

By: Zerwas

H.B. No. 7

A BILL TO BE ENTITLED

AN ACT

relating to the administration, quality, and efficiency of health care, health and human services, and health benefits programs in this state.

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

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

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

Sec. 531.02417. MEDICAID NURSING SERVICES ASSESSMENTS.

(a) In this section, "acute nursing services" means home health skilled nursing services, home health aide services, and private duty nursing services.

(b) If cost-effective, the commission shall develop an objective assessment process for use in assessing a Medicaid recipient's needs for acute nursing services. If the commission develops an objective assessment process under this section, the commission shall require that:

(1) the assessment be conducted:

(A) by a state employee or contractor who is not the person who will deliver any necessary services to the recipient and is not affiliated with the person who will deliver those

1 services; and

2 (B) in a timely manner so as to protect the health
3 and safety of the recipient by avoiding unnecessary delays in
4 service delivery; and

5 (2) the process include:

6 (A) an assessment of specified criteria and
7 documentation of the assessment results on a standard form;

8 (B) an assessment of whether the recipient should
9 be referred for additional assessments regarding the recipient's
10 needs for therapy services, as defined by Section 531.024171,
11 attendant care services, and durable medical equipment; and

12 (C) completion by the person conducting the
13 assessment of any documents related to obtaining prior
14 authorization for necessary nursing services.

15 (c) If the commission develops the objective assessment
16 process under Subsection (b), the commission shall:

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

20 (2) take necessary actions, including modifying
21 contracts with managed care organizations under Chapter 533 to the
22 extent allowed by law, to implement the process within the STAR and
23 STAR + PLUS Medicaid managed care programs.

24 (d) An assessment under Subsection (b)(2)(B) of whether a
25 recipient should be referred for additional therapy services shall
26 be waived if the recipient's need for therapy services has been
27 established by a recommendation from a therapist providing care

1 prior to discharge of the recipient from a licensed hospital or
2 nursing home. The assessment may not be waived if the
3 recommendation is made by a therapist who will deliver any services
4 to the recipient or is affiliated with a person who will deliver
5 those services when the recipient is discharged from the licensed
6 hospital or nursing home.

7 (e) The executive commissioner shall adopt rules providing
8 for a process by which a provider of acute nursing services who
9 disagrees with the results of the assessment conducted under
10 Subsection (b) may request and obtain a review of those results.

11 Sec. 531.024171. THERAPY SERVICES ASSESSMENTS. (a) In
12 this section, "therapy services" includes occupational, physical,
13 and speech therapy services.

14 (b) After implementing the objective assessment process for
15 acute nursing services in accordance with Section 531.02417, the
16 commission shall consider whether implementing age- and
17 diagnosis-appropriate objective assessment processes for assessing
18 the needs of a Medicaid recipient for therapy services would be
19 feasible and beneficial.

20 (c) If the commission determines that implementing age- and
21 diagnosis-appropriate processes with respect to one or more types
22 of therapy services is feasible and would be beneficial, the
23 commission may implement the processes within:

24 (1) the Medicaid fee-for-service model;
25 (2) the primary care case management Medicaid managed
26 care model; and

27 (3) the STAR and STAR + PLUS Medicaid managed care

1 programs.

2 (d) An objective assessment process implemented under this
3 section must include a process that allows a provider of therapy
4 services to request and obtain a review of the results of an
5 assessment conducted as provided by this section that is comparable
6 to the process implemented under rules adopted under Section
7 531.02417(e).

8 Sec. 531.024172. ELECTRONIC VISIT VERIFICATION SYSTEM.

9 (a) In this section, "acute nursing services" has the meaning
10 assigned by Section 531.02417.

11 (b) If it is cost-effective and feasible, the commission
12 shall implement an electronic visit verification system to
13 electronically verify and document, through a telephone or
14 computer-based system, basic information relating to the delivery
15 of Medicaid acute nursing services, including:

16 (1) the provider's name;

17 (2) the recipient's name; and

18 (3) the date and time the provider begins and ends each
19 service delivery visit.

20 (b) Not later than September 1, 2012, the Health and Human
21 Services Commission shall implement the electronic visit
22 verification system required by Section 531.024172, Government
23 Code, as added by this section, if the commission determines that
24 implementation of that system is cost-effective and feasible.

25 SECTION 1.02. (a) Subsection (e), Section 533.0025,
26 Government Code, is amended to read as follows:

27 (e) The commission shall determine the most cost-effective

1 alignment of managed care service delivery areas. The commissioner
2 may consider the number of lives impacted, the usual source of
3 health care services for residents in an area, and other factors
4 that impact the delivery of health care services in the area.
5 ~~[Notwithstanding Subsection (b)(1), the commission may not provide~~
6 ~~medical assistance using a health maintenance organization in~~
7 ~~Cameron County, Hidalgo County, or Maverick County.]~~

8 (b) Subchapter A, Chapter 533, Government Code, is amended
9 by adding Sections 533.0027, 533.0028, and 533.0029 to read as
10 follows:

11 Sec. 533.0027. PROCEDURES TO ENSURE CERTAIN RECIPIENTS ARE
12 ENROLLED IN SAME MANAGED CARE PLAN. The commission shall ensure
13 that all recipients who are children and who reside in the same
14 household may, at the family's election, be enrolled in the same
15 managed care plan.

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

23 Sec. 533.0029. PROMOTION AND PRINCIPLES OF
24 PATIENT-CENTERED MEDICAL HOMES FOR RECIPIENTS. (a) For purposes
25 of this section, a "patient-centered medical home" means a medical
26 relationship:

27 (1) between a primary care physician and a child or

1 adult patient in which the physician:

2 (A) provides comprehensive primary care to the
3 patient; and

4 (B) facilitates partnerships between the
5 physician, the patient, acute care and other care providers, and,
6 when appropriate, the patient's family; and

7 (2) that encompasses the following primary
8 principles:

9 (A) the patient has an ongoing relationship with
10 the physician, who is trained to be the first contact for the
11 patient and to provide continuous and comprehensive care to the
12 patient;

13 (B) the physician leads a team of individuals at
14 the practice level who are collectively responsible for the ongoing
15 care of the patient;

16 (C) the physician is responsible for providing
17 all of the care the patient needs or for coordinating with other
18 qualified providers to provide care to the patient throughout the
19 patient's life, including preventive care, acute care, chronic
20 care, and end-of-life care;

21 (D) the patient's care is coordinated across
22 health care facilities and the patient's community and is
23 facilitated by registries, information technology, and health
24 information exchange systems to ensure that the patient receives
25 care when and where the patient wants and needs the care and in a
26 culturally and linguistically appropriate manner; and

27 (E) quality and safe care is provided.

1 (b) The commission shall, to the extent possible, work to
2 ensure that managed care organizations:

3 (1) promote the development of patient-centered
4 medical homes for recipients; and

5 (2) provide payment incentives for providers that meet
6 the requirements of a patient-centered medical home.

7 (c) Section 533.003, Government Code, is amended to read as
8 follows:

9 Sec. 533.003. CONSIDERATIONS IN AWARDING CONTRACTS. (a)
10 In awarding contracts to managed care organizations, the commission
11 shall:

12 (1) give preference to organizations that have
13 significant participation in the organization's provider network
14 from each health care provider in the region who has traditionally
15 provided care to Medicaid and charity care patients;

16 (2) give extra consideration to organizations that
17 agree to assure continuity of care for at least three months beyond
18 the period of Medicaid eligibility for recipients;

19 (3) consider the need to use different managed care
20 plans to meet the needs of different populations; ~~and~~

21 (4) consider the ability of organizations to process
22 Medicaid claims electronically; and

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

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

1 (B) is in compliance with the requirements of
2 Section 533.004.

3 (b) The commission, in considering approval of a
4 subcontract between a managed care organization and a pharmacy
5 benefit manager for the provision of prescription drug benefits
6 under the Medicaid program, shall review and consider whether the
7 pharmacy benefit manager has been in the preceding three years:

8 (1) convicted of an offense involving a material
9 misrepresentation or an act of fraud or of another violation of
10 state or federal criminal law;

11 (2) adjudicated to have committed a breach of
12 contract; or

13 (3) assessed a penalty or fine in the amount of
14 \$500,000 or more in a state or federal administrative proceeding.

15 (d) Section 533.005, Government Code, is amended by
16 amending Subsection (a) and adding Subsection (a-1) to read as
17 follows:

18 (a) A contract between a managed care organization and the
19 commission for the organization to provide health care services to
20 recipients must contain:

21 (1) procedures to ensure accountability to the state
22 for the provision of health care services, including procedures for
23 financial reporting, quality assurance, utilization review, and
24 assurance of contract and subcontract compliance;

25 (2) capitation rates that ensure the cost-effective
26 provision of quality health care;

27 (3) a requirement that the managed care organization

1 provide ready access to a person who assists recipients in
2 resolving issues relating to enrollment, plan administration,
3 education and training, access to services, and grievance
4 procedures;

5 (4) a requirement that the managed care organization
6 provide ready access to a person who assists providers in resolving
7 issues relating to payment, plan administration, education and
8 training, and grievance procedures;

9 (5) a requirement that the managed care organization
10 provide information and referral about the availability of
11 educational, social, and other community services that could
12 benefit a recipient;

13 (6) procedures for recipient outreach and education;

14 (7) a requirement that the managed care organization
15 make payment to a physician or provider for health care services
16 rendered to a recipient under a managed care plan not later than the
17 45th day after the date a claim for payment is received with
18 documentation reasonably necessary for the managed care
19 organization to process the claim, or within a period, not to exceed
20 60 days, specified by a written agreement between the physician or
21 provider and the managed care organization;

22 (8) a requirement that the commission, on the date of a
23 recipient's enrollment in a managed care plan issued by the managed
24 care organization, inform the organization of the recipient's
25 Medicaid certification date;

26 (9) a requirement that the managed care organization
27 comply with Section 533.006 as a condition of contract retention

1 and renewal;

2 (10) a requirement that the managed care organization
3 provide the information required by Section 533.012 and otherwise
4 comply and cooperate with the commission's office of inspector
5 general and the office of the attorney general;

6 (11) a requirement that the managed care
7 organization's usages of out-of-network providers or groups of
8 out-of-network providers may not exceed limits for those usages
9 relating to total inpatient admissions, total outpatient services,
10 and emergency room admissions determined by the commission;

11 (12) if the commission finds that a managed care
12 organization has violated Subdivision (11), a requirement that the
13 managed care organization reimburse an out-of-network provider for
14 health care services at a rate that is equal to the allowable rate
15 for those services, as determined under Sections 32.028 and
16 32.0281, Human Resources Code;

17 (13) a requirement that the organization use advanced
18 practice nurses in addition to physicians as primary care providers
19 to increase the availability of primary care providers in the
20 organization's provider network;

21 (14) a requirement that the managed care organization
22 reimburse a federally qualified health center or rural health
23 clinic for health care services provided to a recipient outside of
24 regular business hours, including on a weekend day or holiday, at a
25 rate that is equal to the allowable rate for those services as
26 determined under Section 32.028, Human Resources Code, if the
27 recipient does not have a referral from the recipient's primary

1 care physician; ~~and~~

2 (15) a requirement that the managed care organization
3 develop, implement, and maintain a system for tracking and
4 resolving all provider appeals related to claims payment, including
5 a process that will require:

6 (A) a tracking mechanism to document the status
7 and final disposition of each provider's claims payment appeal;

8 (B) the contracting with physicians who are not
9 network providers and who are of the same or related specialty as
10 the appealing physician to resolve claims disputes related to
11 denial on the basis of medical necessity that remain unresolved
12 subsequent to a provider appeal; and

13 (C) the determination of the physician resolving
14 the dispute to be binding on the managed care organization and
15 provider;

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

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

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

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

4 (20) a requirement that the managed care organization
5 develop and submit to the commission, before the organization
6 begins to provide health care services to recipients, a
7 comprehensive plan that describes how the organization's provider
8 network will provide recipients sufficient access to:

9 (A) preventive care;

10 (B) primary care;

11 (C) specialty care;

12 (D) after-hours urgent care; and

13 (E) chronic care;

14 (21) a requirement that the managed care organization
15 demonstrate to the commission, before the organization begins to
16 provide health care services to recipients, that:

17 (A) the organization's provider network has the
18 capacity to serve the number of recipients expected to enroll in a
19 managed care plan offered by the organization;

20 (B) the organization's provider network
21 includes:

22 (i) a sufficient number of primary care
23 providers;

24 (ii) a sufficient variety of provider
25 types; and

26 (iii) providers located throughout the
27 region where the organization will provide health care services;

1 and

2 (C) health care services will be accessible to
3 recipients through the organization's provider network to a
4 comparable extent that health care services would be available to
5 recipients under a fee-for-service or primary care case management
6 model of Medicaid managed care;

7 (22) a requirement that the managed care organization
8 develop a monitoring program for measuring the quality of the
9 health care services provided by the organization's provider
10 network that:

11 (A) incorporates the National Committee for
12 Quality Assurance's Healthcare Effectiveness Data and Information
13 Set (HEDIS) measures;

14 (B) focuses on measuring outcomes; and

15 (C) includes the collection and analysis of
16 clinical data relating to prenatal care, preventive care, mental
17 health care, and the treatment of acute and chronic health
18 conditions and substance abuse;

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

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

25 (B) that adheres to the applicable preferred drug
26 list adopted by the commission under Section 531.072;

27 (C) that includes the prior authorization

1 procedures and requirements prescribed by or implemented under
2 Sections 531.073(b), (c), and (g) for the vendor drug program;

3 (D) for purposes of which the managed care
4 organization:

5 (i) may not negotiate or collect rebates
6 associated with pharmacy products on the vendor drug program
7 formulary; and

8 (ii) may not receive drug rebate or pricing
9 information that is confidential under Section 531.071;

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

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

17 (G) that allows the managed care organization or
18 any subcontracted pharmacy benefit manager to contract with a
19 pharmacist or pharmacy providers separately for specialty pharmacy
20 services, except that:

21 (i) the managed care organization and
22 pharmacy benefit manager are prohibited from allowing exclusive
23 contracts with a specialty pharmacy owned wholly or partly by the
24 pharmacy benefit manager responsible for the administration of the
25 pharmacy benefit program; and

26 (ii) the managed care organization and
27 pharmacy benefit manager must adopt policies and procedures for

1 reclassifying prescription drugs from retail to specialty drugs,
2 and those policies and procedures must be consistent with rules
3 adopted by the executive commissioner and include notice to network
4 pharmacy providers from the managed care organization;

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

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

16 (J) under which the managed care organization or
17 pharmacy benefit manager must pay claims in accordance with Section
18 843.339, Insurance Code; and

19 (24) a requirement that the managed care organization
20 and any entity with which the managed care organization contracts
21 for the performance of services under a managed care plan disclose,
22 at no cost, to the commission and, on request, the office of the
23 attorney general all discounts, incentives, rebates, fees, free
24 goods, bundling arrangements, and other agreements affecting the
25 net cost of goods or services provided under the plan.

26 (a-1) The requirements imposed by Subsections (a)(23)(A),
27 (B), and (C) do not apply, and may not be enforced, on and after

1 August 31, 2013.

2 (e) Subchapter A, Chapter 533, Government Code, is amended
3 by adding Section 533.0066 to read as follows:

4 Sec. 533.0066. PROVIDER INCENTIVES. The commission shall,
5 to the extent possible, work to ensure that managed care
6 organizations provide payment incentives to health care providers
7 in the organizations' networks whose performance in promoting
8 recipients' use of preventive services exceeds minimum established
9 standards.

10 (f) Section 533.0071, Government Code, is amended to read as
11 follows:

12 Sec. 533.0071. ADMINISTRATION OF CONTRACTS. The commission
13 shall make every effort to improve the administration of contracts
14 with managed care organizations. To improve the administration of
15 these contracts, the commission shall:

16 (1) ensure that the commission has appropriate
17 expertise and qualified staff to effectively manage contracts with
18 managed care organizations under the Medicaid managed care program;

19 (2) evaluate options for Medicaid payment recovery
20 from managed care organizations if the enrollee dies or is
21 incarcerated or if an enrollee is enrolled in more than one state
22 program or is covered by another liable third party insurer;

23 (3) maximize Medicaid payment recovery options by
24 contracting with private vendors to assist in the recovery of
25 capitation payments, payments from other liable third parties, and
26 other payments made to managed care organizations with respect to
27 enrollees who leave the managed care program;

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

6 (A) where possible, decreasing the duplication
7 of administrative reporting requirements for the managed care
8 organizations, such as requirements for the submission of encounter
9 data, quality reports, historically underutilized business
10 reports, and claims payment summary reports;

11 (B) allowing managed care organizations to
12 provide updated address information directly to the commission for
13 correction in the state system;

14 (C) promoting consistency and uniformity among
15 managed care organization policies, including policies relating to
16 the preauthorization process, lengths of hospital stays, filing
17 deadlines, levels of care, and case management services; ~~and~~

18 (D) reviewing the appropriateness of primary
19 care case management requirements in the admission and clinical
20 criteria process, such as requirements relating to including a
21 separate cover sheet for all communications, submitting
22 handwritten communications instead of electronic or typed review
23 processes, and admitting patients listed on separate
24 notifications; and

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

1 (5) reserve the right to amend the managed care
2 organization's process for resolving provider appeals of denials
3 based on medical necessity to include an independent review process
4 established by the commission for final determination of these
5 disputes.

6 (g) Subchapter A, Chapter 533, Government Code, is amended
7 by adding Section 533.0073 to read as follows:

8 Sec. 533.0073. MEDICAL DIRECTOR QUALIFICATIONS. A person
9 who serves as a medical director for a managed care plan must be a
10 physician licensed to practice medicine in this state under
11 Subtitle B, Title 3, Occupations Code.

12 (h) Subsections (a) and (c), Section 533.0076, Government
13 Code, are amended to read as follows:

14 (a) Except as provided by Subsections (b) and (c), and to
15 the extent permitted by federal law, [~~the commission may prohibit~~]
16 a recipient enrolled [~~from disenrolling~~] in a managed care plan
17 under this chapter may not disenroll from that plan and enroll
18 [~~enrolling~~] in another managed care plan during the 12-month period
19 after the date the recipient initially enrolls in a plan.

20 (c) The commission shall allow a recipient who is enrolled
21 in a managed care plan under this chapter to disenroll from [~~in~~]
22 that plan and enroll in another managed care plan:

23 (1) at any time for cause in accordance with federal
24 law; and

25 (2) once for any reason after the periods described by
26 Subsections (a) and (b).

