By: Nelson, et al. (Zerwas) S.B. No. 7

Substitute the following for S.B. No. 7:

By: Zerwas C.S.S.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, AND FRAUD PREVENTION 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

services; and

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

(2) the process include:

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

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

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

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

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

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

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

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

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

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

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

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

(1) the Medicaid fee-for-service model;

(2) the primary care case management Medicaid managed care model; and

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

programs.

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

Sec. 531.024172. ELECTRONIC VISIT VERIFICATION SYSTEM. (a) In this section, "acute nursing services" has the meaning assigned by Section 531.02417.

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

(1) the provider's name;

(2) the recipient's name; and

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

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

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

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

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

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

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

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

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

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

adult patient in which the physician:

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

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

(2) that encompasses the following primary principles:

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

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

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

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

(E) quality and safe care is provided.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) a requirement that the managed care organization

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

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

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

(6) procedures for recipient outreach and education;

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

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

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

and renewal;

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

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

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

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

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

care physician; [~~and~~]

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

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

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

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

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

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

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

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

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

(A) preventive care;

(B) primary care;

(C) specialty care;

(D) after-hours urgent care; and

(E) chronic care;

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

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

(B) the organization's provider network includes:

(i) a sufficient number of primary care providers;

(ii) a sufficient variety of provider types; and

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

and

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

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

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

(B) focuses on measuring outcomes; and

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

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

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

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

(C) that includes the prior authorization

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

August 31, 2013.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Government Code, are amended to read as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

regulations.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) If H.B. No. 710, Acts of the 82nd Legislature, Regular Session, 2011, does not become law, Section 31.0325, Human Resources Code, is repealed.

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

(f) If H.B. No. 710, Acts of the 82nd Legislature, Regular Session, 2011, becomes law, Section 33.0231, Human Resources Code, as added by that Act, is repealed.

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

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

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

(2) payment of the license fee; and

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

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

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

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

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

SECTION 1.06. (a) Section 161.081, Human Resources Code, as effective September 1, 2011, is amended to read as follows:

Sec. 161.081. LONG-TERM CARE MEDICAID WAIVER PROGRAMS: STREAMLINING AND UNIFORMITY. (a) In this section, "Section

1915(c) waiver program" has the meaning assigned by Section 531.001, Government Code.

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

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

(2) revising program provider manuals and training curricula;

(3) consolidating service authorization systems;

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

(5) standardizing individual service plan processes across the programs; [~~and~~]

(6) if feasible:

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

(B) streamlining other billing and auditing requirements;

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

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

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

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

(d) The department and the commission shall jointly explore the development of uniform licensing and contracting standards that would:

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

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

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

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

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

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

waiver program guidelines.

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

Sec. 161.086. ELECTRONIC VISIT VERIFICATION SYSTEM. If it is cost-effective, the department shall implement an electronic visit verification system under appropriate programs administered by the department under the Medicaid program that allows providers to electronically verify and document basic information relating to the delivery of services, including:

(1) the provider's name;

(2) the recipient's name;

(3) the date and time the provider begins and ends the delivery of services; and

(4) the location of service delivery.

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

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

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

(B) provides:

(i) personal care services; or

(ii) administration of medication by a person licensed or otherwise authorized in this state to administer the medication; [~~and~~]

(C) may provide assistance with or supervision of

the administration of medication; and

(D) may provide skilled nursing services for the following limited purposes:

(i) coordination of resident care with outside home and community support services agencies and other health care professionals;

(ii) provision or delegation of personal care services and medication administration as described by this subdivision;

(iii) assessment of residents to determine the care required; and

(iv) for periods of time as established by department rule, delivery of temporary skilled nursing treatment for a minor illness, injury, or emergency.

(b) Section 247.004, Health and Safety Code, as effective September 1, 2011, is amended to read as follows:

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

(1) a boarding home facility as defined by Section 260.001;

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

(3) a facility conducted by or for the adherents of a

qualified religious society classified as a tax-exempt organization under an Internal Revenue Service group exemption ruling for the purpose of providing personal care services without charge solely for the society's professed members or ministers in retirement, if the facility complies with local safety, sanitation, and quarantine ordinances and regulations; or

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

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

(B) is funded in whole or in part by the Department of State Health Services and that is monitored by that department, or by its designated local mental health authority in accordance with standards set by the department.

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

(b) Unless otherwise prohibited by law, a [~~A~~] health care professional may be employed by an assisted living facility to provide at the facility to the facility's residents services that are authorized by this chapter and that are within the professional's scope of practice [~~to a resident of an assisted living facility at the facility~~]. This subsection does not authorize a facility to provide ongoing services comparable to the services available in an institution licensed under Chapter 242. A health care professional providing services under this subsection

shall maintain medical records of those services in accordance with the licensing, certification, or other regulatory standards applicable to the health care professional under law.

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

Sec. 531.086. STUDY REGARDING PHYSICIAN INCENTIVE PROGRAMS TO REDUCE HOSPITAL EMERGENCY ROOM USE FOR NON-EMERGENT CONDITIONS. (a) The commission shall conduct a study to evaluate physician incentive programs that attempt to reduce hospital emergency room use for non-emergent conditions by recipients under the medical assistance program. Each physician incentive program evaluated in the study must:

(1) be administered by a health maintenance organization participating in the STAR or STAR + PLUS Medicaid managed care program; and

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

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

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

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

(c) Not later than August 31, 2013, the executive commissioner shall submit to the governor and the Legislative Budget Board a report summarizing the findings of the study

required by this section.

(d) This section expires September 1, 2014.

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

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

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

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

Sec. 32.0641. RECIPIENT ACCOUNTABILITY PROVISIONS; COST-SHARING REQUIREMENT TO IMPROVE APPROPRIATE UTILIZATION OF [~~COST SHARING FOR CERTAIN HIGH-COST MEDICAL~~] SERVICES. (a) To [~~If the department determines that it is feasible and cost-effective, and to~~] the extent permitted under and in a manner that is consistent with Title XIX, Social Security Act (42 U.S.C. Section 1396 et seq.) and any other applicable law or regulation or under a federal waiver or other authorization, the executive commissioner

of the Health and Human Services Commission shall adopt, after consulting with the Medicaid and CHIP Quality-Based Payment Advisory Committee established under Section 536.002, Government Code, cost-sharing provisions that encourage personal accountability and appropriate utilization of health care services, including a cost-sharing provision applicable to [~~require~~] a recipient who chooses to receive a nonemergency [~~a high-cost~~] medical service [~~provided~~] through a hospital emergency room [~~to pay a copayment, premium payment, or other cost-sharing payment for the high-cost medical service if:~~

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

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

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

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

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

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

[~~(C) offers to provide the recipient with a referral to the nonemergency provider to facilitate scheduling of~~

~~the service; and~~

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

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

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

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

[~~(c) If the executive commissioner of the Health and Human Services Commission adopts a copayment or other cost-sharing payment under Subsection (a), the commission may not reduce hospital payments to reflect the potential receipt of a copayment or other payment from a recipient receiving medical services provided through a hospital emergency room.~~]

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

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

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

(1) contract to expand all or part of the billing

coordination system established under Section 531.02413 to process claims for services provided through other benefits programs administered by the commission or a health and human services agency;

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

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

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

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

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

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

(2) money provided by the federal government in lieu

of some or all of the payments under one or both of those programs;

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

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

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

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

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

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

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

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

(2) exploring the feasibility of:

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

(B) depositing federal matching money received as provided by Paragraph (A) with other federal money deposited as provided by Section 531.504, or substituting that federal matching money for federal money that otherwise would be received under the disproportionate share hospitals and upper payment limit supplemental payment programs as a match for local funds received

by this state through intergovernmental transfers.

