission" and "executive commissioner" and to redefine "department" for purposes of provisions relating to the Texas Health Care Information Council.

Section 7.02
C.S.S.B. 7 amends the Health and Safety Code to account for the transfer of powers and duties from the Texas Health Care Information Council to DSHS in accordance with Chapter 198 (H.B. 2292), Acts of the 78th Legislature, Regular Session, 2003. The bill provides that a reference to the Texas Health Care Information Council means the Department of State Health Services.

Section 7.03
C.S.S.B. 7 amends the Health and Safety Code to require DSHS to accept health care data in the format developed by the American National Standards Institute or its successor, rather than the National Uniform Billing Committee (Uniform Hospital Billing Form UB 92) and HCFA-1500, and to make conforming changes.

Section 7.04
C.S.S.B. 7 amends the Health and Safety Code to authorize DSHS to disclose health care data collected by DSHS that is not included in public use data to any DSHS or HHSC program if the disclosure is reviewed and approved by the institutional review board established by the bill. The bill establishes that confidential data that is disclosed to a DSHS or HHSC program remains subject to applicable confidentiality provisions. The bill requires DSHS to identify the confidential data that is disclosed to a program and requires such a program to maintain the confidentiality of the disclosed confidential data. The bill specifies that provisions relating to the confidentiality of test results for AIDS and related disorders, collection and dissemination of provider quality data, public use data requested about a specific provider, the review and comment period required to be provided for a report issued by DSHS containing certain information relating to public use data, confidential hospital data, and confidential physician-patient communications do not apply to the disclosure of data to a DSHS or HHSC program. The bill specifies that nothing in this section authorizes the disclosure of physician identifying data. The bill makes conforming and nonsubstantive changes.

Section 7.05
C.S.S.B. 7 amends the Health and Safety Code to require DSHS to establish an institutional review board to review and approve requests for access to data not contained in public use data, rather than a scientific review panel to review and approve requests for information other than public use data. The bill requires the executive commissioner of HHSC, 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 on releasing data, rather than rules similar to the federal Health Care Financing Administration's guidelines on releasing data. The bill requires any approval to release such data to require that applicable confidentiality provisions be maintained and that any subsequent use of the information conform to such confidentiality provisions. The bill makes conforming and nonsubstantive changes.

Section 7.06
C.S.S.B. 7 repeals, effective September 1, 2014, certain specified provisions of law relating to the Texas Health Care Information Council if S.B. 156, Acts of the 82nd Legislature, Regular Session, 2011, does not become law. The bill repeals, effective September 1, 2014, certain specified provisions of law relating to the Texas Health Care Information Council if that bill becomes law.

Article 8. Adoption of Vaccine Preventable Diseases Policy by Health Care Facilities

Section 8.01
C.S.S.B. 7 amends the heading of a subtitle of the Health and Safety Code.

Section 8.02
C.S.S.B. 7 amends the Health and Safety Code to require each health care facility to develop and implement a policy to protect its patients from vaccine preventable diseases. The bill sets out policy requirements and 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. The bill authorizes a health care facility, during a public health disaster, to prohibit a covered individual who is exempt from the vaccines required in the vaccine preventable diseases policy developed by the facility from having contact with facility patients. The bill subjects a health care facility that violates the bill's provisions relating to the adoption of a vaccine preventable diseases policy 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 the Health and Safety Code that specifically governs the facility. The bill requires the appropriate rulemaking authority for each state agency that regulates a health care facility to adopt rules necessary to implement the bill's provisions relating to the adoption of a vaccine preventable diseases policy by a health care facility.

C.S.S.B. 7 defines "covered individual," "health care facility," "regulatory authority," and "vaccine preventable diseases" and provides for the meaning of "public health disaster" by reference.

Section 8.03
C.S.S.B. 7 requires the appropriate rulemaking authority for each state agency that regulates a health care facility, not later than June 1, 2012, to adopt rules necessary to implement the bill's provisions relating to the adoption of a vaccine preventable diseases policy by a health care facility.

