

1-1 By: Nelson S.B. No. 7
1-2 (In the Senate - Filed May 31, 2011; May 31, 2011, read
1-3 first time and referred to Committee on Finance; June 2, 2011,
1-4 reported favorably by the following vote: Yeas 14, Nays 0;
1-5 June 2, 2011, sent to printer.)

1-6 A BILL TO BE ENTITLED
1-7 AN ACT

1-8 relating to the administration, quality, efficiency, and funding of
1-9 health care, health and human services, and health benefits
1-10 programs in this state; providing administrative and civil
1-11 penalties.

1-12 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

1-13 ARTICLE 1. ADMINISTRATION OF AND EFFICIENCY, COST-SAVING, FRAUD
1-14 PREVENTION, AND FUNDING MEASURES FOR CERTAIN HEALTH AND HUMAN
1-15 SERVICES AND HEALTH BENEFITS PROGRAMS

1-16 SECTION 1.01. (a) Section 102.054, Business & Commerce
1-17 Code, is amended to read as follows:

1-18 Sec. 102.054. ALLOCATION OF ~~[CERTAIN]~~ REVENUE FOR SEXUAL
1-19 ASSAULT PROGRAMS. The comptroller shall deposit the amount ~~[first~~
1-20 ~~\$25 million]~~ received from the fee imposed under this subchapter
1-21 ~~[in a state fiscal biennium]~~ to the credit of the sexual assault
1-22 program fund.

1-23 (b) Section 420.008, Government Code, is amended by
1-24 amending Subsection (c) and adding Subsection (d) to read as
1-25 follows:

1-26 (c) The legislature may appropriate money deposited to the
1-27 credit of the fund only to:

1-28 (1) the attorney general, for:

1-29 (A) sexual violence awareness and prevention
1-30 campaigns;

1-31 (B) grants to faith-based groups, independent
1-32 school districts, and community action organizations for programs
1-33 for the prevention of sexual assault and programs for victims of
1-34 human trafficking;

1-35 (C) grants for equipment for sexual assault nurse
1-36 examiner programs, to support the preceptorship of future sexual
1-37 assault nurse examiners, and for the continuing education of sexual
1-38 assault nurse examiners;

1-39 (D) grants to increase the level of sexual
1-40 assault services in this state;

1-41 (E) grants to support victim assistance
1-42 coordinators;

1-43 (F) grants to support technology in rape crisis
1-44 centers;

1-45 (G) grants to and contracts with a statewide
1-46 nonprofit organization exempt from federal income taxation under
1-47 Section 501(c)(3), Internal Revenue Code of 1986, having as a
1-48 primary purpose ending sexual violence in this state, for programs
1-49 for the prevention of sexual violence, outreach programs, and
1-50 technical assistance to and support of youth and rape crisis
1-51 centers working to prevent sexual violence; ~~and]~~

1-52 (H) grants to regional nonprofit providers of
1-53 civil legal services to provide legal assistance for sexual assault
1-54 victims;

1-55 (I) grants to health science centers and related
1-56 nonprofit entities exempt from federal income taxation under
1-57 Section 501(a), Internal Revenue Code of 1986, by being listed as an
1-58 exempt organization under Section 501(c)(3) of that code, for
1-59 research relating to the prevention and mitigation of sexual
1-60 assault; and

1-61 (J) Internet Crimes Against Children Task Force
1-62 locations in this state recognized by the United States Department
1-63 of Justice;

1-64 (2) the Department of State Health Services, to

2-1 measure the prevalence of sexual assault in this state and for
2-2 grants to support programs assisting victims of human trafficking;
2-3 (3) the Institute on Domestic Violence and Sexual
2-4 Assault at The University of Texas at Austin, to conduct research on
2-5 all aspects of sexual assault and domestic violence;
2-6 (4) Texas State University, for training and technical
2-7 assistance to independent school districts for campus safety;
2-8 (5) the office of the governor, for grants to support
2-9 sexual assault and human trafficking prosecution projects;
2-10 (6) the Department of Public Safety, to support sexual
2-11 assault training for commissioned officers;
2-12 (7) the comptroller's judiciary section, for
2-13 increasing the capacity of the sex offender civil commitment
2-14 program;
2-15 (8) the Texas Department of Criminal Justice:
2-16 (A) for pilot projects for monitoring sex
2-17 offenders on parole; and
2-18 (B) for increasing the number of adult
2-19 incarcerated sex offenders receiving treatment;
2-20 (9) the Texas Youth Commission, for increasing the
2-21 number of incarcerated juvenile sex offenders receiving treatment;
2-22 (10) the comptroller, for the administration of the
2-23 fee imposed on sexually oriented businesses under Section 102.052,
2-24 Business & Commerce Code; ~~and~~
2-25 (11) the supreme court, to be transferred to the Texas
2-26 Equal Access to Justice Foundation, or a similar entity, to provide
2-27 victim-related legal services to sexual assault victims, including
2-28 legal assistance with protective orders, relocation-related
2-29 matters, victim compensation, and actions to secure privacy
2-30 protections available to victims under law; and
2-31 (12) the Department of Family and Protective Services
2-32 for:
2-33 (A) programs related to sexual assault
2-34 prevention and intervention; and
2-35 (B) research relating to how the department can
2-36 effectively address the prevention of sexual assault.
2-37 (d) A board, commission, department, office, or other
2-38 agency in the executive or judicial branch of state government to
2-39 which money is appropriated from the sexual assault program fund
2-40 under this section shall, not later than December 1 of each
2-41 even-numbered year, provide to the Legislative Budget Board a
2-42 report stating, for the preceding fiscal biennium:
2-43 (1) the amount appropriated to the entity under this
2-44 section;
2-45 (2) the purposes for which the money was used; and
2-46 (3) any results of a program or research funded under
2-47 this section.
2-48 (c) The comptroller of public accounts shall collect the fee
2-49 imposed under Section 102.052, Business & Commerce Code, until a
2-50 court, in a final judgment upheld on appeal or no longer subject to
2-51 appeal, finds Section 102.052, Business & Commerce Code, or its
2-52 predecessor statute, to be unconstitutional.
2-53 (d) Section 102.055, Business & Commerce Code, is repealed.
2-54 (e) This section prevails over any other Act of the 82nd
2-55 Legislature, 1st Called Session, 2011, regardless of the relative
2-56 dates of enactment, that purports to amend or repeal Subchapter B,
2-57 Chapter 102, Business & Commerce Code, or any provision of Chapter
2-58 1206 (H.B. 1751), Acts of the 80th Legislature, Regular Session,
2-59 2007.
2-60 SECTION 1.02. (a) Subchapter B, Chapter 531, Government
2-61 Code, is amended by adding Sections 531.02417, 531.024171, and
2-62 531.024172 to read as follows:
2-63 Sec. 531.02417. MEDICAID NURSING SERVICES ASSESSMENTS.
2-64 (a) In this section, "acute nursing services" means home health
2-65 skilled nursing services, home health aide services, and private
2-66 duty nursing services.
2-67 (b) If cost-effective, the commission shall develop an
2-68 objective assessment process for use in assessing a Medicaid
2-69 recipient's needs for acute nursing services. If the commission

3-1 develops an objective assessment process under this section, the
 3-2 commission shall require that:

3-3 (1) the assessment be conducted:

3-4 (A) by a state employee or contractor who is not
 3-5 the person who will deliver any necessary services to the recipient
 3-6 and is not affiliated with the person who will deliver those
 3-7 services; and

3-8 (B) in a timely manner so as to protect the health
 3-9 and safety of the recipient by avoiding unnecessary delays in
 3-10 service delivery; and

3-11 (2) the process include:

3-12 (A) an assessment of specified criteria and
 3-13 documentation of the assessment results on a standard form;

3-14 (B) an assessment of whether the recipient should
 3-15 be referred for additional assessments regarding the recipient's
 3-16 needs for therapy services, as defined by Section 531.024171,
 3-17 attendant care services, and durable medical equipment; and

3-18 (C) completion by the person conducting the
 3-19 assessment of any documents related to obtaining prior
 3-20 authorization for necessary nursing services.

3-21 (c) If the commission develops the objective assessment
 3-22 process under Subsection (b), the commission shall:

3-23 (1) implement the process within the Medicaid
 3-24 fee-for-service model and the primary care case management Medicaid
 3-25 managed care model; and

3-26 (2) take necessary actions, including modifying
 3-27 contracts with managed care organizations under Chapter 533 to the
 3-28 extent allowed by law, to implement the process within the STAR and
 3-29 STAR + PLUS Medicaid managed care programs.

3-30 (d) An assessment under Subsection (b)(2)(B) of whether a
 3-31 recipient should be referred for additional therapy services shall
 3-32 be waived if the recipient's need for therapy services has been
 3-33 established by a recommendation from a therapist providing care
 3-34 prior to discharge of the recipient from a licensed hospital or
 3-35 nursing home. The assessment may not be waived if the
 3-36 recommendation is made by a therapist who will deliver any services
 3-37 to the recipient or is affiliated with a person who will deliver
 3-38 those services when the recipient is discharged from the licensed
 3-39 hospital or nursing home.

3-40 (e) The executive commissioner shall adopt rules providing
 3-41 for a process by which a provider of acute nursing services who
 3-42 disagrees with the results of the assessment conducted under
 3-43 Subsection (b) may request and obtain a review of those results.

3-44 Sec. 531.024171. THERAPY SERVICES ASSESSMENTS. (a) In
 3-45 this section, "therapy services" includes occupational, physical,
 3-46 and speech therapy services.

3-47 (b) After implementing the objective assessment process for
 3-48 acute nursing services in accordance with Section 531.02417, the
 3-49 commission shall consider whether implementing age- and
 3-50 diagnosis-appropriate objective assessment processes for assessing
 3-51 the needs of a Medicaid recipient for therapy services would be
 3-52 feasible and beneficial.

3-53 (c) If the commission determines that implementing age- and
 3-54 diagnosis-appropriate processes with respect to one or more types
 3-55 of therapy services is feasible and would be beneficial, the
 3-56 commission may implement the processes within:

3-57 (1) the Medicaid fee-for-service model;

3-58 (2) the primary care case management Medicaid managed
 3-59 care model; and

3-60 (3) the STAR and STAR + PLUS Medicaid managed care
 3-61 programs.

3-62 (d) An objective assessment process implemented under this
 3-63 section must include a process that allows a provider of therapy
 3-64 services to request and obtain a review of the results of an
 3-65 assessment conducted as provided by this section that is comparable
 3-66 to the process implemented under rules adopted under Section
 3-67 531.02417(e).

3-68 Sec. 531.024172. ELECTRONIC VISIT VERIFICATION SYSTEM.

3-69 (a) In this section, "acute nursing services" has the meaning

4-1 assigned by Section 531.02417.

4-2 (b) If it is cost-effective and feasible, the commission
 4-3 shall implement an electronic visit verification system to
 4-4 electronically verify and document, through a telephone or
 4-5 computer-based system, basic information relating to the delivery
 4-6 of Medicaid acute nursing services, including:

4-7 (1) the provider's name;

4-8 (2) the recipient's name; and

4-9 (3) the date and time the provider begins and ends each
 4-10 service delivery visit.

4-11 (b) Not later than September 1, 2012, the Health and Human
 4-12 Services Commission shall implement the electronic visit
 4-13 verification system required by Section 531.024172, Government
 4-14 Code, as added by this section, if the commission determines that
 4-15 implementation of that system is cost-effective and feasible.

4-16 SECTION 1.03. (a) Subsection (e), Section 533.0025,
 4-17 Government Code, is amended to read as follows:

4-18 (e) The commission shall determine the most cost-effective
 4-19 alignment of managed care service delivery areas. The commissioner
 4-20 may consider the number of lives impacted, the usual source of
 4-21 health care services for residents in an area, and other factors
 4-22 that impact the delivery of health care services in the area
 4-23 [Notwithstanding Subsection (b)(1), the commission may not provide
 4-24 medical assistance using a health maintenance organization in
 4-25 Cameron County, Hidalgo County, or Maverick County].

4-26 (b) Subchapter A, Chapter 533, Government Code, is amended
 4-27 by adding Sections 533.0027, 533.0028, and 533.0029 to read as
 4-28 follows:

4-29 Sec. 533.0027. PROCEDURES TO ENSURE CERTAIN RECIPIENTS ARE
 4-30 ENROLLED IN SAME MANAGED CARE PLAN. The commission shall ensure
 4-31 that all recipients who are children and who reside in the same
 4-32 household may, at the family's election, be enrolled in the same
 4-33 managed care plan.

4-34 Sec. 533.0028. EVALUATION OF CERTAIN STAR + PLUS MEDICAID
 4-35 MANAGED CARE PROGRAM SERVICES. The external quality review
 4-36 organization shall periodically conduct studies and surveys to
 4-37 assess the quality of care and satisfaction with health care
 4-38 services provided to enrollees in the STAR + PLUS Medicaid managed
 4-39 care program who are eligible to receive health care benefits under
 4-40 both the Medicaid and Medicare programs.

4-41 Sec. 533.0029. PROMOTION AND PRINCIPLES OF
 4-42 PATIENT-CENTERED MEDICAL HOMES FOR RECIPIENTS. (a) For purposes
 4-43 of this section, a "patient-centered medical home" means a medical
 4-44 relationship:

4-45 (1) between a primary care physician and a child or
 4-46 adult patient in which the physician:

4-47 (A) provides comprehensive primary care to the
 4-48 patient; and

4-49 (B) facilitates partnerships between the
 4-50 physician, the patient, acute care and other care providers, and,
 4-51 when appropriate, the patient's family; and

4-52 (2) that encompasses the following primary
 4-53 principles:

4-54 (A) the patient has an ongoing relationship with
 4-55 the physician, who is trained to be the first contact for the
 4-56 patient and to provide continuous and comprehensive care to the
 4-57 patient;

4-58 (B) the physician leads a team of individuals at
 4-59 the practice level who are collectively responsible for the ongoing
 4-60 care of the patient;

4-61 (C) the physician is responsible for providing
 4-62 all of the care the patient needs or for coordinating with other
 4-63 qualified providers to provide care to the patient throughout the
 4-64 patient's life, including preventive care, acute care, chronic
 4-65 care, and end-of-life care;

4-66 (D) the patient's care is coordinated across
 4-67 health care facilities and the patient's community and is
 4-68 facilitated by registries, information technology, and health
 4-69 information exchange systems to ensure that the patient receives

5-1 care when and where the patient wants and needs the care and in a
5-2 culturally and linguistically appropriate manner; and

5-3 (E) quality and safe care is provided.

5-4 (b) The commission shall, to the extent possible, work to
5-5 ensure that managed care organizations:

5-6 (1) promote the development of patient-centered
5-7 medical homes for recipients; and

5-8 (2) provide payment incentives for providers that meet
5-9 the requirements of a patient-centered medical home.

5-10 (c) Section 533.003, Government Code, is amended to read as
5-11 follows:

5-12 Sec. 533.003. CONSIDERATIONS IN AWARDING CONTRACTS. (a) In
5-13 awarding contracts to managed care organizations, the commission
5-14 shall:

5-15 (1) give preference to organizations that have
5-16 significant participation in the organization's provider network
5-17 from each health care provider in the region who has traditionally
5-18 provided care to Medicaid and charity care patients;

5-19 (2) give extra consideration to organizations that
5-20 agree to assure continuity of care for at least three months beyond
5-21 the period of Medicaid eligibility for recipients;

5-22 (3) consider the need to use different managed care
5-23 plans to meet the needs of different populations; ~~and~~

5-24 (4) consider the ability of organizations to process
5-25 Medicaid claims electronically; and

5-26 (5) in the initial implementation of managed care in
5-27 the South Texas service region, give extra consideration to an
5-28 organization that either:

5-29 (A) is locally owned, managed, and operated, if
5-30 one exists; or

5-31 (B) is in compliance with the requirements of
5-32 Section 533.004.

5-33 (b) The commission, in considering approval of a
5-34 subcontract between a managed care organization and a pharmacy
5-35 benefit manager for the provision of prescription drug benefits
5-36 under the Medicaid program, shall review and consider whether the
5-37 pharmacy benefit manager has been in the preceding three years:

5-38 (1) convicted of an offense involving a material
5-39 misrepresentation or an act of fraud or of another violation of
5-40 state or federal criminal law;

5-41 (2) adjudicated to have committed a breach of
5-42 contract; or

5-43 (3) assessed a penalty or fine in the amount of
5-44 \$500,000 or more in a state or federal administrative proceeding.

5-45 (d) Section 533.005, Government Code, is amended by
5-46 amending Subsection (a) and adding Subsection (a-1) to read as
5-47 follows:

5-48 (a) A contract between a managed care organization and the
5-49 commission for the organization to provide health care services to
5-50 recipients must contain:

5-51 (1) procedures to ensure accountability to the state
5-52 for the provision of health care services, including procedures for
5-53 financial reporting, quality assurance, utilization review, and
5-54 assurance of contract and subcontract compliance;

5-55 (2) capitation rates that ensure the cost-effective
5-56 provision of quality health care;

5-57 (3) a requirement that the managed care organization
5-58 provide ready access to a person who assists recipients in
5-59 resolving issues relating to enrollment, plan administration,
5-60 education and training, access to services, and grievance
5-61 procedures;

5-62 (4) a requirement that the managed care organization
5-63 provide ready access to a person who assists providers in resolving
5-64 issues relating to payment, plan administration, education and
5-65 training, and grievance procedures;

5-66 (5) a requirement that the managed care organization
5-67 provide information and referral about the availability of
5-68 educational, social, and other community services that could
5-69 benefit a recipient;

- 6-1 (6) procedures for recipient outreach and education;
- 6-2 (7) a requirement that the managed care organization
- 6-3 make payment to a physician or provider for health care services
- 6-4 rendered to a recipient under a managed care plan not later than the
- 6-5 45th day after the date a claim for payment is received with
- 6-6 documentation reasonably necessary for the managed care
- 6-7 organization to process the claim, or within a period, not to exceed
- 6-8 60 days, specified by a written agreement between the physician or
- 6-9 provider and the managed care organization;
- 6-10 (8) a requirement that the commission, on the date of a
- 6-11 recipient's enrollment in a managed care plan issued by the managed
- 6-12 care organization, inform the organization of the recipient's
- 6-13 Medicaid certification date;
- 6-14 (9) a requirement that the managed care organization
- 6-15 comply with Section 533.006 as a condition of contract retention
- 6-16 and renewal;
- 6-17 (10) a requirement that the managed care organization
- 6-18 provide the information required by Section 533.012 and otherwise
- 6-19 comply and cooperate with the commission's office of inspector
- 6-20 general and the office of the attorney general;
- 6-21 (11) a requirement that the managed care
- 6-22 organization's usages of out-of-network providers or groups of
- 6-23 out-of-network providers may not exceed limits for those usages
- 6-24 relating to total inpatient admissions, total outpatient services,
- 6-25 and emergency room admissions determined by the commission;
- 6-26 (12) if the commission finds that a managed care
- 6-27 organization has violated Subdivision (11), a requirement that the
- 6-28 managed care organization reimburse an out-of-network provider for
- 6-29 health care services at a rate that is equal to the allowable rate
- 6-30 for those services, as determined under Sections 32.028 and
- 6-31 32.0281, Human Resources Code;
- 6-32 (13) a requirement that the organization use advanced
- 6-33 practice nurses in addition to physicians as primary care providers
- 6-34 to increase the availability of primary care providers in the
- 6-35 organization's provider network;
- 6-36 (14) a requirement that the managed care organization
- 6-37 reimburse a federally qualified health center or rural health
- 6-38 clinic for health care services provided to a recipient outside of
- 6-39 regular business hours, including on a weekend day or holiday, at a
- 6-40 rate that is equal to the allowable rate for those services as
- 6-41 determined under Section 32.028, Human Resources Code, if the
- 6-42 recipient does not have a referral from the recipient's primary
- 6-43 care physician; ~~and~~
- 6-44 (15) a requirement that the managed care organization
- 6-45 develop, implement, and maintain a system for tracking and
- 6-46 resolving all provider appeals related to claims payment, including
- 6-47 a process that will require:
- 6-48 (A) a tracking mechanism to document the status
- 6-49 and final disposition of each provider's claims payment appeal;
- 6-50 (B) the contracting with physicians who are not
- 6-51 network providers and who are of the same or related specialty as
- 6-52 the appealing physician to resolve claims disputes related to
- 6-53 denial on the basis of medical necessity that remain unresolved
- 6-54 subsequent to a provider appeal; and
- 6-55 (C) the determination of the physician resolving
- 6-56 the dispute to be binding on the managed care organization and
- 6-57 provider;
- 6-58 (16) a requirement that a medical director who is
- 6-59 authorized to make medical necessity determinations is available to
- 6-60 the region where the managed care organization provides health care
- 6-61 services;
- 6-62 (17) a requirement that the managed care organization
- 6-63 ensure that a medical director and patient care coordinators and
- 6-64 provider and recipient support services personnel are located in
- 6-65 the South Texas service region, if the managed care organization
- 6-66 provides a managed care plan in that region;
- 6-67 (18) a requirement that the managed care organization
- 6-68 provide special programs and materials for recipients with limited
- 6-69 English proficiency or low literacy skills;