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

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

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

(A) be used to supplement Medicaid hospital reimbursements under a waiver that includes terms that are consistent with, or that produce revenues consistent with, disproportionate share hospital and upper payment limit principles [~~offset, in part, the uncompensated health care costs incurred by hospitals~~];

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

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

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

Sec. 531.504. DEPOSITS TO FUND. (a) The comptroller shall

deposit in the fund:

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

(2) state money appropriated to the fund.

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

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

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

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

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

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

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 536.001. DEFINITIONS. In this chapter:

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

(2) "Alternative payment system" includes:

(A) a global payment system;

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

(C) a blended payment system.

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

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

(5) "Episode-based bundled payment system" means a

system for compensating a physician or other health care provider for arranging for or providing health care services to child health plan program enrollees or Medicaid recipients that is based on a flat payment for all services provided in connection with a single episode of medical care.

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

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

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

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

(10) "Hospital" means a public or private institution licensed under Chapter 241 or 577, Health and Safety Code,

including a general or special hospital as defined by Section 241.003, Health and Safety Code.

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

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

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

(14) "Physician" means a person licensed to practice medicine in this state under Subtitle B, Title 3, Occupations Code.

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

(16) "Potentially preventable ancillary service" means a health care service provided or ordered by a physician or other health care provider to supplement or support the evaluation or treatment of a patient, including a diagnostic test, laboratory

test, therapy service, or radiology service, that may not be reasonably necessary for the provision of quality health care or treatment.

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

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

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

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

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

(20) "Potentially preventable readmission" means a return hospitalization of a person within a period specified by the commission that may have resulted from deficiencies in the care or treatment provided to the person during a previous hospital stay or

from deficiencies in post-hospital discharge follow-up. The term does not include a hospital readmission necessitated by the occurrence of unrelated events after the discharge. The term includes the readmission of a person to a hospital for:

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

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

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

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

(21) "Quality-based payment system" means a system for compensating a physician or other health care provider, including an alternative payment system, that provides incentives to the physician or other health care provider for providing high-quality, cost-effective care and bases some portion of the payment made to the physician or other health care provider on quality of care outcomes, which may include the extent to which the physician or other health care provider reduces potentially preventable events.

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

services agency:

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

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

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

(4) outcome and process measures under Section 536.003.

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

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

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

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

medicine;

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

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

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

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

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

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

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

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

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

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

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

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

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

(e) If the commission increases physician and other health care provider reimbursement rates under the child health plan or Medicaid program as a result of an increase in the amounts appropriated for the programs for a state fiscal biennium as compared to the preceding state fiscal biennium, the commission shall, to the extent permitted under federal law and to the extent

otherwise possible considering other relevant factors, correlate the increased reimbursement rates with the quality-based outcome and process measures developed under this section.

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

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

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

(3) promote the coordination of health care;

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

(5) promote effective health care delivery models; and

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

(b) The commission shall develop quality-based payment systems in the manner specified by this chapter. To the extent necessary, the commission shall coordinate the timeline for the development and implementation of a payment system with the implementation of other initiatives such as the Medicaid Information Technology Architecture (MITA) initiative of the Center for Medicaid and State Operations, the ICD-10 code sets initiative, or the ongoing Enterprise Data Warehouse (EDW) planning

process in order to maximize the receipt of federal funds or reduce any administrative burden.

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

(1) an alternative payment system;

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

(A) reduce unnecessary administrative burdens; and

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

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

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

(e) The commission may modify a quality-based payment system developed under this chapter to account for programmatic differences between the child health plan and Medicaid programs and

delivery systems under those programs.

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

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

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

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

(A) quality-based payment and reimbursement systems under Section 536.004 and Subchapters B, C, and D, including the development of outcome and process measures under Section 536.003; and

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

(2) develop guidelines establishing procedures for providing notice and information to, and receiving input from,

managed care organizations, health care providers, including physicians and experts in the various medical specialty fields, and other stakeholders, as appropriate, for purposes of developing and establishing the quality-based payment and reimbursement systems and initiatives described under Subdivision (1); and

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

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

(b) The commission shall:

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

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

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

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

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

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

[Sections 536.009-536.050 reserved for expansion]

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

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

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

Sec. 536.052. PAYMENT AND CONTRACT AWARD INCENTIVES FOR MANAGED CARE ORGANIZATIONS. (a) The commission may allow a

managed care organization participating in the child health plan or Medicaid program increased flexibility to implement quality initiatives in a managed care plan offered by the organization, including flexibility with respect to financial arrangements, in order to:

(1) achieve high-quality, cost-effective health care;

(2) increase the use of high-quality, cost-effective delivery models; and

(3) reduce potentially preventable events.

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

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

(d) In awarding contracts to managed care organizations under the child health plan and Medicaid programs, the commission shall, in addition to considerations under Section 533.003 of this code and Section 62.155, Health and Safety Code, give preference to an organization that offers a managed care plan that successfully implements quality initiatives under Subsection (a) as determined

by the commission based on data or other evidence provided by the organization or meets quality of care and cost-efficiency benchmarks under Subsection (b).

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

[Sections 536.053-536.100 reserved for expansion]

SUBCHAPTER C. QUALITY-BASED HEALTH HOME PAYMENT SYSTEMS

Sec. 536.101. DEFINITIONS. In this subchapter:

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

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

Sec. 536.102. QUALITY-BASED HEALTH HOME PAYMENTS. (a) Subject to this subchapter, the commission, after consulting with the advisory committee, may develop and implement quality-based payment systems for health homes designed to improve quality of care and reduce the provision of unnecessary medical services. A quality-based payment system developed under this section must:

(1) base payments made to a participating enrollee's health home on quality and efficiency measures that may include

measurable wellness and prevention criteria and use of evidence-based best practices, sharing a portion of any realized cost savings achieved by the health home, and ensuring quality of care outcomes, including a reduction in potentially preventable events; and

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

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

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

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

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

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

[Sections 536.104-536.150 reserved for expansion]

SUBCHAPTER D. QUALITY-BASED HOSPITAL REIMBURSEMENT SYSTEM

Sec. 536.151 [~~531.913~~]. COLLECTION AND REPORTING OF CERTAIN [~~HOSPITAL HEALTH~~] INFORMATION [~~EXCHANGE~~]. (a) [~~In this~~

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

[~~(1) the same condition or procedure for which the person was previously admitted;~~

[~~(2) an infection or other complication resulting from care previously provided;~~

[~~(3) a condition or procedure that indicates that a surgical intervention performed during a previous admission was unsuccessful in achieving the anticipated outcome; or~~

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

[~~(b)~~] The executive commissioner shall adopt rules for identifying potentially preventable readmissions of child health plan program enrollees and Medicaid recipients and potentially preventable complications experienced by child health plan program enrollees and Medicaid recipients. The [~~and the~~] commission shall collect [~~exchange~~] data from [~~with~~] hospitals on present-on-admission indicators for purposes of this section.