Section 8.04
C.S.S.B. 7 establishes that a health care facility subject to the requirement to adopt a policy on vaccine preventable diseases is not required to have such a policy in effect until September 1, 2012.

Article 9. Texas Emergency and Trauma Care Education Partnership Program

Section 9.01
C.S.S.B. 7 amends the Education Code to establish the Texas emergency and trauma care education partnership program. The bill requires the Texas Higher Education Coordinating Board to administer the program in accordance with the bill's provisions relating to the program and the rules adopted under those provisions. The bill requires the coordinating board, to the extent funds are available, to make grants under the program 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. The bill authorizes the coordinating board to make a grant to an emergency and trauma care education partnership only if the board makes certain determinations specified by the bill.

C.S.S.B. 7 authorizes a program grant 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. The bill requires the coordinating board, in awarding a grant under the program, to give priority to an emergency and trauma care education partnership that submits a proposal containing specified information and characteristics. The bill authorizes the coordinating board, 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 the program.

C.S.S.B. 7 requires the coordinating board to adopt rules for the administration of the program. The bill requires the rules to include provisions relating to applying for a grant under the program 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 the program. The bill authorizes a reasonable amount, not to exceed three percent, of any money appropriated for purposes of the program to be used to pay the costs of administering the program.

C.S.S.B. 7 defines "emergency and trauma care education partnership" and "participating education program."

Section 9.02
C.S.S.B. 7 requires the Texas Higher Education Coordinating Board, as soon as practicable after

the effective date of this article, to adopt rules for the implementation and administration of the program. The bill authorizes the coordinating board 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
C.S.S.B. 7 amends the Insurance Code to prohibit a contract between an insurer that markets a plan regulated under certain provisions of law relating to preferred provider benefit plans and an institutional provider, as a condition of staff membership or privileges, from requiring a physician or other practitioner to enter into a preferred provider contract.

Repealers

C.S.S.B. 7 repeals the following provisions:

- Section 531.086, Government Code, as added by H.B. 2245, Acts of the 82nd Legislature, Regular Session, 2011, if that bill becomes law
- Section 531.0861, Government Code, as added by H.B. 2245, Acts of the 82nd Legislature, Regular Session, 2011, if that bill becomes law
- Section 531.502(g), Government Code
- Section 533.012(d), Government Code
- Section 98.104, Health and Safety Code, as added by Chapter 359 (S.B. 288), Acts of the 80th Legislature, Regular Session, 2007
- Chapter 109, Health and Safety Code
- Section 31.0325, Human Resources Code, if H.B. 710, Acts of the 82nd Legislature, Regular Session, 2011, does not become law
- Section 33.0231, Human Resources Code, as added by H.B. 710, Acts of the 82nd Legislature, Regular Session, 2011, if that bill becomes law
- Section 1551.159, Insurance Code
- Section 1551.312, Insurance Code

C.S.S.B. 7 repeals the following provisions of the Health and Safety Code, effective September 1, 2014:

- Sections 108.002(5) and (18), if S.B. 156, Acts of the 82nd Legislature, Regular Session, 2011, does not become law
- Section 108.0025, if S.B. 156, Acts of the 82nd Legislature, Regular Session, 2011, does not become law
- Section 108.009(c), if S.B. 156, Acts of the 82nd Legislature, Regular Session, 2011, does not become law
- Section 108.002(18), if S.B. 156, Acts of the 82nd Legislature, Regular Session, 2011, becomes law
- Section 108.0025, if S.B. 156, Acts of the 82nd Legislature, Regular Session, 2011, becomes law
- Section 108.009(c), if S.B. 156, Acts of the 82nd Legislature, Regular Session, 2011, becomes law

EFFECTIVE DATE

Except as otherwise provided, the 91st day after the last day of the legislative session

COMPARISON OF ORIGINAL AND SUBSTITUTE

C.S.S.B. 7 omits provisions included in the original requiring the comptroller of public accounts to deposit the entire amount received from the fee imposed on certain sexually oriented businesses to the credit of the sexual assault program fund and repealing a certain provision of law relating to the allocation of additional money received from such fees. The substitute omits a provision included in the original expanding the list of entities to which and purposes for which the legislature is authorized to appropriate money deposited to the credit of the sexual assault program fund to include appropriations to the attorney general and to the Department of Family and Protective Services for certain specified purposes. The substitute omits a provision included in the original requiring executive branch and judicial branch entities to which money is appropriated from the sexual assault program fund to provide to the Legislative Budget Board a report containing certain specified information.