7-1 (19) a requirement that the managed care organization
7-2 develop and establish a process for responding to provider appeals
7-3 in the region where the organization provides health care services;
7-4 (20) a requirement that the managed care organization
7-5 develop and submit to the commission, before the organization
7-6 begins to provide health care services to recipients, a
7-7 comprehensive plan that describes how the organization's provider
7-8 network will provide recipients sufficient access to:
7-9 (A) preventive care;
7-10 (B) primary care;
7-11 (C) specialty care;
7-12 (D) after-hours urgent care; and
7-13 (E) chronic care;
7-14 (21) a requirement that the managed care organization
7-15 demonstrate to the commission, before the organization begins to
7-16 provide health care services to recipients, that:
7-17 (A) the organization's provider network has the
7-18 capacity to serve the number of recipients expected to enroll in a
7-19 managed care plan offered by the organization;
7-20 (B) the organization's provider network
7-21 includes:
7-22 (i) a sufficient number of primary care
7-23 providers;
7-24 (ii) a sufficient variety of provider
7-25 types; and
7-26 (iii) providers located throughout the
7-27 region where the organization will provide health care services;
7-28 and
7-29 (C) health care services will be accessible to
7-30 recipients through the organization's provider network to a
7-31 comparable extent that health care services would be available to
7-32 recipients under a fee-for-service or primary care case management
7-33 model of Medicaid managed care;
7-34 (22) a requirement that the managed care organization
7-35 develop a monitoring program for measuring the quality of the
7-36 health care services provided by the organization's provider
7-37 network that:
7-38 (A) incorporates the National Committee for
7-39 Quality Assurance's Healthcare Effectiveness Data and Information
7-40 Set (HEDIS) measures;
7-41 (B) focuses on measuring outcomes; and
7-42 (C) includes the collection and analysis of
7-43 clinical data relating to prenatal care, preventive care, mental
7-44 health care, and the treatment of acute and chronic health
7-45 conditions and substance abuse;
7-46 (23) subject to Subsection (a-1), a requirement that
7-47 the managed care organization develop, implement, and maintain an
7-48 outpatient pharmacy benefit plan for its enrolled recipients:
7-49 (A) that exclusively employs the vendor drug
7-50 program formulary and preserves the state's ability to reduce
7-51 waste, fraud, and abuse under the Medicaid program;
7-52 (B) that adheres to the applicable preferred drug
7-53 list adopted by the commission under Section 531.072;
7-54 (C) that includes the prior authorization
7-55 procedures and requirements prescribed by or implemented under
7-56 Sections 531.073(b), (c), and (g) for the vendor drug program;
7-57 (D) for purposes of which the managed care
7-58 organization:
7-59 (i) may not negotiate or collect rebates
7-60 associated with pharmacy products on the vendor drug program
7-61 formulary; and
7-62 (ii) may not receive drug rebate or pricing
7-63 information that is confidential under Section 531.071;
7-64 (E) that complies with the prohibition under
7-65 Section 531.089;
7-66 (F) under which the managed care organization may
7-67 not prohibit, limit, or interfere with a recipient's selection of a
7-68 pharmacy or pharmacist of the recipient's choice for the provision
7-69 of pharmaceutical services under the plan through the imposition of

8-1 different copayments;

8-2 (G) that allows the managed care organization or
8-3 any subcontracted pharmacy benefit manager to contract with a
8-4 pharmacist or pharmacy providers separately for specialty pharmacy
8-5 services, except that:

8-6 (i) the managed care organization and
8-7 pharmacy benefit manager are prohibited from allowing exclusive
8-8 contracts with a specialty pharmacy owned wholly or partly by the
8-9 pharmacy benefit manager responsible for the administration of the
8-10 pharmacy benefit program; and

8-11 (ii) the managed care organization and
8-12 pharmacy benefit manager must adopt policies and procedures for
8-13 reclassifying prescription drugs from retail to specialty drugs,
8-14 and those policies and procedures must be consistent with rules
8-15 adopted by the executive commissioner and include notice to network
8-16 pharmacy providers from the managed care organization;

8-17 (H) under which the managed care organization may
8-18 not prevent a pharmacy or pharmacist from participating as a
8-19 provider if the pharmacy or pharmacist agrees to comply with the
8-20 financial terms and conditions of the contract as well as other
8-21 reasonable administrative and professional terms and conditions of
8-22 the contract;

8-23 (I) under which the managed care organization may
8-24 include mail-order pharmacies in its networks, but may not require
8-25 enrolled recipients to use those pharmacies, and may not charge an
8-26 enrolled recipient who opts to use this service a fee, including
8-27 postage and handling fees; and

8-28 (J) under which the managed care organization or
8-29 pharmacy benefit manager must pay claims in accordance with Section
8-30 843.339, Insurance Code; and

8-31 (24) a requirement that the managed care organization
8-32 and any entity with which the managed care organization contracts
8-33 for the performance of services under a managed care plan disclose,
8-34 at no cost, to the commission and, on request, the office of the
8-35 attorney general all discounts, incentives, rebates, fees, free
8-36 goods, bundling arrangements, and other agreements affecting the
8-37 net cost of goods or services provided under the plan.

8-38 (a-1) The requirements imposed by Subsections (a)(23)(A),
8-39 (B), and (C) do not apply, and may not be enforced, on and after
8-40 August 31, 2013.

8-41 (e) Subchapter A, Chapter 533, Government Code, is amended
8-42 by adding Section 533.0066 to read as follows:

8-43 Sec. 533.0066. PROVIDER INCENTIVES. The commission shall,
8-44 to the extent possible, work to ensure that managed care
8-45 organizations provide payment incentives to health care providers
8-46 in the organizations' networks whose performance in promoting
8-47 recipients' use of preventive services exceeds minimum established
8-48 standards.

8-49 (f) Section 533.0071, Government Code, is amended to read as
8-50 follows:

8-51 Sec. 533.0071. ADMINISTRATION OF CONTRACTS. The commission
8-52 shall make every effort to improve the administration of contracts
8-53 with managed care organizations. To improve the administration of
8-54 these contracts, the commission shall:

8-55 (1) ensure that the commission has appropriate
8-56 expertise and qualified staff to effectively manage contracts with
8-57 managed care organizations under the Medicaid managed care program;

8-58 (2) evaluate options for Medicaid payment recovery
8-59 from managed care organizations if the enrollee dies or is
8-60 incarcerated or if an enrollee is enrolled in more than one state
8-61 program or is covered by another liable third party insurer;

8-62 (3) maximize Medicaid payment recovery options by
8-63 contracting with private vendors to assist in the recovery of
8-64 capitation payments, payments from other liable third parties, and
8-65 other payments made to managed care organizations with respect to
8-66 enrollees who leave the managed care program;

8-67 (4) decrease the administrative burdens of managed
8-68 care for the state, the managed care organizations, and the
8-69 providers under managed care networks to the extent that those

9-1 changes are compatible with state law and existing Medicaid managed
9-2 care contracts, including decreasing those burdens by:

9-3 (A) where possible, decreasing the duplication
9-4 of administrative reporting requirements for the managed care
9-5 organizations, such as requirements for the submission of encounter
9-6 data, quality reports, historically underutilized business
9-7 reports, and claims payment summary reports;

9-8 (B) allowing managed care organizations to
9-9 provide updated address information directly to the commission for
9-10 correction in the state system;

9-11 (C) promoting consistency and uniformity among
9-12 managed care organization policies, including policies relating to
9-13 the preauthorization process, lengths of hospital stays, filing
9-14 deadlines, levels of care, and case management services; ~~and~~

9-15 (D) reviewing the appropriateness of primary
9-16 care case management requirements in the admission and clinical
9-17 criteria process, such as requirements relating to including a
9-18 separate cover sheet for all communications, submitting
9-19 handwritten communications instead of electronic or typed review
9-20 processes, and admitting patients listed on separate
9-21 notifications; and

9-22 (E) providing a single portal through which
9-23 providers in any managed care organization's provider network may
9-24 submit claims; and

9-25 (5) reserve the right to amend the managed care
9-26 organization's process for resolving provider appeals of denials
9-27 based on medical necessity to include an independent review process
9-28 established by the commission for final determination of these
9-29 disputes.

9-30 (g) Subchapter A, Chapter 533, Government Code, is amended
9-31 by adding Section 533.0073 to read as follows:

9-32 Sec. 533.0073. MEDICAL DIRECTOR QUALIFICATIONS. A person
9-33 who serves as a medical director for a managed care plan must be a
9-34 physician licensed to practice medicine in this state under
9-35 Subtitle B, Title 3, Occupations Code.

9-36 (h) Subsections (a) and (c), Section 533.0076, Government
9-37 Code, are amended to read as follows:

9-38 (a) Except as provided by Subsections (b) and (c), and to
9-39 the extent permitted by federal law, ~~[the commission may prohibit]~~
9-40 a recipient enrolled [from disenrolling] in a managed care plan
9-41 under this chapter may not disenroll from that plan and enroll
9-42 [enrolling] in another managed care plan during the 12-month period
9-43 after the date the recipient initially enrolls in a plan.

9-44 (c) The commission shall allow a recipient who is enrolled
9-45 in a managed care plan under this chapter to disenroll from [in]
9-46 that plan and enroll in another managed care plan:

9-47 (1) at any time for cause in accordance with federal
9-48 law; and

9-49 (2) once for any reason after the periods described by
9-50 Subsections (a) and (b).

9-51 (i) Subsections (a), (b), (c), and (e), Section 533.012,
9-52 Government Code, are amended to read as follows:

9-53 (a) Each managed care organization contracting with the
9-54 commission under this chapter shall submit the following, at no
9-55 cost, to the commission and, on request, the office of the attorney
9-56 general:

9-57 (1) a description of any financial or other business
9-58 relationship between the organization and any subcontractor
9-59 providing health care services under the contract;

9-60 (2) a copy of each type of contract between the
9-61 organization and a subcontractor relating to the delivery of or
9-62 payment for health care services;

9-63 (3) a description of the fraud control program used by
9-64 any subcontractor that delivers health care services; and

9-65 (4) a description and breakdown of all funds paid to or
9-66 by the managed care organization, including a health maintenance
9-67 organization, primary care case management provider, pharmacy
9-68 benefit manager, and [an] exclusive provider organization,
9-69 necessary for the commission to determine the actual cost of

10-1 administering the managed care plan.

10-2 (b) The information submitted under this section must be
 10-3 submitted in the form required by the commission or the office of
 10-4 the attorney general, as applicable, and be updated as required by
 10-5 the commission or the office of the attorney general, as
 10-6 applicable.

10-7 (c) The commission's office of investigations and
 10-8 enforcement or the office of the attorney general, as applicable,
 10-9 shall review the information submitted under this section as
 10-10 appropriate in the investigation of fraud in the Medicaid managed
 10-11 care program.

10-12 (e) Information submitted to the commission or the office of
 10-13 the attorney general, as applicable, under Subsection (a)(1) is
 10-14 confidential and not subject to disclosure under Chapter 552,
 10-15 Government Code.

10-16 (j) The heading to Section 32.046, Human Resources Code, is
 10-17 amended to read as follows:

10-18 Sec. 32.046. [~~VENDOR DRUG PROGRAM,~~] SANCTIONS AND PENALTIES
 10-19 RELATED TO THE PROVISION OF PHARMACY PRODUCTS.

10-20 (k) Subsection (a), Section 32.046, Human Resources Code,
 10-21 is amended to read as follows:

10-22 (a) The executive commissioner of the Health and Human
 10-23 Services Commission [~~department~~] shall adopt rules governing
 10-24 sanctions and penalties that apply to a provider who participates
 10-25 in the vendor drug program or is enrolled as a network pharmacy
 10-26 provider of a managed care organization contracting with the
 10-27 commission under Chapter 533, Government Code, or its subcontractor
 10-28 and who submits an improper claim for reimbursement under the
 10-29 program.

10-30 (l) Subsection (d), Section 533.012, Government Code, is
 10-31 repealed.

10-32 (m) Not later than December 1, 2013, the Health and Human
 10-33 Services Commission shall submit a report to the legislature
 10-34 regarding the commission's work to ensure that Medicaid managed
 10-35 care organizations promote the development of patient-centered
 10-36 medical homes for recipients of medical assistance as required
 10-37 under Section 533.0029, Government Code, as added by this section.

10-38 (n) The Health and Human Services Commission shall, in a
 10-39 contract between the commission and a managed care organization
 10-40 under Chapter 533, Government Code, that is entered into or renewed
 10-41 on or after the effective date of this Act, include the provisions
 10-42 required by Subsection (a), Section 533.005, Government Code, as
 10-43 amended by this section.

10-44 (o) Section 533.0073, Government Code, as added by this
 10-45 section, applies only to a person hired or otherwise retained as the
 10-46 medical director of a Medicaid managed care plan on or after the
 10-47 effective date of this Act. A person hired or otherwise retained
 10-48 before the effective date of this Act is governed by the law in
 10-49 effect immediately before the effective date of this Act, and that
 10-50 law is continued in effect for that purpose.

10-51 (p) Subsections (a) and (c), Section 533.0076, Government
 10-52 Code, as amended by this section, apply only to a request for
 10-53 disenrollment from a Medicaid managed care plan under Chapter 533,
 10-54 Government Code, made by a recipient on or after the effective date
 10-55 of this Act. A request made by a recipient before that date is
 10-56 governed by the law in effect on the date the request was made, and
 10-57 the former law is continued in effect for that purpose.

10-58 SECTION 1.04. (a) Section 62.101, Health and Safety Code,
 10-59 is amended by adding Subsection (a-1) to read as follows:

10-60 (a-1) A child who is the dependent of an employee of an
 10-61 agency of this state and who meets the requirements of Subsection
 10-62 (a) may be eligible for health benefits coverage in accordance with
 10-63 42 U.S.C. Section 1397jj(b)(6) and any other applicable law or
 10-64 regulations.

10-65 (b) Sections 1551.159 and 1551.312, Insurance Code, are
 10-66 repealed.

10-67 (c) The State Kids Insurance Program operated by the
 10-68 Employees Retirement System of Texas is abolished on the effective
 10-69 date of this Act. The Health and Human Services Commission shall:

11-1 (1) establish a process in cooperation with the
 11-2 Employees Retirement System of Texas to facilitate the enrollment
 11-3 of eligible children in the child health plan program established
 11-4 under Chapter 62, Health and Safety Code, on or before the date
 11-5 those children are scheduled to stop receiving dependent child
 11-6 coverage under the State Kids Insurance Program; and

11-7 (2) modify any applicable administrative procedures
 11-8 to ensure that children described by this subsection maintain
 11-9 continuous health benefits coverage while transitioning from
 11-10 enrollment in the State Kids Insurance Program to enrollment in the
 11-11 child health plan program.

11-12 SECTION 1.05. (a) Subchapter B, Chapter 31, Human
 11-13 Resources Code, is amended by adding Section 31.0326 to read as
 11-14 follows:

11-15 Sec. 31.0326. VERIFICATION OF IDENTITY AND PREVENTION OF
 11-16 DUPLICATE PARTICIPATION. The Health and Human Services Commission
 11-17 shall use appropriate technology to:

11-18 (1) confirm the identity of applicants for benefits
 11-19 under the financial assistance program; and

11-20 (2) prevent duplicate participation in the program by
 11-21 a person.

11-22 (b) Chapter 33, Human Resources Code, is amended by adding
 11-23 Section 33.0231 to read as follows:

11-24 Sec. 33.0231. VERIFICATION OF IDENTITY AND PREVENTION OF
 11-25 DUPLICATE PARTICIPATION IN SNAP. The department shall use
 11-26 appropriate technology to:

11-27 (1) confirm the identity of applicants for benefits
 11-28 under the supplemental nutrition assistance program; and

11-29 (2) prevent duplicate participation in the program by
 11-30 a person.

11-31 (c) Section 531.109, Government Code, is amended by adding
 11-32 Subsection (d) to read as follows:

11-33 (d) Absent an allegation of fraud, waste, or abuse, the
 11-34 commission may conduct an annual review of claims under this
 11-35 section only after the commission has completed the prior year's
 11-36 annual review of claims.

11-37 (d) Section 31.0325, Human Resources Code, is repealed.

11-38 SECTION 1.06. (a) Section 242.033, Health and Safety Code,
 11-39 is amended by amending Subsection (d) and adding Subsection (g) to
 11-40 read as follows:

11-41 (d) Except as provided by Subsection (f), a license is
 11-42 renewable every three [~~two~~] years after:

11-43 (1) an inspection, unless an inspection is not
 11-44 required as provided by Section 242.047;

11-45 (2) payment of the license fee; and

11-46 (3) department approval of the report filed every
 11-47 three [~~two~~] years by the licensee.

11-48 (g) The executive commissioner by rule shall adopt a system
 11-49 under which an appropriate number of licenses issued by the
 11-50 department under this chapter expire on staggered dates occurring
 11-51 in each three-year period. If the expiration date of a license
 11-52 changes as a result of this subsection, the department shall
 11-53 prorate the licensing fee relating to that license as appropriate.

11-54 (b) Subsection (e-1), Section 242.159, Health and Safety
 11-55 Code, is amended to read as follows:

11-56 (e-1) An institution is not required to comply with
 11-57 Subsections (a) and (e) until September 1, 2014 [~~2012~~]. This
 11-58 subsection expires January 1, 2015 [~~2013~~].

11-59 (c) The executive commissioner of the Health and Human
 11-60 Services Commission shall adopt the rules required under Subsection
 11-61 (g), Section 242.033, Health and Safety Code, as added by this
 11-62 section, as soon as practicable after the effective date of this
 11-63 Act, but not later than December 1, 2012.

11-64 SECTION 1.07. (a) Section 161.077, Human Resources Code,
 11-65 as added by Chapter 759 (S.B. 705), Acts of the 81st Legislature,
 11-66 Regular Session, 2009, is redesignated as Section 161.081, Human
 11-67 Resources Code, and amended to read as follows:

11-68 Sec. 161.081 [~~161.077~~]. LONG-TERM CARE MEDICAID WAIVER
 11-69 PROGRAMS: STREAMLINING AND UNIFORMITY. (a) In this section,

12-1 "Section 1915(c) waiver program" has the meaning assigned by
 12-2 Section 531.001, Government Code.

12-3 (b) The department, in consultation with the commission,
 12-4 shall streamline the administration of and delivery of services
 12-5 through Section 1915(c) waiver programs. In implementing this
 12-6 subsection, the department, subject to Subsection (c), may consider
 12-7 implementing the following streamlining initiatives:

12-8 (1) reducing the number of forms used in administering
 12-9 the programs;

12-10 (2) revising program provider manuals and training
 12-11 curricula;

12-12 (3) consolidating service authorization systems;

12-13 (4) eliminating any physician signature requirements
 12-14 the department considers unnecessary;

12-15 (5) standardizing individual service plan processes
 12-16 across the programs; ~~and~~

12-17 (6) if feasible:

12-18 (A) concurrently conducting program
 12-19 certification and billing audit and review processes and other
 12-20 related audit and review processes;

12-21 (B) streamlining other billing and auditing
 12-22 requirements;

12-23 (C) eliminating duplicative responsibilities
 12-24 with respect to the coordination and oversight of individual care
 12-25 plans for persons receiving waiver services; and

12-26 (D) streamlining cost reports and other cost
 12-27 reporting processes; and

12-28 (7) any other initiatives that will increase
 12-29 efficiencies in the programs.

12-30 (c) The department shall ensure that actions taken under
 12-31 Subsection (b) [~~this section~~] do not conflict with any requirements
 12-32 of the commission under Section 531.0218, Government Code.