27 (i) Subsections (a), (b), (c), and (e), Section 533.012,

1 Government Code, are amended to read as follows:

2 (a) Each managed care organization contracting with the
3 commission under this chapter shall submit the following, at no
4 cost, to the commission and, on request, the office of the attorney
5 general:

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

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

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

14 (4) a description and breakdown of all funds paid to or
15 by the managed care organization, including a health maintenance
16 organization, primary care case management provider, pharmacy
17 benefit manager, and [~~an~~] exclusive provider organization,
18 necessary for the commission to determine the actual cost of
19 administering the managed care plan.

20 (b) The information submitted under this section must be
21 submitted in the form required by the commission or the office of
22 the attorney general, as applicable, and be updated as required by
23 the commission or the office of the attorney general, as
24 applicable.

25 (c) The commission's office of investigations and
26 enforcement or the office of the attorney general, as applicable,
27 shall review the information submitted under this section as

1 appropriate in the investigation of fraud in the Medicaid managed
2 care program.

3 (e) Information submitted to the commission or the office of
4 the attorney general, as applicable, under Subsection (a)(1) is
5 confidential and not subject to disclosure under Chapter 552,
6 Government Code.

7 (j) The heading to Section 32.046, Human Resources Code, is
8 amended to read as follows:

9 Sec. 32.046. [~~VENDOR DRUG PROGRAM,~~] SANCTIONS AND PENALTIES
10 RELATED TO THE PROVISION OF PHARMACY PRODUCTS.

11 (k) Subsection (a), Section 32.046, Human Resources Code,
12 is amended to read as follows:

13 (a) The executive commissioner of the Health and Human
14 Services Commission [~~department~~] shall adopt rules governing
15 sanctions and penalties that apply to a provider who participates
16 in the vendor drug program or is enrolled as a network pharmacy
17 provider of a managed care organization contracting with the
18 commission under Chapter 533, Government Code, or its subcontractor
19 and who submits an improper claim for reimbursement under the
20 program.

21 (l) Subsection (d), Section 533.012, Government Code, is
22 repealed.

23 (m) Not later than December 1, 2013, the Health and Human
24 Services Commission shall submit a report to the legislature
25 regarding the commission's work to ensure that Medicaid managed
26 care organizations promote the development of patient-centered
27 medical homes for recipients of medical assistance as required

1 under Section 533.0029, Government Code, as added by this section.

2 (n) The Health and Human Services Commission shall, in a
3 contract between the commission and a managed care organization
4 under Chapter 533, Government Code, that is entered into or renewed
5 on or after the effective date of this Act, include the provisions
6 required by Subsection (a), Section 533.005, Government Code, as
7 amended by this section.

8 (o) Section 533.0073, Government Code, as added by this
9 section, applies only to a person hired or otherwise retained as the
10 medical director of a Medicaid managed care plan on or after the
11 effective date of this Act. A person hired or otherwise retained
12 before the effective date of this Act is governed by the law in
13 effect immediately before the effective date of this Act, and that
14 law is continued in effect for that purpose.

15 (p) Subsections (a) and (c), Section 533.0076, Government
16 Code, as amended by this section, apply only to a request for
17 disenrollment from a Medicaid managed care plan under Chapter 533,
18 Government Code, made by a recipient on or after the effective date
19 of this Act. A request made by a recipient before that date is
20 governed by the law in effect on the date the request was made, and
21 the former law is continued in effect for that purpose.

22 SECTION 1.03. (a) Section 62.101, Health and Safety Code,
23 is amended by adding Subsection (a-1) to read as follows:

24 (a-1) A child who is the dependent of an employee of an
25 agency of this state and who meets the requirements of Subsection
26 (a) may be eligible for health benefits coverage in accordance with
27 42 U.S.C. Section 1397jj(b)(6) and any other applicable law or

1 regulations.

2 (b) Sections 1551.159 and 1551.312, Insurance Code, are
3 repealed.

4 (c) The State Kids Insurance Program operated by the
5 Employees Retirement System of Texas is abolished on the effective
6 date of this Act. The Health and Human Services Commission shall:

7 (1) establish a process in cooperation with the
8 Employees Retirement System of Texas to facilitate the enrollment
9 of eligible children in the child health plan program established
10 under Chapter 62, Health and Safety Code, on or before the date
11 those children are scheduled to stop receiving dependent child
12 coverage under the State Kids Insurance Program; and

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

18 SECTION 1.04. (a) Subchapter B, Chapter 31, Human
19 Resources Code, is amended by adding Section 31.0326 to read as
20 follows:

21 Sec. 31.0326. VERIFICATION OF IDENTITY AND PREVENTION OF
22 DUPLICATE PARTICIPATION. The Health and Human Services Commission
23 shall use appropriate technology to:

24 (1) confirm the identity of applicants for benefits
25 under the financial assistance program; and

26 (2) prevent duplicate participation in the program by
27 a person.

1 (b) Chapter 33, Human Resources Code, is amended by adding
2 Section 33.0231 to read as follows:

3 Sec. 33.0231. VERIFICATION OF IDENTITY AND PREVENTION OF
4 DUPLICATE PARTICIPATION IN SNAP. The department shall use
5 appropriate technology to:

6 (1) confirm the identity of applicants for benefits
7 under the supplemental nutrition assistance program; and

8 (2) prevent duplicate participation in the program by
9 a person.

10 (c) Section 531.109, Government Code, is amended by adding
11 Subsection (d) to read as follows:

12 (d) Absent an allegation of fraud, waste, or abuse, the
13 commission may conduct an annual review of claims under this
14 section only after the commission has completed the prior year's
15 annual review of claims.

16 (d) Section 31.0325, Human Resources Code, is repealed.

17 SECTION 1.05. (a) Section 242.033, Health and Safety Code,
18 is amended by amending Subsection (d) and adding Subsection (g) to
19 read as follows:

20 (d) Except as provided by Subsection (f), a license is
21 renewable every three [~~two~~] years after:

22 (1) an inspection, unless an inspection is not
23 required as provided by Section 242.047;

24 (2) payment of the license fee; and

25 (3) department approval of the report filed every
26 three [~~two~~] years by the licensee.

27 (g) The executive commissioner by rule shall adopt a system

1 under which an appropriate number of licenses issued by the
2 department under this chapter expire on staggered dates occurring
3 in each three-year period. If the expiration date of a license
4 changes as a result of this subsection, the department shall
5 prorate the licensing fee relating to that license as appropriate.

6 (b) Subsection (e-1), Section 242.159, Health and Safety
7 Code, is amended to read as follows:

8 (e-1) An institution is not required to comply with
9 Subsections (a) and (e) until September 1, 2014 [~~2012~~]. This
10 subsection expires January 1, 2015 [~~2013~~].

11 (c) The executive commissioner of the Health and Human
12 Services Commission shall adopt the rules required under Section
13 242.033(g), Health and Safety Code, as added by this section, as
14 soon as practicable after the effective date of this Act, but not
15 later than December 1, 2012.

16 SECTION 1.06. (a) Section 161.077, Human Resources Code,
17 as added by Chapter 759 (S.B. 705), Acts of the 81st Legislature,
18 Regular Session, 2009, is redesignated as Section 161.081, Human
19 Resources Code, and amended to read as follows:

20 Sec. 161.081 [~~161.077~~]. LONG-TERM CARE MEDICAID WAIVER
21 PROGRAMS: STREAMLINING AND UNIFORMITY. (a) In this section,
22 "Section 1915(c) waiver program" has the meaning assigned by
23 Section 531.001, Government Code.

24 (b) The department, in consultation with the commission,
25 shall streamline the administration of and delivery of services
26 through Section 1915(c) waiver programs. In implementing this
27 subsection, the department, subject to Subsection (c), may consider

1 implementing the following streamlining initiatives:

2 (1) reducing the number of forms used in administering
3 the programs;

4 (2) revising program provider manuals and training
5 curricula;

6 (3) consolidating service authorization systems;

7 (4) eliminating any physician signature requirements
8 the department considers unnecessary;

9 (5) standardizing individual service plan processes
10 across the programs; ~~and~~

11 (6) if feasible:

12 (A) concurrently conducting program
13 certification and billing audit and review processes and other
14 related audit and review processes;

15 (B) streamlining other billing and auditing
16 requirements;

17 (C) eliminating duplicative responsibilities
18 with respect to the coordination and oversight of individual care
19 plans for persons receiving waiver services; and

20 (D) streamlining cost reports and other cost
21 reporting processes; and

22 (7) any other initiatives that will increase
23 efficiencies in the programs.

24 (c) The department shall ensure that actions taken under
25 Subsection (b) ~~[this section]~~ do not conflict with any requirements
26 of the commission under Section 531.0218, Government Code.

27 (d) The department and the commission shall jointly explore

1 the development of uniform licensing and contracting standards that
2 would:

3 (1) apply to all contracts for the delivery of Section
4 1915(c) waiver program services;

5 (2) promote competition among providers of those
6 program services; and

7 (3) integrate with other department and commission
8 efforts to streamline and unify the administration and delivery of
9 the program services, including those required by this section or
10 Section 531.0218, Government Code.

11 (b) Subchapter D, Chapter 161, Human Resources Code, is
12 amended by adding Section 161.082 to read as follows:

13 Sec. 161.082. LONG-TERM CARE MEDICAID WAIVER PROGRAMS:
14 UTILIZATION REVIEW. (a) In this section, "Section 1915(c) waiver
15 program" has the meaning assigned by Section 531.001, Government
16 Code.

17 (b) The department shall perform a utilization review of
18 services in all Section 1915(c) waiver programs. The utilization
19 review must include, at a minimum, reviewing program recipients'
20 levels of care and any plans of care for those recipients that
21 exceed service level thresholds established in the applicable
22 waiver program guidelines.

23 SECTION 1.07. Subchapter D, Chapter 161, Human Resources
24 Code, is amended by adding Section 161.086 to read as follows:

25 Sec. 161.086. ELECTRONIC VISIT VERIFICATION SYSTEM. If it
26 is cost-effective, the department shall implement an electronic
27 visit verification system under appropriate programs administered

1 by the department under the Medicaid program that allows providers
2 to electronically verify and document basic information relating to
3 the delivery of services, including:

- 4 (1) the provider's name;
5 (2) the recipient's name;
6 (3) the date and time the provider begins and ends the
7 delivery of services; and
8 (4) the location of service delivery.

9 SECTION 1.08. (a) Subdivision (1), Section 247.002, Health
10 and Safety Code, is amended to read as follows:

11 (1) "Assisted living facility" means an establishment
12 that:

13 (A) furnishes, in one or more facilities, food
14 and shelter to four or more persons who are unrelated to the
15 proprietor of the establishment;

16 (B) provides:
17 (i) personal care services; or
18 (ii) administration of medication by a
19 person licensed or otherwise authorized in this state to administer
20 the medication; ~~and~~

21 (C) may provide assistance with or supervision of
22 the administration of medication; and

23 (D) may provide skilled nursing services for a
24 limited duration or to facilitate the provision of hospice
25 services.

26 (b) Section 247.004, Health and Safety Code, is amended to
27 read as follows:

1 Sec. 247.004. EXEMPTIONS. This chapter does not apply to:

2 (1) a boarding home facility as defined by Section
3 254.001, as added by Chapter 1106 (H.B. 216), Acts of the 81st
4 Legislature, Regular Session, 2009;

5 (2) an establishment conducted by or for the adherents
6 of the Church of Christ, Scientist, for the purpose of providing
7 facilities for the care or treatment of the sick who depend
8 exclusively on prayer or spiritual means for healing without the
9 use of any drug or material remedy if the establishment complies
10 with local safety, sanitary, and quarantine ordinances and
11 regulations;

12 (3) a facility conducted by or for the adherents of a
13 qualified religious society classified as a tax-exempt
14 organization under an Internal Revenue Service group exemption
15 ruling for the purpose of providing personal care services without
16 charge solely for the society's professed members or ministers in
17 retirement, if the facility complies with local safety, sanitation,
18 and quarantine ordinances and regulations; or

19 (4) a facility that provides personal care services
20 only to persons enrolled in a program that:

21 (A) is funded in whole or in part by the
22 department and that is monitored by the department or its
23 designated local mental retardation authority in accordance with
24 standards set by the department; or

25 (B) is funded in whole or in part by the
26 Department of State Health Services and that is monitored by that
27 department, or by its designated local mental health authority in

1 accordance with standards set by the department.

2 (c) Subsection (b), Section 247.067, Health and Safety
3 Code, is amended to read as follows:

4 (b) Unless otherwise prohibited by law, a [A] health care
5 professional may be employed by an assisted living facility to
6 provide at the facility to the facility's residents services that
7 are authorized by this chapter and that are within the
8 professional's scope of practice [~~to a resident of an assisted~~
9 ~~living facility at the facility~~]. This subsection does not
10 authorize a facility to provide ongoing services comparable to the
11 services available in an institution licensed under Chapter 242. A
12 health care professional providing services under this subsection
13 shall maintain medical records of those services in accordance with
14 the licensing, certification, or other regulatory standards
15 applicable to the health care professional under law.

16 SECTION 1.09. (a) Subchapter B, Chapter 531, Government
17 Code, is amended by adding Sections 531.086 and 531.0861 to read as
18 follows:

19 Sec. 531.086. STUDY REGARDING PHYSICIAN INCENTIVE PROGRAMS
20 TO REDUCE HOSPITAL EMERGENCY ROOM USE FOR NON-EMERGENT CONDITIONS.

21 (a) The commission shall conduct a study to evaluate physician
22 incentive programs that attempt to reduce hospital emergency room
23 use for non-emergent conditions by recipients under the medical
24 assistance program. Each physician incentive program evaluated in
25 the study must:

26 (1) be administered by a health maintenance
27 organization participating in the STAR or STAR + PLUS Medicaid

1 managed care program; and

2 (2) provide incentives to primary care providers who
3 attempt to reduce emergency room use for non-emergent conditions by
4 recipients.

5 (b) The study conducted under Subsection (a) must evaluate:

6 (1) the cost-effectiveness of each component included
7 in a physician incentive program; and

8 (2) any change in statute required to implement each
9 component within the Medicaid fee-for-service payment model.

10 (c) Not later than August 31, 2013, the executive
11 commissioner shall submit to the governor and the Legislative
12 Budget Board a report summarizing the findings of the study
13 required by this section.

14 (d) This section expires September 1, 2014.

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

21 (b) In establishing the physician incentive program under
22 Subsection (a), the executive commissioner may include only the
23 program components identified as cost-effective in the study
24 conducted under Section 531.086.

25 (c) If the physician incentive program includes the payment
26 of an enhanced reimbursement rate for routine after-hours
27 appointments, the executive commissioner shall implement controls

1 to ensure that the after-hours services billed are actually being
2 provided outside of normal business hours.

3 (b) Section 32.0641, Human Resources Code, is amended to
4 read as follows:

5 Sec. 32.0641. RECIPIENT ACCOUNTABILITY PROVISIONS;
6 COST-SHARING REQUIREMENT TO IMPROVE APPROPRIATE UTILIZATION OF
7 [COST SHARING FOR CERTAIN HIGH-COST MEDICAL] SERVICES. (a) To [If
8 the department determines that it is feasible and cost-effective,
9 and to] the extent permitted under and in a manner that is
10 consistent with Title XIX, Social Security Act (42 U.S.C. Section
11 1396 et seq.) and any other applicable law or regulation or under a
12 federal waiver or other authorization, the executive commissioner
13 of the Health and Human Services Commission shall adopt, after
14 consulting with the Medicaid and CHIP Quality-Based Payment
15 Advisory Committee established under Section 536.002, Government
16 Code, cost-sharing provisions that encourage personal
17 accountability and appropriate utilization of health care
18 services, including a cost-sharing provision applicable to
19 [require] a recipient who chooses to receive a nonemergency [a
20 high-cost] medical service [provided] through a hospital emergency
21 room [to pay a copayment, premium payment, or other cost-sharing
22 payment for the high-cost medical service if:

23 [(1) the hospital from which the recipient seeks
24 service:

25 [(A) performs an appropriate medical screening
26 and determines that the recipient does not have a condition
27 requiring emergency medical services;

1 ~~[(B) informs the recipient:~~

2 ~~[(i) that the recipient does not have a~~
3 ~~condition requiring emergency medical services;~~

4 ~~[(ii) that, if the hospital provides the~~
5 ~~nonemergency service, the hospital may require payment of a~~
6 ~~copayment, premium payment, or other cost-sharing payment by the~~
7 ~~recipient in advance; and~~

8 ~~[(iii) of the name and address of a~~
9 ~~nonemergency Medicaid provider who can provide the appropriate~~
10 ~~medical service without imposing a cost-sharing payment; and~~

11 ~~[(C) offers to provide the recipient with a~~
12 ~~referral to the nonemergency provider to facilitate scheduling of~~
13 ~~the service; and~~

14 ~~[(2) after receiving the information and assistance~~
15 ~~described by Subdivision (1) from the hospital, the recipient~~
16 ~~chooses to obtain emergency medical services despite having access~~
17 ~~to medically acceptable, lower-cost medical services].~~

18 (b) The department may not seek a federal waiver or other
19 authorization under this section ~~[Subsection (a)]~~ that would:

20 (1) prevent a Medicaid recipient who has a condition
21 requiring emergency medical services from receiving care through a
22 hospital emergency room; or

23 (2) waive any provision under Section 1867, Social
24 Security Act (42 U.S.C. Section 1395dd).

25 ~~[(c) If the executive commissioner of the Health and Human~~
26 ~~Services Commission adopts a copayment or other cost-sharing~~
27 ~~payment under Subsection (a), the commission may not reduce~~

1 ~~hospital payments to reflect the potential receipt of a copayment~~
2 ~~or other payment from a recipient receiving medical services~~
3 ~~provided through a hospital emergency room.]~~

4 SECTION 1.10. Subchapter B, Chapter 531, Government Code,
5 is amended by adding Section 531.024131 to read as follows:

6 Sec. 531.024131. EXPANSION OF BILLING COORDINATION AND
7 INFORMATION COLLECTION ACTIVITIES. (a) If cost-effective, the
8 commission may:

9 (1) contract to expand all or part of the billing
10 coordination system established under Section 531.02413 to process
11 claims for services provided through other benefits programs
12 administered by the commission or a health and human services
13 agency;

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

19 (3) expand the scope of persons about whom information
20 is collected under Section 32.042, Human Resources Code, to include
21 recipients of services provided through other benefits programs
22 administered by the commission or a health and human services
23 agency.