(b) [~~(c)~~] The commission shall establish a [~~health information exchange~~] program to provide a [~~exchange~~] confidential report to [~~information with~~] each hospital in this state that

participates in the child health plan or Medicaid program regarding the hospital's performance with respect to potentially preventable readmissions and potentially preventable complications. To the extent possible, a report provided under this section should include potentially preventable readmissions and potentially preventable complications information across all child health plan and Medicaid program payment systems. A hospital shall distribute the information contained in the report [~~received from the commission~~] to physicians and other health care providers providing services at the hospital.

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

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

(b) The commission must provide the report required under Section 536.151(b) to a hospital at least one year before the

commission adjusts child health plan and Medicaid reimbursements to the hospital under this section.

[Sections 536.153-536.200 reserved for expansion]

SUBCHAPTER E. QUALITY-BASED PAYMENT INITIATIVES

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

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

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

(2) reduce potentially preventable events;

(3) promote prevention and wellness;

(4) increase the use of evidence-based best practices;

(5) increase appropriate physician and other health care provider collaboration; and

(6) contain costs.

(b) The commission shall:

(1) establish a process by which managed care organizations and physicians and other health care providers may

submit proposals for payment initiatives described by Subsection (a); and

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

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

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

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

(1) one or more regions in this state;

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

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

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

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

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

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

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

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

(b) The Health and Human Services Commission shall convert the hospital reimbursement systems used under the child health plan program under Chapter 62, Health and Safety Code, and medical assistance program under Chapter 32, Human Resources Code, to the diagnosis-related groups (DRG) methodology to the extent possible as required by Section 536.005, Government Code, as added by this section, as soon as practicable after the effective date of this

Act, but not later than:

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

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

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

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

(1) not later than September 1, 2012, based on the hospitals' performances with respect to reducing potentially preventable readmissions; and

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

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

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

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

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

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

(1) must be:

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

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

(2) may include measures of:

(A) quality of care, as determined by clinical performance ratings published by the federal Centers for Medicare

and Medicaid Services, the Agency for Healthcare Research and Quality, or another federal agency [~~life~~];

(B) direct-care staff retention and turnover;

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

(D) employee satisfaction and engagement;

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

(F) regulatory compliance;

(G) level of person-centered care; and

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

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

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

Resources Code, under the medical assistance program:

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

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

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

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

(a) The commissioner:

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

(2) after consulting with the executive commissioner of the Health and Human Services Commission, may transfer to an account in the general revenue fund money appropriated from the account established under this chapter to maximize the receipt of federal funds under the medical assistance program established

under Chapter 32, Human Resources Code, and to fund provider reimbursement payments as provided by Subsection (j).

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

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

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

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

(2) the kidney health care program;

(3) the children with special health care needs program; and

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

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

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

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

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

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

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

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

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

Act.

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) the medical assistance program under Chapter 32, Human Resources Code; or

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

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

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

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

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

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

Sec. 32.0314. REIMBURSEMENT FOR DURABLE MEDICAL EQUIPMENT AND SUPPLIES. The executive commissioner of the Health and Human Services Commission shall adopt rules requiring the electronic submission of any claim for reimbursement for durable medical equipment and supplies under the medical assistance program.

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

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

(1) to eligible entities in the following order of

descending priority:

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

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

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

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

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

(b) Section 32.024, Human Resources Code, is amended by adding Subsection (c-1) to read as follows:

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

SECTION 1.20. If before implementing any provision of this

article a state agency determines that a waiver or authorization from a federal agency is necessary for implementation of that provision, the agency affected by the provision shall request the waiver or authorization and may delay implementing that provision until the waiver or authorization is granted.

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

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

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

(2) improve health care transparency;

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

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

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

to promote the efficiency and quality of health care.

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

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

ARTICLE 3. TEXAS INSTITUTE OF HEALTH CARE QUALITY AND EFFICIENCY

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

CHAPTER 1002. TEXAS INSTITUTE OF HEALTH CARE QUALITY AND EFFICIENCY

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1002.001. DEFINITIONS. In this chapter:

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

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

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

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

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

(6) "Health care facility" means:

(A) a hospital licensed under Chapter 241;

(B) an institution licensed under Chapter 242;

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

(D) a birthing center licensed under Chapter 244;

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

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

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

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

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

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

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

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

(11) "Potentially preventable event" means a potentially preventable admission, a potentially preventable ancillary service, a potentially preventable complication, a potentially preventable emergency room visit, a potentially preventable readmission, or a combination of those events.

(12) "Potentially preventable emergency room visit" means treatment of a person in a hospital emergency room or

freestanding emergency medical care facility for a condition that may not require emergency medical attention because the condition could be, or could have been, treated or prevented by a physician or other health care provider in a nonemergency setting.

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

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

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

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

Sec. 1002.002. ESTABLISHMENT; PURPOSE. The Texas Institute of Health Care Quality and Efficiency is established to improve health care quality, accountability, education, and cost containment in this state by encouraging health care provider collaboration, effective health care delivery models, and coordination of health care services.

[Sections 1002.003-1002.050 reserved for expansion]

SUBCHAPTER B. ADMINISTRATION

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

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

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

(1) the commissioner of the department;

(2) the executive commissioner;

(3) the commissioner of insurance;

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

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

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

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

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

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

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

(11) a representative from each state agency or system

of higher education that purchases or provides health care services, as determined by the governor.

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

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

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

(b) Board members may serve consecutive terms.

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

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

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

Sec. 1002.055. EXPENSES. (a) Members of the board serve

without compensation but, subject to the availability of appropriated funds, may receive reimbursement for actual and necessary expenses incurred in attending meetings of the board.

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

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

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

(c) Each board member shall:

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

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

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

Sec. 1002.057. PROHIBITION ON CERTAIN CONTRACTS AND EMPLOYMENT. (a) The board may not compensate, employ, or contract with any individual who serves as a member of the board of, or on an

advisory board or advisory committee for, any other governmental body, including any agency, council, or committee, in this state.

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

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

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

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

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

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

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

C.F.R. Part 2.