12-33 (d) The department and the commission shall jointly explore
 12-34 the development of uniform licensing and contracting standards that
 12-35 would:

12-36 (1) apply to all contracts for the delivery of Section
 12-37 1915(c) waiver program services;

12-38 (2) promote competition among providers of those
 12-39 program services; and

12-40 (3) integrate with other department and commission
 12-41 efforts to streamline and unify the administration and delivery of
 12-42 the program services, including those required by this section or
 12-43 Section 531.0218, Government Code.

12-44 (b) Subchapter D, Chapter 161, Human Resources Code, is
 12-45 amended by adding Section 161.082 to read as follows:

12-46 Sec. 161.082. LONG-TERM CARE MEDICAID WAIVER PROGRAMS:
 12-47 UTILIZATION REVIEW. (a) In this section, "Section 1915(c) waiver
 12-48 program" has the meaning assigned by Section 531.001, Government
 12-49 Code.

12-50 (b) The department shall perform a utilization review of
 12-51 services in all Section 1915(c) waiver programs. The utilization
 12-52 review must include, at a minimum, reviewing program recipients'
 12-53 levels of care and any plans of care for those recipients that
 12-54 exceed service level thresholds established in the applicable
 12-55 waiver program guidelines.

12-56 SECTION 1.08. Subchapter D, Chapter 161, Human Resources
 12-57 Code, is amended by adding Section 161.086 to read as follows:

12-58 Sec. 161.086. ELECTRONIC VISIT VERIFICATION SYSTEM. If it
 12-59 is cost-effective, the department shall implement an electronic
 12-60 visit verification system under appropriate programs administered
 12-61 by the department under the Medicaid program that allows providers
 12-62 to electronically verify and document basic information relating to
 12-63 the delivery of services, including:

12-64 (1) the provider's name;

12-65 (2) the recipient's name;

12-66 (3) the date and time the provider begins and ends the
 12-67 delivery of services; and

12-68 (4) the location of service delivery.

12-69 SECTION 1.09. (a) Subdivision (1), Section 247.002, Health

13-1 and Safety Code, is amended to read as follows:

13-2 (1) "Assisted living facility" means an establishment
13-3 that:

13-4 (A) furnishes, in one or more facilities, food
13-5 and shelter to four or more persons who are unrelated to the
13-6 proprietor of the establishment;

13-7 (B) provides:
13-8 (i) personal care services; or
13-9 (ii) administration of medication by a

13-10 person licensed or otherwise authorized in this state to administer
13-11 the medication; ~~and~~

13-12 (C) may provide assistance with or supervision of
13-13 the administration of medication; and

13-14 (D) may provide skilled nursing services for a
13-15 limited duration or to facilitate the provision of hospice
13-16 services.

13-17 (b) Section 247.004, Health and Safety Code, is amended to
13-18 read as follows:

13-19 Sec. 247.004. EXEMPTIONS. This chapter does not apply to:

13-20 (1) a boarding home facility as defined by Section
13-21 254.001, as added by Chapter 1106 (H.B. 216), Acts of the 81st
13-22 Legislature, Regular Session, 2009;

13-23 (2) an establishment conducted by or for the adherents
13-24 of the Church of Christ, Scientist, for the purpose of providing
13-25 facilities for the care or treatment of the sick who depend
13-26 exclusively on prayer or spiritual means for healing without the
13-27 use of any drug or material remedy if the establishment complies
13-28 with local safety, sanitary, and quarantine ordinances and
13-29 regulations;

13-30 (3) a facility conducted by or for the adherents of a
13-31 qualified religious society classified as a tax-exempt
13-32 organization under an Internal Revenue Service group exemption
13-33 ruling for the purpose of providing personal care services without
13-34 charge solely for the society's professed members or ministers in
13-35 retirement, if the facility complies with local safety, sanitation,
13-36 and quarantine ordinances and regulations; or

13-37 (4) a facility that provides personal care services
13-38 only to persons enrolled in a program that:

13-39 (A) is funded in whole or in part by the
13-40 department and that is monitored by the department or its
13-41 designated local mental retardation authority in accordance with
13-42 standards set by the department; or

13-43 (B) is funded in whole or in part by the
13-44 Department of State Health Services and that is monitored by that
13-45 department, or by its designated local mental health authority in
13-46 accordance with standards set by the department.

13-47 (c) Subsection (b), Section 247.067, Health and Safety
13-48 Code, is amended to read as follows:

13-49 (b) Unless otherwise prohibited by law, a [A] health care
13-50 professional may be employed by an assisted living facility to
13-51 provide at the facility to the facility's residents services that
13-52 are authorized by this chapter and that are within the
13-53 professional's scope of practice [to a resident of an assisted
13-54 living facility at the facility]. This subsection does not
13-55 authorize a facility to provide ongoing services comparable to the
13-56 services available in an institution licensed under Chapter 242. A
13-57 health care professional providing services under this subsection
13-58 shall maintain medical records of those services in accordance with
13-59 the licensing, certification, or other regulatory standards
13-60 applicable to the health care professional under law.

13-61 SECTION 1.10. (a) Subchapter B, Chapter 531, Government
13-62 Code, is amended by adding Sections 531.086 and 531.0861 to read as
13-63 follows:

13-64 Sec. 531.086. STUDY REGARDING PHYSICIAN INCENTIVE PROGRAMS
13-65 TO REDUCE HOSPITAL EMERGENCY ROOM USE FOR NON-EMERGENT CONDITIONS.

13-66 (a) The commission shall conduct a study to evaluate physician
13-67 incentive programs that attempt to reduce hospital emergency room
13-68 use for non-emergent conditions by recipients under the medical
13-69 assistance program. Each physician incentive program evaluated in

14-1 the study must:

14-2 (1) be administered by a health maintenance
 14-3 organization participating in the STAR or STAR + PLUS Medicaid
 14-4 managed care program; and

14-5 (2) provide incentives to primary care providers who
 14-6 attempt to reduce emergency room use for non-emergent conditions by
 14-7 recipients.

14-8 (b) The study conducted under Subsection (a) must evaluate:

14-9 (1) the cost-effectiveness of each component included
 14-10 in a physician incentive program; and

14-11 (2) any change in statute required to implement each
 14-12 component within the Medicaid fee-for-service payment model.

14-13 (c) Not later than August 31, 2013, the executive
 14-14 commissioner shall submit to the governor and the Legislative
 14-15 Budget Board a report summarizing the findings of the study
 14-16 required by this section.

14-17 (d) This section expires September 1, 2014.

14-18 Sec. 531.0861. PHYSICIAN INCENTIVE PROGRAM TO REDUCE
 14-19 HOSPITAL EMERGENCY ROOM USE FOR NON-EMERGENT CONDITIONS. (a) If
 14-20 cost-effective, the executive commissioner by rule shall establish
 14-21 a physician incentive program designed to reduce the use of
 14-22 hospital emergency room services for non-emergent conditions by
 14-23 recipients under the medical assistance program.

14-24 (b) In establishing the physician incentive program under
 14-25 Subsection (a), the executive commissioner may include only the
 14-26 program components identified as cost-effective in the study
 14-27 conducted under Section 531.086.

14-28 (c) If the physician incentive program includes the payment
 14-29 of an enhanced reimbursement rate for routine after-hours
 14-30 appointments, the executive commissioner shall implement controls
 14-31 to ensure that the after-hours services billed are actually being
 14-32 provided outside of normal business hours.

14-33 (b) Section 32.0641, Human Resources Code, is amended to
 14-34 read as follows:

14-35 Sec. 32.0641. RECIPIENT ACCOUNTABILITY PROVISIONS;
 14-36 COST-SHARING REQUIREMENT TO IMPROVE APPROPRIATE UTILIZATION OF
 14-37 [COST SHARING FOR CERTAIN HIGH-COST MEDICAL] SERVICES. (a) To [if
 14-38 the department determines that it is feasible and cost-effective,
 14-39 and to] the extent permitted under and in a manner that is
 14-40 consistent with Title XIX, Social Security Act (42 U.S.C. Section
 14-41 1396 et seq.) and any other applicable law or regulation or under a
 14-42 federal waiver or other authorization, the executive commissioner
 14-43 of the Health and Human Services Commission shall adopt, after
 14-44 consulting with the Medicaid and CHIP Quality-Based Payment
 14-45 Advisory Committee established under Section 536.002, Government
 14-46 Code, cost-sharing provisions that encourage personal
 14-47 accountability and appropriate utilization of health care
 14-48 services, including a cost-sharing provision applicable to
 14-49 [require] a recipient who chooses to receive a nonemergency [a
 14-50 high-cost] medical service [provided] through a hospital emergency
 14-51 room [to pay a copayment, premium payment, or other cost-sharing
 14-52 payment for the high-cost medical service if:

14-53 [(1) the hospital from which the recipient seeks
 14-54 service:

14-55 [(A) performs an appropriate medical screening
 14-56 and determines that the recipient does not have a condition
 14-57 requiring emergency medical services;

14-58 [(B) informs the recipient:

14-59 [(i) that the recipient does not have a
 14-60 condition requiring emergency medical services;

14-61 [(ii) that, if the hospital provides the
 14-62 nonemergency service, the hospital may require payment of a
 14-63 copayment, premium payment, or other cost-sharing payment by the
 14-64 recipient in advance; and

14-65 [(iii) of the name and address of a
 14-66 nonemergency Medicaid provider who can provide the appropriate
 14-67 medical service without imposing a cost-sharing payment; and

14-68 [(C) offers to provide the recipient with a
 14-69 referral to the nonemergency provider to facilitate scheduling of

15-1 ~~the service, and~~

15-2 ~~[(2) after receiving the information and assistance~~
 15-3 ~~described by Subdivision (1) from the hospital, the recipient~~
 15-4 ~~chooses to obtain emergency medical services despite having access~~
 15-5 ~~to medically acceptable, lower-cost medical services].~~

15-6 (b) The department may not seek a federal waiver or other
 15-7 authorization under this section [~~Subsection (a)~~] that would:

15-8 (1) prevent a Medicaid recipient who has a condition
 15-9 requiring emergency medical services from receiving care through a
 15-10 hospital emergency room; or

15-11 (2) waive any provision under Section 1867, Social
 15-12 Security Act (42 U.S.C. Section 1395dd).

15-13 [~~(c) If the executive commissioner of the Health and Human~~
 15-14 ~~Services Commission adopts a copayment or other cost-sharing~~
 15-15 ~~payment under Subsection (a), the commission may not reduce~~
 15-16 ~~hospital payments to reflect the potential receipt of a copayment~~
 15-17 ~~or other payment from a recipient receiving medical services~~
 15-18 ~~provided through a hospital emergency room.]~~

15-19 SECTION 1.11. Subchapter B, Chapter 531, Government Code,
 15-20 is amended by adding Section 531.024131 to read as follows:

15-21 Sec. 531.024131. EXPANSION OF BILLING COORDINATION AND
 15-22 INFORMATION COLLECTION ACTIVITIES. (a) If cost-effective, the
 15-23 commission may:

15-24 (1) contract to expand all or part of the billing
 15-25 coordination system established under Section 531.02413 to process
 15-26 claims for services provided through other benefits programs
 15-27 administered by the commission or a health and human services
 15-28 agency;

15-29 (2) expand any other billing coordination tools and
 15-30 resources used to process claims for health care services provided
 15-31 through the Medicaid program to process claims for services
 15-32 provided through other benefits programs administered by the
 15-33 commission or a health and human services agency; and

15-34 (3) expand the scope of persons about whom information
 15-35 is collected under Section 32.042, Human Resources Code, to include
 15-36 recipients of services provided through other benefits programs
 15-37 administered by the commission or a health and human services
 15-38 agency.

15-39 (b) Notwithstanding any other state law, each health and
 15-40 human services agency shall provide the commission with any
 15-41 information necessary to allow the commission or the commission's
 15-42 designee to perform the billing coordination and information
 15-43 collection activities authorized by this section.

15-44 SECTION 1.12. (a) Subsections (b), (c), and (d), Section
 15-45 531.502, Government Code, are amended to read as follows:

15-46 (b) The executive commissioner may include the following
 15-47 federal money in the waiver:

15-48 (1) [~~all~~] money provided under the disproportionate
 15-49 share hospitals or [~~and~~] upper payment limit supplemental payment
 15-50 program, or both [~~programs~~];

15-51 (2) money provided by the federal government in lieu
 15-52 of some or all of the payments under one or both of those programs;

15-53 (3) any combination of funds authorized to be pooled
 15-54 by Subdivisions (1) and (2); and

15-55 (4) any other money available for that purpose,
 15-56 including:

15-57 (A) federal money and money identified under
 15-58 Subsection (c);

15-59 (B) gifts, grants, or donations for that purpose;

15-60 (C) local funds received by this state through
 15-61 intergovernmental transfers; and

15-62 (D) if approved in the waiver, federal money
 15-63 obtained through the use of certified public expenditures.

15-64 (c) The commission shall seek to optimize federal funding
 15-65 by:

15-66 (1) identifying health care related state and local
 15-67 funds and program expenditures that, before September 1, 2011
 15-68 [~~2007~~], are not being matched with federal money; and

15-69 (2) exploring the feasibility of:

16-1 (A) certifying or otherwise using those funds and
 16-2 expenditures as state expenditures for which this state may receive
 16-3 federal matching money; and

16-4 (B) depositing federal matching money received
 16-5 as provided by Paragraph (A) with other federal money deposited as
 16-6 provided by Section 531.504, or substituting that federal matching
 16-7 money for federal money that otherwise would be received under the
 16-8 disproportionate share hospitals and upper payment limit
 16-9 supplemental payment programs as a match for local funds received
 16-10 by this state through intergovernmental transfers.

16-11 (d) The terms of a waiver approved under this section must:

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

16-22 (2) allow for the development by this state of a
 16-23 methodology for allocating money in the fund to:

16-24 (A) be used to supplement Medicaid hospital
 16-25 reimbursements under a waiver that includes terms that are
 16-26 consistent with, or that produce revenues consistent with,
 16-27 disproportionate share hospital and upper payment limit principles
 16-28 ~~[offset, in part, the uncompensated health care costs incurred by~~
 16-29 ~~hospitals];~~

16-30 (B) reduce the number of persons in this state
 16-31 who do not have health benefits coverage; and

16-32 (C) maintain and enhance the community public
 16-33 health infrastructure provided by hospitals.

16-34 (b) Section 531.504, Government Code, is amended to read as
 16-35 follows:

16-36 Sec. 531.504. DEPOSITS TO FUND. (a) The comptroller shall
 16-37 deposit in the fund:

16-38 (1) ~~[all]~~ federal money provided to this state under
 16-39 the disproportionate share hospitals supplemental payment program
 16-40 or [and] the hospital upper payment limit supplemental payment
 16-41 program, or both, other than money provided under those programs to
 16-42 state-owned and operated hospitals, and all other non-supplemental
 16-43 payment program federal money provided to this state that is
 16-44 included in the waiver authorized by Section 531.502; and

16-45 (2) state money appropriated to the fund.

16-46 (b) The commission and comptroller may accept gifts,
 16-47 grants, and donations from any source, and receive
 16-48 intergovernmental transfers, for purposes consistent with this
 16-49 subchapter and the terms of the waiver. The comptroller shall
 16-50 deposit a gift, grant, or donation made for those purposes in the
 16-51 fund. Any intergovernmental transfer received, including
 16-52 associated federal matching funds, shall be used, if feasible, for
 16-53 the purposes intended by the transferring entity and in accordance
 16-54 with the terms of the waiver.

16-55 (c) Section 531.508, Government Code, is amended by adding
 16-56 Subsection (d) to read as follows:

16-57 (d) Money from the fund may not be used to finance the
 16-58 construction, improvement, or renovation of a building or land
 16-59 unless the construction, improvement, or renovation is approved by
 16-60 the commission, according to rules adopted by the executive
 16-61 commissioner for that purpose.

16-62 (d) Subsection (g), Section 531.502, Government Code, is
 16-63 repealed.

16-64 SECTION 1.13. (a) Subtitle I, Title 4, Government Code, is
 16-65 amended by adding Chapter 536, and Section 531.913, Government
 16-66 Code, is transferred to Subchapter D, Chapter 536, Government Code,
 16-67 redesignated as Section 536.151, Government Code, and amended to
 16-68 read as follows:

16-

17-1 CHAPTER 536. MEDICAID AND CHILD HEALTH PLAN PROGRAMS:

17-2 QUALITY-BASED OUTCOMES AND PAYMENTS

17-3 SUBCHAPTER A. GENERAL PROVISIONS

17-4 Sec. 536.001. DEFINITIONS. In this chapter:

17-5 (1) "Advisory committee" means the Medicaid and CHIP
 17-6 Quality-Based Payment Advisory Committee established under Section
 17-7 536.002.

17-8 (2) "Alternative payment system" includes:

17-9 (A) a global payment system;

17-10 (B) an episode-based bundled payment system; and

17-11 (C) a blended payment system.

17-12 (3) "Blended payment system" means a system for
 17-13 compensating a physician or other health care provider that
 17-14 includes at least one or more features of a global payment system
 17-15 and an episode-based bundled payment system, but that may also
 17-16 include a system under which a portion of the compensation paid to a
 17-17 physician or other health care provider is based on a
 17-18 fee-for-service payment arrangement.

17-19 (4) "Child health plan program," "commission,"
 17-20 "executive commissioner," and "health and human services agencies"
 17-21 have the meanings assigned by Section 531.001.

17-22 (5) "Episode-based bundled payment system" means a
 17-23 system for compensating a physician or other health care provider
 17-24 for arranging for or providing health care services to child health
 17-25 plan program enrollees or Medicaid recipients that is based on a
 17-26 flat payment for all services provided in connection with a single
 17-27 episode of medical care.

17-28 (6) "Exclusive provider benefit plan" means a managed
 17-29 care plan subject to 28 T.A.C. Part 1, Chapter 3, Subchapter KK.

17-30 (7) "Freestanding emergency medical care facility"
 17-31 means a facility licensed under Chapter 254, Health and Safety
 17-32 Code.

17-33 (8) "Global payment system" means a system for
 17-34 compensating a physician or other health care provider for
 17-35 arranging for or providing a defined set of covered health care
 17-36 services to child health plan program enrollees or Medicaid
 17-37 recipients for a specified period that is based on a predetermined
 17-38 payment per enrollee or recipient, as applicable, for the specified
 17-39 period, without regard to the quantity of services actually
 17-40 provided.

17-41 (9) "Health care provider" means any person,
 17-42 partnership, professional association, corporation, facility, or
 17-43 institution licensed, certified, registered, or chartered by this
 17-44 state to provide health care. The term includes an employee,
 17-45 independent contractor, or agent of a health care provider acting
 17-46 in the course and scope of the employment or contractual
 17-47 relationship.

17-48 (10) "Hospital" means a public or private institution
 17-49 licensed under Chapter 241 or 577, Health and Safety Code,
 17-50 including a general or special hospital as defined by Section
 17-51 241.003, Health and Safety Code.

17-52 (11) "Managed care organization" means a person that
 17-53 is authorized or otherwise permitted by law to arrange for or
 17-54 provide a managed care plan. The term includes health maintenance
 17-55 organizations and exclusive provider organizations.

17-56 (12) "Managed care plan" means a plan, including an
 17-57 exclusive provider benefit plan, under which a person undertakes to
 17-58 provide, arrange for, pay for, or reimburse any part of the cost of
 17-59 any health care services. A part of the plan must consist of
 17-60 arranging for or providing health care services as distinguished
 17-61 from indemnification against the cost of those services on a
 17-62 prepaid basis through insurance or otherwise. The term does not
 17-63 include a plan that indemnifies a person for the cost of health care
 17-64 services through insurance.

17-65 (13) "Medicaid program" means the medical assistance
 17-66 program established under Chapter 32, Human Resources Code.

17-67 (14) "Physician" means a person licensed to practice
 17-68 medicine in this state under Subtitle B, Title 3, Occupations Code.

17-69 (15) "Potentially preventable admission" means an

18-1 admission of a person to a hospital or long-term care facility that
 18-2 may have reasonably been prevented with adequate access to
 18-3 ambulatory care or health care coordination.

18-4 (16) "Potentially preventable ancillary service"
 18-5 means a health care service provided or ordered by a physician or
 18-6 other health care provider to supplement or support the evaluation
 18-7 or treatment of a patient, including a diagnostic test, laboratory
 18-8 test, therapy service, or radiology service, that may not be
 18-9 reasonably necessary for the provision of quality health care or
 18-10 treatment.