24 (b) Notwithstanding any other state law, each health and
25 human services agency shall provide the commission with any
26 information necessary to allow the commission or the commission's
27 designee to perform the billing coordination and information

1 collection activities authorized by this section.

2 SECTION 1.11. (a) Subsections (b), (c), and (d), Section
3 531.502, Government Code, are amended to read as follows:

4 (b) The executive commissioner may include the following
5 federal money in the waiver:

6 (1) ~~[all]~~ money provided under the disproportionate
7 share hospitals or ~~[and]~~ upper payment limit supplemental payment
8 program, or both [programs];

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

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

13 (4) any other money available for that purpose,
14 including:

15 (A) federal money and money identified under
16 Subsection (c);

17 (B) gifts, grants, or donations for that purpose;

18 (C) local funds received by this state through
19 intergovernmental transfers; and

20 (D) if approved in the waiver, federal money
21 obtained through the use of certified public expenditures.

22 (c) The commission shall seek to optimize federal funding
23 by:

24 (1) identifying health care related state and local
25 funds and program expenditures that, before September 1, 2011
26 ~~[2007]~~, are not being matched with federal money; and

27 (2) exploring the feasibility of:

1 (A) certifying or otherwise using those funds and
2 expenditures as state expenditures for which this state may receive
3 federal matching money; and

4 (B) depositing federal matching money received
5 as provided by Paragraph (A) with other federal money deposited as
6 provided by Section 531.504, or substituting that federal matching
7 money for federal money that otherwise would be received under the
8 disproportionate share hospitals and upper payment limit
9 supplemental payment programs as a match for local funds received
10 by this state through intergovernmental transfers.

11 (d) The terms of a waiver approved under this section must:

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

22 (2) allow for the development by this state of a
23 methodology for allocating money in the fund to:

24 (A) be used to supplement Medicaid hospital
25 reimbursements under a waiver that includes terms that are
26 consistent with, or that produce revenues consistent with,
27 disproportionate share hospital and upper payment limit principles

1 ~~[offset, in part, the uncompensated health care costs incurred by~~
2 ~~hospitals];~~

3 (B) reduce the number of persons in this state
4 who do not have health benefits coverage; and

5 (C) maintain and enhance the community public
6 health infrastructure provided by hospitals.

7 (b) Section 531.504, Government Code, is amended to read as
8 follows:

9 Sec. 531.504. DEPOSITS TO FUND. (a) The comptroller shall
10 deposit in the fund:

11 (1) ~~[all]~~ federal money provided to this state under
12 the disproportionate share hospitals supplemental payment program
13 or ~~[and]~~ the hospital upper payment limit supplemental payment
14 program, or both, other than money provided under those programs to
15 state-owned and operated hospitals, and all other non-supplemental
16 payment program federal money provided to this state that is
17 included in the waiver authorized by Section 531.502; and

18 (2) state money appropriated to the fund.

19 (b) The commission and comptroller may accept gifts,
20 grants, and donations from any source, and receive
21 intergovernmental transfers, for purposes consistent with this
22 subchapter and the terms of the waiver. The comptroller shall
23 deposit a gift, grant, or donation made for those purposes in the
24 fund. Any intergovernmental transfer received, including
25 associated federal matching funds, shall be used, if feasible, for
26 the purposes intended by the transferring entity and in accordance
27 with the terms of the waiver.

1 (c) Section 531.508, Government Code, is amended by adding
2 Subsection (d) to read as follows:

3 (d) Money from the fund may not be used to finance the
4 construction, improvement, or renovation of a building or land
5 unless the construction, improvement, or renovation is approved by
6 the commission, according to rules adopted by the executive
7 commissioner for that purpose.

8 (d) Subsection (g), Section 531.502, Government Code, is
9 repealed.

10 SECTION 1.12. (a) Subtitle I, Title 4, Government Code, is
11 amended by adding Chapter 536, and Section 531.913, Government
12 Code, is transferred to Subchapter D, Chapter 536, Government Code,
13 redesignated as Section 536.151, Government Code, and amended to
14 read as follows:

15 CHAPTER 536. MEDICAID AND CHILD HEALTH PLAN PROGRAMS:

16 QUALITY-BASED OUTCOMES AND PAYMENTS

17 SUBCHAPTER A. GENERAL PROVISIONS

18 Sec. 536.001. DEFINITIONS. In this chapter:

19 (1) "Advisory committee" means the Medicaid and CHIP
20 Quality-Based Payment Advisory Committee established under Section
21 536.002.

22 (2) "Alternative payment system" includes:

23 (A) a global payment system;

24 (B) an episode-based bundled payment system; and

25 (C) a blended payment system.

26 (3) "Blended payment system" means a system for
27 compensating a physician or other health care provider that

1 includes at least one or more features of a global payment system
2 and an episode-based bundled payment system, but that may also
3 include a system under which a portion of the compensation paid to a
4 physician or other health care provider is based on a
5 fee-for-service payment arrangement.

6 (4) "Child health plan program," "commission,"
7 "executive commissioner," and "health and human services agencies"
8 have the meanings assigned by Section 531.001.

9 (5) "Episode-based bundled payment system" means a
10 system for compensating a physician or other health care provider
11 for arranging for or providing health care services to child health
12 plan program enrollees or Medicaid recipients that is based on a
13 flat payment for all services provided in connection with a single
14 episode of medical care.

15 (6) "Exclusive provider benefit plan" means a managed
16 care plan subject to 28 T.A.C. Part 1, Chapter 3, Subchapter KK.

17 (7) "Freestanding emergency medical care facility"
18 means a facility licensed under Chapter 254, Health and Safety
19 Code.

20 (8) "Global payment system" means a system for
21 compensating a physician or other health care provider for
22 arranging for or providing a defined set of covered health care
23 services to child health plan program enrollees or Medicaid
24 recipients for a specified period that is based on a predetermined
25 payment per enrollee or recipient, as applicable, for the specified
26 period, without regard to the quantity of services actually
27 provided.

1 (9) "Health care provider" means any person,
2 partnership, professional association, corporation, facility, or
3 institution licensed, certified, registered, or chartered by this
4 state to provide health care. The term includes an employee,
5 independent contractor, or agent of a health care provider acting
6 in the course and scope of the employment or contractual
7 relationship.

8 (10) "Hospital" means a public or private institution
9 licensed under Chapter 241 or 577, Health and Safety Code,
10 including a general or special hospital as defined by Section
11 241.003, Health and Safety Code.

12 (11) "Managed care organization" means a person that
13 is authorized or otherwise permitted by law to arrange for or
14 provide a managed care plan. The term includes health maintenance
15 organizations and exclusive provider organizations.

16 (12) "Managed care plan" means a plan, including an
17 exclusive provider benefit plan, under which a person undertakes to
18 provide, arrange for, pay for, or reimburse any part of the cost of
19 any health care services. A part of the plan must consist of
20 arranging for or providing health care services as distinguished
21 from indemnification against the cost of those services on a
22 prepaid basis through insurance or otherwise. The term does not
23 include a plan that indemnifies a person for the cost of health care
24 services through insurance.

25 (13) "Medicaid program" means the medical assistance
26 program established under Chapter 32, Human Resources Code.

27 (14) "Physician" means a person licensed to practice

1 medicine in this state under Subtitle B, Title 3, Occupations Code.

2 (15) "Potentially preventable admission" means an
3 admission of a person to a hospital or long-term care facility that
4 may have reasonably been prevented with adequate access to
5 ambulatory care or health care coordination.

6 (16) "Potentially preventable ancillary service"
7 means a health care service provided or ordered by a physician or
8 other health care provider to supplement or support the evaluation
9 or treatment of a patient, including a diagnostic test, laboratory
10 test, therapy service, or radiology service, that may not be
11 reasonably necessary for the provision of quality health care or
12 treatment.

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

16 (A) occurs after the person's admission to a
17 hospital or long-term care facility; and

18 (B) may have resulted from the care, lack of
19 care, or treatment provided during the hospital or long-term care
20 facility stay rather than from a natural progression of an
21 underlying disease.

22 (18) "Potentially preventable event" means a
23 potentially preventable admission, a potentially preventable
24 ancillary service, a potentially preventable complication, a
25 potentially preventable emergency room visit, a potentially
26 preventable readmission, or a combination of those events.

27 (19) "Potentially preventable emergency room visit"

1 means treatment of a person in a hospital emergency room or
2 freestanding emergency medical care facility for a condition that
3 may not require emergency medical attention because the condition
4 could be, or could have been, treated or prevented by a physician or
5 other health care provider in a nonemergency setting.

6 (20) "Potentially preventable readmission" means a
7 return hospitalization of a person within a period specified by the
8 commission that may have resulted from deficiencies in the care or
9 treatment provided to the person during a previous hospital stay or
10 from deficiencies in post-hospital discharge follow-up. The term
11 does not include a hospital readmission necessitated by the
12 occurrence of unrelated events after the discharge. The term
13 includes the readmission of a person to a hospital for:

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

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

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

21 (D) another condition or procedure of a similar
22 nature, as determined by the executive commissioner after
23 consulting with the advisory committee.

24 (21) "Quality-based payment system" means a system for
25 compensating a physician or other health care provider, including
26 an alternative payment system, that provides incentives to the
27 physician or other health care provider for providing high-quality,

1 cost-effective care and bases some portion of the payment made to
2 the physician or other health care provider on quality of care
3 outcomes, which may include the extent to which the physician or
4 other health care provider reduces potentially preventable events.

5 Sec. 536.002. MEDICAID AND CHIP QUALITY-BASED PAYMENT
6 ADVISORY COMMITTEE. (a) The Medicaid and CHIP Quality-Based
7 Payment Advisory Committee is established to advise the commission
8 on establishing, for purposes of the child health plan and Medicaid
9 programs administered by the commission or a health and human
10 services agency:

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

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

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

23 (4) outcome and process measures under Section
24 536.003.

25 (b) The executive commissioner shall appoint the members of
26 the advisory committee. The committee must consist of physicians
27 and other health care providers, representatives of health care

1 facilities, representatives of managed care organizations, and
2 other stakeholders interested in health care services provided in
3 this state, including:

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

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

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

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

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

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

18 (7) at least one member who is a member of the Advisory
19 Panel on Health Care-Associated Infections and Preventable Adverse
20 Events who meets the qualifications prescribed by Section
21 98.052(a)(4), Health and Safety Code.

22 (c) The executive commissioner shall appoint the presiding
23 officer of the advisory committee.

24 Sec. 536.003. DEVELOPMENT OF QUALITY-BASED OUTCOME AND
25 PROCESS MEASURES. (a) The commission, in consultation with the
26 advisory committee, shall develop quality-based outcome and
27 process measures that promote the provision of efficient, quality

1 health care and that can be used in the child health plan and
2 Medicaid programs to implement quality-based payments for acute and
3 long-term care services across all delivery models and payment
4 systems, including fee-for-service and managed care payment
5 systems. The commission, in developing outcome measures under this
6 section, must consider measures addressing potentially preventable
7 events.

8 (b) To the extent feasible, the commission shall develop
9 outcome and process measures:

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

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

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

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

19 (c) The commission shall, to the extent feasible, align
20 outcome and process measures developed under this section with
21 measures required or recommended under reporting guidelines
22 established by the federal Centers for Medicare and Medicaid
23 Services, the Agency for Healthcare Research and Quality, or
24 another federal agency.

25 (d) The executive commissioner by rule may require managed
26 care organizations and physicians and other health care providers
27 participating in the child health plan and Medicaid programs to

1 report to the commission in a format specified by the executive
2 commissioner information necessary to develop outcome and process
3 measures under this section.

4 (e) If the commission increases physician and other health
5 care provider reimbursement rates under the child health plan or
6 Medicaid program as a result of an increase in the amounts
7 appropriated for the programs for a state fiscal biennium as
8 compared to the preceding state fiscal biennium, the commission
9 shall, to the extent permitted under federal law and to the extent
10 otherwise possible considering other relevant factors, correlate
11 the increased reimbursement rates with the quality-based outcome
12 and process measures developed under this section.

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

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

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

23 (3) promote the coordination of health care;

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

26 (5) promote effective health care delivery models; and

27 (6) take into account the specific needs of the child

1 health plan program enrollee and Medicaid recipient populations.

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

12 (c) In developing quality-based payment systems under this
13 chapter, the commission shall examine and consider implementing:

14 (1) an alternative payment system;

15 (2) any existing performance-based payment system
16 used under the Medicare program that meets the requirements of this
17 chapter, modified as necessary to account for programmatic
18 differences, if implementing the system would:

19 (A) reduce unnecessary administrative burdens;

20 and

21 (B) align quality-based payment incentives for
22 physicians and other health care providers with the Medicare
23 program; and

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

1 Medicaid programs.

2 (d) In developing quality-based payment systems under this
3 chapter, the commission shall ensure that a managed care
4 organization or physician or other health care provider will not be
5 rewarded by the system for withholding or delaying the provision of
6 medically necessary care.

7 (e) The commission may modify a quality-based payment
8 system developed under this chapter to account for programmatic
9 differences between the child health plan and Medicaid programs and
10 delivery systems under those programs.

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

18 (b) Subsection (a) does not authorize the commission to
19 direct a managed care organization to compensate physicians and
20 other health care providers providing services under the
21 organization's managed care plan based on a diagnosis-related
22 groups (DRG) methodology.

23 Sec. 536.006. TRANSPARENCY. The commission and the
24 advisory committee shall:

25 (1) ensure transparency in the development and
26 establishment of:

27 (A) quality-based payment and reimbursement

1 systems under Section 536.004 and Subchapters B, C, and D,
2 including the development of outcome and process measures under
3 Section 536.003; and

4 (B) quality-based payment initiatives under
5 Subchapter E, including the development of quality of care and
6 cost-efficiency benchmarks under Section 536.204(a) and efficiency
7 performance standards under Section 536.204(b);

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

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

23 Sec. 536.007. PERIODIC EVALUATION. (a) At least once each
24 two-year period, the commission shall evaluate the outcomes and
25 cost-effectiveness of any quality-based payment system or other
26 payment initiative implemented under this chapter.

27 (b) The commission shall:

1 (1) present the results of its evaluation under
2 Subsection (a) to the advisory committee for the committee's input
3 and recommendations; and

4 (2) provide a process by which managed care
5 organizations and physicians and other health care providers may
6 comment and provide input into the committee's recommendations
7 under Subdivision (1).

8 Sec. 536.008. ANNUAL REPORT. (a) The commission shall
9 submit an annual report to the legislature regarding:

10 (1) the quality-based outcome and process measures
11 developed under Section 536.003; and

12 (2) the progress of the implementation of
13 quality-based payment systems and other payment initiatives
14 implemented under this chapter.

15 (b) The commission shall report outcome and process
16 measures under Subsection (a)(1) by health care service region and
17 service delivery model.

18 [Sections 536.009-536.050 reserved for expansion]

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

20 ORGANIZATIONS

21 Sec. 536.051. DEVELOPMENT OF QUALITY-BASED PREMIUM
22 PAYMENTS; PERFORMANCE REPORTING. (a) Subject to Section
23 1903(m)(2)(A), Social Security Act (42 U.S.C. Section
24 1396b(m)(2)(A)), and other applicable federal law, the commission
25 shall base a percentage of the premiums paid to a managed care
26 organization participating in the child health plan or Medicaid
27 program on the organization's performance with respect to outcome

1 and process measures developed under Section 536.003, including
2 outcome measures addressing potentially preventable events.

3 (b) The commission shall make available information
4 relating to the performance of a managed care organization with
5 respect to outcome and process measures under this subchapter to
6 child health plan program enrollees and Medicaid recipients before
7 those enrollees and recipients choose their managed care plans.

8 Sec. 536.052. PAYMENT AND CONTRACT AWARD INCENTIVES FOR
9 MANAGED CARE ORGANIZATIONS. (a) The commission may allow a
10 managed care organization participating in the child health plan or
11 Medicaid program increased flexibility to implement quality
12 initiatives in a managed care plan offered by the organization,
13 including flexibility with respect to financial arrangements, in
14 order to:

15 (1) achieve high-quality, cost-effective health care;
16 (2) increase the use of high-quality, cost-effective
17 delivery models; and

18 (3) reduce potentially preventable events.

19 (b) The commission, after consulting with the advisory
20 committee, shall develop quality of care and cost-efficiency
21 benchmarks, including benchmarks based on a managed care
22 organization's performance with respect to reducing potentially
23 preventable events and containing the growth rate of health care
24 costs.

25 (c) The commission may include in a contract between a
26 managed care organization and the commission financial incentives
27 that are based on the organization's successful implementation of

1 quality initiatives under Subsection (a) or success in achieving
2 quality of care and cost-efficiency benchmarks under Subsection
3 (b).

4 (d) In awarding contracts to managed care organizations
5 under the child health plan and Medicaid programs, the commission
6 shall, in addition to considerations under Section 533.003 of this
7 code and Section 62.155, Health and Safety Code, give preference to
8 an organization that offers a managed care plan that successfully
9 implements quality initiatives under Subsection (a) as determined
10 by the commission based on data or other evidence provided by the
11 organization or meets quality of care and cost-efficiency
12 benchmarks under Subsection (b).

13 (e) The commission may implement financial incentives under
14 this section only if implementing the incentives would be
15 cost-effective.

16 [Sections 536.053-536.100 reserved for expansion]

17 SUBCHAPTER C. QUALITY-BASED HEALTH HOME PAYMENT SYSTEMS

18 Sec. 536.101. DEFINITIONS. In this subchapter:

19 (1) "Health home" means a primary care provider
20 practice or, if appropriate, a specialty care provider practice,
21 incorporating several features, including comprehensive care
22 coordination, family-centered care, and data management, that are
23 focused on improving outcome-based quality of care and increasing
24 patient and provider satisfaction under the child health plan and
25 Medicaid programs.

26 (2) "Participating enrollee" means a child health plan
27 program enrollee or Medicaid recipient who has a health home.