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

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

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

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

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

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

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

[Sections 1002.062-1002.100 reserved for expansion]

SUBCHAPTER C. POWERS AND DUTIES

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

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

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

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

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

(i) using nationally accredited measures; or

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

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

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

(2) improving reporting, consolidation, and

transparency of health care information; and

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

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

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

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

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

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

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

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

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

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

(4) the child health plan under Chapter 62.

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

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

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

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

[Sections 1002.103-1002.150 reserved for expansion]

SUBCHAPTER D. HEALTH CARE COLLABORATIVE GUIDELINES AND SUPPORT

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

(b) The institute shall recommend methods to evaluate a health care collaborative's effectiveness, including methods to evaluate:

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

(2) alternative health care payment and delivery

systems used by the collaborative;

(3) the quality of care;

(4) health care provider collaboration and coordination;

(5) the protection of patients;

(6) patient satisfaction; and

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

[Sections 1002.152-1002.200 reserved for expansion]

SUBCHAPTER E. IMPROVED TRANSPARENCY

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

(b) The institute shall develop a plan:

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

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

(3) providing recommendations to the legislature on

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 3.03. On the effective date of this Act:

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

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

SECTION 3.04. (a) The governor shall appoint voting members of the board of directors of the Texas Institute of Health Care Quality and Efficiency under Section 1002.052, Health and

Safety Code, as added by this Act, as soon as practicable after the effective date of this Act.

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

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

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

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

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

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

(b) Not later than December 1, 2012, the Texas Institute of Health Care Quality and Efficiency shall submit a report regarding recommendations for an all payor claims database to the governor, the lieutenant governor, the speaker of the house of

representatives, and the chairs of the appropriate standing committees of the legislature outlining:

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

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

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

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

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

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

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

(A) the extent of the differences in the amounts

accepted as payment in full for a service or supply;

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

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

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

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

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

(ii) adhere to the posted amount.

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

(c) This section expires September 1, 2013.

ARTICLE 4. HEALTH CARE COLLABORATIVES

SECTION 4.01. Subtitle C, Title 6, Insurance Code, is amended by adding Chapter 848 to read as follows:

CHAPTER 848. HEALTH CARE COLLABORATIVES

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 848.001. DEFINITIONS. In this chapter:

(1) "Affiliate" means a person who controls, is

controlled by, or is under common control with one or more other persons.

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

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

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

(C) that consists of:

(i) physicians;

(ii) physicians and other health care providers;

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

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

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

(3) "Health care services" means services provided by a physician or health care provider to prevent, alleviate, cure, or heal human illness or injury. The term includes:

(A) pharmaceutical services;

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

(C) hospitalization.

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

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

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

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

(8) "Physician" means:

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

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

(C) a partnership or limited liability partnership formed by a group of individuals licensed to practice medicine in this state;

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

(E) a company formed by a group of individuals

licensed to practice medicine in this state under the Texas Limited Liability Company Act (Article 1528n, Vernon's Texas Civil Statutes) or the Texas Professional Limited Liability Company Law; or

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

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

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

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

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

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

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

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

Sec. 848.003. USE OF INSURANCE-RELATED TERMS BY HEALTH CARE COLLABORATIVE. A health care collaborative that is not an insurer

or health maintenance organization may not use in its name, contracts, or literature:

(1) the following words or initials:

(A) "insurance";

(B) "casualty";

(C) "surety";

(D) "mutual";

(E) "health maintenance organization"; or

(F) "HMO"; or

(2) any other words or initials that are:

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

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

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

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

(1) Section 38.001;

(2) Subchapter A, Chapter 542;

(3) Chapter 541;

(4) Chapter 543;

(5) Chapter 602;

(6) Chapter 701;

(7) Chapter 803; and

(8) Chapter 804.

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

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

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

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

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

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

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

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

(2) a written description of a contract, agreement, or

other arrangement described by Subdivision (1);

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

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

(B) the attorney general under Section 848.059;

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

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

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

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

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

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

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

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

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

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

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

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

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

[Sections 848.007-848.050 reserved for expansion]

SUBCHAPTER B. AUTHORITY TO ENGAGE IN BUSINESS

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

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

(b) The person who establishes a health care collaborative shall appoint an initial board of directors. Each member of the initial board serves a term of not more than 18 months. Subsequent members of the board shall be elected to serve two-year terms by physicians and health care providers who participate in the health

care collaborative as provided by this section. The board shall elect a chair from among its members.

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

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

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

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

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

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

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

(1) another health care collaborative that provides

health care services in the same service area as the health care collaborative; or

(2) a physician or health care provider that:

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

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

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

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

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

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

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

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

(A) a physician who is not a participant in the

health care collaborative, selected by the physicians who are participants in the collaborative; and

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

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

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

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

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

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

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

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

(c) A medical school, medical and dental unit, or health science center as described by Section 61.003, 61.501, or 74.601,

Education Code, is not required to obtain a certificate of authority under this chapter to the extent that the medical school, medical and dental unit, or health science center contracts to deliver medical care services within a health care collaborative. This chapter is otherwise applicable to a medical school, medical and dental unit, or health science center.

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

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

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

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

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

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

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

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

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

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

(d) The commissioner by rule may:

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

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

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

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

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

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

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

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

(iii) reduces the occurrence of potentially preventable events;

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

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

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

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

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

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

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

(B) the composition of the collaborative, including the distribution of physicians by specialty within the collaborative in relation to the number of competing health care

providers in the health care collaborative's geographic market; and

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

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

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

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

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

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

the attorney general shall notify the commissioner.

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

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

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

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

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

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

(b) An application for renewal must:

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

(2) include:

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

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

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

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

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

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

(G) any other information required by the commissioner.

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

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

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

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

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

[Sections 848.061-848.100 reserved for expansion]

SUBCHAPTER C. GENERAL POWERS AND DUTIES OF HEALTH CARE COLLABORATIVE

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

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

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

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

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

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

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

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

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

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

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

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

(b) Notwithstanding any other law, a health care collaborative that is in compliance with this code, including Chapters 841, 842, and 843, as applicable, may contract for, accept, and distribute payments from governmental or private payors based on fee-for-service or alternative payment mechanisms, including:

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

(2) capitation or global payments; or

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

(c) Except as provided by Subsection (d), a health care collaborative may not contract for and accept from a governmental or private entity payments on a prospective basis, including bundled or global payments, unless the health care collaborative is licensed under Chapter 843.

(d) A health care collaborative may contract for and accept from an insurance company or a health maintenance organization payments on a prospective basis, including bundled or global payments.

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

Sec. 848.105. CORPORATION, PARTNERSHIP, OR ASSOCIATION

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

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

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

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

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

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

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

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

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

(2) a participating physician or health care provider.

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

(c) A health care collaborative may not take a retaliatory or adverse action against a physician or health care provider who files a complaint with a regulatory authority regarding an action of the health care collaborative.

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

(b) Section 1272.301 does not apply to a delegation agreement entered into by a health care collaborative.