18-11 (17) "Potentially preventable complication" means a
 18-12 harmful event or negative outcome with respect to a person,
 18-13 including an infection or surgical complication, that:

18-14 (A) occurs after the person's admission to a
 18-15 hospital or long-term care facility; and

18-16 (B) may have resulted from the care, lack of
 18-17 care, or treatment provided during the hospital or long-term care
 18-18 facility stay rather than from a natural progression of an
 18-19 underlying disease.

18-20 (18) "Potentially preventable event" means a
 18-21 potentially preventable admission, a potentially preventable
 18-22 ancillary service, a potentially preventable complication, a
 18-23 potentially preventable emergency room visit, a potentially
 18-24 preventable readmission, or a combination of those events.

18-25 (19) "Potentially preventable emergency room visit"
 18-26 means treatment of a person in a hospital emergency room or
 18-27 freestanding emergency medical care facility for a condition that
 18-28 may not require emergency medical attention because the condition
 18-29 could be, or could have been, treated or prevented by a physician or
 18-30 other health care provider in a nonemergency setting.

18-31 (20) "Potentially preventable readmission" means a
 18-32 return hospitalization of a person within a period specified by the
 18-33 commission that may have resulted from deficiencies in the care or
 18-34 treatment provided to the person during a previous hospital stay or
 18-35 from deficiencies in post-hospital discharge follow-up. The term
 18-36 does not include a hospital readmission necessitated by the
 18-37 occurrence of unrelated events after the discharge. The term
 18-38 includes the readmission of a person to a hospital for:

18-39 (A) the same condition or procedure for which the
 18-40 person was previously admitted;

18-41 (B) an infection or other complication resulting
 18-42 from care previously provided;

18-43 (C) a condition or procedure that indicates that
 18-44 a surgical intervention performed during a previous admission was
 18-45 unsuccessful in achieving the anticipated outcome; or

18-46 (D) another condition or procedure of a similar
 18-47 nature, as determined by the executive commissioner after
 18-48 consulting with the advisory committee.

18-49 (21) "Quality-based payment system" means a system for
 18-50 compensating a physician or other health care provider, including
 18-51 an alternative payment system, that provides incentives to the
 18-52 physician or other health care provider for providing high-quality,
 18-53 cost-effective care and bases some portion of the payment made to
 18-54 the physician or other health care provider on quality of care
 18-55 outcomes, which may include the extent to which the physician or
 18-56 other health care provider reduces potentially preventable events.

18-57 Sec. 536.002. MEDICAID AND CHIP QUALITY-BASED PAYMENT
 18-58 ADVISORY COMMITTEE. (a) The Medicaid and CHIP Quality-Based
 18-59 Payment Advisory Committee is established to advise the commission
 18-60 on establishing, for purposes of the child health plan and Medicaid
 18-61 programs administered by the commission or a health and human
 18-62 services agency:

18-63 (1) reimbursement systems used to compensate
 18-64 physicians or other health care providers under those programs that
 18-65 reward the provision of high-quality, cost-effective health care
 18-66 and quality performance and quality of care outcomes with respect
 18-67 to health care services;

18-68 (2) standards and benchmarks for quality performance,
 18-69 quality of care outcomes, efficiency, and accountability by managed

19-1 care organizations and physicians and other health care providers;
 19-2 (3) programs and reimbursement policies that
 19-3 encourage high-quality, cost-effective health care delivery models
 19-4 that increase appropriate provider collaboration, promote wellness
 19-5 and prevention, and improve health outcomes; and

19-6 (4) outcome and process measures under Section
 19-7 536.003.

19-8 (b) The executive commissioner shall appoint the members of
 19-9 the advisory committee. The committee must consist of physicians
 19-10 and other health care providers, representatives of health care
 19-11 facilities, representatives of managed care organizations, and
 19-12 other stakeholders interested in health care services provided in
 19-13 this state, including:

19-14 (1) at least one member who is a physician with
 19-15 clinical practice experience in obstetrics and gynecology;

19-16 (2) at least one member who is a physician with
 19-17 clinical practice experience in pediatrics;

19-18 (3) at least one member who is a physician with
 19-19 clinical practice experience in internal medicine or family
 19-20 medicine;

19-21 (4) at least one member who is a physician with
 19-22 clinical practice experience in geriatric medicine;

19-23 (5) at least one member who is or who represents a
 19-24 health care provider that primarily provides long-term care
 19-25 services;

19-26 (6) at least one member who is a consumer
 19-27 representative; and

19-28 (7) at least one member who is a member of the Advisory
 19-29 Panel on Health Care-Associated Infections and Preventable Adverse
 19-30 Events who meets the qualifications prescribed by Section
 19-31 98.052(a)(4), Health and Safety Code.

19-32 (c) The executive commissioner shall appoint the presiding
 19-33 officer of the advisory committee.

19-34 Sec. 536.003. DEVELOPMENT OF QUALITY-BASED OUTCOME AND
 19-35 PROCESS MEASURES. (a) The commission, in consultation with the
 19-36 advisory committee, shall develop quality-based outcome and
 19-37 process measures that promote the provision of efficient, quality
 19-38 health care and that can be used in the child health plan and
 19-39 Medicaid programs to implement quality-based payments for acute and
 19-40 long-term care services across all delivery models and payment
 19-41 systems, including fee-for-service and managed care payment
 19-42 systems. The commission, in developing outcome measures under this
 19-43 section, must consider measures addressing potentially preventable
 19-44 events.

19-45 (b) To the extent feasible, the commission shall develop
 19-46 outcome and process measures:

19-47 (1) consistently across all child health plan and
 19-48 Medicaid program delivery models and payment systems;

19-49 (2) in a manner that takes into account appropriate
 19-50 patient risk factors, including the burden of chronic illness on a
 19-51 patient and the severity of a patient's illness;

19-52 (3) that will have the greatest effect on improving
 19-53 quality of care and the efficient use of services; and

19-54 (4) that are similar to outcome and process measures
 19-55 used in the private sector, as appropriate.

19-56 (c) The commission shall, to the extent feasible, align
 19-57 outcome and process measures developed under this section with
 19-58 measures required or recommended under reporting guidelines
 19-59 established by the federal Centers for Medicare and Medicaid
 19-60 Services, the Agency for Healthcare Research and Quality, or
 19-61 another federal agency.

19-62 (d) The executive commissioner by rule may require managed
 19-63 care organizations and physicians and other health care providers
 19-64 participating in the child health plan and Medicaid programs to
 19-65 report to the commission in a format specified by the executive
 19-66 commissioner information necessary to develop outcome and process
 19-67 measures under this section.

19-68 (e) If the commission increases physician and other health
 19-69 care provider reimbursement rates under the child health plan or

20-1 Medicaid program as a result of an increase in the amounts
 20-2 appropriated for the programs for a state fiscal biennium as
 20-3 compared to the preceding state fiscal biennium, the commission
 20-4 shall, to the extent permitted under federal law and to the extent
 20-5 otherwise possible considering other relevant factors, correlate
 20-6 the increased reimbursement rates with the quality-based outcome
 20-7 and process measures developed under this section.

20-8 Sec. 536.004. DEVELOPMENT OF QUALITY-BASED PAYMENT
 20-9 SYSTEMS. (a) Using quality-based outcome and process measures
 20-10 developed under Section 536.003 and subject to this section, the
 20-11 commission, after consulting with the advisory committee, shall
 20-12 develop quality-based payment systems for compensating a physician
 20-13 or other health care provider participating in the child health
 20-14 plan or Medicaid program that:

20-15 (1) align payment incentives with high-quality,
 20-16 cost-effective health care;

20-17 (2) reward the use of evidence-based best practices;

20-18 (3) promote the coordination of health care;

20-19 (4) encourage appropriate physician and other health
 20-20 care provider collaboration;

20-21 (5) promote effective health care delivery models; and

20-22 (6) take into account the specific needs of the child
 20-23 health plan program enrollee and Medicaid recipient populations.

20-24 (b) The commission shall develop quality-based payment
 20-25 systems in the manner specified by this chapter. To the extent
 20-26 necessary, the commission shall coordinate the timeline for the
 20-27 development and implementation of a payment system with the
 20-28 implementation of other initiatives such as the Medicaid
 20-29 Information Technology Architecture (MITA) initiative of the
 20-30 Center for Medicaid and State Operations, the ICD-10 code sets
 20-31 initiative, or the ongoing Enterprise Data Warehouse (EDW) planning
 20-32 process in order to maximize the receipt of federal funds or reduce
 20-33 any administrative burden.

20-34 (c) In developing quality-based payment systems under this
 20-35 chapter, the commission shall examine and consider implementing:

20-36 (1) an alternative payment system;

20-37 (2) any existing performance-based payment system
 20-38 used under the Medicare program that meets the requirements of this
 20-39 chapter, modified as necessary to account for programmatic
 20-40 differences, if implementing the system would:

20-41 (A) reduce unnecessary administrative burdens;
 20-42 and

20-43 (B) align quality-based payment incentives for
 20-44 physicians and other health care providers with the Medicare
 20-45 program; and

20-46 (3) alternative payment methodologies within the
 20-47 system that are used in the Medicare program, modified as necessary
 20-48 to account for programmatic differences, and that will achieve cost
 20-49 savings and improve quality of care in the child health plan and
 20-50 Medicaid programs.

20-51 (d) In developing quality-based payment systems under this
 20-52 chapter, the commission shall ensure that a managed care
 20-53 organization or physician or other health care provider will not be
 20-54 rewarded by the system for withholding or delaying the provision of
 20-55 medically necessary care.

20-56 (e) The commission may modify a quality-based payment
 20-57 system developed under this chapter to account for programmatic
 20-58 differences between the child health plan and Medicaid programs and
 20-59 delivery systems under those programs.

20-60 Sec. 536.005. CONVERSION OF PAYMENT METHODOLOGY. (a) To
 20-61 the extent possible, the commission shall convert hospital
 20-62 reimbursement systems under the child health plan and Medicaid
 20-63 programs to a diagnosis-related groups (DRG) methodology that will
 20-64 allow the commission to more accurately classify specific patient
 20-65 populations and account for severity of patient illness and
 20-66 mortality risk.

20-67 (b) Subsection (a) does not authorize the commission to
 20-68 direct a managed care organization to compensate physicians and
 20-69 other health care providers providing services under the

21-1 organization's managed care plan based on a diagnosis-related
 21-2 groups (DRG) methodology.

21-3 Sec. 536.006. TRANSPARENCY. The commission and the
 21-4 advisory committee shall:

21-5 (1) ensure transparency in the development and
 21-6 establishment of:

21-7 (A) quality-based payment and reimbursement
 21-8 systems under Section 536.004 and Subchapters B, C, and D,
 21-9 including the development of outcome and process measures under
 21-10 Section 536.003; and

21-11 (B) quality-based payment initiatives under
 21-12 Subchapter E, including the development of quality of care and
 21-13 cost-efficiency benchmarks under Section 536.204(a) and efficiency
 21-14 performance standards under Section 536.204(b);

21-15 (2) develop guidelines establishing procedures for
 21-16 providing notice and information to, and receiving input from,
 21-17 managed care organizations, health care providers, including
 21-18 physicians and experts in the various medical specialty fields, and
 21-19 other stakeholders, as appropriate, for purposes of developing and
 21-20 establishing the quality-based payment and reimbursement systems
 21-21 and initiatives described under Subdivision (1); and

21-22 (3) in developing and establishing the quality-based
 21-23 payment and reimbursement systems and initiatives described under
 21-24 Subdivision (1), consider that as the performance of a managed care
 21-25 organization or physician or other health care provider improves
 21-26 with respect to an outcome or process measure, quality of care and
 21-27 cost-efficiency benchmark, or efficiency performance standard, as
 21-28 applicable, there will be a diminishing rate of improved
 21-29 performance over time.

21-30 Sec. 536.007. PERIODIC EVALUATION. (a) At least once each
 21-31 two-year period, the commission shall evaluate the outcomes and
 21-32 cost-effectiveness of any quality-based payment system or other
 21-33 payment initiative implemented under this chapter.

21-34 (b) The commission shall:

21-35 (1) present the results of its evaluation under
 21-36 Subsection (a) to the advisory committee for the committee's input
 21-37 and recommendations; and

21-38 (2) provide a process by which managed care
 21-39 organizations and physicians and other health care providers may
 21-40 comment and provide input into the committee's recommendations
 21-41 under Subdivision (1).

21-42 Sec. 536.008. ANNUAL REPORT. (a) The commission shall
 21-43 submit an annual report to the legislature regarding:

21-44 (1) the quality-based outcome and process measures
 21-45 developed under Section 536.003; and

21-46 (2) the progress of the implementation of
 21-47 quality-based payment systems and other payment initiatives
 21-48 implemented under this chapter.

21-49 (b) The commission shall report outcome and process
 21-50 measures under Subsection (a)(1) by health care service region and
 21-51 service delivery model.

21-52 [Sections 536.009-536.050 reserved for expansion]

21-53 SUBCHAPTER B. QUALITY-BASED PAYMENTS RELATING TO MANAGED CARE
 21-54 ORGANIZATIONS

21-55 Sec. 536.051. DEVELOPMENT OF QUALITY-BASED PREMIUM
 21-56 PAYMENTS; PERFORMANCE REPORTING. (a) Subject to Section
 21-57 1903(m)(2)(A), Social Security Act (42 U.S.C. Section
 21-58 1396b(m)(2)(A)), and other applicable federal law, the commission
 21-59 shall base a percentage of the premiums paid to a managed care
 21-60 organization participating in the child health plan or Medicaid
 21-61 program on the organization's performance with respect to outcome
 21-62 and process measures developed under Section 536.003, including
 21-63 outcome measures addressing potentially preventable events.

21-64 (b) The commission shall make available information
 21-65 relating to the performance of a managed care organization with
 21-66 respect to outcome and process measures under this subchapter to
 21-67 child health plan program enrollees and Medicaid recipients before
 21-68 those enrollees and recipients choose their managed care plans.

21-69 Sec. 536.052. PAYMENT AND CONTRACT AWARD INCENTIVES FOR

22-1 MANAGED CARE ORGANIZATIONS. (a) The commission may allow a
 22-2 managed care organization participating in the child health plan or
 22-3 Medicaid program increased flexibility to implement quality
 22-4 initiatives in a managed care plan offered by the organization,
 22-5 including flexibility with respect to financial arrangements, in
 22-6 order to:

- 22-7 (1) achieve high-quality, cost-effective health care;
- 22-8 (2) increase the use of high-quality, cost-effective
- 22-9 delivery models; and
- 22-10 (3) reduce potentially preventable events.

22-11 (b) The commission, after consulting with the advisory
 22-12 committee, shall develop quality of care and cost-efficiency
 22-13 benchmarks, including benchmarks based on a managed care
 22-14 organization's performance with respect to reducing potentially
 22-15 preventable events and containing the growth rate of health care
 22-16 costs.

22-17 (c) The commission may include in a contract between a
 22-18 managed care organization and the commission financial incentives
 22-19 that are based on the organization's successful implementation of
 22-20 quality initiatives under Subsection (a) or success in achieving
 22-21 quality of care and cost-efficiency benchmarks under Subsection
 22-22 (b).

22-23 (d) In awarding contracts to managed care organizations
 22-24 under the child health plan and Medicaid programs, the commission
 22-25 shall, in addition to considerations under Section 533.003 of this
 22-26 code and Section 62.155, Health and Safety Code, give preference to
 22-27 an organization that offers a managed care plan that successfully
 22-28 implements quality initiatives under Subsection (a) as determined
 22-29 by the commission based on data or other evidence provided by the
 22-30 organization or meets quality of care and cost-efficiency
 22-31 benchmarks under Subsection (b).

22-32 (e) The commission may implement financial incentives under
 22-33 this section only if implementing the incentives would be
 22-34 cost-effective.

22-35 [Sections 536.053-536.100 reserved for expansion]

22-36 SUBCHAPTER C. QUALITY-BASED HEALTH HOME PAYMENT SYSTEMS

22-37 Sec. 536.101. DEFINITIONS. In this subchapter:

22-38 (1) "Health home" means a primary care provider
 22-39 practice or, if appropriate, a specialty care provider practice,
 22-40 incorporating several features, including comprehensive care
 22-41 coordination, family-centered care, and data management, that are
 22-42 focused on improving outcome-based quality of care and increasing
 22-43 patient and provider satisfaction under the child health plan and
 22-44 Medicaid programs.

22-45 (2) "Participating enrollee" means a child health plan
 22-46 program enrollee or Medicaid recipient who has a health home.

22-47 Sec. 536.102. QUALITY-BASED HEALTH HOME PAYMENTS.

22-48 (a) Subject to this subchapter, the commission, after consulting
 22-49 with the advisory committee, may develop and implement
 22-50 quality-based payment systems for health homes designed to improve
 22-51 quality of care and reduce the provision of unnecessary medical
 22-52 services. A quality-based payment system developed under this
 22-53 section must:

22-54 (1) base payments made to a participating enrollee's
 22-55 health home on quality and efficiency measures that may include
 22-56 measurable wellness and prevention criteria and use of
 22-57 evidence-based best practices, sharing a portion of any realized
 22-58 cost savings achieved by the health home, and ensuring quality of
 22-59 care outcomes, including a reduction in potentially preventable
 22-60 events; and

22-61 (2) allow for the examination of measurable wellness
 22-62 and prevention criteria, use of evidence-based best practices, and
 22-63 quality of care outcomes based on the type of primary or specialty
 22-64 care provider practice.

22-65 (b) The commission may develop a quality-based payment
 22-66 system for health homes under this subchapter only if implementing
 22-67 the system would be feasible and cost-effective.

22-68 Sec. 536.103. PROVIDER ELIGIBILITY. To be eligible to
 22-69 receive reimbursement under a quality-based payment system under

23-1 this subchapter, a health home provider must:

23-2 (1) provide participating enrollees, directly or
 23-3 indirectly, with access to health care services outside of regular
 23-4 business hours;

23-5 (2) educate participating enrollees about the
 23-6 availability of health care services outside of regular business
 23-7 hours; and

23-8 (3) provide evidence satisfactory to the commission
 23-9 that the provider meets the requirement of Subdivision (1).

23-10 [Sections 536.104-536.150 reserved for expansion]

23-11 SUBCHAPTER D. QUALITY-BASED HOSPITAL REIMBURSEMENT SYSTEM

23-12 Sec. 536.151 [531.913]. COLLECTION AND REPORTING OF
 23-13 CERTAIN [HOSPITAL HEALTH] INFORMATION [EXCHANGE]. (a) [In this
 23-14 section, "potentially preventable readmission" means a return
 23-15 hospitalization of a person within a period specified by the
 23-16 commission that results from deficiencies in the care or treatment
 23-17 provided to the person during a previous hospital stay or from
 23-18 deficiencies in post-hospital discharge follow-up. The term does
 23-19 not include a hospital readmission necessitated by the occurrence
 23-20 of unrelated events after the discharge. The term includes the
 23-21 readmission of a person to a hospital for:

23-22 [~~(1) the same condition or procedure for which the~~
 23-23 person was previously admitted,

23-24 [~~(2) an infection or other complication resulting from~~
 23-25 care previously provided,

23-26 [~~(3) a condition or procedure that indicates that a~~
 23-27 surgical intervention performed during a previous admission was
 23-28 unsuccessful in achieving the anticipated outcome, or

23-29 [~~(4) another condition or procedure of a similar~~
 23-30 nature, as determined by the executive commissioner.

23-31 [~~(b)~~] The executive commissioner shall adopt rules for
 23-32 identifying potentially preventable readmissions of child health
 23-33 plan program enrollees and Medicaid recipients and potentially
 23-34 preventable complications experienced by child health plan program
 23-35 enrollees and Medicaid recipients. The [~~and the~~] commission shall
 23-36 collect [~~exchange~~] data from [~~with~~] hospitals on
 23-37 present-on-admission indicators for purposes of this section.

23-38 (b) [~~(c)~~] The commission shall establish a [~~health~~
 23-39 information exchange] program to provide a [~~exchange~~] confidential
 23-40 report to [~~information with~~] each hospital in this state that
 23-41 participates in the child health plan or Medicaid program regarding
 23-42 the hospital's performance with respect to potentially preventable
 23-43 readmissions and potentially preventable complications. To the
 23-44 extent possible, a report provided under this section should
 23-45 include potentially preventable readmissions and potentially
 23-46 preventable complications information across all child health plan
 23-47 and Medicaid program payment systems. A hospital shall distribute
 23-48 the information contained in the report [~~received from the~~
 23-49 commission] to physicians and other health care providers providing
 23-50 services at the hospital.