1 Sec. 536.102. QUALITY-BASED HEALTH HOME PAYMENTS.

2 (a) Subject to this subchapter, the commission, after consulting
3 with the advisory committee, may develop and implement
4 quality-based payment systems for health homes designed to improve
5 quality of care and reduce the provision of unnecessary medical
6 services. A quality-based payment system developed under this
7 section must:

8 (1) base payments made to a participating enrollee's
9 health home on quality and efficiency measures that may include
10 measurable wellness and prevention criteria and use of
11 evidence-based best practices, sharing a portion of any realized
12 cost savings achieved by the health home, and ensuring quality of
13 care outcomes, including a reduction in potentially preventable
14 events; and

15 (2) allow for the examination of measurable wellness
16 and prevention criteria, use of evidence-based best practices, and
17 quality of care outcomes based on the type of primary or specialty
18 care provider practice.

19 (b) The commission may develop a quality-based payment
20 system for health homes under this subchapter only if implementing
21 the system would be feasible and cost-effective.

22 Sec. 536.103. PROVIDER ELIGIBILITY. To be eligible to
23 receive reimbursement under a quality-based payment system under
24 this subchapter, a health home provider must:

25 (1) provide participating enrollees, directly or
26 indirectly, with access to health care services outside of regular
27 business hours;

1 (2) educate participating enrollees about the
2 availability of health care services outside of regular business
3 hours; and

4 (3) provide evidence satisfactory to the commission
5 that the provider meets the requirement of Subdivision (1).

6 [Sections 536.104-536.150 reserved for expansion]

7 SUBCHAPTER D. QUALITY-BASED HOSPITAL REIMBURSEMENT SYSTEM

8 Sec. 536.151 [531.913]. COLLECTION AND REPORTING OF
9 CERTAIN [HOSPITAL HEALTH] INFORMATION [EXCHANGE]. (a) [In this
10 section, "potentially preventable readmission" means a return
11 hospitalization of a person within a period specified by the
12 commission that results from deficiencies in the care or treatment
13 provided to the person during a previous hospital stay or from
14 deficiencies in post-hospital discharge follow-up. The term does
15 not include a hospital readmission necessitated by the occurrence
16 of unrelated events after the discharge. The term includes the
17 readmission of a person to a hospital for:

18 [(1) the same condition or procedure for which the
19 person was previously admitted,

20 [(2) an infection or other complication resulting from
21 care previously provided,

22 [(3) a condition or procedure that indicates that a
23 surgical intervention performed during a previous admission was
24 unsuccessful in achieving the anticipated outcome, or

25 [(4) another condition or procedure of a similar
26 nature, as determined by the executive commissioner.

27 [(b)] The executive commissioner shall adopt rules for

1 identifying potentially preventable readmissions of child health
2 plan program enrollees and Medicaid recipients and potentially
3 preventable complications experienced by child health plan program
4 enrollees and Medicaid recipients. The ~~[and the]~~ commission shall
5 collect ~~[exchange]~~ data from ~~[with]~~ hospitals on
6 present-on-admission indicators for purposes of this section.

7 (b) ~~[(c)]~~ The commission shall establish a ~~[health~~
8 ~~information exchange]~~ program to provide a ~~[exchange]~~ confidential
9 report to ~~[information with]~~ each hospital in this state that
10 participates in the child health plan or Medicaid program regarding
11 the hospital's performance with respect to potentially preventable
12 readmissions and potentially preventable complications. To the
13 extent possible, a report provided under this section should
14 include potentially preventable readmissions and potentially
15 preventable complications information across all child health plan
16 and Medicaid program payment systems. A hospital shall distribute
17 the information contained in the report ~~[received from the~~
18 ~~commission]~~ to physicians and other health care providers providing
19 services at the hospital.

20 (c) A report provided to a hospital under this section is
21 confidential and is not subject to Chapter 552.

22 Sec. 536.152. REIMBURSEMENT ADJUSTMENTS. (a) Subject to
23 Subsection (b), using the data collected under Section 536.151 and
24 the diagnosis-related groups (DRG) methodology implemented under
25 Section 536.005, the commission, after consulting with the advisory
26 committee, shall to the extent feasible adjust child health plan
27 and Medicaid reimbursements to hospitals, including payments made

1 under the disproportionate share hospitals and upper payment limit
2 supplemental payment programs, in a manner that may reward or
3 penalize a hospital based on the hospital's performance with
4 respect to exceeding, or failing to achieve, outcome and process
5 measures developed under Section 536.003 that address the rates of
6 potentially preventable readmissions and potentially preventable
7 complications.

8 (b) The commission must provide the report required under
9 Section 536.151(b) to a hospital at least one year before the
10 commission adjusts child health plan and Medicaid reimbursements to
11 the hospital under this section.

12 [Sections 536.153-536.200 reserved for expansion]

13 SUBCHAPTER E. QUALITY-BASED PAYMENT INITIATIVES

14 Sec. 536.201. DEFINITION. In this subchapter, "payment
15 initiative" means a quality-based payment initiative established
16 under this subchapter.

17 Sec. 536.202. PAYMENT INITIATIVES; DETERMINATION OF
18 BENEFIT TO STATE. (a) The commission shall, after consulting with
19 the advisory committee, establish payment initiatives to test the
20 effectiveness of quality-based payment systems, alternative
21 payment methodologies, and high-quality, cost-effective health
22 care delivery models that provide incentives to physicians and
23 other health care providers to develop health care interventions
24 for child health plan program enrollees or Medicaid recipients, or
25 both, that will:

26 (1) improve the quality of health care provided to the
27 enrollees or recipients;

- 1 (2) reduce potentially preventable events;
- 2 (3) promote prevention and wellness;
- 3 (4) increase the use of evidence-based best practices;
- 4 (5) increase appropriate physician and other health
5 care provider collaboration; and
- 6 (6) contain costs.

7 (b) The commission shall:

8 (1) establish a process by which managed care
9 organizations and physicians and other health care providers may
10 submit proposals for payment initiatives described by Subsection
11 (a); and

12 (2) determine whether it is feasible and
13 cost-effective to implement one or more of the proposed payment
14 initiatives.

15 Sec. 536.203. PURPOSE AND IMPLEMENTATION OF PAYMENT
16 INITIATIVES. (a) If the commission determines under Section
17 536.202 that implementation of one or more payment initiatives is
18 feasible and cost-effective for this state, the commission shall
19 establish one or more payment initiatives as provided by this
20 subchapter.

21 (b) The commission shall administer any payment initiative
22 established under this subchapter. The executive commissioner may
23 adopt rules, plans, and procedures and enter into contracts and
24 other agreements as the executive commissioner considers
25 appropriate and necessary to administer this subchapter.

26 (c) The commission may limit a payment initiative to:

- 27 (1) one or more regions in this state;

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

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

6 (d) A payment initiative implemented under this subchapter
7 must be operated for at least one calendar year.

8 Sec. 536.204. STANDARDS; PROTOCOLS. (a) The executive
9 commissioner shall:

10 (1) consult with the advisory committee to develop
11 quality of care and cost-efficiency benchmarks and measurable goals
12 that a payment initiative must meet to ensure high-quality and
13 cost-effective health care services and healthy outcomes; and

14 (2) approve benchmarks and goals developed as provided
15 by Subdivision (1).

16 (b) In addition to the benchmarks and goals under Subsection
17 (a), the executive commissioner may approve efficiency performance
18 standards that may include the sharing of realized cost savings
19 with physicians and other health care providers who provide health
20 care services that exceed the efficiency performance standards.
21 The efficiency performance standards may not create any financial
22 incentive for or involve making a payment to a physician or other
23 health care provider that directly or indirectly induces the
24 limitation of medically necessary services.

25 Sec. 536.205. PAYMENT RATES UNDER PAYMENT INITIATIVES. The
26 executive commissioner may contract with appropriate entities,
27 including qualified actuaries, to assist in determining

1 appropriate payment rates for a payment initiative implemented
2 under this subchapter.

3 (b) The Health and Human Services Commission shall convert
4 the hospital reimbursement systems used under the child health plan
5 program under Chapter 62, Health and Safety Code, and medical
6 assistance program under Chapter 32, Human Resources Code, to the
7 diagnosis-related groups (DRG) methodology to the extent possible
8 as required by Section 536.005, Government Code, as added by this
9 section, as soon as practicable after the effective date of this
10 Act, but not later than:

11 (1) September 1, 2013, for reimbursements paid to
12 children's hospitals; and

13 (2) September 1, 2012, for reimbursements paid to
14 other hospitals under those programs.

15 (c) Not later than September 1, 2012, the Health and Human
16 Services Commission shall begin providing performance reports to
17 hospitals regarding the hospitals' performances with respect to
18 potentially preventable complications as required by Section
19 536.151, Government Code, as designated and amended by this
20 section.

21 (d) Subject to Section 536.004(b), Government Code, as
22 added by this section, the Health and Human Services Commission
23 shall begin making adjustments to child health plan and Medicaid
24 reimbursements to hospitals as required by Section 536.152,
25 Government Code, as added by this section:

26 (1) not later than September 1, 2012, based on the
27 hospitals' performances with respect to reducing potentially

1 preventable readmissions; and

2 (2) not later than September 1, 2013, based on the
3 hospitals' performances with respect to reducing potentially
4 preventable complications.

5 SECTION 1.13. (a) The heading to Section 531.912,
6 Government Code, is amended to read as follows:

7 Sec. 531.912. COMMON PERFORMANCE MEASUREMENTS AND
8 PAY-FOR-PERFORMANCE INCENTIVES FOR [~~QUALITY OF CARE HEALTH~~
9 ~~INFORMATION EXCHANGE WITH~~] CERTAIN NURSING FACILITIES.

10 (b) Subsections (b), (c), and (f), Section 531.912,
11 Government Code, are amended to read as follows:

12 (b) If feasible, the executive commissioner by rule may
13 [~~shall~~] establish an incentive payment program for [~~a quality of~~
14 ~~care health information exchange with~~] nursing facilities that
15 choose to participate. The [~~in a~~] program must be designed to
16 improve the quality of care and services provided to medical
17 assistance recipients. Subject to Subsection (f), the program may
18 provide incentive payments in accordance with this section to
19 encourage facilities to participate in the program.

20 (c) In establishing an incentive payment [~~a quality of care~~
21 ~~health information exchange~~] program under this section, the
22 executive commissioner shall, subject to Subsection (d), adopt
23 common [~~exchange information with participating nursing facilities~~
24 ~~regarding~~] performance measures to be used in evaluating nursing
25 facilities that are related to structure, process, and outcomes
26 that positively correlate to nursing facility quality and
27 improvement. The common performance measures:

1 (1) must be:

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

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

7 (2) may include measures of:

8 (A) quality of care, as determined by clinical
9 performance ratings published by the federal Centers for Medicare
10 and Medicaid Services, the Agency for Healthcare Research and
11 Quality, or another federal agency [~~Life~~];

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

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

19 (D) employee satisfaction and engagement;

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

22 (F) regulatory compliance;

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

24 (H) direct-care staff training, including a
25 facility's [~~level of occupancy or of facility~~] utilization of
26 independent distance learning programs for the continuous training
27 of direct-care staff.

1 (f) The commission may make incentive payments under the
2 program only if money is [~~specifically~~] appropriated for that
3 purpose.

4 (c) The Department of Aging and Disability Services shall
5 conduct a study to evaluate the feasibility of expanding any
6 incentive payment program established for nursing facilities under
7 Section 531.912, Government Code, as amended by this section, by
8 providing incentive payments for the following types of providers
9 of long-term care services, as defined by Section 22.0011, Human
10 Resources Code, under the medical assistance program:

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

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

17 (d) Not later than September 1, 2012, the Department of
18 Aging and Disability Services shall submit to the legislature a
19 written report containing the findings of the study conducted under
20 Subsection (c) of this section and the department's
21 recommendations.

22 SECTION 1.14. Section 780.004, Health and Safety Code, is
23 amended by amending Subsection (a) and adding Subsection (j) to
24 read as follows:

25 (a) The commissioner:

26 (1) [~~7~~] with advice and counsel from the chairpersons
27 of the trauma service area regional advisory councils, shall use

1 money appropriated from the account established under this chapter
2 to fund designated trauma facilities, county and regional emergency
3 medical services, and trauma care systems in accordance with this
4 section; and

5 (2) after consulting with the executive commissioner
6 of the Health and Human Services Commission, may transfer to an
7 account in the general revenue fund money appropriated from the
8 account established under this chapter to maximize the receipt of
9 federal funds under the medical assistance program established
10 under Chapter 32, Human Resources Code, and to fund provider
11 reimbursement payments as provided by Subsection (j).

12 (j) Money in the account described by Subsection (a)(2) may
13 be appropriated only to the Health and Human Services Commission to
14 fund provider reimbursement payments under the medical assistance
15 program established under Chapter 32, Human Resources Code,
16 including reimbursement enhancements to the statewide dollar
17 amount (SDA) rate used to reimburse designated trauma hospitals
18 under the program.

19 SECTION 1.15. Subchapter B, Chapter 531, Government Code,
20 is amended by adding Section 531.0697 to read as follows:

21 Sec. 531.0697. PRIOR APPROVAL AND PROVIDER ACCESS TO
22 CERTAIN COMMUNICATIONS WITH CERTAIN RECIPIENTS. (a) This section
23 applies to:

24 (1) the vendor drug program for the Medicaid and child
25 health plan programs;

26 (2) the kidney health care program;

27 (3) the children with special health care needs

1 program; and

2 (4) any other state program administered by the
3 commission that provides prescription drug benefits.

4 (b) A managed care organization, including a health
5 maintenance organization, or a pharmacy benefit manager, that
6 administers claims for prescription drug benefits under a program
7 to which this section applies shall, at least 10 days before the
8 date the organization or pharmacy benefit manager intends to
9 deliver a communication to recipients collectively under a program:

10 (1) submit a copy of the communication to the
11 commission for approval; and

12 (2) if applicable, allow the pharmacy providers of
13 recipients who are to receive the communication access to the
14 communication.

15 SECTION 1.16. (a) Subchapter A, Chapter 61, Health and
16 Safety Code, is amended by adding Section 61.012 to read as follows:

17 Sec. 61.012. REIMBURSEMENT FOR SERVICES. (a) In this
18 section, "sponsored alien" means a person who has been lawfully
19 admitted to the United States for permanent residence under the
20 Immigration and Nationality Act (8 U.S.C. Section 1101 et seq.) and
21 who, as a condition of admission, was sponsored by a person who
22 executed an affidavit of support on behalf of the person.

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

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

7 (b) Section 61.012, Health and Safety Code, as added by this
8 section, applies only to health care services provided by a public
9 hospital or hospital district on or after the effective date of this
10 Act.

11 SECTION 1.17. Subchapter B, Chapter 531, Government Code,
12 is amended by adding Sections 531.024181 and 531.024182 to read as
13 follows:

14 Sec. 531.024181. VERIFICATION OF IMMIGRATION STATUS OF
15 APPLICANTS FOR CERTAIN BENEFITS WHO ARE QUALIFIED ALIENS. (a) This
16 section applies only with respect to the following benefits
17 programs:

18 (1) the child health plan program under Chapter 62,
19 Health and Safety Code;

20 (2) the financial assistance program under Chapter 31,
21 Human Resources Code;

22 (3) the medical assistance program under Chapter 32,
23 Human Resources Code; and

24 (4) the nutritional assistance program under Chapter
25 33, Human Resources Code.

26 (b) If, at the time of application for benefits under a
27 program to which this section applies, a person states that the

1 person is a qualified alien, as that term is defined by 8 U.S.C.
2 Section 1641(b), the commission shall, to the extent allowed by
3 federal law, verify information regarding the immigration status of
4 the person using an automated system or systems where available.

5 (c) The executive commissioner shall adopt rules necessary
6 to implement this section.

7 (d) Nothing in this section adds to or changes the
8 eligibility requirements for any of the benefits programs to which
9 this section applies.

10 Sec. 531.024182. VERIFICATION OF SPONSORSHIP INFORMATION
11 FOR CERTAIN BENEFITS RECIPIENTS; REIMBURSEMENT. (a) In this
12 section, "sponsored alien" means a person who has been lawfully
13 admitted to the United States for permanent residence under the
14 Immigration and Nationality Act (8 U.S.C. Section 1101 et seq.) and
15 who, as a condition of admission, was sponsored by a person who
16 executed an affidavit of support on behalf of the person.

17 (b) If, at the time of application for benefits, a person
18 stated that the person is a sponsored alien, the commission may, to
19 the extent allowed by federal law, verify information relating to
20 the sponsorship, using an automated system or systems where
21 available, after the person is determined eligible for and begins
22 receiving benefits under any of the following benefits programs:

23 (1) the child health plan program under Chapter 62,
24 Health and Safety Code;

25 (2) the financial assistance program under Chapter 31,
26 Human Resources Code;

27 (3) the medical assistance program under Chapter 32,

1 Human Resources Code; or

2 (4) the nutritional assistance program under Chapter
3 33, Human Resources Code.

4 (c) If the commission verifies that a person who receives
5 benefits under a program listed in Subsection (b) is a sponsored
6 alien, the commission may seek reimbursement from the person's
7 sponsor for benefits provided to the person under those programs to
8 the extent allowed by federal law, provided the commission
9 determines that seeking reimbursement is cost-effective.

10 (d) If, at the time a person applies for benefits under a
11 program listed in Subsection (b), the person states that the person
12 is a sponsored alien, the commission shall make a reasonable effort
13 to notify the person that the commission may seek reimbursement
14 from the person's sponsor for any benefits the person receives
15 under those programs.

16 (e) The executive commissioner shall adopt rules necessary
17 to implement this section, including rules that specify the most
18 cost-effective procedures by which the commission may seek
19 reimbursement under Subsection (c).

20 (f) Nothing in this section adds to or changes the
21 eligibility requirements for any of the benefits programs listed in
22 Subsection (b).

23 SECTION 1.18. Subchapter B, Chapter 32, Human Resources
24 Code, is amended by adding Section 32.0314 to read as follows:

25 Sec. 32.0314. REIMBURSEMENT FOR DURABLE MEDICAL EQUIPMENT
26 AND SUPPLIES. The executive commissioner of the Health and Human
27 Services Commission shall adopt rules requiring the electronic

1 submission of any claim for reimbursement for durable medical
2 equipment and supplies under the medical assistance program.