(c) A health care collaborative may enter into a delegation agreement with an entity licensed under Chapter 841, 842, or 883 if the delegation agreement assigns to the entity responsibility for:

(1) a function regulated by:

(A) Chapter 222;

(B) Chapter 841;

(C) Chapter 842;

(D) Chapter 883;

(E) Chapter 1272;

(F) Chapter 1301;

(G) Chapter 4201;

(H) Section 1367.053; or

(I) Subchapter A, Chapter 1507; or

(2) another function specified by commissioner rule.

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

(e) A health care collaborative that enters into a delegation agreement under this section is subject to Chapters 404, 441, and 443 and is considered to be an insurer for purposes of those chapters.

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

provision of law.

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

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

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

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

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

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

[Sections 848.111-848.150 reserved for expansion]

SUBCHAPTER D. REGULATION OF HEALTH CARE COLLABORATIVES

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

Sec. 848.152. FEES AND ASSESSMENTS. (a) The commissioner

shall, within the limits prescribed by this section, prescribe the fees to be charged and the assessments to be imposed under this section.

(b) Amounts collected under this section shall be deposited to the credit of the Texas Department of Insurance operating account.

(c) A health care collaborative shall pay to the department:

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

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

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

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

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

(c) On request of the commissioner or attorney general, a

health care collaborative shall provide to the commissioner or attorney general, as applicable:

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

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

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

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

[Sections 848.154-848.200 reserved for expansion]

SUBCHAPTER E. ENFORCEMENT

Sec. 848.201. ENFORCEMENT ACTIONS. (a) After notice and opportunity for a hearing, the commissioner may:

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

(2) impose sanctions under Chapter 82;

(3) issue a cease and desist order under Chapter 83; or

(4) impose administrative penalties under Chapter 84.

(b) The commissioner may take an enforcement action listed

in Subsection (a) against a health care collaborative if the commissioner finds that the health care collaborative:

(1) is operating in a manner that is:

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

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

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

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

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

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

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

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

(8) has not taken corrective action the commissioner considers necessary to correct a failure to comply with this

chapter, any applicable provision of this code, or any applicable rule or order of the commissioner not later than the 30th day after the date of notice of the failure or within any longer period specified in the notice and determined by the commissioner to be reasonable; or

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

Sec. 848.202. OPERATIONS DURING SUSPENSION OR AFTER REVOCATION OF CERTIFICATE OF AUTHORITY. (a) During the period a certificate of authority of a health care collaborative is suspended, the health care collaborative may not:

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

(2) advertise or solicit in any way.

(b) After a certificate of authority of a health care collaborative is revoked, the health care collaborative:

(1) shall proceed, immediately following the effective date of the order of revocation, to conclude its affairs;

(2) may not conduct further business except as essential to the orderly conclusion of its affairs; and

(3) may not advertise or solicit in any way.

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

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

Sec. 848.204. NOTICE. The commissioner shall:

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

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

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

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

Sec. 848.205. INDEPENDENT AUTHORITY OF ATTORNEY GENERAL. (a) The attorney general may:

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

(2) request that the commissioner:

(A) impose a penalty or sanction;

(B) issue a cease and desist order; or

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

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

SECTION 4.02. Paragraph (A), Subdivision (12), Subsection

(a), Section 74.001, Civil Practice and Remedies Code, is amended to read as follows:

(A) "Health care provider" means any person, partnership, professional association, corporation, facility, or institution duly licensed, certified, registered, or chartered by the State of Texas to provide health care, including:

(i) a registered nurse;

(ii) a dentist;

(iii) a podiatrist;

(iv) a pharmacist;

(v) a chiropractor;

(vi) an optometrist; [~~or~~]

(vii) a health care institution; or

(viii) a health care collaborative certified under Chapter 848, Insurance Code.

SECTION 4.03. Subchapter B, Chapter 1301, Insurance Code, is amended by adding Section 1301.0625 to read as follows:

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

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

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

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

SECTION 4.04. Subtitle F, Title 4, Health and Safety Code, is amended by adding Chapter 316 to read as follows:

CHAPTER 316. ESTABLISHMENT OF HEALTH CARE COLLABORATIVES

Sec. 316.001. AUTHORITY TO ESTABLISH HEALTH CARE COLLABORATIVE. A public hospital created under Subtitle C or D or a hospital district created under general or special law may form and sponsor a nonprofit health care collaborative that is certified under Chapter 848, Insurance Code.

SECTION 4.05. Section 102.005, Occupations Code, is amended to read as follows:

Sec. 102.005. APPLICABILITY TO CERTAIN ENTITIES. Section 102.001 does not apply to:

(1) a licensed insurer;

(2) a governmental entity, including:

(A) an intergovernmental risk pool established under Chapter 172, Local Government Code; and

(B) a system as defined by Section 1601.003, Insurance Code;

(3) a group hospital service corporation; [~~or~~]

(4) a health maintenance organization that reimburses, provides, offers to provide, or administers hospital, medical, dental, or other health-related benefits under a health benefits plan for which it is the payor; or

(5) a health care collaborative certified under Chapter 848, Insurance Code.

SECTION 4.06. Subdivision (5), Subsection (a), Section 151.002, Occupations Code, is amended to read as follows:

(5) "Health care entity" means:

(A) a hospital licensed under Chapter 241 or 577, Health and Safety Code;

(B) an entity, including a health maintenance organization, group medical practice, nursing home, health science center, university medical school, hospital district, hospital authority, or other health care facility, that:

(i) provides or pays for medical care or health care services; and

(ii) follows a formal peer review process to further quality medical care or health care;

(C) a professional society or association of physicians, or a committee of such a society or association, that follows a formal peer review process to further quality medical care or health care; [~~or~~]

(D) an organization established by a

professional society or association of physicians, hospitals, or both, that:

(i) collects and verifies the authenticity of documents and other information concerning the qualifications, competence, or performance of licensed health care professionals; and

(ii) acts as a health care facility's agent under the Health Care Quality Improvement Act of 1986 (42 U.S.C. Section 11101 et seq.); or

(E) a health care collaborative certified under Chapter 848, Insurance Code.

SECTION 4.07. Not later than September 1, 2012, the commissioner of insurance and the attorney general shall adopt rules as necessary to implement this article.

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

ARTICLE 5. PATIENT IDENTIFICATION

SECTION 5.01. Subchapter A, Chapter 311, Health and Safety Code, is amended by adding Section 311.004 to read as follows:

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

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

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

maintained or operated by this state.

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

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

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

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

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

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, Regular Session, 2007, is amended by amending Subsection (b) and adding Subsection (d-1) to read as follows:

(b) A pediatric and adolescent hospital shall report the incidence of surgical site infections, including the causative pathogen if the infection is laboratory-confirmed, occurring in the

following procedures to the department:

(1) cardiac procedures, excluding thoracic cardiac procedures;

(2) ventricular [~~ventriculoperitoneal~~] shunt procedures; and

(3) spinal surgery with instrumentation.