C.S.S.B. 7 omits a provision included in the original requiring the comptroller to collect the fee imposed on certain sexually oriented businesses until a court, in a final judgment upheld on appeal or no longer subject to appeal, finds that the provision of law imposing the fee, or its predecessor statute, to be unconstitutional. The substitute omits a provision included in the original establishing that its provisions relating to the sexual assault program fund and the fee imposed on certain sexually oriented businesses prevail over any other act of the 82nd Legislature, 1st Called Session, 2011, regardless of the relative dates of enactment, that purports to amend or repeal Subchapter B, Chapter 102, Business and Commerce Code, or any provision of Chapter 1206 (H.B. 1751), Acts of the 80th Legislature, Regular Session, 2007.

C.S.S.B. 7 differs from the original by repealing a certain provision of law relating to electronic fingerprint-imaging or photo-imaging program for adult and teen parent applicants for and recipients of financial assistance under the Temporary Assistance for Needy Families (TANF) program or food stamp benefits only if H.B. 710, Acts of the 82nd Legislature, Regular Session, 2011, does not become law, whereas the original repeals that provision of law without condition. The substitute contains a provision not included in the original specifying that the bill's provisions relating to the verification of identity and prevention of duplicate participation in the TANF program have no effect if H.B. 710, Acts of the 82nd Legislature, Regular Session, 2011, becomes law. The substitute contains a provision not included in the original repealing a provision added by H.B. 710, Acts of the 82nd Legislature, Regular Session, 2011, if that Act becomes law, relating to the verification of identity and prevention of duplicate participation in the Supplemental Nutrition Assistance Program (SNAP).

C.S.S.B. 7 differs from the original by including among the establishments included in the definition of "assisted living facility" an establishment that may provide skilled nursing services for the limited purposes of coordination of resident care with outside home and community support services agencies and other health care professionals; certain provision or delegation of personal care services and medication administration; assessment of residents to determine the care required; and, for periods as established by DADS rule, delivery of temporary skilled nursing treatment for a minor illness, injury, or emergency, whereas the original includes an establishment that may provide skilled nursing services for a limited duration or to facilitate the provision of hospice services.

C.S.S.B. 7 contains a provision not included in the original repealing provisions added by H.B. 2245, Acts of the 82nd Legislature, Regular Session, 2011, if that bill becomes law, requiring the Health and Human Services Commission (HHSC) to conduct a study regarding physician incentive programs that reduce hospital emergency room use for non-emergent conditions and requiring the executive commissioner of HHSC by rule to establish such a physician incentive

program.

C.S.S.B. 7 differs from the original by authorizing the commissioner of insurance to take certain enforcement action against a health care collaborative if the commissioner finds that 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, whereas the original authorizes the commissioner to take such action on a finding that 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 unfair manner.

C.S.S.B. 7 differs from the original, in a provision repealing provisions of law relating to the Texas Health Care Information Council, by making the repeal of certain specified provisions of law contingent on S.B. 156, Acts of the 82nd Legislature, Regular Session, 2011, becoming law and by making the repeal of certain specified provisions of law contingent on that bill not becoming law, whereas the original repeals the provisions without any such contingency.

C.S.S.B. 7 contains a provision not included in the original prohibiting a contract between an insurer that markets a plan regulated under certain provisions of law relating to preferred provider benefit plans and an institutional provider, as a condition of staff membership or privileges, from requiring a physician or other practitioner to enter into a preferred provider contract.

C.S.S.B. 7 differs from the original in nonsubstantive ways by conforming to certain bill drafting conventions.