3 SECTION 1.19. (a) Subchapter A, Chapter 531, Government
4 Code, is amended by adding Section 531.0025 to read as follows:

5 Sec. 531.0025. RESTRICTIONS ON AWARDS TO FAMILY PLANNING
6 SERVICE PROVIDERS. (a) Notwithstanding any other law, money
7 appropriated to the Department of State Health Services for the
8 purpose of providing family planning services must be awarded:

9 (1) to eligible entities in the following order of
10 descending priority:

11 (A) public entities that provide family planning
12 services, including state, county, and local community health
13 clinics;

14 (B) nonpublic entities that provide
15 comprehensive primary and preventive care services in addition to
16 family planning services; and

17 (C) nonpublic entities that provide family
18 planning services but do not provide comprehensive primary and
19 preventive care services; or

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

22 (b) Notwithstanding Subsection (a), the Department of State
23 Health Services shall, in compliance with federal law, ensure
24 distribution of funds for family planning services in a manner that
25 does not severely limit or eliminate access to those services in any
26 region of the state.

27 (b) Section 32.024, Human Resources Code, is amended by

1 adding Subsection (c-1) to read as follows:

2 (c-1) The department shall ensure that money spent for
3 purposes of the demonstration project for women's health care
4 services under former Section 32.0248, Human Resources Code, or a
5 similar successor program is not used to perform or promote
6 elective abortions, or to contract with entities that perform or
7 promote elective abortions or affiliate with entities that perform
8 or promote elective abortions.

9 SECTION 1.20. If before implementing any provision of this
10 article a state agency determines that a waiver or authorization
11 from a federal agency is necessary for implementation of that
12 provision, the agency affected by the provision shall request the
13 waiver or authorization and may delay implementing that provision
14 until the waiver or authorization is granted.

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

17 SECTION 2.01. (a) The legislature finds that it would
18 benefit the State of Texas to:

19 (1) explore innovative health care delivery and
20 payment models to improve the quality and efficiency of health care
21 in this state;

22 (2) improve health care transparency;

23 (3) give health care providers the flexibility to
24 collaborate and innovate to improve the quality and efficiency of
25 health care; and

26 (4) create incentives to improve the quality and
27 efficiency of health care.

1 (b) The legislature finds that the use of certified health
2 care collaboratives will increase pro-competitive effects as the
3 ability to compete on the basis of quality of care and the
4 furtherance of the quality of care through a health care
5 collaborative will overcome any anticompetitive effects of joining
6 competitors to create the health care collaboratives and the
7 payment mechanisms that will be used to encourage the furtherance
8 of quality of care. Consequently, the legislature finds it
9 appropriate and necessary to authorize health care collaboratives
10 to promote the efficiency and quality of health care.

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

20 (d) The legislature intends to permit the use of alternative
21 payment mechanisms, including bundled or global payments and
22 quality-based payments, among physicians and other health care
23 providers participating in a health care collaborative that holds a
24 certificate of authority under Chapter 848, Insurance Code, as
25 added by Article 4 of this Act. The legislature intends to
26 authorize a health care collaborative to contract for and accept
27 payments from governmental and private payors based on alternative

1 payment mechanisms, and intends that the receipt and distribution
2 of payments to participating physicians and health care providers
3 is not a violation of any existing state law.

4 ARTICLE 3. TEXAS INSTITUTE OF HEALTH CARE QUALITY AND EFFICIENCY

5 SECTION 3.01. Title 12, Health and Safety Code, is amended
6 by adding Chapter 1002 to read as follows:

7 CHAPTER 1002. TEXAS INSTITUTE OF HEALTH CARE QUALITY AND

8 EFFICIENCY

9 SUBCHAPTER A. GENERAL PROVISIONS

10 Sec. 1002.001. DEFINITIONS. In this chapter:

11 (1) "Board" means the board of directors of the Texas
12 Institute of Health Care Quality and Efficiency established under
13 this chapter.

14 (2) "Commission" means the Health and Human Services
15 Commission.

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

18 (4) "Executive commissioner" means the executive
19 commissioner of the Health and Human Services Commission.

20 (5) "Health care collaborative" has the meaning
21 assigned by Section 848.001, Insurance Code.

22 (6) "Health care facility" means:

23 (A) a hospital licensed under Chapter 241;

24 (B) an institution licensed under Chapter 242;

25 (C) an ambulatory surgical center licensed under
26 Chapter 243;

27 (D) a birthing center licensed under Chapter 244;

1 (E) an end stage renal disease facility licensed
2 under Chapter 251; or

3 (F) a freestanding emergency medical care
4 facility licensed under Chapter 254.

5 (7) "Institute" means the Texas Institute of Health
6 Care Quality and Efficiency established under this chapter.

7 (8) "Potentially preventable admission" means an
8 admission of a person to a hospital or long-term care facility that
9 may have reasonably been prevented with adequate access to
10 ambulatory care or health care coordination.

11 (9) "Potentially preventable ancillary service" means
12 a health care service provided or ordered by a physician or other
13 health care provider to supplement or support the evaluation or
14 treatment of a patient, including a diagnostic test, laboratory
15 test, therapy service, or radiology service, that may not be
16 reasonably necessary for the provision of quality health care or
17 treatment.

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

21 (A) occurs after the person's admission to a
22 hospital or long-term care facility; and

23 (B) may have resulted from the care, lack of
24 care, or treatment provided during the hospital or long-term care
25 facility stay rather than from a natural progression of an
26 underlying disease.

27 (11) "Potentially preventable event" means a

1 potentially preventable admission, a potentially preventable
2 ancillary service, a potentially preventable complication, a
3 potentially preventable emergency room visit, a potentially
4 preventable readmission, or a combination of those events.

5 (12) "Potentially preventable emergency room visit"
6 means treatment of a person in a hospital emergency room or
7 freestanding emergency medical care facility for a condition that
8 may not require emergency medical attention because the condition
9 could be, or could have been, treated or prevented by a physician or
10 other health care provider in a nonemergency setting.

11 (13) "Potentially preventable readmission" means a
12 return hospitalization of a person within a period specified by the
13 commission that may have resulted from deficiencies in the care or
14 treatment provided to the person during a previous hospital stay or
15 from deficiencies in post-hospital discharge follow-up. The term
16 does not include a hospital readmission necessitated by the
17 occurrence of unrelated events after the discharge. The term
18 includes the readmission of a person to a hospital for:

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

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

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

26 Sec. 1002.002. ESTABLISHMENT; PURPOSE. The Texas Institute
27 of Health Care Quality and Efficiency is established to improve

1 health care quality, accountability, education, and cost
2 containment in this state by encouraging health care provider
3 collaboration, effective health care delivery models, and
4 coordination of health care services.

5 [Sections 1002.003-1002.050 reserved for expansion]

6 SUBCHAPTER B. ADMINISTRATION

7 Sec. 1002.051. APPLICATION OF SUNSET ACT. The institute is
8 subject to Chapter 325, Government Code (Texas Sunset Act). Unless
9 continued in existence as provided by that chapter, the institute
10 is abolished and this chapter expires September 1, 2017.

11 Sec. 1002.052. COMPOSITION OF BOARD OF DIRECTORS. (a) The
12 institute is governed by a board of 15 directors appointed by the
13 governor.

14 (b) The following ex officio, nonvoting members also serve
15 on the board:

16 (1) the commissioner of the department;

17 (2) the executive commissioner;

18 (3) the commissioner of insurance;

19 (4) the executive director of the Employees Retirement
20 System of Texas;

21 (5) the executive director of the Teacher Retirement
22 System of Texas;

23 (6) the state Medicaid director of the Health and
24 Human Services Commission;

25 (7) the executive director of the Texas Medical Board;

26 (8) the commissioner of the Department of Aging and
27 Disability Services;

1 (9) the executive director of the Texas Workforce
2 Commission;

3 (10) the commissioner of the Texas Higher Education
4 Coordinating Board; and

5 (11) a representative from each state agency or system
6 of higher education that purchases or provides health care
7 services, as determined by the governor.

8 (c) The governor shall appoint as board members health care
9 providers, payors, consumers, and health care quality experts or
10 persons who possess expertise in any other area the governor finds
11 necessary for the successful operation of the institute.

12 (d) A person may not serve as a voting member of the board if
13 the person serves on or advises another board or advisory board of a
14 state agency.

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

19 (b) Board members may serve consecutive terms.

20 Sec. 1002.054. ADMINISTRATIVE SUPPORT. (a) The institute
21 is administratively attached to the commission.

22 (b) The commission shall coordinate administrative
23 responsibilities with the institute to streamline and integrate the
24 institute's administrative operations and avoid unnecessary
25 duplication of effort and costs.

26 (c) The institute may collaborate with, and coordinate its
27 administrative functions, including functions related to research

1 and reporting activities with, other public or private entities,
2 including academic institutions and nonprofit organizations, that
3 perform research on health care issues or other topics consistent
4 with the purpose of the institute.

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

9 (b) Information relating to the billing and payment of
10 expenses under this section is subject to Chapter 552, Government
11 Code.

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

15 (b) Any board member or a member of a committee formed by the
16 board with direct interest, personally or through an employer, in a
17 matter before the board shall abstain from deliberations and
18 actions on the matter in which the conflict of interest arises and
19 shall further abstain on any vote on the matter, and may not
20 otherwise participate in a decision on the matter.

21 (c) Each board member shall:

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

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

1 (d) A statement filed under Subsection (c) is subject to
2 Chapter 552, Government Code.

3 Sec. 1002.057. PROHIBITION ON CERTAIN CONTRACTS AND
4 EMPLOYMENT. (a) The board may not compensate, employ, or contract
5 with any individual who serves as a member of the board of, or on an
6 advisory board or advisory committee for, any other governmental
7 body, including any agency, council, or committee, in this state.

8 (b) The board may not compensate, employ, or contract with
9 any person that provides financial support to the board, including
10 a person who provides a gift, grant, or donation to the board.

11 Sec. 1002.058. MEETINGS. (a) The board may meet as often
12 as necessary, but shall meet at least once each calendar quarter.

13 (b) The board shall develop and implement policies that
14 provide the public with a reasonable opportunity to appear before
15 the board and to speak on any issue under the authority of the
16 institute.

17 Sec. 1002.059. BOARD MEMBER IMMUNITY. (a) A board member
18 may not be held civilly liable for an act performed, or omission
19 made, in good faith in the performance of the member's powers and
20 duties under this chapter.

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

23 Sec. 1002.060. PRIVACY OF INFORMATION. (a) Protected
24 health information and individually identifiable health
25 information collected, assembled, or maintained by the institute is
26 confidential and is not subject to disclosure under Chapter 552,
27 Government Code.

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

7 (c) The commission, department, or institute or an officer
8 or employee of the commission, department, or institute, including
9 a board member, may not disclose any information that is
10 confidential under this section.

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

15 (e) An officer or employee of the commission, department, or
16 institute, including a board member, may not be examined in a civil,
17 criminal, special, administrative, or other proceeding as to
18 information that is confidential under this section.

19 Sec. 1002.061. FUNDING. (a) The institute may be funded
20 through the General Appropriations Act and may request, accept, and
21 use gifts, grants, and donations as necessary to implement its
22 functions.

23 (b) The institute may participate in other
24 revenue-generating activity that is consistent with the
25 institute's purposes.

26 (c) Except as otherwise provided by law, each state agency
27 represented on the board as a nonvoting member shall provide funds

1 to support the institute and implement this chapter. The
2 commission shall establish a funding formula to determine the level
3 of support each state agency is required to provide.

4 (d) This section does not permit the sale of information
5 that is confidential under Section 1002.060.

6 [Sections 1002.062-1002.100 reserved for expansion]

7 SUBCHAPTER C. POWERS AND DUTIES

8 Sec. 1002.101. GENERAL POWERS AND DUTIES. The institute
9 shall make recommendations to the legislature on:

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

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

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

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

22 (i) using nationally accredited measures;

23 or

24 (ii) if no nationally accredited measures
25 exist, using measures based on expert consensus;

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

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

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

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

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

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

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

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

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

25 (b) The institute shall study and develop recommendations
26 for measuring quality of care and efficiency across:

27 (1) all state employee and state retiree benefit

1 plans;

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

4 (3) the state medical assistance program under Chapter
5 32, Human Resources Code; and

6 (4) the child health plan under Chapter 62.

7 (c) In developing recommendations under Subsection (b), the
8 institute shall use nationally accredited measures or, if no
9 nationally accredited measures exist, measures based on expert
10 consensus.

11 (d) The institute may study and develop recommendations for
12 measuring the quality of care and efficiency in state or federally
13 funded health care delivery systems other than those described by
14 Subsection (b).

15 (e) In developing recommendations under Subsections (a) and
16 (b), the institute may not base its recommendations solely on
17 actuarial data.

18 (f) Using the studies described by Subsections (a) and (b),
19 the institute shall develop recommendations for a statewide plan
20 for quality and efficiency of the delivery of health care.

21 [Sections 1002.103-1002.150 reserved for expansion]

22 SUBCHAPTER D. HEALTH CARE COLLABORATIVE GUIDELINES AND SUPPORT

23 Sec. 1002.151. INSTITUTE STUDIES AND RECOMMENDATIONS
24 REGARDING HEALTH CARE PAYMENT AND DELIVERY SYSTEMS. (a) The
25 institute shall study and make recommendations for alternative
26 health care payment and delivery systems.

27 (b) The institute shall recommend methods to evaluate a

1 health care collaborative's effectiveness, including methods to
2 evaluate:

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

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

7 (3) the quality of care;

8 (4) health care provider collaboration and
9 coordination;

10 (5) the protection of patients;

11 (6) patient satisfaction; and

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

15 [Sections 1002.152-1002.200 reserved for expansion]

16 SUBCHAPTER E. IMPROVED TRANSPARENCY

17 Sec. 1002.201. HEALTH CARE ACCOUNTABILITY; IMPROVED
18 TRANSPARENCY. (a) With the assistance of the department, the
19 institute shall complete an assessment of all health-related data
20 collected by the state, what information is available to the
21 public, and how the public and health care providers currently
22 benefit and could potentially benefit from this information,
23 including health care cost and quality information.

24 (b) The institute shall develop a plan:

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

1 payors;

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

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

10 Sec. 1002.202. ALL PAYOR CLAIMS DATABASE. (a) The
11 institute shall study the feasibility and desirability of
12 establishing a centralized database for health care claims
13 information across all payors.

14 (b) The study described by Subsection (a) shall:

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

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

22 (3) identify the best available sources of data
23 necessary for the state's purposes under this chapter and Chapter
24 848, Insurance Code, that are not collected by the state under
25 existing law;

26 (4) describe how an all payor claims database may
27 facilitate carrying out the state's purposes under this chapter and

1 Chapter 848, Insurance Code;

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

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

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

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

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

14 (c) The institute shall consult with the department and the
15 Texas Department of Insurance to develop recommendations to submit
16 to the legislature on the establishment of the centralized claims
17 database described by Subsection (a).

18 SECTION 3.02. Chapter 109, Health and Safety Code, is
19 repealed.

20 SECTION 3.03. On the effective date of this Act:

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

23 (2) any unexpended and unobligated balance of money
24 appropriated by the legislature to the Texas Health Care Policy
25 Council established under Chapter 109, Health and Safety Code, as
26 it existed immediately before the effective date of this Act, is
27 transferred to the Texas Institute of Health Care Quality and

1 Efficiency created by Chapter 1002, Health and Safety Code, as
2 added by this Act.

3 SECTION 3.04. (a) The governor shall appoint voting
4 members of the board of directors of the Texas Institute of Health
5 Care Quality and Efficiency under Section 1002.052, Health and
6 Safety Code, as added by this Act, as soon as practicable after the
7 effective date of this Act.

8 (b) In making the initial appointments under this section,
9 the governor shall designate seven members to terms expiring
10 January 31, 2013, and eight members to terms expiring January 31,
11 2015.

12 SECTION 3.05. (a) Not later than December 1, 2012, the
13 Texas Institute of Health Care Quality and Efficiency shall submit
14 a report regarding recommendations for improved health care
15 reporting to the governor, the lieutenant governor, the speaker of
16 the house of representatives, and the chairs of the appropriate
17 standing committees of the legislature outlining:

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

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

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

25 (4) the cost implications to state agencies, small
26 businesses, micro businesses, payors, and health care providers to
27 implement the assessment and plans described by Subdivisions (1)

1 and (2) of this subsection.

2 (b) Not later than December 1, 2012, the Texas Institute of
3 Health Care Quality and Efficiency shall submit a report regarding
4 recommendations for an all payor claims database to the governor,
5 the lieutenant governor, the speaker of the house of
6 representatives, and the chairs of the appropriate standing
7 committees of the legislature outlining:

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

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

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

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

19 SECTION 3.06. (a) The Texas Institute of Health Care
20 Quality and Efficiency under Chapter 1002, Health and Safety Code,
21 as added by this Act, with the assistance of and in coordination
22 with the Texas Department of Insurance, shall conduct a study:

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

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

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

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

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

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

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

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

20 (ii) adhere to the posted amount.

21 (b) The institute shall submit a report to the legislature
22 outlining the results of the study conducted under this section and
23 any recommendations for potential legislation not later than
24 January 1, 2013.

25 (c) This section expires September 1, 2013.

26 ARTICLE 4. HEALTH CARE COLLABORATIVES

27 SECTION 4.01. Subtitle C, Title 6, Insurance Code, is

1 amended by adding Chapter 848 to read as follows:

2 CHAPTER 848. HEALTH CARE COLLABORATIVES

3 SUBCHAPTER A. GENERAL PROVISIONS

4 Sec. 848.001. DEFINITIONS. In this chapter:

5 (1) "Affiliate" means a person who controls, is
6 controlled by, or is under common control with one or more other
7 persons.

8 (2) "Health care collaborative" means an entity:

9 (A) that undertakes to arrange for medical and
10 health care services for insurers, health maintenance
11 organizations, and other payors in exchange for payments in cash or
12 in kind;

13 (B) that accepts and distributes payments for
14 medical and health care services;

15 (C) that consists of:

16 (i) physicians;

17 (ii) physicians and other health care
18 providers;

19 (iii) physicians and insurers or health
20 maintenance organizations; or

21 (iv) physicians, other health care
22 providers, and insurers or health maintenance organizations; and

23 (D) that is certified by the commissioner under
24 this chapter to lawfully accept and distribute payments to
25 physicians and other health care providers using the reimbursement
26 methodologies authorized by this chapter.

27 (3) "Health care services" means services provided by

1 a physician or health care provider to prevent, alleviate, cure, or
2 heal human illness or injury. The term includes:

3 (A) pharmaceutical services;

4 (B) medical, chiropractic, or dental care; and

5 (C) hospitalization.

6 (4) "Health care provider" means any person,
7 partnership, professional association, corporation, facility, or
8 institution licensed, certified, registered, or chartered by this
9 state to provide health care services. The term includes a hospital
10 but does not include a physician.