23-51 (c) A report provided to a hospital under this section is
 23-52 confidential and is not subject to Chapter 552.

23-53 Sec. 536.152. REIMBURSEMENT ADJUSTMENTS. (a) Subject to
 23-54 Subsection (b), using the data collected under Section 536.151 and
 23-55 the diagnosis-related groups (DRG) methodology implemented under
 23-56 Section 536.005, the commission, after consulting with the advisory
 23-57 committee, shall to the extent feasible adjust child health plan
 23-58 and Medicaid reimbursements to hospitals, including payments made
 23-59 under the disproportionate share hospitals and upper payment limit
 23-60 supplemental payment programs, in a manner that may reward or
 23-61 penalize a hospital based on the hospital's performance with
 23-62 respect to exceeding, or failing to achieve, outcome and process
 23-63 measures developed under Section 536.003 that address the rates of
 23-64 potentially preventable readmissions and potentially preventable
 23-65 complications.

23-66 (b) The commission must provide the report required under
 23-67 Section 536.151(b) to a hospital at least one year before the
 23-68 commission adjusts child health plan and Medicaid reimbursements to
 23-69 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,

25-1 including qualified actuaries, to assist in determining
 25-2 appropriate payment rates for a payment initiative implemented
 25-3 under this subchapter.

25-4 (b) The Health and Human Services Commission shall convert
 25-5 the hospital reimbursement systems used under the child health plan
 25-6 program under Chapter 62, Health and Safety Code, and medical
 25-7 assistance program under Chapter 32, Human Resources Code, to the
 25-8 diagnosis-related groups (DRG) methodology to the extent possible
 25-9 as required by Section 536.005, Government Code, as added by this
 25-10 section, as soon as practicable after the effective date of this
 25-11 Act, but not later than:

25-12 (1) September 1, 2013, for reimbursements paid to
 25-13 children's hospitals; and

25-14 (2) September 1, 2012, for reimbursements paid to
 25-15 other hospitals under those programs.

25-16 (c) Not later than September 1, 2012, the Health and Human
 25-17 Services Commission shall begin providing performance reports to
 25-18 hospitals regarding the hospitals' performances with respect to
 25-19 potentially preventable complications as required by Section
 25-20 536.151, Government Code, as designated and amended by this
 25-21 section.

25-22 (d) Subject to Subsection (b), Section 536.004, Government
 25-23 Code, as added by this section, the Health and Human Services
 25-24 Commission shall begin making adjustments to child health plan and
 25-25 Medicaid reimbursements to hospitals as required by Section
 25-26 536.152, Government Code, as added by this section:

25-27 (1) not later than September 1, 2012, based on the
 25-28 hospitals' performances with respect to reducing potentially
 25-29 preventable readmissions; and

25-30 (2) not later than September 1, 2013, based on the
 25-31 hospitals' performances with respect to reducing potentially
 25-32 preventable complications.

25-33 SECTION 1.14. (a) The heading to Section 531.912,
 25-34 Government Code, is amended to read as follows:

25-35 Sec. 531.912. COMMON PERFORMANCE MEASUREMENTS AND
 25-36 PAY-FOR-PERFORMANCE INCENTIVES FOR [QUALITY OF CARE HEALTH
 25-37 INFORMATION EXCHANGE WITH] CERTAIN NURSING FACILITIES.

25-38 (b) Subsections (b), (c), and (f), Section 531.912,
 25-39 Government Code, are amended to read as follows:

25-40 (b) If feasible, the executive commissioner by rule may
 25-41 [shall] establish an incentive payment program for [a quality of
 25-42 care health information exchange with] nursing facilities that
 25-43 choose to participate. The [in a] program must be designed to
 25-44 improve the quality of care and services provided to medical
 25-45 assistance recipients. Subject to Subsection (f), the program may
 25-46 provide incentive payments in accordance with this section to
 25-47 encourage facilities to participate in the program.

25-48 (c) In establishing an incentive payment [a quality of care
 25-49 health information exchange] program under this section, the
 25-50 executive commissioner shall, subject to Subsection (d), adopt
 25-51 common [exchange information with participating nursing facilities
 25-52 regarding] performance measures to be used in evaluating nursing
 25-53 facilities that are related to structure, process, and outcomes
 25-54 that positively correlate to nursing facility quality and
 25-55 improvement. The common performance measures:

25-56 (1) must be:

25-57 (A) recognized by the executive commissioner as
 25-58 valid indicators of the overall quality of care received by medical
 25-59 assistance recipients; and

25-60 (B) designed to encourage and reward
 25-61 evidence-based practices among nursing facilities; and

25-62 (2) may include measures of:

25-63 (A) quality of care, as determined by clinical
 25-64 performance ratings published by the federal Centers for Medicare
 25-65 and Medicaid Services, the Agency for Healthcare Research and
 25-66 Quality, or another federal agency [life];

25-67 (B) direct-care staff retention and turnover;

25-68 (C) recipient satisfaction, including the
 25-69 satisfaction of recipients who are short-term and long-term

26-1 residents of facilities, and family satisfaction, as determined by
 26-2 the Nursing Home Consumer Assessment of Health Providers and
 26-3 Systems survey relied upon by the federal Centers for Medicare and
 26-4 Medicaid Services;

26-5 (D) employee satisfaction and engagement;
 26-6 (E) the incidence of preventable acute care
 26-7 emergency room services use;

26-8 (F) regulatory compliance;

26-9 (G) level of person-centered care; and

26-10 (H) direct-care staff training, including a
 26-11 facility's [level of occupancy or of facility] utilization of
 26-12 independent distance learning programs for the continuous training
 26-13 of direct-care staff.

26-14 (f) The commission may make incentive payments under the
 26-15 program only if money is [~~specifically~~] appropriated for that
 26-16 purpose.

26-17 (c) The Department of Aging and Disability Services shall
 26-18 conduct a study to evaluate the feasibility of expanding any
 26-19 incentive payment program established for nursing facilities under
 26-20 Section 531.912, Government Code, as amended by this section, by
 26-21 providing incentive payments for the following types of providers
 26-22 of long-term care services, as defined by Section 22.0011, Human
 26-23 Resources Code, under the medical assistance program:

26-24 (1) intermediate care facilities for persons with
 26-25 mental retardation licensed under Chapter 252, Health and Safety
 26-26 Code; and

26-27 (2) providers of home and community-based services, as
 26-28 described by 42 U.S.C. Section 1396n(c), who are licensed or
 26-29 otherwise authorized to provide those services in this state.

26-30 (d) Not later than September 1, 2012, the Department of
 26-31 Aging and Disability Services shall submit to the legislature a
 26-32 written report containing the findings of the study conducted under
 26-33 Subsection (c) of this section and the department's
 26-34 recommendations.

26-35 SECTION 1.15. Section 780.004, Health and Safety Code, is
 26-36 amended by amending Subsection (a) and adding Subsection (j) to
 26-37 read as follows:

26-38 (a) The commissioner:

26-39 (1) [~~r~~] with advice and counsel from the chairpersons
 26-40 of the trauma service area regional advisory councils, shall use
 26-41 money appropriated from the account established under this chapter
 26-42 to fund designated trauma facilities, county and regional emergency
 26-43 medical services, and trauma care systems in accordance with this
 26-44 section; and

26-45 (2) after consulting with the executive commissioner
 26-46 of the Health and Human Services Commission, may transfer to an
 26-47 account in the general revenue fund money appropriated from the
 26-48 account established under this chapter to maximize the receipt of
 26-49 federal funds under the medical assistance program established
 26-50 under Chapter 32, Human Resources Code, and to fund provider
 26-51 reimbursement payments as provided by Subsection (j).

26-52 (j) Money in the account described by Subsection (a)(2) may
 26-53 be appropriated only to the Health and Human Services Commission to
 26-54 fund provider reimbursement payments under the medical assistance
 26-55 program established under Chapter 32, Human Resources Code,
 26-56 including reimbursement enhancements to the statewide dollar
 26-57 amount (SDA) rate used to reimburse designated trauma hospitals
 26-58 under the program.

26-59 SECTION 1.16. Subchapter B, Chapter 531, Government Code,
 26-60 is amended by adding Section 531.0697 to read as follows:

26-61 Sec. 531.0697. PRIOR APPROVAL AND PROVIDER ACCESS TO
 26-62 CERTAIN COMMUNICATIONS WITH CERTAIN RECIPIENTS. (a) This section
 26-63 applies to:

26-64 (1) the vendor drug program for the Medicaid and child
 26-65 health plan programs;

26-66 (2) the kidney health care program;

26-67 (3) the children with special health care needs
 26-68 program; and

26-69 (4) any other state program administered by the

27-1 commission that provides prescription drug benefits.

27-2 (b) A managed care organization, including a health
 27-3 maintenance organization, or a pharmacy benefit manager, that
 27-4 administers claims for prescription drug benefits under a program
 27-5 to which this section applies shall, at least 10 days before the
 27-6 date the organization or pharmacy benefit manager intends to
 27-7 deliver a communication to recipients collectively under a program:

27-8 (1) submit a copy of the communication to the
 27-9 commission for approval; and

27-10 (2) if applicable, allow the pharmacy providers of
 27-11 recipients who are to receive the communication access to the
 27-12 communication.

27-13 SECTION 1.17. (a) Subchapter A, Chapter 61, Health and
 27-14 Safety Code, is amended by adding Section 61.012 to read as follows:

27-15 Sec. 61.012. REIMBURSEMENT FOR SERVICES. (a) In this
 27-16 section, "sponsored alien" means a person who has been lawfully
 27-17 admitted to the United States for permanent residence under the
 27-18 Immigration and Nationality Act (8 U.S.C. Section 1101 et seq.) and
 27-19 who, as a condition of admission, was sponsored by a person who
 27-20 executed an affidavit of support on behalf of the person.

27-21 (b) A public hospital or hospital district that provides
 27-22 health care services to a sponsored alien under this chapter may
 27-23 recover from a person who executed an affidavit of support on behalf
 27-24 of the alien the costs of the health care services provided to the
 27-25 alien.

27-26 (c) A public hospital or hospital district described by
 27-27 Subsection (b) must notify a sponsored alien and a person who
 27-28 executed an affidavit of support on behalf of the alien, at the time
 27-29 the alien applies for health care services, that a person who
 27-30 executed an affidavit of support on behalf of a sponsored alien is
 27-31 liable for the cost of health care services provided to the alien.

27-32 (b) Section 61.012, Health and Safety Code, as added by this
 27-33 section, applies only to health care services provided by a public
 27-34 hospital or hospital district on or after the effective date of this
 27-35 Act.

27-36 SECTION 1.18. Subchapter B, Chapter 531, Government Code,
 27-37 is amended by adding Sections 531.024181 and 531.024182 to read as
 27-38 follows:

27-39 Sec. 531.024181. VERIFICATION OF IMMIGRATION STATUS OF
 27-40 APPLICANTS FOR CERTAIN BENEFITS WHO ARE QUALIFIED ALIENS.

27-41 (a) This section applies only with respect to the following
 27-42 benefits programs:

27-43 (1) the child health plan program under Chapter 62,
 27-44 Health and Safety Code;

27-45 (2) the financial assistance program under Chapter 31,
 27-46 Human Resources Code;

27-47 (3) the medical assistance program under Chapter 32,
 27-48 Human Resources Code; and

27-49 (4) the nutritional assistance program under Chapter
 27-50 33, Human Resources Code.

27-51 (b) If, at the time of application for benefits under a
 27-52 program to which this section applies, a person states that the
 27-53 person is a qualified alien, as that term is defined by 8 U.S.C.
 27-54 Section 1641(b), the commission shall, to the extent allowed by
 27-55 federal law, verify information regarding the immigration status of
 27-56 the person using an automated system or systems where available.

27-57 (c) The executive commissioner shall adopt rules necessary
 27-58 to implement this section.

27-59 (d) Nothing in this section adds to or changes the
 27-60 eligibility requirements for any of the benefits programs to which
 27-61 this section applies.

27-62 Sec. 531.024182. VERIFICATION OF SPONSORSHIP INFORMATION
 27-63 FOR CERTAIN BENEFITS RECIPIENTS; REIMBURSEMENT. (a) In this

27-64 section, "sponsored alien" means a person who has been lawfully
 27-65 admitted to the United States for permanent residence under the
 27-66 Immigration and Nationality Act (8 U.S.C. Section 1101 et seq.) and
 27-67 who, as a condition of admission, was sponsored by a person who
 27-68 executed an affidavit of support on behalf of the person.

27-69 (b) If, at the time of application for benefits, a person

28-1 stated that the person is a sponsored alien, the commission may, to
 28-2 the extent allowed by federal law, verify information relating to
 28-3 the sponsorship, using an automated system or systems where
 28-4 available, after the person is determined eligible for and begins
 28-5 receiving benefits under any of the following benefits programs:

28-6 (1) the child health plan program under Chapter 62,
 28-7 Health and Safety Code;

28-8 (2) the financial assistance program under Chapter 31,
 28-9 Human Resources Code;

28-10 (3) the medical assistance program under Chapter 32,
 28-11 Human Resources Code; or

28-12 (4) the nutritional assistance program under Chapter
 28-13 33, Human Resources Code.

28-14 (c) If the commission verifies that a person who receives
 28-15 benefits under a program listed in Subsection (b) is a sponsored
 28-16 alien, the commission may seek reimbursement from the person's
 28-17 sponsor for benefits provided to the person under those programs to
 28-18 the extent allowed by federal law, provided the commission
 28-19 determines that seeking reimbursement is cost-effective.

28-20 (d) If, at the time a person applies for benefits under a
 28-21 program listed in Subsection (b), the person states that the person
 28-22 is a sponsored alien, the commission shall make a reasonable effort
 28-23 to notify the person that the commission may seek reimbursement
 28-24 from the person's sponsor for any benefits the person receives
 28-25 under those programs.

28-26 (e) The executive commissioner shall adopt rules necessary
 28-27 to implement this section, including rules that specify the most
 28-28 cost-effective procedures by which the commission may seek
 28-29 reimbursement under Subsection (c).

28-30 (f) Nothing in this section adds to or changes the
 28-31 eligibility requirements for any of the benefits programs listed in
 28-32 Subsection (b).

28-33 SECTION 1.19. Subchapter B, Chapter 32, Human Resources
 28-34 Code, is amended by adding Section 32.0314 to read as follows:

28-35 Sec. 32.0314. REIMBURSEMENT FOR DURABLE MEDICAL EQUIPMENT
 28-36 AND SUPPLIES. The executive commissioner of the Health and Human
 28-37 Services Commission shall adopt rules requiring the electronic
 28-38 submission of any claim for reimbursement for durable medical
 28-39 equipment and supplies under the medical assistance program.

28-40 SECTION 1.20. (a) Subchapter A, Chapter 531, Government
 28-41 Code, is amended by adding Section 531.0025 to read as follows:

28-42 Sec. 531.0025. RESTRICTIONS ON AWARDS TO FAMILY PLANNING
 28-43 SERVICE PROVIDERS. (a) Notwithstanding any other law, money
 28-44 appropriated to the Department of State Health Services for the
 28-45 purpose of providing family planning services must be awarded:

28-46 (1) to eligible entities in the following order of
 28-47 descending priority:

28-48 (A) public entities that provide family planning
 28-49 services, including state, county, and local community health
 28-50 clinics;

28-51 (B) nonpublic entities that provide
 28-52 comprehensive primary and preventive care services in addition to
 28-53 family planning services; and

28-54 (C) nonpublic entities that provide family
 28-55 planning services but do not provide comprehensive primary and
 28-56 preventive care services; or

28-57 (2) as otherwise directed by the legislature in the
 28-58 General Appropriations Act.

28-59 (b) Notwithstanding Subsection (a), the Department of State
 28-60 Health Services shall, in compliance with federal law, ensure
 28-61 distribution of funds for family planning services in a manner that
 28-62 does not severely limit or eliminate access to those services in any
 28-63 region of the state.

28-64 (b) Section 32.024, Human Resources Code, is amended by
 28-65 adding Subsection (c-1) to read as follows:

28-66 (c-1) The department shall ensure that money spent for
 28-67 purposes of the demonstration project for women's health care
 28-68 services under former Section 32.0248, Human Resources Code, or a
 28-69 similar successor program is not used to perform or promote

29-1 elective abortions, or to contract with entities that perform or
 29-2 promote elective abortions or affiliate with entities that perform
 29-3 or promote elective abortions.

29-4 SECTION 1.21. If before implementing any provision of this
 29-5 article a state agency determines that a waiver or authorization
 29-6 from a federal agency is necessary for implementation of that
 29-7 provision, the agency affected by the provision shall request the
 29-8 waiver or authorization and may delay implementing that provision
 29-9 until the waiver or authorization is granted.

29-10 ARTICLE 2. LEGISLATIVE FINDINGS AND INTENT; COMPLIANCE WITH
 29-11 ANTITRUST LAWS

29-12 SECTION 2.01. (a) The legislature finds that it would
 29-13 benefit the State of Texas to:

29-14 (1) explore innovative health care delivery and
 29-15 payment models to improve the quality and efficiency of health care
 29-16 in this state;

29-17 (2) improve health care transparency;
 29-18 (3) give health care providers the flexibility to
 29-19 collaborate and innovate to improve the quality and efficiency of
 29-20 health care; and

29-21 (4) create incentives to improve the quality and
 29-22 efficiency of health care.

29-23 (b) The legislature finds that the use of certified health
 29-24 care collaboratives will increase pro-competitive effects as the
 29-25 ability to compete on the basis of quality of care and the
 29-26 furtherance of the quality of care through a health care
 29-27 collaborative will overcome any anticompetitive effects of joining
 29-28 competitors to create the health care collaboratives and the
 29-29 payment mechanisms that will be used to encourage the furtherance
 29-30 of quality of care. Consequently, the legislature finds it
 29-31 appropriate and necessary to authorize health care collaboratives
 29-32 to promote the efficiency and quality of health care.

29-33 (c) The legislature intends to exempt from antitrust laws
 29-34 and provide immunity from federal antitrust laws through the state
 29-35 action doctrine a health care collaborative that holds a
 29-36 certificate of authority under Chapter 848, Insurance Code, as
 29-37 added by Article 4 of this Act, and that collaborative's
 29-38 negotiations of contracts with payors. The legislature does not
 29-39 intend or authorize any person or entity to engage in activities or
 29-40 to conspire to engage in activities that would constitute per se
 29-41 violations of federal antitrust laws.

29-42 (d) The legislature intends to permit the use of alternative
 29-43 payment mechanisms, including bundled or global payments and
 29-44 quality-based payments, among physicians and other health care
 29-45 providers participating in a health care collaborative that holds a
 29-46 certificate of authority under Chapter 848, Insurance Code, as
 29-47 added by Article 4 of this Act. The legislature intends to
 29-48 authorize a health care collaborative to contract for and accept
 29-49 payments from governmental and private payors based on alternative
 29-50 payment mechanisms, and intends that the receipt and distribution
 29-51 of payments to participating physicians and health care providers
 29-52 is not a violation of any existing state law.

29-53 ARTICLE 3. TEXAS INSTITUTE OF HEALTH CARE QUALITY AND EFFICIENCY
 29-54 SECTION 3.01. Title 12, Health and Safety Code, is amended
 29-55 by adding Chapter 1002 to read as follows:

29-56 CHAPTER 1002. TEXAS INSTITUTE OF HEALTH CARE QUALITY AND
 29-57 EFFICIENCY
 29-58 SUBCHAPTER A. GENERAL PROVISIONS

29-59 Sec. 1002.001. DEFINITIONS. In this chapter:

29-60 (1) "Board" means the board of directors of the Texas
 29-61 Institute of Health Care Quality and Efficiency established under
 29-62 this chapter.

29-63 (2) "Commission" means the Health and Human Services
 29-64 Commission.

29-65 (3) "Department" means the Department of State Health
 29-66 Services.

29-67 (4) "Executive commissioner" means the executive
 29-68 commissioner of the Health and Human Services Commission.