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

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

(c) The executive commissioner by rule may designate an agency of the United States Department of Health and Human Services to receive reports of preventable adverse events by health care facilities on behalf of the department. A health care facility shall authorize the department to have access to facility-specific

data contained in a report made in accordance with a designation made under this subsection.

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

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

(b) The department shall make the reports compiled under Subsection (a) available to the public on the department's Internet website.

(c) The department may not disclose the identity of a patient or health care professional in the reports authorized in this section.

Sec. 98.1047. STUDIES ON LONG-TERM CARE FACILITY REPORTING OF ADVERSE HEALTH CONDITIONS. (a) In consultation with the Texas Institute of Health Care Quality and Efficiency under Chapter 1002, the department shall study which adverse health conditions commonly occur in long-term care facilities and, of those health conditions, which are potentially preventable.

(b) The department shall develop recommendations for reporting adverse health conditions identified under Subsection (a).

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

Sec. 98.105. REPORTING SYSTEM MODIFICATIONS. Based on the recommendations of the advisory panel, the executive commissioner by rule may modify in accordance with this chapter the list of procedures that are reportable under Section 98.103 [~~or 98.104~~]. The modifications must be based on changes in reporting guidelines and in definitions established by the federal Centers for Disease Control and Prevention.

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

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

(1) the infections reported by facilities under Section [~~Sections~~] 98.103 [~~and 98.104~~]; and

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

(b) Information included in the departmental summary with respect to infections reported by facilities under Section [~~Sections~~] 98.103 [~~and 98.104~~] must be risk adjusted and include a comparison of the risk-adjusted infection rates for each health

care facility in this state that is required to submit a report under Section [~~Sections~~] 98.103 [~~and 98.104~~].

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

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

Sec. 98.1065. STUDY OF INCENTIVES AND RECOGNITION FOR HEALTH CARE QUALITY. The department, in consultation with the Texas Institute of Health Care Quality and Efficiency under Chapter 1002, shall conduct a study on developing a recognition program to recognize exemplary health care facilities for superior quality of health care and make recommendations based on that study.

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

Sec. 98.108. FREQUENCY OF REPORTING. (a) In consultation with the advisory panel, the executive commissioner by rule shall establish the frequency of reporting by health care facilities required under Sections 98.103[~~, 98.104,~~] and 98.1045.

(b) Except as provided by Subsection (c), facilities [~~Facilities~~] may not be required to report more frequently than quarterly.

(c) The executive commissioner may adopt rules requiring reporting more frequently than quarterly if more frequent reporting is necessary to meet the requirements for participation in the federal Centers for Disease Control and Prevention's National Healthcare Safety Network.

SECTION 6.10. Subsection (a), Section 98.109, Health and Safety Code, as added by Chapter 359 (S.B. 288), Acts of the 80th Legislature, Regular Session, 2007, is amended to read as follows:

(a) Except as provided by Sections 98.1046, 98.106, and 98.110, all information and materials obtained or compiled or reported by the department under this chapter or compiled or reported by a health care facility under this chapter, and all related information and materials, are confidential and:

(1) are not subject to disclosure under Chapter 552, Government Code, or discovery, subpoena, or other means of legal compulsion for release to any person; and

(2) may not be admitted as evidence or otherwise disclosed in any civil, criminal, or administrative proceeding.

SECTION 6.11. Section 98.110, Health and Safety Code, as added by Chapter 359 (S.B. 288), Acts of the 80th Legislature, Regular Session, 2007, is amended to read as follows:

Sec. 98.110. DISCLOSURE AMONG CERTAIN AGENCIES. (a) Notwithstanding any other law, the department may disclose information reported by health care facilities under Section 98.103[~~, 98.104,~~] or 98.1045 to other programs within the department, to the Health and Human Services Commission, [~~and~~] to other health and human services agencies, as defined by Section

531.001, Government Code, and to the federal Centers for Disease Control and Prevention, or any other agency of the United States Department of Health and Human Services, for public health research or analysis purposes only, provided that the research or analysis relates to health care-associated infections or preventable adverse events. The privilege and confidentiality provisions contained in this chapter apply to such disclosures.

(b) If the executive commissioner designates an agency of the United States Department of Health and Human Services to receive reports of health care-associated infections or preventable adverse events, that agency may use the information submitted for purposes allowed by federal law.

SECTION 6.12. Section 98.104, Health and Safety Code, as added by Chapter 359 (S.B. 288), Acts of the 80th Legislature, Regular Session, 2007, is repealed.

SECTION 6.13. Not later than December 1, 2012, the Department of State Health Services shall submit a report regarding recommendations for improved health care reporting to the governor, the lieutenant governor, the speaker of the house of representatives, and the chairs of the appropriate standing committees of the legislature outlining:

(1) the initial assessment in the study conducted under Section 98.1065, Health and Safety Code, as added by this Act;

(2) based on the study described by Subdivision (1) of this subsection, the feasibility and desirability of establishing a recognition program to recognize exemplary health care facilities for superior quality of health care;

(3) the recommendations developed under Section 98.1065, Health and Safety Code, as added by this Act; and

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

ARTICLE 7. INFORMATION MAINTAINED BY DEPARTMENT OF STATE HEALTH SERVICES

SECTION 7.01. Section 108.002, Health and Safety Code, is amended by adding Subdivisions (4-a) and (8-a) and amending Subdivision (7) to read as follows:

(4-a) "Commission" means the Health and Human Services Commission.

(7) "Department" means the [~~Texas~~] Department of State Health Services.

(8-a) "Executive commissioner" means the executive commissioner of the Health and Human Services Commission.

SECTION 7.02. Chapter 108, Health and Safety Code, is amended by adding Section 108.0026 to read as follows:

Sec. 108.0026. TRANSFER OF DUTIES; REFERENCE TO COUNCIL. (a) The powers and duties of the Texas Health Care Information Council under this chapter were transferred to the Department of State Health Services in accordance with Section 1.19, Chapter 198 (H.B. 2292), Acts of the 78th Legislature, Regular Session, 2003.

(b) In this chapter or other law, a reference to the Texas Health Care Information Council means the Department of State Health Services.

SECTION 7.03. Subsection (h), Section 108.009, Health and

Safety Code, is amended to read as follows:

(h) The department [~~council~~] shall coordinate data collection with the data submission formats used by hospitals and other providers. The department [~~council~~] shall accept data in the format developed by the American National Standards Institute [~~National Uniform Billing Committee (Uniform Hospital Billing Form UB-92) and HCFA-1500~~] or its successor [~~their successors~~] or other nationally [~~universally~~] accepted standardized forms that hospitals and other providers use for other complementary purposes.

SECTION 7.04. Section 108.013, Health and Safety Code, is amended by amending Subsections (a) through (d), (g), (i), and (j) and adding Subsections (k) through (n) to read as follows:

(a) The data received by the department under this chapter [~~council~~] shall be used by the department and commission [~~council~~] for the benefit of the public. Subject to specific limitations established by this chapter and executive commissioner [~~council~~] rule, the department [~~council~~] shall make determinations on requests for information in favor of access.