11 (5) "Health maintenance organization" means an
12 organization operating under Chapter 843.

13 (6) "Hospital" means a general or special hospital,
14 including a public or private institution licensed under Chapter
15 241 or 577, Health and Safety Code.

16 (7) "Institute" means the Texas Institute of Health
17 Care Quality and Efficiency established under Chapter 1002, Health
18 and Safety Code.

19 (8) "Physician" means:

20 (A) an individual licensed to practice medicine
21 in this state;

22 (B) a professional association organized under
23 the Texas Professional Association Act (Article 1528f, Vernon's
24 Texas Civil Statutes) or the Texas Professional Association Law by
25 an individual or group of individuals licensed to practice medicine
26 in this state;

27 (C) a partnership or limited liability

1 partnership formed by a group of individuals licensed to practice
2 medicine in this state;

3 (D) a nonprofit health corporation certified
4 under Section 162.001, Occupations Code;

5 (E) a company formed by a group of individuals
6 licensed to practice medicine in this state under the Texas Limited
7 Liability Company Act (Article 1528n, Vernon's Texas Civil
8 Statutes) or the Texas Professional Limited Liability Company Law;
9 or

10 (F) an organization wholly owned and controlled
11 by individuals licensed to practice medicine in this state.

12 (9) "Potentially preventable event" has the meaning
13 assigned by Section 1002.001, Health and Safety Code.

14 Sec. 848.002. EXCEPTION: DELEGATED ENTITIES. (a) This
15 section applies only to an entity, other than a health maintenance
16 organization, that:

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

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

23 (A) Chapter 222, 251, 258, or 1272, as
24 applicable, to a health maintenance organization; or

25 (B) Chapter 843, Chapter 1271, Section 1367.053,
26 Subchapter A, Chapter 1452, or Subchapter B, Chapter 1507, as
27 applicable, solely on behalf of health maintenance organizations.

1 (b) An entity described by Subsection (a) is subject to
2 Chapter 1272 and is not required to obtain a certificate of
3 authority or determination of approval under this chapter.

4 Sec. 848.003. USE OF INSURANCE-RELATED TERMS BY HEALTH CARE
5 COLLABORATIVE. A health care collaborative that is not an insurer
6 or health maintenance organization may not use in its name,
7 contracts, or literature:

8 (1) the following words or initials:

9 (A) "insurance";

10 (B) "casualty";

11 (C) "surety";

12 (D) "mutual";

13 (E) "health maintenance organization"; or

14 (F) "HMO"; or

15 (2) any other words or initials that are:

16 (A) descriptive of the insurance, casualty,
17 surety, or health maintenance organization business; or

18 (B) deceptively similar to the name or
19 description of an insurer, surety corporation, or health
20 maintenance organization engaging in business in this state.

21 Sec. 848.004. APPLICABILITY OF INSURANCE LAWS. (a) An
22 organization may not arrange for or provide health care services to
23 enrollees on a prepaid or indemnity basis through health insurance
24 or a health benefit plan, including a health care plan, as defined
25 by Section 843.002, unless the organization as an insurer or health
26 maintenance organization holds the appropriate certificate of
27 authority issued under another chapter of this code.

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

5 (1) Section 38.001;

6 (2) Subchapter A, Chapter 542;

7 (3) Chapter 541;

8 (4) Chapter 543;

9 (5) Chapter 602;

10 (6) Chapter 701;

11 (7) Chapter 803; and

12 (8) Chapter 804.

13 (c) The remedies available under this chapter in the manner
14 provided by Chapter 541 do not include:

15 (1) a private cause of action under Subchapter D,
16 Chapter 541; or

17 (2) a class action under Subchapter F, Chapter 541.

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

22 (b) The following information is confidential and is not
23 subject to disclosure under Chapter 552, Government Code:

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

26 (A) between a health care collaborative and a
27 governmental or private entity for all or part of health care

1 services provided or arranged for by the health care collaborative;

2 or

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

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

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

9 (A) the department under Sections 848.057(a)(5)
10 and (6); or

11 (B) the attorney general under Section 848.059;

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

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

17 Sec. 848.006. COVERAGE BY HEALTH CARE COLLABORATIVE NOT
18 REQUIRED. (a) Except as provided by Subsection (b) and subject to
19 Chapter 843 and Section 1301.0625, an individual may not be
20 required to obtain or maintain coverage under:

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

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

26 (b) This chapter does not require an individual to obtain or
27 maintain health insurance coverage.

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

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

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

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

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

12 (d) Except as provided by Subsection (e), a fine or penalty
13 may not be imposed on an individual if the individual chooses not to
14 obtain or maintain coverage described by Subsection (a).

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

19 [Sections 848.007-848.050 reserved for expansion]

20 SUBCHAPTER B. AUTHORITY TO ENGAGE IN BUSINESS

21 Sec. 848.051. OPERATION OF HEALTH CARE COLLABORATIVE. A
22 health care collaborative that is certified by the department under
23 this chapter may provide or arrange to provide health care services
24 under contract with a governmental or private entity.

25 Sec. 848.052. FORMATION AND GOVERNANCE OF HEALTH CARE
26 COLLABORATIVE. (a) A health care collaborative is governed by a
27 board of directors.

1 (b) The person who establishes a health care collaborative
2 shall appoint an initial board of directors. Each member of the
3 initial board serves a term of not more than 18 months. Subsequent
4 members of the board shall be elected to serve two-year terms by
5 physicians and health care providers who participate in the health
6 care collaborative as provided by this section. The board shall
7 elect a chair from among its members.

8 (c) If the participants in a health care collaborative are
9 all physicians, each member of the board of directors must be an
10 individual physician who is a participant in the health care
11 collaborative.

12 (d) If the participants in a health care collaborative are
13 both physicians and other health care providers, the board of
14 directors must consist of:

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

18 (2) a number of members equal to the number of members
19 under Subdivision (1) who represent health care providers, one of
20 whom is an individual physician, selected by health care providers
21 who participate in the health care collaborative; and

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

25 (e) The board of directors must include at least three
26 nonvoting ex officio members who represent the community in which
27 the health care collaborative operates.

1 (f) An individual may not serve on the board of directors of
2 a health care collaborative if the individual has an ownership
3 interest in, serves on the board of directors of, or maintains an
4 officer position with:

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

8 (2) a physician or health care provider that:

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

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

13 (g) In addition to the requirements of Subsection (f), the
14 board of directors of a health care collaborative shall adopt a
15 conflict of interest policy to be followed by members.

16 (h) The board of directors may remove a member for cause. A
17 member may not be removed from the board without cause.

18 (i) The organizational documents of a health care
19 collaborative may not conflict with any provision of this chapter,
20 including this section.

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

1 committee must include:

2 (1) a member of the board of directors; and

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

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

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

10 (b) A health care collaborative shall establish and enforce
11 policies to prevent the sharing of charge, fee, and payment data
12 among nonparticipating physicians and health care providers.

13 Sec. 848.054. CERTIFICATE OF AUTHORITY AND DETERMINATION OF
14 APPROVAL REQUIRED. (a) An organization may not organize or
15 operate a health care collaborative in this state unless the
16 organization holds a certificate of authority issued under this
17 chapter.

18 (b) The commissioner shall adopt rules governing the
19 application for a certificate of authority under this subchapter.

20 Sec. 848.055. EXCEPTIONS. (a) An organization is not
21 required to obtain a certificate of authority under this chapter if
22 the organization holds an appropriate certificate of authority
23 issued under another chapter of this code.

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

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

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

4 (c) A medical school, medical and dental unit, or health
5 science center as described by Section 61.003, 61.501, or 74.601,
6 Education Code, is not required to obtain a certificate of
7 authority under this chapter to the extent that the medical school,
8 medical and dental unit, or health science center contracts to
9 deliver medical care services within a health care collaborative.
10 This chapter is otherwise applicable to a medical school, medical
11 and dental unit, or health science center.

12 (d) An entity licensed under the Health and Safety Code that
13 employs a physician under a specific statutory authority is not
14 required to obtain a certificate of authority under this chapter to
15 the extent that the entity contracts to deliver medical care
16 services and health care services within a health care
17 collaborative. This chapter is otherwise applicable to the entity.

18 Sec. 848.056. APPLICATION FOR CERTIFICATE OF AUTHORITY.

19 (a) An organization may apply to the commissioner for and obtain a
20 certificate of authority to organize and operate a health care
21 collaborative.

22 (b) An application for a certificate of authority must:

23 (1) comply with all rules adopted by the commissioner;
24 (2) be verified under oath by the applicant or an
25 officer or other authorized representative of the applicant;

26 (3) be reviewed by the division within the office of
27 attorney general that is primarily responsible for enforcing the

1 antitrust laws of this state and of the United States under Section
2 848.059;

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

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

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

11 (c) Not later than the 190th day after the date an applicant
12 submits an application to the commissioner under this section, the
13 commissioner shall approve or deny the application.

14 (d) The commissioner by rule may:

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

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

20 Sec. 848.057. REQUIREMENTS FOR APPROVAL OF APPLICATION.

21 (a) The commissioner shall issue a certificate of authority on
22 payment of the application fee prescribed by Section 848.152 if the
23 commissioner is satisfied that:

24 (1) the applicant meets the requirements of Section
25 848.056;

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

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

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

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

9 (iii) reduces the occurrence of potentially
10 preventable events;

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

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

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

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

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

26 (5) the applicant's proposed health care collaborative
27 is not likely to reduce competition in any market for physician,

1 hospital, or ancillary health care services due to:

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

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

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

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

13 Sec. 848.058. DENIAL OF CERTIFICATE OF AUTHORITY. (a) The
14 commissioner may not issue a certificate of authority if the
15 commissioner determines that the applicant's proposed plan of
16 operation does not meet the requirements of Section 848.057.

17 (b) If the commissioner denies an application for a
18 certificate of authority under Subsection (a), the commissioner
19 shall notify the applicant that the plan is deficient and specify
20 the deficiencies.

21 Sec. 848.059. CONCURRENCE OF ATTORNEY GENERAL. (a) If the
22 commissioner determines that an application for a certificate of
23 authority filed under Section 848.056 complies with the
24 requirements of Section 848.057, the commissioner shall forward the
25 application, and all data, documents, and analysis considered by
26 the commissioner in making the determination, to the attorney
27 general. The attorney general shall review the application and the

1 data, documents, and analysis and, if the attorney general concurs
2 with the commissioner's determination under Sections 848.057(a)(5)
3 and (6), the attorney general shall notify the commissioner.

4 (b) If the attorney general does not concur with the
5 commissioner's determination under Sections 848.057(a)(5) and (6),
6 the attorney general shall notify the commissioner.

7 (c) A determination under this section shall be made not
8 later than the 60th day after the date the attorney general receives
9 the application and the data, documents, and analysis from the
10 commissioner.

11 (d) If the attorney general lacks sufficient information to
12 make a determination under Sections 848.057(a)(5) and (6), within
13 60 days of the attorney general's receipt of the application and the
14 data, documents, and analysis the attorney general shall inform the
15 commissioner that the attorney general lacks sufficient
16 information as well as what information the attorney general
17 requires. The commissioner shall then either provide the
18 additional information to the attorney general or request the
19 additional information from the applicant. The commissioner shall
20 promptly deliver any such additional information to the attorney
21 general. The attorney general shall then have 30 days from receipt
22 of the additional information to make a determination under
23 Subsection (a) or (b).

24 (e) If the attorney general notifies the commissioner that
25 the attorney general does not concur with the commissioner's
26 determination under Sections 848.057(a)(5) and (6), then,
27 notwithstanding any other provision of this subchapter, the

1 commissioner shall deny the application.

2 (f) In reviewing the commissioner's determination, the
3 attorney general shall consider the findings, conclusions, or
4 analyses contained in any other governmental entity's evaluation of
5 the health care collaborative.

6 (g) The attorney general at any time may request from the
7 commissioner additional time to consider an application under this
8 section. The commissioner shall grant the request and notify the
9 applicant of the request. A request by the attorney general or an
10 order by the commissioner granting a request under this section is
11 not subject to administrative or judicial review.

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

18 (b) An application for renewal must:

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

21 (2) include:

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

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

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

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

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

10 (F) the number, nature, and disposition of any
11 complaints filed with the health care collaborative under Section
12 848.107; and

13 (G) any other information required by the
14 commissioner.

15 (c) If a completed application for renewal is filed under
16 this section:

17 (1) the commissioner shall conduct a review under
18 Section 848.057 as if the application for renewal were a new
19 application, and, on approval by the commissioner, the attorney
20 general shall review the application under Section 848.059 as if
21 the application for renewal were a new application; and

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

26 (d) If the commissioner does not act on a renewal
27 application before the one-year anniversary of the date on which a

1 health care collaborative's certificate of authority was issued or
2 renewed, the health care collaborative's certificate of authority
3 expires on the 90th day after the date of the one-year anniversary
4 unless the renewal of the certificate of authority or determination
5 of approval, as applicable, is approved before that date.

6 (e) A health care collaborative shall report to the
7 department a material change in the size or composition of the
8 collaborative. On receipt of a report under this subsection, the
9 department may require the collaborative to file an application for
10 renewal before the date required by Subsection (a).

11 [Sections 848.061-848.100 reserved for expansion]

12 SUBCHAPTER C. GENERAL POWERS AND DUTIES OF HEALTH CARE

13 COLLABORATIVE

14 Sec. 848.101. PROVIDING OR ARRANGING FOR SERVICES. (a) A
15 health care collaborative may provide or arrange for health care
16 services through contracts with physicians and health care
17 providers or with entities contracting on behalf of participating
18 physicians and health care providers.

19 (b) A health care collaborative may not prohibit a physician
20 or other health care provider, as a condition of participating in
21 the health care collaborative, from participating in another health
22 care collaborative.

23 (c) A health care collaborative may not use a covenant not
24 to compete to prohibit a physician from providing medical services
25 or participating in another health care collaborative in the same
26 service area.

27 (d) Except as provided by Subsection (f), on written consent

1 of a patient who was treated by a physician participating in a
2 health care collaborative, the health care collaborative shall
3 provide the physician with the medical records of the patient,
4 regardless of whether the physician is participating in the health
5 care collaborative at the time the request for the records is made.

6 (e) Records provided under Subsection (d) shall be made
7 available to the physician in the format in which the records are
8 maintained by the health care collaborative. The health care
9 collaborative may charge the physician a fee for copies of the
10 records, as established by the Texas Medical Board.

11 (f) If a physician requests a patient's records from a
12 health care collaborative under Subsection (d) for the purpose of
13 providing emergency treatment to the patient:

14 (1) the health care collaborative may not charge a fee
15 to the physician under Subsection (e); and

16 (2) the health care collaborative shall provide the
17 records to the physician regardless of whether the patient has
18 provided written consent.

19 Sec. 848.102. INSURANCE, REINSURANCE, INDEMNITY, AND
20 REIMBURSEMENT. A health care collaborative may contract with an
21 insurer authorized to engage in business in this state to provide
22 insurance, reinsurance, indemnification, or reimbursement against
23 the cost of health care and medical care services provided by the
24 health care collaborative. This section does not affect the
25 requirement that the health care collaborative maintain sufficient
26 working capital and reserves.

27 Sec. 848.103. PAYMENT BY GOVERNMENTAL OR PRIVATE ENTITY.

1 (a) A health care collaborative may:

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

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

8 (b) Notwithstanding any other law, a health care
9 collaborative that is in compliance with this code, including
10 Chapters 841, 842, and 843, as applicable, may contract for,
11 accept, and distribute payments from governmental or private payors
12 based on fee-for-service or alternative payment mechanisms,
13 including:

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

16 (2) capitation or global payments; or

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

18 (c) Except as provided by Subsection (d), a health care
19 collaborative may not contract for and accept from a governmental
20 or private entity payments on a prospective basis, including
21 bundled or global payments, unless the health care collaborative is
22 licensed under Chapter 843.

23 (d) A health care collaborative may contract for and accept
24 from an insurance company or a health maintenance organization
25 payments on a prospective basis, including bundled or global
26 payments.

27 Sec. 848.104. CONTRACTS FOR ADMINISTRATIVE OR MANAGEMENT

1 SERVICES. A health care collaborative may contract with any
2 person, including an affiliated entity, to perform administrative,
3 management, or any other required business functions on behalf of
4 the health care collaborative.

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

12 Sec. 848.106. QUALITY AND COST OF HEALTH CARE SERVICES.
13 (a) A health care collaborative shall establish policies to
14 improve the quality and control the cost of health care services
15 provided by participating physicians and health care providers that
16 are consistent with prevailing professionally recognized standards
17 of medical practice. The policies must include standards and
18 procedures relating to:

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

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

27 (3) the development, implementation, monitoring, and

1 evaluation of processes to improve patient engagement and
2 coordination of health care services provided by participating
3 physicians and health care providers; and

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

6 (b) The governing body of a health care collaborative shall
7 establish a procedure for the periodic review of quality
8 improvement and cost control measures.

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

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

15 (2) a participating physician or health care provider.

16 (b) The complaint system for complaints initiated by
17 patients must include a process for the notice and appeal of a
18 complaint.

19 (c) A health care collaborative may not take a retaliatory
20 or adverse action against a physician or health care provider who
21 files a complaint with a regulatory authority regarding an action
22 of the health care collaborative.

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

1 (b) Section 1272.301 does not apply to a delegation
2 agreement entered into by a health care collaborative.

3 (c) A health care collaborative may enter into a delegation
4 agreement with an entity licensed under Chapter 841, 842, or 883 if
5 the delegation agreement assigns to the entity responsibility for:

6 (1) a function regulated by:

7 (A) Chapter 222;

8 (B) Chapter 841;

9 (C) Chapter 842;

10 (D) Chapter 883;

11 (E) Chapter 1272;

12 (F) Chapter 1301;

13 (G) Chapter 4201;

14 (H) Section 1367.053; or

15 (I) Subchapter A, Chapter 1507; or

16 (2) another function specified by commissioner rule.

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

23 (e) A health care collaborative that enters into a
24 delegation agreement under this section is subject to Chapters 404,
25 441, and 443 and is considered to be an insurer for purposes of
26 those chapters.

27 Sec. 848.109. VALIDITY OF OPERATIONS AND TRADE PRACTICES OF

1 HEALTH CARE COLLABORATIVES. The operations and trade practices of
2 a health care collaborative that are consistent with the provisions
3 of this chapter, the rules adopted under this chapter, and
4 applicable federal antitrust laws are presumed to be consistent
5 with Chapter 15, Business & Commerce Code, or any other applicable
6 provision of law.