29-69 (5) "Health care collaborative" has the meaning

30-1 assigned by Section 848.001, Insurance Code.
 30-2 (6) "Health care facility" means:
 30-3 (A) a hospital licensed under Chapter 241;
 30-4 (B) an institution licensed under Chapter 242;
 30-5 (C) an ambulatory surgical center licensed under
 30-6 Chapter 243;
 30-7 (D) a birthing center licensed under Chapter 244;
 30-8 (E) an end stage renal disease facility licensed
 30-9 under Chapter 251; or
 30-10 (F) a freestanding emergency medical care
 30-11 facility licensed under Chapter 254.
 30-12 (7) "Institute" means the Texas Institute of Health
 30-13 Care Quality and Efficiency established under this chapter.
 30-14 (8) "Potentially preventable admission" means an
 30-15 admission of a person to a hospital or long-term care facility that
 30-16 may have reasonably been prevented with adequate access to
 30-17 ambulatory care or health care coordination.
 30-18 (9) "Potentially preventable ancillary service" means
 30-19 a health care service provided or ordered by a physician or other
 30-20 health care provider to supplement or support the evaluation or
 30-21 treatment of a patient, including a diagnostic test, laboratory
 30-22 test, therapy service, or radiology service, that may not be
 30-23 reasonably necessary for the provision of quality health care or
 30-24 treatment.
 30-25 (10) "Potentially preventable complication" means a
 30-26 harmful event or negative outcome with respect to a person,
 30-27 including an infection or surgical complication, that:
 30-28 (A) occurs after the person's admission to a
 30-29 hospital or long-term care facility; and
 30-30 (B) may have resulted from the care, lack of
 30-31 care, or treatment provided during the hospital or long-term care
 30-32 facility stay rather than from a natural progression of an
 30-33 underlying disease.
 30-34 (11) "Potentially preventable event" means a
 30-35 potentially preventable admission, a potentially preventable
 30-36 ancillary service, a potentially preventable complication, a
 30-37 potentially preventable emergency room visit, a potentially
 30-38 preventable readmission, or a combination of those events.
 30-39 (12) "Potentially preventable emergency room visit"
 30-40 means treatment of a person in a hospital emergency room or
 30-41 freestanding emergency medical care facility for a condition that
 30-42 may not require emergency medical attention because the condition
 30-43 could be, or could have been, treated or prevented by a physician or
 30-44 other health care provider in a nonemergency setting.
 30-45 (13) "Potentially preventable readmission" means a
 30-46 return hospitalization of a person within a period specified by the
 30-47 commission that may have resulted from deficiencies in the care or
 30-48 treatment provided to the person during a previous hospital stay or
 30-49 from deficiencies in post-hospital discharge follow-up. The term
 30-50 does not include a hospital readmission necessitated by the
 30-51 occurrence of unrelated events after the discharge. The term
 30-52 includes the readmission of a person to a hospital for:
 30-53 (A) the same condition or procedure for which the
 30-54 person was previously admitted;
 30-55 (B) an infection or other complication resulting
 30-56 from care previously provided; or
 30-57 (C) a condition or procedure that indicates that
 30-58 a surgical intervention performed during a previous admission was
 30-59 unsuccessful in achieving the anticipated outcome.
 30-60 Sec. 1002.002. ESTABLISHMENT; PURPOSE. The Texas Institute
 30-61 of Health Care Quality and Efficiency is established to improve
 30-62 health care quality, accountability, education, and cost
 30-63 containment in this state by encouraging health care provider
 30-64 collaboration, effective health care delivery models, and
 30-65 coordination of health care services.
 30-66 [Sections 1002.003-1002.050 reserved for expansion]
 30-67 SUBCHAPTER B. ADMINISTRATION
 30-68 Sec. 1002.051. APPLICATION OF SUNSET ACT. The institute is
 30-69 subject to Chapter 325, Government Code (Texas Sunset Act). Unless

31-1 continued in existence as provided by that chapter, the institute
31-2 is abolished and this chapter expires September 1, 2017.

31-3 Sec. 1002.052. COMPOSITION OF BOARD OF DIRECTORS. (a) The
31-4 institute is governed by a board of 15 directors appointed by the
31-5 governor.

31-6 (b) The following ex officio, nonvoting members also serve
31-7 on the board:

31-8 (1) the commissioner of the department;

31-9 (2) the executive commissioner;

31-10 (3) the commissioner of insurance;

31-11 (4) the executive director of the Employees Retirement
31-12 System of Texas;

31-13 (5) the executive director of the Teacher Retirement
31-14 System of Texas;

31-15 (6) the state Medicaid director of the Health and
31-16 Human Services Commission;

31-17 (7) the executive director of the Texas Medical Board;

31-18 (8) the commissioner of the Department of Aging and
31-19 Disability Services;

31-20 (9) the executive director of the Texas Workforce
31-21 Commission;

31-22 (10) the commissioner of the Texas Higher Education
31-23 Coordinating Board; and

31-24 (11) a representative from each state agency or system
31-25 of higher education that purchases or provides health care
31-26 services, as determined by the governor.

31-27 (c) The governor shall appoint as board members health care
31-28 providers, payors, consumers, and health care quality experts or
31-29 persons who possess expertise in any other area the governor finds
31-30 necessary for the successful operation of the institute.

31-31 (d) A person may not serve as a voting member of the board if
31-32 the person serves on or advises another board or advisory board of a
31-33 state agency.

31-34 Sec. 1002.053. TERMS OF OFFICE. (a) Appointed members of
31-35 the board serve staggered terms of four years, with the terms of as
31-36 close to one-half of the members as possible expiring January 31 of
31-37 each odd-numbered year.

31-38 (b) Board members may serve consecutive terms.

31-39 Sec. 1002.054. ADMINISTRATIVE SUPPORT. (a) The institute
31-40 is administratively attached to the commission.

31-41 (b) The commission shall coordinate administrative
31-42 responsibilities with the institute to streamline and integrate the
31-43 institute's administrative operations and avoid unnecessary
31-44 duplication of effort and costs.

31-45 (c) The institute may collaborate with, and coordinate its
31-46 administrative functions, including functions related to research
31-47 and reporting activities with, other public or private entities,
31-48 including academic institutions and nonprofit organizations, that
31-49 perform research on health care issues or other topics consistent
31-50 with the purpose of the institute.

31-51 Sec. 1002.055. EXPENSES. (a) Members of the board serve
31-52 without compensation but, subject to the availability of
31-53 appropriated funds, may receive reimbursement for actual and
31-54 necessary expenses incurred in attending meetings of the board.

31-55 (b) Information relating to the billing and payment of
31-56 expenses under this section is subject to Chapter 552, Government
31-57 Code.

31-58 Sec. 1002.056. OFFICER; CONFLICT OF INTEREST. (a) The
31-59 governor shall designate a member of the board as presiding officer
31-60 to serve in that capacity at the pleasure of the governor.

31-61 (b) Any board member or a member of a committee formed by the
31-62 board with direct interest, personally or through an employer, in a
31-63 matter before the board shall abstain from deliberations and
31-64 actions on the matter in which the conflict of interest arises and
31-65 shall further abstain on any vote on the matter, and may not
31-66 otherwise participate in a decision on the matter.

31-67 (c) Each board member shall:

31-68 (1) file a conflict of interest statement and a
31-69 statement of ownership interests with the board to ensure

32-1 disclosure of all existing and potential personal interests related
 32-2 to board business; and

32-3 (2) update the statements described by Subdivision (1)
 32-4 at least annually.

32-5 (d) A statement filed under Subsection (c) is subject to
 32-6 Chapter 552, Government Code.

32-7 Sec. 1002.057. PROHIBITION ON CERTAIN CONTRACTS AND
 32-8 EMPLOYMENT. (a) The board may not compensate, employ, or contract
 32-9 with any individual who serves as a member of the board of, or on an
 32-10 advisory board or advisory committee for, any other governmental
 32-11 body, including any agency, council, or committee, in this state.

32-12 (b) The board may not compensate, employ, or contract with
 32-13 any person that provides financial support to the board, including
 32-14 a person who provides a gift, grant, or donation to the board.

32-15 Sec. 1002.058. MEETINGS. (a) The board may meet as often
 32-16 as necessary, but shall meet at least once each calendar quarter.

32-17 (b) The board shall develop and implement policies that
 32-18 provide the public with a reasonable opportunity to appear before
 32-19 the board and to speak on any issue under the authority of the
 32-20 institute.

32-21 Sec. 1002.059. BOARD MEMBER IMMUNITY. (a) A board member
 32-22 may not be held civilly liable for an act performed, or omission
 32-23 made, in good faith in the performance of the member's powers and
 32-24 duties under this chapter.

32-25 (b) A cause of action does not arise against a member of the
 32-26 board for an act or omission described by Subsection (a).

32-27 Sec. 1002.060. PRIVACY OF INFORMATION. (a) Protected
 32-28 health information and individually identifiable health
 32-29 information collected, assembled, or maintained by the institute is
 32-30 confidential and is not subject to disclosure under Chapter 552,
 32-31 Government Code.

32-32 (b) The institute shall comply with all state and federal
 32-33 laws and rules relating to the protection, confidentiality, and
 32-34 transmission of health information, including the Health Insurance
 32-35 Portability and Accountability Act of 1996 (Pub. L. No. 104-191)
 32-36 and rules adopted under that Act, 42 U.S.C. Section 290dd-2, and 42
 32-37 C.F.R. Part 2.

32-38 (c) The commission, department, or institute or an officer
 32-39 or employee of the commission, department, or institute, including
 32-40 a board member, may not disclose any information that is
 32-41 confidential under this section.

32-42 (d) Information, documents, and records that are
 32-43 confidential as provided by this section are not subject to
 32-44 subpoena or discovery and may not be introduced into evidence in any
 32-45 civil or criminal proceeding.

32-46 (e) An officer or employee of the commission, department, or
 32-47 institute, including a board member, may not be examined in a civil,
 32-48 criminal, special, administrative, or other proceeding as to
 32-49 information that is confidential under this section.

32-50 Sec. 1002.061. FUNDING. (a) The institute may be funded
 32-51 through the General Appropriations Act and may request, accept, and
 32-52 use gifts, grants, and donations as necessary to implement its
 32-53 functions.

32-54 (b) The institute may participate in other
 32-55 revenue-generating activity that is consistent with the
 32-56 institute's purposes.

32-57 (c) Except as otherwise provided by law, each state agency
 32-58 represented on the board as a nonvoting member shall provide funds
 32-59 to support the institute and implement this chapter. The
 32-60 commission shall establish a funding formula to determine the level
 32-61 of support each state agency is required to provide.

32-62 (d) This section does not permit the sale of information
 32-63 that is confidential under Section 1002.060.

32-64 [Sections 1002.062-1002.100 reserved for expansion]

32-65 SUBCHAPTER C. POWERS AND DUTIES

32-66 Sec. 1002.101. GENERAL POWERS AND DUTIES. The institute
 32-67 shall make recommendations to the legislature on:

32-68 (1) improving quality and efficiency of health care
 32-69 delivery by:

33-1 (A) providing a forum for regulators, payors, and
 33-2 providers to discuss and make recommendations for initiatives that
 33-3 promote the use of best practices, increase health care provider
 33-4 collaboration, improve health care outcomes, and contain health
 33-5 care costs;

33-6 (B) researching, developing, supporting, and
 33-7 promoting strategies to improve the quality and efficiency of
 33-8 health care in this state;

33-9 (C) determining the outcome measures that are the
 33-10 most effective measures of quality and efficiency:

33-11 (i) using nationally accredited measures;
 33-12 or

33-13 (ii) if no nationally accredited measures
 33-14 exist, using measures based on expert consensus;

33-15 (D) reducing the incidence of potentially
 33-16 preventable events; and

33-17 (E) creating a state plan that takes into
 33-18 consideration the regional differences of the state to encourage
 33-19 the improvement of the quality and efficiency of health care
 33-20 services;

33-21 (2) improving reporting, consolidation, and
 33-22 transparency of health care information; and

33-23 (3) implementing and supporting innovative health
 33-24 care collaborative payment and delivery systems under Chapter 848,
 33-25 Insurance Code.

33-26 Sec. 1002.102. GOALS FOR QUALITY AND EFFICIENCY OF HEALTH
 33-27 CARE; STATEWIDE PLAN. (a) The institute shall study and develop
 33-28 recommendations to improve the quality and efficiency of health
 33-29 care delivery in this state, including:

33-30 (1) quality-based payment systems that align payment
 33-31 incentives with high-quality, cost-effective health care;

33-32 (2) alternative health care delivery systems that
 33-33 promote health care coordination and provider collaboration;

33-34 (3) quality of care and efficiency outcome
 33-35 measurements that are effective measures of prevention, wellness,
 33-36 coordination, provider collaboration, and cost-effective health
 33-37 care; and

33-38 (4) meaningful use of electronic health records by
 33-39 providers and electronic exchange of health information among
 33-40 providers.

33-41 (b) The institute shall study and develop recommendations
 33-42 for measuring quality of care and efficiency across:

33-43 (1) all state employee and state retiree benefit
 33-44 plans;

33-45 (2) employee and retiree benefit plans provided
 33-46 through the Teacher Retirement System of Texas;

33-47 (3) the state medical assistance program under Chapter
 33-48 32, Human Resources Code; and

33-49 (4) the child health plan under Chapter 62.

33-50 (c) In developing recommendations under Subsection (b), the
 33-51 institute shall use nationally accredited measures or, if no
 33-52 nationally accredited measures exist, measures based on expert
 33-53 consensus.

33-54 (d) The institute may study and develop recommendations for
 33-55 measuring the quality of care and efficiency in state or federally
 33-56 funded health care delivery systems other than those described by
 33-57 Subsection (b).

33-58 (e) In developing recommendations under Subsections (a) and
 33-59 (b), the institute may not base its recommendations solely on
 33-60 actuarial data.

33-61 (f) Using the studies described by Subsections (a) and (b),
 33-62 the institute shall develop recommendations for a statewide plan
 33-63 for quality and efficiency of the delivery of health care.

33-64 [Sections 1002.103-1002.150 reserved for expansion]

33-65 SUBCHAPTER D. HEALTH CARE COLLABORATIVE GUIDELINES AND SUPPORT

33-66 Sec. 1002.151. INSTITUTE STUDIES AND RECOMMENDATIONS
 33-67 REGARDING HEALTH CARE PAYMENT AND DELIVERY SYSTEMS. (a) The
 33-68 institute shall study and make recommendations for alternative
 33-69 health care payment and delivery systems.

34-1 (b) The institute shall recommend methods to evaluate a
 34-2 health care collaborative's effectiveness, including methods to
 34-3 evaluate:
 34-4 (1) the efficiency and effectiveness of
 34-5 cost-containment methods used by the collaborative;
 34-6 (2) alternative health care payment and delivery
 34-7 systems used by the collaborative;
 34-8 (3) the quality of care;
 34-9 (4) health care provider collaboration and
 34-10 coordination;
 34-11 (5) the protection of patients;
 34-12 (6) patient satisfaction; and
 34-13 (7) the meaningful use of electronic health records by
 34-14 providers and electronic exchange of health information among
 34-15 providers.

34-16 [Sections 1002.152-1002.200 reserved for expansion]

34-17 SUBCHAPTER E. IMPROVED TRANSPARENCY

34-18 Sec. 1002.201. HEALTH CARE ACCOUNTABILITY; IMPROVED
 34-19 TRANSPARENCY. (a) With the assistance of the department, the
 34-20 institute shall complete an assessment of all health-related data
 34-21 collected by the state, what information is available to the
 34-22 public, and how the public and health care providers currently
 34-23 benefit and could potentially benefit from this information,
 34-24 including health care cost and quality information.

34-25 (b) The institute shall develop a plan:

34-26 (1) for consolidating reports of health-related data
 34-27 from various sources to reduce administrative costs to the state
 34-28 and reduce the administrative burden to health care providers and
 34-29 payors;

34-30 (2) for improving health care transparency to the
 34-31 public and health care providers by making information available in
 34-32 the most effective format; and

34-33 (3) providing recommendations to the legislature on
 34-34 enhancing existing health-related information available to health
 34-35 care providers and the public, including provider reporting of
 34-36 additional information not currently required to be reported under
 34-37 existing law, to improve quality of care.

34-38 Sec. 1002.202. ALL PAYOR CLAIMS DATABASE. (a) The
 34-39 institute shall study the feasibility and desirability of
 34-40 establishing a centralized database for health care claims
 34-41 information across all payors.

34-42 (b) The study described by Subsection (a) shall:

34-43 (1) use the assessment described by Section 1002.201
 34-44 to develop recommendations relating to the adequacy of existing
 34-45 data sources for carrying out the state's purposes under this
 34-46 chapter and Chapter 848, Insurance Code;

34-47 (2) determine whether the establishment of an all
 34-48 payor claims database would reduce the need for some data
 34-49 submissions provided by payors;

34-50 (3) identify the best available sources of data
 34-51 necessary for the state's purposes under this chapter and Chapter
 34-52 848, Insurance Code, that are not collected by the state under
 34-53 existing law;

34-54 (4) describe how an all payor claims database may
 34-55 facilitate carrying out the state's purposes under this chapter and
 34-56 Chapter 848, Insurance Code;

34-57 (5) identify national standards for claims data
 34-58 collection and use, including standardized data sets, standardized
 34-59 methodology, and standard outcome measures of health care quality
 34-60 and efficiency; and

34-61 (6) estimate the costs of implementing an all payor
 34-62 claims database, including:

34-63 (A) the costs to the state for collecting and
 34-64 processing data;

34-65 (B) the cost to the payors for supplying the
 34-66 data; and

34-67 (C) the available funding mechanisms that might
 34-68 support an all payor claims database.

34-69 (c) The institute shall consult with the department and the

35-1 Texas Department of Insurance to develop recommendations to submit
 35-2 to the legislature on the establishment of the centralized claims
 35-3 database described by Subsection (a).

35-4 SECTION 3.02. Chapter 109, Health and Safety Code, is
 35-5 repealed.

35-6 SECTION 3.03. On the effective date of this Act:

35-7 (1) the Texas Health Care Policy Council established
 35-8 under Chapter 109, Health and Safety Code, is abolished; and

35-9 (2) any unexpended and unobligated balance of money
 35-10 appropriated by the legislature to the Texas Health Care Policy
 35-11 Council established under Chapter 109, Health and Safety Code, as
 35-12 it existed immediately before the effective date of this Act, is
 35-13 transferred to the Texas Institute of Health Care Quality and
 35-14 Efficiency created by Chapter 1002, Health and Safety Code, as
 35-15 added by this Act.

35-16 SECTION 3.04. (a) The governor shall appoint voting
 35-17 members of the board of directors of the Texas Institute of Health
 35-18 Care Quality and Efficiency under Section 1002.052, Health and
 35-19 Safety Code, as added by this Act, as soon as practicable after the
 35-20 effective date of this Act.

35-21 (b) In making the initial appointments under this section,
 35-22 the governor shall designate seven members to terms expiring
 35-23 January 31, 2013, and eight members to terms expiring January 31,
 35-24 2015.

35-25 SECTION 3.05. (a) Not later than December 1, 2012, the
 35-26 Texas Institute of Health Care Quality and Efficiency shall submit
 35-27 a report regarding recommendations for improved health care
 35-28 reporting to the governor, the lieutenant governor, the speaker of
 35-29 the house of representatives, and the chairs of the appropriate
 35-30 standing committees of the legislature outlining:

35-31 (1) the initial assessment conducted under Subsection
 35-32 (a), Section 1002.201, Health and Safety Code, as added by this Act;

35-33 (2) the plans initially developed under Subsection
 35-34 (b), Section 1002.201, Health and Safety Code, as added by this Act;

35-35 (3) the changes in existing law that would be
 35-36 necessary to implement the assessment and plans described by
 35-37 Subdivisions (1) and (2) of this subsection; and

35-38 (4) the cost implications to state agencies, small
 35-39 businesses, micro businesses, payors, and health care providers to
 35-40 implement the assessment and plans described by Subdivisions (1)
 35-41 and (2) of this subsection.

35-42 (b) Not later than December 1, 2012, the Texas Institute of
 35-43 Health Care Quality and Efficiency shall submit a report regarding
 35-44 recommendations for an all payor claims database to the governor,
 35-45 the lieutenant governor, the speaker of the house of
 35-46 representatives, and the chairs of the appropriate standing
 35-47 committees of the legislature outlining:

35-48 (1) the feasibility and desirability of establishing a
 35-49 centralized database for health care claims;

35-50 (2) the recommendations developed under Subsection
 35-51 (c), Section 1002.202, Health and Safety Code, as added by this Act;

35-52 (3) the changes in existing law that would be
 35-53 necessary to implement the recommendations described by
 35-54 Subdivision (2) of this subsection; and

35-55 (4) the cost implications to state agencies, small
 35-56 businesses, micro businesses, payors, and health care providers to
 35-57 implement the recommendations described by Subdivision (2) of this
 35-58 subsection.