(b) The executive commissioner [~~council~~] by rule shall designate the characters to be used as uniform patient identifiers. The basis for assignment of the characters and the manner in which the characters are assigned are confidential.

(c) Unless specifically authorized by this chapter, the department [~~council~~] may not release and a person or entity may not gain access to any data obtained under this chapter:

(1) that could reasonably be expected to reveal the identity of a patient;

(2) that could reasonably be expected to reveal the identity of a physician;

(3) disclosing provider discounts or differentials between payments and billed charges;

(4) relating to actual payments to an identified provider made by a payer; or

(5) submitted to the department [~~council~~] in a uniform submission format that is not included in the public use data set established under Sections 108.006(f) and (g), except in accordance with Section 108.0135.

(d) Except as provided by this section, all [~~All~~] data collected and used by the department [~~and the council~~] under this chapter is subject to the confidentiality provisions and criminal penalties of:

(1) Section 311.037;

(2) Section 81.103; and

(3) Section 159.002, Occupations Code.

(g) Unless specifically authorized by this chapter, the department [~~The council~~] may not release data elements in a manner that will reveal the identity of a patient. The department [~~council~~] may not release data elements in a manner that will reveal the identity of a physician.

(i) Notwithstanding any other law and except as provided by this section, the [~~council and the~~] department may not provide information made confidential by this section to any other agency of this state.

(j) The executive commissioner [~~council~~] shall by rule[~~,~~

~~with the assistance of the advisory committee under Section 108.003(g)(5),~~] develop and implement a mechanism to comply with Subsections (c)(1) and (2).

(k) The department may disclose data collected under this chapter that is not included in public use data to any department or commission program if the disclosure is reviewed and approved by the institutional review board under Section 108.0135.

(l) Confidential data collected under this chapter that is disclosed to a department or commission program remains subject to the confidentiality provisions of this chapter and other applicable law. The department shall identify the confidential data that is disclosed to a program under Subsection (k). The program shall maintain the confidentiality of the disclosed confidential data.

(m) The following provisions do not apply to the disclosure of data to a department or commission program:

(1) Section 81.103;

(2) Sections 108.010(g) and (h);

(3) Sections 108.011(e) and (f);

(4) Section 311.037; and

(5) Section 159.002, Occupations Code.

(n) Nothing in this section authorizes the disclosure of physician identifying data.

SECTION 7.05. Section 108.0135, Health and Safety Code, is amended to read as follows:

Sec. 108.0135. INSTITUTIONAL [~~SCIENTIFIC~~] REVIEW BOARD [~~PANEL~~]. (a) The department [~~council~~] shall establish an institutional [~~a scientific~~] review board [~~panel~~] to review and

approve requests for access to data not contained in [~~information other than~~] public use data. The members of the institutional review board must [~~panel shall~~] have experience and expertise in ethics, patient confidentiality, and health care data.

(b) To assist the institutional review board [~~panel~~] in determining whether to approve a request for information, the executive commissioner [~~council~~] shall adopt rules similar to the federal Centers for Medicare and Medicaid Services' [~~Health Care Financing Administration's~~] guidelines on releasing data.

(c) A request for information other than public use data must be made on the form prescribed [~~created~~] by the department [~~council~~].

(d) Any approval to release information under this section must require that the confidentiality provisions of this chapter be maintained and that any subsequent use of the information conform to the confidentiality provisions of this chapter.

SECTION 7.06. (a) If S.B. No. 156, Acts of the 82nd Legislature, Regular Session, 2011, does not become law, effective September 1, 2014, Subdivisions (5) and (18), Section 108.002, Section 108.0025, and Subsection (c), Section 108.009, Health and Safety Code, are repealed.

(b) If S.B. No. 156, Acts of the 82nd Legislature, Regular Session, 2011, becomes law, effective September 1, 2014, Subdivision (18), Section 108.002, Section 108.0025, and Subsection (c), Section 108.009, Health and Safety Code, are repealed.

ARTICLE 8. ADOPTION OF VACCINE PREVENTABLE DISEASES POLICY BY

HEALTH CARE FACILITIES

SECTION 8.01. The heading to Subtitle A, Title 4, Health and Safety Code, is amended to read as follows:

SUBTITLE A. FINANCING, CONSTRUCTING, REGULATING, AND INSPECTING HEALTH FACILITIES

SECTION 8.02. Subtitle A, Title 4, Health and Safety Code, is amended by adding Chapter 224 to read as follows:

CHAPTER 224. POLICY ON VACCINE PREVENTABLE DISEASES

Sec. 224.001. DEFINITIONS. In this chapter:

(1) "Covered individual" means:

(A) an employee of the health care facility;

(B) an individual providing direct patient care under a contract with a health care facility; or

(C) an individual to whom a health care facility has granted privileges to provide direct patient care.

(2) "Health care facility" means:

(A) a facility licensed under Subtitle B, including a hospital as defined by Section 241.003; or

(B) a hospital maintained or operated by this state.

(3) "Regulatory authority" means a state agency that regulates a health care facility under this code.

(4) "Vaccine preventable diseases" means the diseases included in the most current recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

Sec. 224.002. VACCINE PREVENTABLE DISEASES POLICY

REQUIRED. (a) Each health care facility shall develop and implement a policy to protect its patients from vaccine preventable diseases.

(b) The policy must:

(1) require covered individuals to receive vaccines for the vaccine preventable diseases specified by the facility based on the level of risk the individual presents to patients by the individual's routine and direct exposure to patients;

(2) specify the vaccines a covered individual is required to receive based on the level of risk the individual presents to patients by the individual's routine and direct exposure to patients;

(3) include procedures for verifying whether a covered individual has complied with the policy;

(4) include procedures for a covered individual to be exempt from the required vaccines for the medical conditions identified as contraindications or precautions by the Centers for Disease Control and Prevention;

(5) for a covered individual who is exempt from the required vaccines, include procedures the individual must follow to protect facility patients from exposure to disease, such as the use of protective medical equipment, such as gloves and masks, based on the level of risk the individual presents to patients by the individual's routine and direct exposure to patients;

(6) prohibit discrimination or retaliatory action against a covered individual who is exempt from the required vaccines for the medical conditions identified as

contraindications or precautions by the Centers for Disease Control and Prevention, except that required use of protective medical equipment, such as gloves and masks, may not be considered retaliatory action for purposes of this subdivision;

(7) require the health care facility to maintain a written or electronic record of each covered individual's compliance with or exemption from the policy; and

(8) include disciplinary actions the health care facility is authorized to take against a covered individual who fails to comply with the policy.

(c) The policy may include procedures for a covered individual to be exempt from the required vaccines based on reasons of conscience, including a religious belief.

Sec. 224.003. DISASTER EXEMPTION. (a) In this section, "public health disaster" has the meaning assigned by Section 81.003.