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

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

15 (2) an opportunity for a hearing not earlier than the
16 30th day after receiving notice under Subdivision (1);

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

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

21 (b) A health care collaborative may limit a physician or
22 group of physicians from participating in the health care
23 collaborative if the limitation is based on an established
24 development plan approved by the board of directors. Each
25 applicant physician or group shall be provided with a copy of the
26 development plan.

27 [Sections 848.111-848.150 reserved for expansion]

1 SUBCHAPTER D. REGULATION OF HEALTH CARE COLLABORATIVES

2 Sec. 848.151. RULES. The commissioner and the attorney
3 general may adopt reasonable rules as necessary and proper to
4 implement the requirements of this chapter.

5 Sec. 848.152. FEES AND ASSESSMENTS. (a) The commissioner
6 shall, within the limits prescribed by this section, prescribe the
7 fees to be charged and the assessments to be imposed under this
8 section.

9 (b) Amounts collected under this section shall be deposited
10 to the credit of the Texas Department of Insurance operating
11 account.

12 (c) A health care collaborative shall pay to the department:

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

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

17 (d) The commissioner shall set fees and assessments under
18 this section in an amount sufficient to pay the reasonable expenses
19 of the department and attorney general in administering this
20 chapter, including the direct and indirect expenses incurred by the
21 department and attorney general in examining and reviewing health
22 care collaboratives. Fees and assessments imposed under this
23 section shall be allocated among health care collaboratives on a
24 pro rata basis to the extent that the allocation is feasible.

25 Sec. 848.153. EXAMINATIONS. (a) The commissioner may
26 examine the financial affairs and operations of any health care
27 collaborative or applicant for a certificate of authority under

1 this chapter.

2 (b) A health care collaborative shall make its books and
3 records relating to its financial affairs and operations available
4 for an examination by the commissioner or attorney general.

5 (c) On request of the commissioner or attorney general, a
6 health care collaborative shall provide to the commissioner or
7 attorney general, as applicable:

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

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

14 (d) Documentation provided to the commissioner or attorney
15 general under this section is confidential and is not subject to
16 disclosure under Chapter 552, Government Code.

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

23 [Sections 848.154-848.200 reserved for expansion]

24 SUBCHAPTER E. ENFORCEMENT

25 Sec. 848.201. ENFORCEMENT ACTIONS. (a) After notice and
26 opportunity for a hearing, the commissioner may:

27 (1) suspend or revoke a certificate of authority

1 issued to a health care collaborative under this chapter;
2 (2) impose sanctions under Chapter 82;
3 (3) issue a cease and desist order under Chapter 83; or
4 (4) impose administrative penalties under Chapter 84.
5 (b) The commissioner may take an enforcement action listed
6 in Subsection (a) against a health care collaborative if the
7 commissioner finds that the health care collaborative:
8 (1) is operating in a manner that is:
9 (A) significantly contrary to its basic
10 organizational documents; or
11 (B) contrary to the manner described in and
12 reasonably inferred from other information submitted under Section
13 848.057;
14 (2) does not meet the requirements of Section 848.057;
15 (3) cannot fulfill its obligation to provide health
16 care services as required under its contracts with governmental or
17 private entities;
18 (4) does not meet the requirements of Chapter 1272, if
19 applicable;
20 (5) has not implemented the complaint system required
21 by Section 848.107 in a manner to resolve reasonably valid
22 complaints;
23 (6) has advertised or merchandised its services in an
24 untrue, misrepresentative, misleading, deceptive, or unfair manner
25 or a person on behalf of the health care collaborative has
26 advertised or merchandised the health care collaborative's
27 services in an untrue, misrepresentative, misleading, deceptive,

1 or untrue manner;

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

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

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

14 Sec. 848.202. OPERATIONS DURING SUSPENSION OR AFTER
15 REVOCAION OF CERTIFICATE OF AUTHORITY. (a) During the period a
16 certificate of authority of a health care collaborative is
17 suspended, the health care collaborative may not:

18 (1) enter into a new contract with a governmental or
19 private entity; or

20 (2) advertise or solicit in any way.

21 (b) After a certificate of authority of a health care
22 collaborative is revoked, the health care collaborative:

23 (1) shall proceed, immediately following the
24 effective date of the order of revocation, to conclude its affairs;

25 (2) may not conduct further business except as
26 essential to the orderly conclusion of its affairs; and

27 (3) may not advertise or solicit in any way.

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

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

12 Sec. 848.204. NOTICE. The commissioner shall:

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

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

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

18 (2) post notice of the action on the department's
19 Internet website.

20 Sec. 848.205. INDEPENDENT AUTHORITY OF ATTORNEY GENERAL.

21 (a) The attorney general may:

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

25 (2) request that the commissioner:

26 (A) impose a penalty or sanction;

27 (B) issue a cease and desist order; or

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

3 (b) This section does not limit any other authority or power
4 of the attorney general.

5 SECTION 4.02. Paragraph (A), Subdivision (12), Subsection
6 (a), Section 74.001, Civil Practice and Remedies Code, is amended
7 to read as follows:

8 (A) "Health care provider" means any person,
9 partnership, professional association, corporation, facility, or
10 institution duly licensed, certified, registered, or chartered by
11 the State of Texas to provide health care, including:

- 12 (i) a registered nurse;
- 13 (ii) a dentist;
- 14 (iii) a podiatrist;
- 15 (iv) a pharmacist;
- 16 (v) a chiropractor;
- 17 (vi) an optometrist; ~~or~~
- 18 (vii) a health care institution; or
- 19 (viii) a health care collaborative
20 certified under Chapter 848, Insurance Code.

21 SECTION 4.03. Subchapter B, Chapter 1301, Insurance Code,
22 is amended by adding Section 1301.0625 to read as follows:

23 Sec. 1301.0625. HEALTH CARE COLLABORATIVES. (a) Subject
24 to the requirements of this chapter, a health care collaborative
25 may be designated as a preferred provider under a preferred
26 provider benefit plan and may offer enhanced benefits for care
27 provided by the health care collaborative.

1 (b) A preferred provider contract between an insurer and a
2 health care collaborative may use a payment methodology other than
3 a fee-for-service or discounted fee methodology. A reimbursement
4 methodology used in a contract under this subsection is not subject
5 to Chapter 843.

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

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

17 SECTION 4.04. Subtitle F, Title 4, Health and Safety Code,
18 is amended by adding Chapter 315 to read as follows:

19 CHAPTER 315. ESTABLISHMENT OF HEALTH CARE COLLABORATIVES

20 Sec. 315.001. AUTHORITY TO ESTABLISH HEALTH CARE
21 COLLABORATIVE. A public hospital created under Subtitle C or D or a
22 hospital district created under general or special law may form and
23 sponsor a nonprofit health care collaborative that is certified
24 under Chapter 848, Insurance Code.

25 SECTION 4.05. Section 102.005, Occupations Code, is amended
26 to read as follows:

27 Sec. 102.005. APPLICABILITY TO CERTAIN ENTITIES. Section

1 102.001 does not apply to:

2 (1) a licensed insurer;

3 (2) a governmental entity, including:

4 (A) an intergovernmental risk pool established
5 under Chapter 172, Local Government Code; and

6 (B) a system as defined by Section 1601.003,
7 Insurance Code;

8 (3) a group hospital service corporation; ~~[or]~~

9 (4) a health maintenance organization that
10 reimburses, provides, offers to provide, or administers hospital,
11 medical, dental, or other health-related benefits under a health
12 benefits plan for which it is the payor; or

13 (5) a health care collaborative certified under
14 Chapter 848, Insurance Code.

15 SECTION 4.06. Subdivision (5), Subsection (a), Section
16 151.002, Occupations Code, is amended to read as follows:

17 (5) "Health care entity" means:

18 (A) a hospital licensed under Chapter 241 or 577,
19 Health and Safety Code;

20 (B) an entity, including a health maintenance
21 organization, group medical practice, nursing home, health science
22 center, university medical school, hospital district, hospital
23 authority, or other health care facility, that:

24 (i) provides or pays for medical care or
25 health care services; and

26 (ii) follows a formal peer review process
27 to further quality medical care or health care;

1 (C) a professional society or association of
2 physicians, or a committee of such a society or association, that
3 follows a formal peer review process to further quality medical
4 care or health care; [~~or~~]

5 (D) an organization established by a
6 professional society or association of physicians, hospitals, or
7 both, that:

8 (i) collects and verifies the authenticity
9 of documents and other information concerning the qualifications,
10 competence, or performance of licensed health care professionals;
11 and

12 (ii) acts as a health care facility's agent
13 under the Health Care Quality Improvement Act of 1986 (42 U.S.C.
14 Section 11101 et seq.); or

15 (E) a health care collaborative certified under
16 Chapter 848, Insurance Code.

17 SECTION 4.07. Not later than September 1, 2012, the
18 commissioner of insurance and the attorney general shall adopt
19 rules as necessary to implement this article.

20 SECTION 4.08. As soon as practicable after the effective
21 date of this Act, the commissioner of insurance shall designate or
22 employ staff with antitrust expertise sufficient to carry out the
23 duties required by this Act.

24 ARTICLE 5. PATIENT IDENTIFICATION

25 SECTION 5.01. Subchapter A, Chapter 311, Health and Safety
26 Code, is amended by adding Section 311.004 to read as follows:

27 Sec. 311.004. STANDARDIZED PATIENT RISK IDENTIFICATION

1 SYSTEM. (a) In this section:

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

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

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

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

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

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

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

ARTICLE 6. REPORTING OF HEALTH CARE-ASSOCIATED INFECTIONS

SECTION 6.01. Section 98.001, Health and Safety Code, as added by Chapter 359 (S.B. 288), Acts of the 80th Legislature, Regular Session, 2007, is amended by adding Subdivisions (8-a) and (10-a) to read as follows:

(8-a) "Health care professional" means an individual licensed, certified, or otherwise authorized to administer health care, for profit or otherwise, in the ordinary course of business or professional practice. The term does not include a health care facility.

(10-a) "Potentially preventable complication" and "potentially preventable readmission" have the meanings assigned by Section 1002.001, Health and Safety Code.

SECTION 6.02. Subsection (c), Section 98.102, Health and Safety Code, as added by Chapter 359 (S.B. 288), Acts of the 80th Legislature, Regular Session, 2007, is amended to read as follows:

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

- (1) avoid duplicate submission of records;
- (2) allow the department to verify the accuracy and completeness of the data reported; and
- (3) for data reported under Section 98.103 [~~or 98.104~~], allow the department to risk adjust the facilities' infection rates.

SECTION 6.03. Section 98.103, Health and Safety Code, as added by Chapter 359 (S.B. 288), Acts of the 80th Legislature,

1 Regular Session, 2007, is amended by amending Subsection (b) and
2 adding Subsection (d-1) to read as follows:

3 (b) A pediatric and adolescent hospital shall report the
4 incidence of surgical site infections, including the causative
5 pathogen if the infection is laboratory-confirmed, occurring in the
6 following procedures to the department:

7 (1) cardiac procedures, excluding thoracic cardiac
8 procedures;

9 (2) ventricular [~~ventriculoperitoneal~~] shunt
10 procedures; and

11 (3) spinal surgery with instrumentation.

12 (d-1) The executive commissioner by rule may designate the
13 federal Centers for Disease Control and Prevention's National
14 Healthcare Safety Network, or its successor, to receive reports of
15 health care-associated infections from health care facilities on
16 behalf of the department. A health care facility must file a report
17 required in accordance with a designation made under this
18 subsection in accordance with the National Healthcare Safety
19 Network's definitions, methods, requirements, and procedures. A
20 health care facility shall authorize the department to have access
21 to facility-specific data contained in a report filed with the
22 National Healthcare Safety Network in accordance with a designation
23 made under this subsection.

24 SECTION 6.04. Section 98.1045, Health and Safety Code, as
25 added by Chapter 359 (S.B. 288), Acts of the 80th Legislature,
26 Regular Session, 2007, is amended by adding Subsection (c) to read
27 as follows:

1 (c) The executive commissioner by rule may designate an
2 agency of the United States Department of Health and Human Services
3 to receive reports of preventable adverse events by health care
4 facilities on behalf of the department. A health care facility
5 shall authorize the department to have access to facility-specific
6 data contained in a report made in accordance with a designation
7 made under this subsection.

8 SECTION 6.05. Subchapter C, Chapter 98, Health and Safety
9 Code, as added by Chapter 359 (S.B. 288), Acts of the 80th
10 Legislature, Regular Session, 2007, is amended by adding Sections
11 98.1046 and 98.1047 to read as follows:

12 Sec. 98.1046. PUBLIC REPORTING OF CERTAIN POTENTIALLY
13 PREVENTABLE EVENTS FOR HOSPITALS. (a) In consultation with the
14 Texas Institute of Health Care Quality and Efficiency under Chapter
15 1002, the department, using data submitted under Chapter 108, shall
16 publicly report for hospitals in this state risk-adjusted outcome
17 rates for those potentially preventable complications and
18 potentially preventable readmissions that the department, in
19 consultation with the institute, has determined to be the most
20 effective measures of quality and efficiency.

21 (b) The department shall make the reports compiled under
22 Subsection (a) available to the public on the department's Internet
23 website.

24 (c) The department may not disclose the identity of a
25 patient or health care professional in the reports authorized in
26 this section.

27 Sec. 98.1047. STUDIES ON LONG-TERM CARE FACILITY REPORTING

1 OF ADVERSE HEALTH CONDITIONS. (a) In consultation with the Texas
2 Institute of Health Care Quality and Efficiency under Chapter 1002,
3 the department shall study which adverse health conditions commonly
4 occur in long-term care facilities and, of those health conditions,
5 which are potentially preventable.

6 (b) The department shall develop recommendations for
7 reporting adverse health conditions identified under Subsection
8 (a).

9 SECTION 6.06. Section 98.105, Health and Safety Code, as
10 added by Chapter 359 (S.B. 288), Acts of the 80th Legislature,
11 Regular Session, 2007, is amended to read as follows:

12 Sec. 98.105. REPORTING SYSTEM MODIFICATIONS. Based on the
13 recommendations of the advisory panel, the executive commissioner
14 by rule may modify in accordance with this chapter the list of
15 procedures that are reportable under Section 98.103 [~~or 98.104~~].
16 The modifications must be based on changes in reporting guidelines
17 and in definitions established by the federal Centers for Disease
18 Control and Prevention.

19 SECTION 6.07. Subsections (a), (b), and (d), Section
20 98.106, Health and Safety Code, as added by Chapter 359 (S.B. 288),
21 Acts of the 80th Legislature, Regular Session, 2007, are amended to
22 read as follows:

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

25 (1) the infections reported by facilities under
26 Section [~~Sections~~] 98.103 [~~and 98.104~~]; and

27 (2) the preventable adverse events reported by

1 facilities under Section 98.1045.

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

8 (d) The department shall publish the departmental summary
9 at least annually and may publish the summary more frequently as the
10 department considers appropriate. Data made available to the
11 public must include aggregate data covering a period of at least a
12 full calendar quarter.

13 SECTION 6.08. Subchapter C, Chapter 98, Health and Safety
14 Code, as added by Chapter 359 (S.B. 288), Acts of the 80th
15 Legislature, Regular Session, 2007, is amended by adding Section
16 98.1065 to read as follows:

17 Sec. 98.1065. STUDY OF INCENTIVES AND RECOGNITION FOR
18 HEALTH CARE QUALITY. The department, in consultation with the
19 Texas Institute of Health Care Quality and Efficiency under Chapter
20 1002, shall conduct a study on developing a recognition program to
21 recognize exemplary health care facilities for superior quality of
22 health care and make recommendations based on that study.

23 SECTION 6.09. Section 98.108, Health and Safety Code, as
24 added by Chapter 359 (S.B. 288), Acts of the 80th Legislature,
25 Regular Session, 2007, is amended to read as follows:

26 Sec. 98.108. FREQUENCY OF REPORTING. (a) In consultation
27 with the advisory panel, the executive commissioner by rule shall

1 establish the frequency of reporting by health care facilities
2 required under Sections 98.103[~~, 98.104,~~] and 98.1045.

3 (b) Except as provided by Subsection (c), facilities
4 [~~Facilities~~] may not be required to report more frequently than
5 quarterly.

6 (c) The executive commissioner may adopt rules requiring
7 reporting more frequently than quarterly if more frequent reporting
8 is necessary to meet the requirements for participation in the
9 federal Centers for Disease Control and Prevention's National
10 Healthcare Safety Network.

11 SECTION 6.10. Subsection (a), Section 98.109, Health and
12 Safety Code, as added by Chapter 359 (S.B. 288), Acts of the 80th
13 Legislature, Regular Session, 2007, is amended to read as follows:

14 (a) Except as provided by Sections 98.1046, 98.106, and
15 98.110, all information and materials obtained or compiled or
16 reported by the department under this chapter or compiled or
17 reported by a health care facility under this chapter, and all
18 related information and materials, are confidential and:

19 (1) are not subject to disclosure under Chapter 552,
20 Government Code, or discovery, subpoena, or other means of legal
21 compulsion for release to any person; and

22 (2) may not be admitted as evidence or otherwise
23 disclosed in any civil, criminal, or administrative proceeding.

24 SECTION 6.11. Section 98.110, Health and Safety Code, as
25 added by Chapter 359 (S.B. 288), Acts of the 80th Legislature,
26 Regular Session, 2007, is amended to read as follows:

27 Sec. 98.110. DISCLOSURE AMONG CERTAIN AGENCIES.

1 (a) Notwithstanding any other law, the department may disclose
2 information reported by health care facilities under Section
3 98.103[~~98.104~~] or 98.1045 to other programs within the
4 department, to the Health and Human Services Commission, [~~and~~] to
5 other health and human services agencies, as defined by Section
6 531.001, Government Code, and to the federal Centers for Disease
7 Control and Prevention, or any other agency of the United States
8 Department of Health and Human Services, for public health research
9 or analysis purposes only, provided that the research or analysis
10 relates to health care-associated infections or preventable
11 adverse events. The privilege and confidentiality provisions
12 contained in this chapter apply to such disclosures.

13 (b) If the executive commissioner designates an agency of
14 the United States Department of Health and Human Services to
15 receive reports of health care-associated infections or
16 preventable adverse events, that agency may use the information
17 submitted for purposes allowed by federal law.