35-59 SECTION 3.06. (a) The Texas Institute of Health Care
 35-60 Quality and Efficiency under Chapter 1002, Health and Safety Code,
 35-61 as added by this Act, with the assistance of and in coordination
 35-62 with the Texas Department of Insurance, shall conduct a study:

35-63 (1) evaluating how the legislature may promote a
 35-64 consumer-driven health care system, including by increasing the
 35-65 adoption of high-deductible insurance products with health savings
 35-66 accounts by consumers and employers to lower health care costs and
 35-67 increase personal responsibility for health care; and

35-68 (2) examining the issue of differing amounts of
 35-69 payment in full accepted by a provider for the same or similar

36-1 health care services or supplies, including bundled health care
36-2 services and supplies, and addressing:

36-3 (A) the extent of the differences in the amounts
36-4 accepted as payment in full for a service or supply;

36-5 (B) the reasons that amounts accepted as payment
36-6 in full differ for the same or similar services or supplies;

36-7 (C) the availability of information to the
36-8 consumer regarding the amount accepted as payment in full for a
36-9 service or supply;

36-10 (D) the effects on consumers of differing amounts
36-11 accepted as payment in full; and

36-12 (E) potential methods for improving consumers'
36-13 access to information in relation to the amounts accepted as
36-14 payment in full for health care services or supplies, including the
36-15 feasibility and desirability of requiring providers to:

36-16 (i) publicly post the amount that is
36-17 accepted as payment in full for a service or supply; and

36-18 (ii) adhere to the posted amount.

36-19 (b) The Texas Institute of Health Care Quality and
36-20 Efficiency shall submit a report to the legislature outlining the
36-21 results of the study conducted under this section and any
36-22 recommendations for potential legislation not later than January 1,
36-23 2013.

36-24 (c) This section expires September 1, 2013.

36-25 ARTICLE 4. HEALTH CARE COLLABORATIVES

36-26 SECTION 4.01. Subtitle C, Title 6, Insurance Code, is
36-27 amended by adding Chapter 848 to read as follows:

36-28 CHAPTER 848. HEALTH CARE COLLABORATIVES

36-29 SUBCHAPTER A. GENERAL PROVISIONS

36-30 Sec. 848.001. DEFINITIONS. In this chapter:

36-31 (1) "Affiliate" means a person who controls, is
36-32 controlled by, or is under common control with one or more other
36-33 persons.

36-34 (2) "Health care collaborative" means an entity:

36-35 (A) that undertakes to arrange for medical and
36-36 health care services for insurers, health maintenance
36-37 organizations, and other payors in exchange for payments in cash or
36-38 in kind;

36-39 (B) that accepts and distributes payments for
36-40 medical and health care services;

36-41 (C) that consists of:

36-42 (i) physicians;

36-43 (ii) physicians and other health care
36-44 providers;

36-45 (iii) physicians and insurers or health
36-46 maintenance organizations; or

36-47 (iv) physicians, other health care
36-48 providers, and insurers or health maintenance organizations; and

36-49 (D) that is certified by the commissioner under
36-50 this chapter to lawfully accept and distribute payments to
36-51 physicians and other health care providers using the reimbursement
36-52 methodologies authorized by this chapter.

36-53 (3) "Health care services" means services provided by
36-54 a physician or health care provider to prevent, alleviate, cure, or
36-55 heal human illness or injury. The term includes:

36-56 (A) pharmaceutical services;

36-57 (B) medical, chiropractic, or dental care; and

36-58 (C) hospitalization.

36-59 (4) "Health care provider" means any person,
36-60 partnership, professional association, corporation, facility, or
36-61 institution licensed, certified, registered, or chartered by this
36-62 state to provide health care services. The term includes a hospital
36-63 but does not include a physician.

36-64 (5) "Health maintenance organization" means an
36-65 organization operating under Chapter 843.

36-66 (6) "Hospital" means a general or special hospital,
36-67 including a public or private institution licensed under Chapter
36-68 241 or 577, Health and Safety Code.

36-69 (7) "Institute" means the Texas Institute of Health

37-1 Care Quality and Efficiency established under Chapter 1002, Health
 37-2 and Safety Code.

37-3 (8) "Physician" means:

37-4 (A) an individual licensed to practice medicine
 37-5 in this state;

37-6 (B) a professional association organized under
 37-7 the Texas Professional Association Act (Article 1528f, Vernon's
 37-8 Texas Civil Statutes) or the Texas Professional Association Law by
 37-9 an individual or group of individuals licensed to practice medicine
 37-10 in this state;

37-11 (C) a partnership or limited liability
 37-12 partnership formed by a group of individuals licensed to practice
 37-13 medicine in this state;

37-14 (D) a nonprofit health corporation certified
 37-15 under Section 162.001, Occupations Code;

37-16 (E) a company formed by a group of individuals
 37-17 licensed to practice medicine in this state under the Texas Limited
 37-18 Liability Company Act (Article 1528n, Vernon's Texas Civil
 37-19 Statutes) or the Texas Professional Limited Liability Company Law;
 37-20 or

37-21 (F) an organization wholly owned and controlled
 37-22 by individuals licensed to practice medicine in this state.

37-23 (9) "Potentially preventable event" has the meaning
 37-24 assigned by Section 1002.001, Health and Safety Code.

37-25 Sec. 848.002. EXCEPTION: DELEGATED ENTITIES. (a) This
 37-26 section applies only to an entity, other than a health maintenance
 37-27 organization, that:

37-28 (1) by itself or through a subcontract with another
 37-29 entity, undertakes to arrange for or provide medical care or health
 37-30 care services to enrollees in exchange for predetermined payments
 37-31 on a prospective basis; and

37-32 (2) accepts responsibility for performing functions
 37-33 that are required by:

37-34 (A) Chapter 222, 251, 258, or 1272, as
 37-35 applicable, to a health maintenance organization; or

37-36 (B) Chapter 843, Chapter 1271, Section 1367.053,
 37-37 Subchapter A, Chapter 1452, or Subchapter B, Chapter 1507, as
 37-38 applicable, solely on behalf of health maintenance organizations.

37-39 (b) An entity described by Subsection (a) is subject to
 37-40 Chapter 1272 and is not required to obtain a certificate of
 37-41 authority or determination of approval under this chapter.

37-42 Sec. 848.003. USE OF INSURANCE-RELATED TERMS BY HEALTH CARE
 37-43 COLLABORATIVE. A health care collaborative that is not an insurer
 37-44 or health maintenance organization may not use in its name,
 37-45 contracts, or literature:

37-46 (1) the following words or initials:

37-47 (A) "insurance";

37-48 (B) "casualty";

37-49 (C) "surety";

37-50 (D) "mutual";

37-51 (E) "health maintenance organization"; or

37-52 (F) "HMO"; or

37-53 (2) any other words or initials that are:

37-54 (A) descriptive of the insurance, casualty,
 37-55 surety, or health maintenance organization business; or

37-56 (B) deceptively similar to the name or
 37-57 description of an insurer, surety corporation, or health
 37-58 maintenance organization engaging in business in this state.

37-59 Sec. 848.004. APPLICABILITY OF INSURANCE LAWS. (a) An
 37-60 organization may not arrange for or provide health care services to
 37-61 enrollees on a prepaid or indemnity basis through health insurance
 37-62 or a health benefit plan, including a health care plan, as defined
 37-63 by Section 843.002, unless the organization as an insurer or health
 37-64 maintenance organization holds the appropriate certificate of
 37-65 authority issued under another chapter of this code.

37-66 (b) Except as provided by Subsection (c), the following
 37-67 provisions of this code apply to a health care collaborative in the
 37-68 same manner and to the same extent as they apply to an individual or
 37-69 entity otherwise subject to the provision:

38-1 (1) Section 38.001;
38-2 (2) Subchapter A, Chapter 542;
38-3 (3) Chapter 541;
38-4 (4) Chapter 543;
38-5 (5) Chapter 602;
38-6 (6) Chapter 701;
38-7 (7) Chapter 803; and
38-8 (8) Chapter 804.
38-9 (c) The remedies available under this chapter in the manner
38-10 provided by Chapter 541 do not include:
38-11 (1) a private cause of action under Subchapter D,
38-12 Chapter 541; or
38-13 (2) a class action under Subchapter F, Chapter 541.
38-14 Sec. 848.005. CERTAIN INFORMATION CONFIDENTIAL.
38-15 (a) Except as provided by Subsection (b), an application, filing,
38-16 or report required under this chapter is public information subject
38-17 to disclosure under Chapter 552, Government Code.
38-18 (b) The following information is confidential and is not
38-19 subject to disclosure under Chapter 552, Government Code:
38-20 (1) a contract, agreement, or document that
38-21 establishes another arrangement:
38-22 (A) between a health care collaborative and a
38-23 governmental or private entity for all or part of health care
38-24 services provided or arranged for by the health care collaborative;
38-25 or
38-26 (B) between a health care collaborative and
38-27 participating physicians and health care providers;
38-28 (2) a written description of a contract, agreement, or
38-29 other arrangement described by Subdivision (1);
38-30 (3) information relating to bidding, pricing, or other
38-31 trade secrets submitted to:
38-32 (A) the department under Sections 848.057(a)(5)
38-33 and (6); or
38-34 (B) the attorney general under Section 848.059;
38-35 (4) information relating to the diagnosis, treatment,
38-36 or health of a patient who receives health care services from a
38-37 health care collaborative under a contract for services; and
38-38 (5) information relating to quality improvement or
38-39 peer review activities of a health care collaborative.
38-40 Sec. 848.006. COVERAGE BY HEALTH CARE COLLABORATIVE NOT
38-41 REQUIRED. (a) Except as provided by Subsection (b) and subject to
38-42 Chapter 843 and Section 1301.0625, an individual may not be
38-43 required to obtain or maintain coverage under:
38-44 (1) an individual health insurance policy written
38-45 through a health care collaborative; or
38-46 (2) any plan or program for health care services
38-47 provided on an individual basis through a health care
38-48 collaborative.
38-49 (b) This chapter does not require an individual to obtain or
38-50 maintain health insurance coverage.
38-51 (c) Subsection (a) does not apply to an individual:
38-52 (1) who is required to obtain or maintain health
38-53 benefit plan coverage:
38-54 (A) written by an institution of higher education
38-55 at which the individual is or will be enrolled as a student; or
38-56 (B) under an order requiring medical support for
38-57 a child; or
38-58 (2) who voluntarily applies for benefits under a state
38-59 administered program under Title XIX of the Social Security Act (42
38-60 U.S.C. Section 1396 et seq.), or Title XXI of the Social Security
38-61 Act (42 U.S.C. Section 1397aa et seq.).
38-62 (d) Except as provided by Subsection (e), a fine or penalty
38-63 may not be imposed on an individual if the individual chooses not to
38-64 obtain or maintain coverage described by Subsection (a).
38-65 (e) Subsection (d) does not apply to a fine or penalty
38-66 imposed on an individual described in Subsection (c) for the
38-67 individual's failure to obtain or maintain health benefit plan
38-68 coverage.
38-69 [Sections 848.007-848.050 reserved for expansion]

39-1 SUBCHAPTER B. AUTHORITY TO ENGAGE IN BUSINESS

39-2 Sec. 848.051. OPERATION OF HEALTH CARE COLLABORATIVE. A
 39-3 health care collaborative that is certified by the department under
 39-4 this chapter may provide or arrange to provide health care services
 39-5 under contract with a governmental or private entity.

39-6 Sec. 848.052. FORMATION AND GOVERNANCE OF HEALTH CARE
 39-7 COLLABORATIVE. (a) A health care collaborative is governed by a
 39-8 board of directors.

39-9 (b) The person who establishes a health care collaborative
 39-10 shall appoint an initial board of directors. Each member of the
 39-11 initial board serves a term of not more than 18 months. Subsequent
 39-12 members of the board shall be elected to serve two-year terms by
 39-13 physicians and health care providers who participate in the health
 39-14 care collaborative as provided by this section. The board shall
 39-15 elect a chair from among its members.

39-16 (c) If the participants in a health care collaborative are
 39-17 all physicians, each member of the board of directors must be an
 39-18 individual physician who is a participant in the health care
 39-19 collaborative.

39-20 (d) If the participants in a health care collaborative are
 39-21 both physicians and other health care providers, the board of
 39-22 directors must consist of:

39-23 (1) an even number of members who are individual
 39-24 physicians, selected by physicians who participate in the health
 39-25 care collaborative;

39-26 (2) a number of members equal to the number of members
 39-27 under Subdivision (1) who represent health care providers, one of
 39-28 whom is an individual physician, selected by health care providers
 39-29 who participate in the health care collaborative; and

39-30 (3) one individual member with business expertise,
 39-31 selected by unanimous vote of the members described by Subdivisions
 39-32 (1) and (2).

39-33 (e) The board of directors must include at least three
 39-34 nonvoting ex officio members who represent the community in which
 39-35 the health care collaborative operates.

39-36 (f) An individual may not serve on the board of directors of
 39-37 a health care collaborative if the individual has an ownership
 39-38 interest in, serves on the board of directors of, or maintains an
 39-39 officer position with:

39-40 (1) another health care collaborative that provides
 39-41 health care services in the same service area as the health care
 39-42 collaborative; or

39-43 (2) a physician or health care provider that:
 39-44 (A) does not participate in the health care
 39-45 collaborative; and

39-46 (B) provides health care services in the same
 39-47 service area as the health care collaborative.

39-48 (g) In addition to the requirements of Subsection (f), the
 39-49 board of directors of a health care collaborative shall adopt a
 39-50 conflict of interest policy to be followed by members.

39-51 (h) The board of directors may remove a member for cause. A
 39-52 member may not be removed from the board without cause.

39-53 (i) The organizational documents of a health care
 39-54 collaborative may not conflict with any provision of this chapter,
 39-55 including this section.

39-56 Sec. 848.053. COMPENSATION ADVISORY COMMITTEE; SHARING OF
 39-57 CERTAIN DATA. (a) The board of directors of a health care
 39-58 collaborative shall establish a compensation advisory committee to
 39-59 develop and make recommendations to the board regarding charges,
 39-60 fees, payments, distributions, or other compensation assessed for
 39-61 health care services provided by physicians or health care
 39-62 providers who participate in the health care collaborative. The
 39-63 committee must include:

39-64 (1) a member of the board of directors; and

39-65 (2) if the health care collaborative consists of
 39-66 physicians and other health care providers:

39-67 (A) a physician who is not a participant in the
 39-68 health care collaborative, selected by the physicians who are
 39-69 participants in the collaborative; and

40-1 (B) a member selected by the other health care
 40-2 providers who participate in the collaborative.

40-3 (b) A health care collaborative shall establish and enforce
 40-4 policies to prevent the sharing of charge, fee, and payment data
 40-5 among nonparticipating physicians and health care providers.

40-6 Sec. 848.054. CERTIFICATE OF AUTHORITY AND DETERMINATION OF
 40-7 APPROVAL REQUIRED. (a) An organization may not organize or
 40-8 operate a health care collaborative in this state unless the
 40-9 organization holds a certificate of authority issued under this
 40-10 chapter.

40-11 (b) The commissioner shall adopt rules governing the
 40-12 application for a certificate of authority under this subchapter.

40-13 Sec. 848.055. EXCEPTIONS. (a) An organization is not
 40-14 required to obtain a certificate of authority under this chapter if
 40-15 the organization holds an appropriate certificate of authority
 40-16 issued under another chapter of this code.

40-17 (b) A person is not required to obtain a certificate of
 40-18 authority under this chapter to the extent that the person is:

40-19 (1) a physician engaged in the delivery of medical
 40-20 care; or

40-21 (2) a health care provider engaged in the delivery of
 40-22 health care services other than medical care as part of a health
 40-23 maintenance organization delivery network.

40-24 (c) A medical school, medical and dental unit, or health
 40-25 science center as described by Section 61.003, 61.501, or 74.601,
 40-26 Education Code, is not required to obtain a certificate of
 40-27 authority under this chapter to the extent that the medical school,
 40-28 medical and dental unit, or health science center contracts to
 40-29 deliver medical care services within a health care collaborative.
 40-30 This chapter is otherwise applicable to a medical school, medical
 40-31 and dental unit, or health science center.

40-32 (d) An entity licensed under the Health and Safety Code that
 40-33 employs a physician under a specific statutory authority is not
 40-34 required to obtain a certificate of authority under this chapter to
 40-35 the extent that the entity contracts to deliver medical care
 40-36 services and health care services within a health care
 40-37 collaborative. This chapter is otherwise applicable to the entity.

40-38 Sec. 848.056. APPLICATION FOR CERTIFICATE OF AUTHORITY.
 40-39 (a) An organization may apply to the commissioner for and obtain a
 40-40 certificate of authority to organize and operate a health care
 40-41 collaborative.

40-42 (b) An application for a certificate of authority must:

40-43 (1) comply with all rules adopted by the commissioner;
 40-44 (2) be verified under oath by the applicant or an
 40-45 officer or other authorized representative of the applicant;

40-46 (3) be reviewed by the division within the office of
 40-47 attorney general that is primarily responsible for enforcing the
 40-48 antitrust laws of this state and of the United States under Section
 40-49 848.059;

40-50 (4) demonstrate that the health care collaborative
 40-51 contracts with a sufficient number of primary care physicians in
 40-52 the health care collaborative's service area;

40-53 (5) state that enrollees may obtain care from any
 40-54 physician or health care provider in the health care collaborative;
 40-55 and

40-56 (6) identify a service area within which medical
 40-57 services are available and accessible to enrollees.

40-58 (c) Not later than the 190th day after the date an applicant
 40-59 submits an application to the commissioner under this section, the
 40-60 commissioner shall approve or deny the application.

40-61 (d) The commissioner by rule may:

40-62 (1) extend the date by which an application is due
 40-63 under this section; and

40-64 (2) require the disclosure of any additional
 40-65 information necessary to implement and administer this chapter,
 40-66 including information necessary to antitrust review and oversight.

40-67 Sec. 848.057. REQUIREMENTS FOR APPROVAL OF APPLICATION.
 40-68 (a) The commissioner shall issue a certificate of authority on
 40-69 payment of the application fee prescribed by Section 848.152 if the

41-1 commissioner is satisfied that:
41-2 (1) the applicant meets the requirements of Section
41-3 848.056;
41-4 (2) with respect to health care services to be
41-5 provided, the applicant:
41-6 (A) has demonstrated the willingness and
41-7 potential ability to ensure that the health care services will be
41-8 provided in a manner that:
41-9 (i) increases collaboration among health
41-10 care providers and integrates health care services;
41-11 (ii) promotes improvement in quality-based
41-12 health care outcomes, patient safety, patient engagement, and
41-13 coordination of services; and
41-14 (iii) reduces the occurrence of potentially
41-15 preventable events;
41-16 (B) has processes that contain health care costs
41-17 without jeopardizing the quality of patient care;
41-18 (C) has processes to develop, compile, evaluate,
41-19 and report statistics on performance measures relating to the
41-20 quality and cost of health care services, the pattern of
41-21 utilization of services, and the availability and accessibility of
41-22 services; and
41-23 (D) has processes to address complaints made by
41-24 patients receiving services provided through the organization;
41-25 (3) the applicant is in compliance with all rules
41-26 adopted by the commissioner under Section 848.151;
41-27 (4) the applicant has working capital and reserves
41-28 sufficient to operate and maintain the health care collaborative
41-29 and to arrange for services and expenses incurred by the health care
41-30 collaborative;
41-31 (5) the applicant's proposed health care collaborative
41-32 is not likely to reduce competition in any market for physician,
41-33 hospital, or ancillary health care services due to:
41-34 (A) the size of the health care collaborative; or
41-35 (B) the composition of the collaborative,
41-36 including the distribution of physicians by specialty within the
41-37 collaborative in relation to the number of competing health care
41-38 providers in the health care collaborative's geographic market; and
41-39 (6) the pro-competitive benefits of the applicant's
41-40 proposed health care collaborative are likely to substantially
41-41 outweigh the anticompetitive effects of any increase in market
41-42 power.
41-43 (b) A certificate of authority is effective for a period of
41-44 one year, subject to Section 848.060(d).
41-45 Sec. 848.058. DENIAL OF CERTIFICATE OF AUTHORITY. (a) The
41-46 commissioner may not issue a certificate of authority if the
41-47 commissioner determines that the applicant's proposed plan of
41-48 operation does not meet the requirements of Section 848.057.
41-49 (b) If the commissioner denies an application for a
41-50 certificate of authority under Subsection (a), the commissioner
41-51 shall notify the applicant that the plan is deficient and specify
41-52 the deficiencies.
41-53 Sec. 848.059. CONCURRENCE OF ATTORNEY GENERAL. (a) If the
41-54 commissioner determines that an application for a certificate of
41-55 authority filed under Section 848.056 complies with the
41-56 requirements of Section 848.057, the commissioner shall forward the
41-57 application, and all data, documents, and analysis considered by
41-58 the commissioner in making the determination, to the attorney
41-59 general. The attorney general shall review the application and the
41-60 data, documents, and analysis and, if the attorney general concurs
41-61 with the commissioner's determination under Sections 848.057(a)(5)
41-62 and (6), the attorney general shall notify the commissioner.
41-63 (b) If the attorney general does not concur with the
41-64 commissioner's determination under Sections 848.057(a)(5) and (6),
41-65 the attorney general shall notify the commissioner.
41-66 (c) A determination under this section shall be made not
41-67 later than the 60th day after the date the attorney general receives
41-68 the application and the data, documents, and analysis from the
41-69 commissioner.