(b) During a public health disaster, a health care facility may prohibit a covered individual who is exempt from the vaccines required in the policy developed by the facility under Section 224.002 from having contact with facility patients.

Sec. 224.004. DISCIPLINARY ACTION. A health care facility that violates this chapter is subject to an administrative or civil penalty in the same manner, and subject to the same procedures, as if the facility had violated a provision of this code that specifically governs the facility.

Sec. 224.005. RULES. The appropriate rulemaking authority for each regulatory authority shall adopt rules necessary to

implement this chapter.

SECTION 8.03. Not later than June 1, 2012, a state agency that regulates a health care facility subject to Chapter 224, Health and Safety Code, as added by this Act, shall adopt the rules necessary to implement that chapter.

SECTION 8.04. Notwithstanding Chapter 224, Health and Safety Code, as added by this Act, a health care facility subject to that chapter is not required to have a policy on vaccine preventable diseases in effect until September 1, 2012.

ARTICLE 9. TEXAS EMERGENCY AND TRAUMA CARE EDUCATION PARTNERSHIP PROGRAM

SECTION 9.01. Chapter 61, Education Code, is amended by adding Subchapter HH to read as follows:

SUBCHAPTER HH. TEXAS EMERGENCY AND TRAUMA CARE EDUCATION PARTNERSHIP PROGRAM

Sec. 61.9801. DEFINITIONS. In this subchapter:

(1) "Emergency and trauma care education partnership" means a partnership that:

(A) consists of one or more hospitals in this state and one or more graduate professional nursing or graduate medical education programs in this state; and

(B) serves to increase training opportunities in emergency and trauma care for doctors and registered nurses at participating graduate medical education and graduate professional nursing programs.

(2) "Participating education program" means a graduate professional nursing program as that term is defined by

Section 54.221 or a graduate medical education program leading to board certification by the American Board of Medical Specialties that participates in an emergency and trauma care education partnership.

Sec. 61.9802. PROGRAM: ESTABLISHMENT; ADMINISTRATION; PURPOSE. (a) The Texas emergency and trauma care education partnership program is established.

(b) The board shall administer the program in accordance with this subchapter and rules adopted under this subchapter.

(c) Under the program, to the extent funds are available under Section 61.9805, the board shall make grants to emergency and trauma care education partnerships to assist those partnerships to meet the state's needs for doctors and registered nurses with training in emergency and trauma care by offering one-year or two-year fellowships to students enrolled in graduate professional nursing or graduate medical education programs through collaboration between hospitals and graduate professional nursing or graduate medical education programs and the use of the existing expertise and facilities of those hospitals and programs.

Sec. 61.9803. GRANTS: CONDITIONS; LIMITATIONS. (a) The board may make a grant under this subchapter to an emergency and trauma care education partnership only if the board determines that:

(1) the partnership will meet applicable standards for instruction and student competency for each program offered by each participating education program;

(2) each participating education program will, as a

result of the partnership, enroll in the education program a sufficient number of additional students as established by the board;

(3) each hospital participating in an emergency and trauma care education partnership will provide to students enrolled in a participating education program clinical placements that:

(A) allow the students to take part in providing or to observe, as appropriate, emergency and trauma care services offered by the hospital; and

(B) meet the clinical education needs of the students; and

(4) the partnership will satisfy any other requirement established by board rule.

(b) A grant under this subchapter may be spent only on costs related to the development or operation of an emergency and trauma care education partnership that prepares a student to complete a graduate professional nursing program with a specialty focus on emergency and trauma care or earn board certification by the American Board of Medical Specialties.

Sec. 61.9804. PRIORITY FOR FUNDING. In awarding a grant under this subchapter, the board shall give priority to an emergency and trauma care education partnership that submits a proposal that:

(1) provides for collaborative educational models between one or more participating hospitals and one or more participating education programs that have signed a memorandum of understanding or other written agreement under which the

participants agree to comply with standards established by the board, including any standards the board may establish that:

(A) provide for program management that offers a centralized decision-making process allowing for inclusion of each entity participating in the partnership;

(B) provide for access to clinical training positions for students in graduate professional nursing and graduate medical education programs that are not participating in the partnership; and

(C) specify the details of any requirement relating to a student in a participating education program being employed after graduation in a hospital participating in the partnership, including any details relating to the employment of students who do not complete the program, are not offered a position at the hospital, or choose to pursue other employment;

(2) includes a demonstrable education model to:

(A) increase the number of students enrolled in, the number of students graduating from, and the number of faculty employed by each participating education program; and

(B) improve student or resident retention in each participating education program;

(3) indicates the availability of money to match a portion of the grant money, including matching money or in-kind services approved by the board from a hospital, private or nonprofit entity, or institution of higher education;

(4) can be replicated by other emergency and trauma care education partnerships or other graduate professional nursing

or graduate medical education programs; and

(5) includes plans for sustainability of the partnership.

Sec. 61.9805. GRANTS, GIFTS, AND DONATIONS. In addition to money appropriated by the legislature, the board may solicit, accept, and spend grants, gifts, and donations from any public or private source for the purposes of this subchapter.

Sec. 61.9806. RULES. The board shall adopt rules for the administration of the Texas emergency and trauma care education partnership program. The rules must include:

(1) provisions relating to applying for a grant under this subchapter; and

(2) standards of accountability consistent with other graduate professional nursing and graduate medical education programs to be met by any emergency and trauma care education partnership awarded a grant under this subchapter.

Sec. 61.9807. ADMINISTRATIVE COSTS. A reasonable amount, not to exceed three percent, of any money appropriated for purposes of this subchapter may be used to pay the costs of administering this subchapter.

SECTION 9.02. As soon as practicable after the effective date of this article, the Texas Higher Education Coordinating Board shall adopt rules for the implementation and administration of the Texas emergency and trauma care education partnership program established under Subchapter HH, Chapter 61, Education Code, as added by this Act. The board may adopt the initial rules in the manner provided by law for emergency rules.

ARTICLE 10. INSURER CONTRACTS REGARDING CERTAIN BENEFIT PLANS

SECTION 10.01. Section 1301.006, Insurance Code, is amended to read as follows:

Sec. 1301.006. AVAILABILITY OF AND ACCESSIBILITY TO HEALTH CARE SERVICES. (a) An insurer that markets a preferred provider benefit plan shall contract with physicians and health care providers to ensure that all medical and health care services and items contained in the package of benefits for which coverage is provided, including treatment of illnesses and injuries, will be provided under the health insurance policy in a manner ensuring availability of and accessibility to adequate personnel, specialty care, and facilities.

(b) A contract between an insurer that markets a plan regulated under this chapter and an institutional provider may not, as a condition of staff membership or privileges, require a physician or other practitioner to enter into a preferred provider contract.

ARTICLE 11. EFFECTIVE DATE

SECTION 11.01. Except as otherwise provided by this Act, this Act takes effect on the 91st day after the last day of the legislative session.