18 SECTION 6.12. Section 98.104, Health and Safety Code, as
19 added by Chapter 359 (S.B. 288), Acts of the 80th Legislature,
20 Regular Session, 2007, is repealed.

21 SECTION 6.13. Not later than December 1, 2012, the
22 Department of State Health Services shall submit a report regarding
23 recommendations for improved health care reporting to the governor,
24 the lieutenant governor, the speaker of the house of
25 representatives, and the chairs of the appropriate standing
26 committees of the legislature outlining:

27 (1) the initial assessment in the study conducted

1 under Section 98.1065, Health and Safety Code, as added by this Act;

2 (2) based on the study described by Subdivision (1) of
3 this subsection, the feasibility and desirability of establishing a
4 recognition program to recognize exemplary health care facilities
5 for superior quality of health care;

6 (3) the recommendations developed under Section
7 98.1065, Health and Safety Code, as added by this Act; and

8 (4) the changes in existing law that would be
9 necessary to implement the recommendations described by
10 Subdivision (3) of this subsection.

11 ARTICLE 7. INFORMATION MAINTAINED BY DEPARTMENT OF STATE HEALTH
12 SERVICES

13 SECTION 7.01. Section 108.002, Health and Safety Code, is
14 amended by adding Subdivisions (4-a) and (8-a) and amending
15 Subdivision (7) to read as follows:

16 (4-a) "Commission" means the Health and Human Services
17 Commission.

18 (7) "Department" means the [~~Texas~~] Department of State
19 Health Services.

20 (8-a) "Executive commissioner" means the executive
21 commissioner of the Health and Human Services Commission.

22 SECTION 7.02. Chapter 108, Health and Safety Code, is
23 amended by adding Section 108.0026 to read as follows:

24 Sec. 108.0026. TRANSFER OF DUTIES; REFERENCE TO COUNCIL.

25 (a) The powers and duties of the Texas Health Care Information
26 Council under this chapter were transferred to the Department of
27 State Health Services in accordance with Section 1.19, Chapter 198

1 (H.B. 2292), Acts of the 78th Legislature, Regular Session, 2003.

2 (b) In this chapter or other law, a reference to the Texas
3 Health Care Information Council means the Department of State
4 Health Services.

5 SECTION 7.03. Subsection (h), Section 108.009, Health and
6 Safety Code, is amended to read as follows:

7 (h) The department [~~council~~] shall coordinate data
8 collection with the data submission formats used by hospitals and
9 other providers. The department [~~council~~] shall accept data in the
10 format developed by the American National Standards Institute
11 [~~National Uniform Billing Committee (Uniform Hospital Billing Form~~
12 ~~UB 92) and HCFA-1500~~] or its successor [~~their successors~~] or other
13 nationally [~~universally~~] accepted standardized forms that
14 hospitals and other providers use for other complementary purposes.

15 SECTION 7.04. Section 108.013, Health and Safety Code, is
16 amended by amending Subsections (a) through (d), (g), (i), and (j)
17 and adding Subsections (k) through (n) to read as follows:

18 (a) The data received by the department under this chapter
19 [~~council~~] shall be used by the department and commission [~~council~~]
20 for the benefit of the public. Subject to specific limitations
21 established by this chapter and executive commissioner [~~council~~]
22 rule, the department [~~council~~] shall make determinations on
23 requests for information in favor of access.

24 (b) The executive commissioner [~~council~~] by rule shall
25 designate the characters to be used as uniform patient identifiers.
26 The basis for assignment of the characters and the manner in which
27 the characters are assigned are confidential.

1 (c) Unless specifically authorized by this chapter, the
2 department [~~council~~] may not release and a person or entity may not
3 gain access to any data obtained under this chapter:

4 (1) that could reasonably be expected to reveal the
5 identity of a patient;

6 (2) that could reasonably be expected to reveal the
7 identity of a physician;

8 (3) disclosing provider discounts or differentials
9 between payments and billed charges;

10 (4) relating to actual payments to an identified
11 provider made by a payer; or

12 (5) submitted to the department [~~council~~] in a uniform
13 submission format that is not included in the public use data set
14 established under Sections 108.006(f) and (g), except in accordance
15 with Section 108.0135.

16 (d) Except as provided by this section, all [~~All~~] data
17 collected and used by the department [~~and the council~~] under this
18 chapter is subject to the confidentiality provisions and criminal
19 penalties of:

20 (1) Section 311.037;

21 (2) Section 81.103; and

22 (3) Section 159.002, Occupations Code.

23 (g) Unless specifically authorized by this chapter, the
24 department [~~The council~~] may not release data elements in a manner
25 that will reveal the identity of a patient. The department
26 [~~council~~] may not release data elements in a manner that will reveal
27 the identity of a physician.

1 (i) Notwithstanding any other law and except as provided by
2 this section, the [~~council and the~~] department may not provide
3 information made confidential by this section to any other agency
4 of this state.

5 (j) The executive commissioner [~~council~~] shall by rule[~~7~~
6 ~~with the assistance of the advisory committee under Section~~
7 ~~108.003(g)(5),~~] develop and implement a mechanism to comply with
8 Subsections (c)(1) and (2).

9 (k) The department may disclose data collected under this
10 chapter that is not included in public use data to any department or
11 commission program if the disclosure is reviewed and approved by
12 the institutional review board under Section 108.0135.

13 (l) Confidential data collected under this chapter that is
14 disclosed to a department or commission program remains subject to
15 the confidentiality provisions of this chapter and other applicable
16 law. The department shall identify the confidential data that is
17 disclosed to a program under Subsection (k). The program shall
18 maintain the confidentiality of the disclosed confidential data.

19 (m) The following provisions do not apply to the disclosure
20 of data to a department or commission program:

- 21 (1) Section 81.103;
- 22 (2) Sections 108.010(g) and (h);
- 23 (3) Sections 108.011(e) and (f);
- 24 (4) Section 311.037; and
- 25 (5) Section 159.002, Occupations Code.

26 (n) Nothing in this section authorizes the disclosure of
27 physician identifying data.

1 SECTION 7.05. Section 108.0135, Health and Safety Code, is
2 amended to read as follows:

3 Sec. 108.0135. INSTITUTIONAL [~~SCIENTIFIC~~] REVIEW BOARD
4 [~~PANEL~~]. (a) The department [~~council~~] shall establish an
5 institutional [~~a scientific~~] review board [~~panel~~] to review and
6 approve requests for access to data not contained in [~~information~~
7 ~~other than~~] public use data. The members of the institutional
8 review board must [~~panel shall~~] have experience and expertise in
9 ethics, patient confidentiality, and health care data.

10 (b) To assist the institutional review board [~~panel~~] in
11 determining whether to approve a request for information, the
12 executive commissioner [~~council~~] shall adopt rules similar to the
13 federal Centers for Medicare and Medicaid Services' [~~Health Care~~
14 ~~Financing Administration's~~] guidelines on releasing data.

15 (c) A request for information other than public use data
16 must be made on the form prescribed [~~created~~] by the department
17 [~~council~~].

18 (d) Any approval to release information under this section
19 must require that the confidentiality provisions of this chapter be
20 maintained and that any subsequent use of the information conform
21 to the confidentiality provisions of this chapter.

22 SECTION 7.06. Effective September 1, 2014, Subdivisions (5)
23 and (18), Section 108.002, Section 108.0025, and Subsection (c),
24 Section 108.009, Health and Safety Code, are repealed.

25 ARTICLE 8. ADOPTION OF VACCINE PREVENTABLE DISEASES POLICY BY
26 HEALTH CARE FACILITIES

27 SECTION 8.01. The heading to Subtitle A, Title 4, Health and

1 Safety Code, is amended to read as follows:

2 SUBTITLE A. FINANCING, CONSTRUCTING, REGULATING, AND INSPECTING
3 HEALTH FACILITIES

4 SECTION 8.02. Subtitle A, Title 4, Health and Safety Code,
5 is amended by adding Chapter 224 to read as follows:

6 CHAPTER 224. POLICY ON VACCINE PREVENTABLE DISEASES

7 Sec. 224.001. DEFINITIONS. In this chapter:

8 (1) "Covered individual" means:

9 (A) an employee of the health care facility;

10 (B) an individual providing direct patient care
11 under a contract with a health care facility; or

12 (C) an individual to whom a health care facility
13 has granted privileges to provide direct patient care.

14 (2) "Health care facility" means:

15 (A) a facility licensed under Subtitle B,
16 including a hospital as defined by Section 241.003; or

17 (B) a hospital maintained or operated by this
18 state.

19 (3) "Regulatory authority" means a state agency that
20 regulates a health care facility under this code.

21 (4) "Vaccine preventable diseases" means the diseases
22 included in the most current recommendations of the Advisory
23 Committee on Immunization Practices of the Centers for Disease
24 Control and Prevention.

25 Sec. 224.002. VACCINE PREVENTABLE DISEASES POLICY
26 REQUIRED. (a) Each health care facility shall develop and
27 implement a policy to protect its patients from vaccine preventable

1 diseases.

2 (b) The policy must:

3 (1) require covered individuals to receive vaccines
4 for the vaccine preventable diseases specified by the facility
5 based on the level of risk the individual presents to patients by
6 the individual's routine and direct exposure to patients;

7 (2) specify the vaccines a covered individual is
8 required to receive based on the level of risk the individual
9 presents to patients by the individual's routine and direct
10 exposure to patients;

11 (3) include procedures for verifying whether a covered
12 individual has complied with the policy;

13 (4) include procedures for a covered individual to be
14 exempt from the required vaccines for the medical conditions
15 identified as contraindications or precautions by the Centers for
16 Disease Control and Prevention;

17 (5) for a covered individual who is exempt from the
18 required vaccines, include procedures the individual must follow to
19 protect facility patients from exposure to disease, such as the use
20 of protective medical equipment, such as gloves and masks, based on
21 the level of risk the individual presents to patients by the
22 individual's routine and direct exposure to patients;

23 (6) prohibit discrimination or retaliatory action
24 against a covered individual who is exempt from the required
25 vaccines for the medical conditions identified as
26 contraindications or precautions by the Centers for Disease Control
27 and Prevention, except that required use of protective medical

1 equipment, such as gloves and masks, may not be considered
2 retaliatory action for purposes of this subdivision;

3 (7) require the health care facility to maintain a
4 written or electronic record of each covered individual's
5 compliance with or exemption from the policy; and

6 (8) include disciplinary actions the health care
7 facility is authorized to take against a covered individual who
8 fails to comply with the policy.

9 (c) The policy may include procedures for a covered
10 individual to be exempt from the required vaccines based on reasons
11 of conscience, including a religious belief.

12 Sec. 224.003. DISASTER EXEMPTION. (a) In this section,
13 "public health disaster" has the meaning assigned by Section
14 81.003.

15 (b) During a public health disaster, a health care facility
16 may prohibit a covered individual who is exempt from the vaccines
17 required in the policy developed by the facility under Section
18 224.002 from having contact with facility patients.

19 Sec. 224.004. DISCIPLINARY ACTION. A health care facility
20 that violates this chapter is subject to an administrative or civil
21 penalty in the same manner, and subject to the same procedures, as
22 if the facility had violated a provision of this code that
23 specifically governs the facility.

24 Sec. 224.005. RULES. The appropriate rulemaking authority
25 for each regulatory authority shall adopt rules necessary to
26 implement this chapter.

27 SECTION 8.03. Not later than June 1, 2012, a state agency

1 that regulates a health care facility subject to Chapter 224,
2 Health and Safety Code, as added by this Act, shall adopt the rules
3 necessary to implement that chapter.

4 SECTION 8.04. Notwithstanding Chapter 224, Health and
5 Safety Code, as added by this Act, a health care facility subject to
6 that chapter is not required to have a policy on vaccine preventable
7 diseases in effect until September 1, 2012.

8 ARTICLE 9. TEXAS EMERGENCY AND TRAUMA CARE EDUCATION

9 PARTNERSHIP PROGRAM

10 SECTION 9.01. Chapter 61, Education Code, is amended by
11 adding Subchapter GG to read as follows:

12 SUBCHAPTER GG. TEXAS EMERGENCY AND TRAUMA CARE EDUCATION

13 PARTNERSHIP PROGRAM

14 Sec. 61.9801. DEFINITIONS. In this subchapter:

15 (1) "Emergency and trauma care education partnership"
16 means a partnership that:

17 (A) consists of one or more hospitals in this
18 state and one or more graduate professional nursing or graduate
19 medical education programs in this state; and

20 (B) serves to increase training opportunities in
21 emergency and trauma care for doctors and registered nurses at
22 participating graduate medical education and graduate professional
23 nursing programs.

24 (2) "Participating education program" means a
25 graduate professional nursing program as that term is defined by
26 Section 54.221 or a graduate medical education program leading to
27 board certification by the American Board of Medical Specialties

1 that participates in an emergency and trauma care education
2 partnership.

3 Sec. 61.9802. PROGRAM: ESTABLISHMENT; ADMINISTRATION;
4 PURPOSE. (a) The Texas emergency and trauma care education
5 partnership program is established.

6 (b) The board shall administer the program in accordance
7 with this subchapter and rules adopted under this subchapter.

8 (c) Under the program, to the extent funds are available
9 under Section 61.9805, the board shall make grants to emergency and
10 trauma care education partnerships to assist those partnerships to
11 meet the state's needs for doctors and registered nurses with
12 training in emergency and trauma care by offering one-year or
13 two-year fellowships to students enrolled in graduate professional
14 nursing or graduate medical education programs through
15 collaboration between hospitals and graduate professional nursing
16 or graduate medical education programs and the use of the existing
17 expertise and facilities of those hospitals and programs.

18 Sec. 61.9803. GRANTS: CONDITIONS; LIMITATIONS. (a) The
19 board may make a grant under this subchapter to an emergency and
20 trauma care education partnership only if the board determines
21 that:

22 (1) the partnership will meet applicable standards for
23 instruction and student competency for each program offered by each
24 participating education program;

25 (2) each participating education program will, as a
26 result of the partnership, enroll in the education program a
27 sufficient number of additional students as established by the

1 board;

2 (3) each hospital participating in an emergency and
3 trauma care education partnership will provide to students enrolled
4 in a participating education program clinical placements that:

5 (A) allow the students to take part in providing
6 or to observe, as appropriate, emergency and trauma care services
7 offered by the hospital; and

8 (B) meet the clinical education needs of the
9 students; and

10 (4) the partnership will satisfy any other requirement
11 established by board rule.

12 (b) A grant under this subchapter may be spent only on costs
13 related to the development or operation of an emergency and trauma
14 care education partnership that prepares a student to complete a
15 graduate professional nursing program with a specialty focus on
16 emergency and trauma care or earn board certification by the
17 American Board of Medical Specialties.

18 Sec. 61.9804. PRIORITY FOR FUNDING. In awarding a grant
19 under this subchapter, the board shall give priority to an
20 emergency and trauma care education partnership that submits a
21 proposal that:

22 (1) provides for collaborative educational models
23 between one or more participating hospitals and one or more
24 participating education programs that have signed a memorandum of
25 understanding or other written agreement under which the
26 participants agree to comply with standards established by the
27 board, including any standards the board may establish that:

1 (A) provide for program management that offers a
2 centralized decision-making process allowing for inclusion of each
3 entity participating in the partnership;

4 (B) provide for access to clinical training
5 positions for students in graduate professional nursing and
6 graduate medical education programs that are not participating in
7 the partnership; and

8 (C) specify the details of any requirement
9 relating to a student in a participating education program being
10 employed after graduation in a hospital participating in the
11 partnership, including any details relating to the employment of
12 students who do not complete the program, are not offered a position
13 at the hospital, or choose to pursue other employment;

14 (2) includes a demonstrable education model to:

15 (A) increase the number of students enrolled in,
16 the number of students graduating from, and the number of faculty
17 employed by each participating education program; and

18 (B) improve student or resident retention in each
19 participating education program;

20 (3) indicates the availability of money to match a
21 portion of the grant money, including matching money or in-kind
22 services approved by the board from a hospital, private or
23 nonprofit entity, or institution of higher education;

24 (4) can be replicated by other emergency and trauma
25 care education partnerships or other graduate professional nursing
26 or graduate medical education programs; and

27 (5) includes plans for sustainability of the

1 partnership.

2 Sec. 61.9805. GRANTS, GIFTS, AND DONATIONS. In addition to
3 money appropriated by the legislature, the board may solicit,
4 accept, and spend grants, gifts, and donations from any public or
5 private source for the purposes of this subchapter.

6 Sec. 61.9806. RULES. The board shall adopt rules for the
7 administration of the Texas emergency and trauma care education
8 partnership program. The rules must include:

9 (1) provisions relating to applying for a grant under
10 this subchapter; and

11 (2) standards of accountability consistent with other
12 graduate professional nursing and graduate medical education
13 programs to be met by any emergency and trauma care education
14 partnership awarded a grant under this subchapter.

15 Sec. 61.9807. ADMINISTRATIVE COSTS. A reasonable amount,
16 not to exceed three percent, of any money appropriated for purposes
17 of this subchapter may be used to pay the costs of administering
18 this subchapter.

19 SECTION 9.02. As soon as practicable after the effective
20 date of this article, the Texas Higher Education Coordinating Board
21 shall adopt rules for the implementation and administration of the
22 Texas emergency and trauma care education partnership program
23 established under Subchapter GG, Chapter 61, Education Code, as
24 added by this Act. The board may adopt the initial rules in the
25 manner provided by law for emergency rules.

26 ARTICLE 10. INSURER CONTRACTS REGARDING CERTAIN BENEFIT PLANS

27 SECTION 10.01. Section 1301.006, Insurance Code, is amended

1 to read as follows:

2 Sec. 1301.006. AVAILABILITY OF AND ACCESSIBILITY TO HEALTH
3 CARE SERVICES. (a) An insurer that markets a preferred provider
4 benefit plan shall contract with physicians and health care
5 providers to ensure that all medical and health care services and
6 items contained in the package of benefits for which coverage is
7 provided, including treatment of illnesses and injuries, will be
8 provided under the health insurance policy in a manner ensuring
9 availability of and accessibility to adequate personnel, specialty
10 care, and facilities.

11 (b) A contract between an insurer that markets a plan
12 regulated under this chapter and an institutional provider may not,
13 as a condition of staff membership or privileges, require a
14 physician or other practitioner to enter into a preferred provider
15 contract.

16 ARTICLE 11. EFFECTIVE DATE

17 SECTION 11.01. Except as otherwise provided by this Act,
18 this Act takes effect on the 91st day after the last day of the
19 legislative session.