42-1 (d) If the attorney general lacks sufficient information to
 42-2 make a determination under Sections 848.057(a)(5) and (6), within
 42-3 60 days of the attorney general's receipt of the application and the
 42-4 data, documents, and analysis the attorney general shall inform the
 42-5 commissioner that the attorney general lacks sufficient
 42-6 information as well as what information the attorney general
 42-7 requires. The commissioner shall then either provide the
 42-8 additional information to the attorney general or request the
 42-9 additional information from the applicant. The commissioner shall
 42-10 promptly deliver any such additional information to the attorney
 42-11 general. The attorney general shall then have 30 days from receipt
 42-12 of the additional information to make a determination under
 42-13 Subsection (a) or (b).

42-14 (e) If the attorney general notifies the commissioner that
 42-15 the attorney general does not concur with the commissioner's
 42-16 determination under Sections 848.057(a)(5) and (6), then,
 42-17 notwithstanding any other provision of this subchapter, the
 42-18 commissioner shall deny the application.

42-19 (f) In reviewing the commissioner's determination, the
 42-20 attorney general shall consider the findings, conclusions, or
 42-21 analyses contained in any other governmental entity's evaluation of
 42-22 the health care collaborative.

42-23 (g) The attorney general at any time may request from the
 42-24 commissioner additional time to consider an application under this
 42-25 section. The commissioner shall grant the request and notify the
 42-26 applicant of the request. A request by the attorney general or an
 42-27 order by the commissioner granting a request under this section is
 42-28 not subject to administrative or judicial review.

42-29 Sec. 848.060. RENEWAL OF CERTIFICATE OF AUTHORITY AND
 42-30 DETERMINATION OF APPROVAL. (a) Not later than the 180th day
 42-31 before the one-year anniversary of the date on which a health care
 42-32 collaborative's certificate of authority was issued or most
 42-33 recently renewed, the health care collaborative shall file with the
 42-34 commissioner an application to renew the certificate.

42-35 (b) An application for renewal must:

42-36 (1) be verified by at least two principal officers of
 42-37 the health care collaborative; and

42-38 (2) include:

42-39 (A) a financial statement of the health care
 42-40 collaborative, including a balance sheet and receipts and
 42-41 disbursements for the preceding calendar year, certified by an
 42-42 independent certified public accountant;

42-43 (B) a description of the service area of the
 42-44 health care collaborative;

42-45 (C) a description of the number and types of
 42-46 physicians and health care providers participating in the health
 42-47 care collaborative;

42-48 (D) an evaluation of the quality and cost of
 42-49 health care services provided by the health care collaborative;

42-50 (E) an evaluation of the health care
 42-51 collaborative's processes to promote evidence-based medicine,
 42-52 patient engagement, and coordination of health care services
 42-53 provided by the health care collaborative;

42-54 (F) the number, nature, and disposition of any
 42-55 complaints filed with the health care collaborative under Section
 42-56 848.107; and

42-57 (G) any other information required by the
 42-58 commissioner.

42-59 (c) If a completed application for renewal is filed under
 42-60 this section:

42-61 (1) the commissioner shall conduct a review under
 42-62 Section 848.057 as if the application for renewal were a new
 42-63 application, and, on approval by the commissioner, the attorney
 42-64 general shall review the application under Section 848.059 as if
 42-65 the application for renewal were a new application; and

42-66 (2) the commissioner shall renew or deny the renewal
 42-67 of a certificate of authority at least 20 days before the one-year
 42-68 anniversary of the date on which a health care collaborative's
 42-69 certificate of authority was issued.

43-1 (d) If the commissioner does not act on a renewal
 43-2 application before the one-year anniversary of the date on which a
 43-3 health care collaborative's certificate of authority was issued or
 43-4 renewed, the health care collaborative's certificate of authority
 43-5 expires on the 90th day after the date of the one-year anniversary
 43-6 unless the renewal of the certificate of authority or determination
 43-7 of approval, as applicable, is approved before that date.

43-8 (e) A health care collaborative shall report to the
 43-9 department a material change in the size or composition of the
 43-10 collaborative. On receipt of a report under this subsection, the
 43-11 department may require the collaborative to file an application for
 43-12 renewal before the date required by Subsection (a).

43-13 [Sections 848.061-848.100 reserved for expansion]

43-14 SUBCHAPTER C. GENERAL POWERS AND DUTIES OF HEALTH CARE
 43-15 COLLABORATIVE

43-16 Sec. 848.101. PROVIDING OR ARRANGING FOR SERVICES. (a) A
 43-17 health care collaborative may provide or arrange for health care
 43-18 services through contracts with physicians and health care
 43-19 providers or with entities contracting on behalf of participating
 43-20 physicians and health care providers.

43-21 (b) A health care collaborative may not prohibit a physician
 43-22 or other health care provider, as a condition of participating in
 43-23 the health care collaborative, from participating in another health
 43-24 care collaborative.

43-25 (c) A health care collaborative may not use a covenant not
 43-26 to compete to prohibit a physician from providing medical services
 43-27 or participating in another health care collaborative in the same
 43-28 service area.

43-29 (d) Except as provided by Subsection (f), on written consent
 43-30 of a patient who was treated by a physician participating in a
 43-31 health care collaborative, the health care collaborative shall
 43-32 provide the physician with the medical records of the patient,
 43-33 regardless of whether the physician is participating in the health
 43-34 care collaborative at the time the request for the records is made.

43-35 (e) Records provided under Subsection (d) shall be made
 43-36 available to the physician in the format in which the records are
 43-37 maintained by the health care collaborative. The health care
 43-38 collaborative may charge the physician a fee for copies of the
 43-39 records, as established by the Texas Medical Board.

43-40 (f) If a physician requests a patient's records from a
 43-41 health care collaborative under Subsection (d) for the purpose of
 43-42 providing emergency treatment to the patient:

43-43 (1) the health care collaborative may not charge a fee
 43-44 to the physician under Subsection (e); and

43-45 (2) the health care collaborative shall provide the
 43-46 records to the physician regardless of whether the patient has
 43-47 provided written consent.

43-48 Sec. 848.102. INSURANCE, REINSURANCE, INDEMNITY, AND
 43-49 REIMBURSEMENT. A health care collaborative may contract with an
 43-50 insurer authorized to engage in business in this state to provide
 43-51 insurance, reinsurance, indemnification, or reimbursement against
 43-52 the cost of health care and medical care services provided by the
 43-53 health care collaborative. This section does not affect the
 43-54 requirement that the health care collaborative maintain sufficient
 43-55 working capital and reserves.

43-56 Sec. 848.103. PAYMENT BY GOVERNMENTAL OR PRIVATE ENTITY.

43-57 (a) A health care collaborative may:

43-58 (1) contract for and accept payments from a
 43-59 governmental or private entity for all or part of the cost of
 43-60 services provided or arranged for by the health care collaborative;
 43-61 and

43-62 (2) distribute payments to participating physicians
 43-63 and health care providers.

43-64 (b) Notwithstanding any other law, a health care
 43-65 collaborative that is in compliance with this code, including
 43-66 Chapters 841, 842, and 843, as applicable, may contract for,
 43-67 accept, and distribute payments from governmental or private payors
 43-68 based on fee-for-service or alternative payment mechanisms,
 43-69 including:

44-1 (1) episode-based or condition-based bundled
 44-2 payments;
 44-3 (2) capitation or global payments; or
 44-4 (3) pay-for-performance or quality-based payments.

44-5 (c) Except as provided by Subsection (d), a health care
 44-6 collaborative may not contract for and accept from a governmental
 44-7 or private entity payments on a prospective basis, including
 44-8 bundled or global payments, unless the health care collaborative is
 44-9 licensed under Chapter 843.

44-10 (d) A health care collaborative may contract for and accept
 44-11 from an insurance company or a health maintenance organization
 44-12 payments on a prospective basis, including bundled or global
 44-13 payments.

44-14 Sec. 848.104. CONTRACTS FOR ADMINISTRATIVE OR MANAGEMENT
 44-15 SERVICES. A health care collaborative may contract with any
 44-16 person, including an affiliated entity, to perform administrative,
 44-17 management, or any other required business functions on behalf of
 44-18 the health care collaborative.

44-19 Sec. 848.105. CORPORATION, PARTNERSHIP, OR ASSOCIATION
 44-20 POWERS. A health care collaborative has all powers of a
 44-21 partnership, association, corporation, or limited liability
 44-22 company, including a professional association or corporation, as
 44-23 appropriate under the organizational documents of the health care
 44-24 collaborative, that are not in conflict with this chapter or other
 44-25 applicable law.

44-26 Sec. 848.106. QUALITY AND COST OF HEALTH CARE SERVICES.
 44-27 (a) A health care collaborative shall establish policies to
 44-28 improve the quality and control the cost of health care services
 44-29 provided by participating physicians and health care providers that
 44-30 are consistent with prevailing professionally recognized standards
 44-31 of medical practice. The policies must include standards and
 44-32 procedures relating to:

44-33 (1) the selection and credentialing of participating
 44-34 physicians and health care providers;

44-35 (2) the development, implementation, monitoring, and
 44-36 evaluation of evidence-based best practices and other processes to
 44-37 improve the quality and control the cost of health care services
 44-38 provided by participating physicians and health care providers,
 44-39 including practices or processes to reduce the occurrence of
 44-40 potentially preventable events;

44-41 (3) the development, implementation, monitoring, and
 44-42 evaluation of processes to improve patient engagement and
 44-43 coordination of health care services provided by participating
 44-44 physicians and health care providers; and

44-45 (4) complaints initiated by participating physicians,
 44-46 health care providers, and patients under Section 848.107.

44-47 (b) The governing body of a health care collaborative shall
 44-48 establish a procedure for the periodic review of quality
 44-49 improvement and cost control measures.

44-50 Sec. 848.107. COMPLAINT SYSTEMS. (a) A health care
 44-51 collaborative shall implement and maintain complaint systems that
 44-52 provide reasonable procedures to resolve an oral or written
 44-53 complaint initiated by:

44-54 (1) a patient who received health care services
 44-55 provided by a participating physician or health care provider; or

44-56 (2) a participating physician or health care provider.

44-57 (b) The complaint system for complaints initiated by
 44-58 patients must include a process for the notice and appeal of a
 44-59 complaint.

44-60 (c) A health care collaborative may not take a retaliatory
 44-61 or adverse action against a physician or health care provider who
 44-62 files a complaint with a regulatory authority regarding an action
 44-63 of the health care collaborative.

44-64 Sec. 848.108. DELEGATION AGREEMENTS. (a) Except as
 44-65 provided by Subsection (b), a health care collaborative that enters
 44-66 into a delegation agreement described by Section 1272.001 is
 44-67 subject to the requirements of Chapter 1272 in the same manner as a
 44-68 health maintenance organization.

44-69 (b) Section 1272.301 does not apply to a delegation

45-1 agreement entered into by a health care collaborative.

45-2 (c) A health care collaborative may enter into a delegation
45-3 agreement with an entity licensed under Chapter 841, 842, or 883 if
45-4 the delegation agreement assigns to the entity responsibility for:

45-5 (1) a function regulated by:

45-6 (A) Chapter 222;

45-7 (B) Chapter 841;

45-8 (C) Chapter 842;

45-9 (D) Chapter 883;

45-10 (E) Chapter 1272;

45-11 (F) Chapter 1301;

45-12 (G) Chapter 4201;

45-13 (H) Section 1367.053; or

45-14 (I) Subchapter A, Chapter 1507; or

45-15 (2) another function specified by commissioner rule.

45-16 (d) A health care collaborative that enters into a
45-17 delegation agreement under this section shall maintain reserves and
45-18 capital in addition to the amounts required under Chapter 1272, in
45-19 an amount and form determined by rule of the commissioner to be
45-20 necessary for the liabilities and risks assumed by the health care
45-21 collaborative.

45-22 (e) A health care collaborative that enters into a
45-23 delegation agreement under this section is subject to Chapters 404,
45-24 441, and 443 and is considered to be an insurer for purposes of
45-25 those chapters.

45-26 Sec. 848.109. VALIDITY OF OPERATIONS AND TRADE PRACTICES OF
45-27 HEALTH CARE COLLABORATIVES. The operations and trade practices of
45-28 a health care collaborative that are consistent with the provisions
45-29 of this chapter, the rules adopted under this chapter, and
45-30 applicable federal antitrust laws are presumed to be consistent
45-31 with Chapter 15, Business & Commerce Code, or any other applicable
45-32 provision of law.

45-33 Sec. 848.110. RIGHTS OF PHYSICIANS; LIMITATIONS ON
45-34 PARTICIPATION. (a) Before a complaint against a physician under
45-35 Section 848.107 is resolved, or before a physician's association
45-36 with a health care collaborative is terminated, the physician is
45-37 entitled to an opportunity to dispute the complaint or termination
45-38 through a process that includes:

45-39 (1) written notice of the complaint or basis of the
45-40 termination;

45-41 (2) an opportunity for a hearing not earlier than the
45-42 30th day after receiving notice under Subdivision (1);

45-43 (3) the right to provide information at the hearing,
45-44 including testimony and a written statement; and

45-45 (4) a written decision that includes the specific
45-46 facts and reasons for the decision.

45-47 (b) A health care collaborative may limit a physician or
45-48 group of physicians from participating in the health care
45-49 collaborative if the limitation is based on an established
45-50 development plan approved by the board of directors. Each
45-51 applicant physician or group shall be provided with a copy of the
45-52 development plan.

45-53 [Sections 848.111-848.150 reserved for expansion]

45-54 SUBCHAPTER D. REGULATION OF HEALTH CARE COLLABORATIVES

45-55 Sec. 848.151. RULES. The commissioner and the attorney
45-56 general may adopt reasonable rules as necessary and proper to
45-57 implement the requirements of this chapter.

45-58 Sec. 848.152. FEES AND ASSESSMENTS. (a) The commissioner
45-59 shall, within the limits prescribed by this section, prescribe the
45-60 fees to be charged and the assessments to be imposed under this
45-61 section.

45-62 (b) Amounts collected under this section shall be deposited
45-63 to the credit of the Texas Department of Insurance operating
45-64 account.

45-65 (c) A health care collaborative shall pay to the department:

45-66 (1) an application fee in an amount determined by
45-67 commissioner rule; and

45-68 (2) an annual assessment in an amount determined by
45-69 commissioner rule.

46-1 (d) The commissioner shall set fees and assessments under
 46-2 this section in an amount sufficient to pay the reasonable expenses
 46-3 of the department and attorney general in administering this
 46-4 chapter, including the direct and indirect expenses incurred by the
 46-5 department and attorney general in examining and reviewing health
 46-6 care collaboratives. Fees and assessments imposed under this
 46-7 section shall be allocated among health care collaboratives on a
 46-8 pro rata basis to the extent that the allocation is feasible.

46-9 Sec. 848.153. EXAMINATIONS. (a) The commissioner may
 46-10 examine the financial affairs and operations of any health care
 46-11 collaborative or applicant for a certificate of authority under
 46-12 this chapter.

46-13 (b) A health care collaborative shall make its books and
 46-14 records relating to its financial affairs and operations available
 46-15 for an examination by the commissioner or attorney general.

46-16 (c) On request of the commissioner or attorney general, a
 46-17 health care collaborative shall provide to the commissioner or
 46-18 attorney general, as applicable:

46-19 (1) a copy of any contract, agreement, or other
 46-20 arrangement between the health care collaborative and a physician
 46-21 or health care provider; and

46-22 (2) a general description of the fee arrangements
 46-23 between the health care collaborative and the physician or health
 46-24 care provider.

46-25 (d) Documentation provided to the commissioner or attorney
 46-26 general under this section is confidential and is not subject to
 46-27 disclosure under Chapter 552, Government Code.

46-28 (e) The commissioner or attorney general may disclose the
 46-29 results of an examination conducted under this section or
 46-30 documentation provided under this section to a governmental agency
 46-31 that contracts with a health care collaborative for the purpose of
 46-32 determining financial stability, readiness, or other contractual
 46-33 compliance needs.

46-34 [Sections 848.154-848.200 reserved for expansion]

46-35 SUBCHAPTER E. ENFORCEMENT

46-36 Sec. 848.201. ENFORCEMENT ACTIONS. (a) After notice and
 46-37 opportunity for a hearing, the commissioner may:

46-38 (1) suspend or revoke a certificate of authority
 46-39 issued to a health care collaborative under this chapter;

46-40 (2) impose sanctions under Chapter 82;

46-41 (3) issue a cease and desist order under Chapter 83; or

46-42 (4) impose administrative penalties under Chapter 84.

46-43 (b) The commissioner may take an enforcement action listed
 46-44 in Subsection (a) against a health care collaborative if the
 46-45 commissioner finds that the health care collaborative:

46-46 (1) is operating in a manner that is:

46-47 (A) significantly contrary to its basic
 46-48 organizational documents; or

46-49 (B) contrary to the manner described in and
 46-50 reasonably inferred from other information submitted under Section
 46-51 848.057;

46-52 (2) does not meet the requirements of Section 848.057;

46-53 (3) cannot fulfill its obligation to provide health
 46-54 care services as required under its contracts with governmental or
 46-55 private entities;

46-56 (4) does not meet the requirements of Chapter 1272, if
 46-57 applicable;

46-58 (5) has not implemented the complaint system required
 46-59 by Section 848.107 in a manner to resolve reasonably valid
 46-60 complaints;

46-61 (6) has advertised or merchandised its services in an
 46-62 untrue, misrepresentative, misleading, deceptive, or unfair manner
 46-63 or a person on behalf of the health care collaborative has
 46-64 advertised or merchandised the health care collaborative's
 46-65 services in an untrue, misrepresentative, misleading, deceptive,
 46-66 or unfair manner;

46-67 (7) has not complied substantially with this chapter
 46-68 or a rule adopted under this chapter;

46-69 (8) has not taken corrective action the commissioner

47-1 considers necessary to correct a failure to comply with this
 47-2 chapter, any applicable provision of this code, or any applicable
 47-3 rule or order of the commissioner not later than the 30th day after
 47-4 the date of notice of the failure or within any longer period
 47-5 specified in the notice and determined by the commissioner to be
 47-6 reasonable; or

47-7 (9) has or is utilizing market power in an
 47-8 anticompetitive manner, in accordance with established antitrust
 47-9 principles of market power analysis.

47-10 Sec. 848.202. OPERATIONS DURING SUSPENSION OR AFTER
 47-11 REVOCAION OF CERTIFICATE OF AUTHORITY. (a) During the period a
 47-12 certificate of authority of a health care collaborative is
 47-13 suspended, the health care collaborative may not:

47-14 (1) enter into a new contract with a governmental or
 47-15 private entity; or

47-16 (2) advertise or solicit in any way.

47-17 (b) After a certificate of authority of a health care
 47-18 collaborative is revoked, the health care collaborative:

47-19 (1) shall proceed, immediately following the
 47-20 effective date of the order of revocation, to conclude its affairs;

47-21 (2) may not conduct further business except as
 47-22 essential to the orderly conclusion of its affairs; and

47-23 (3) may not advertise or solicit in any way.

47-24 (c) Notwithstanding Subsection (b), the commissioner may,
 47-25 by written order, permit the further operation of the health care
 47-26 collaborative to the extent that the commissioner finds necessary
 47-27 to serve the best interest of governmental or private entities that
 47-28 have entered into contracts with the health care collaborative.

47-29 Sec. 848.203. INJUNCTIONS. If the commissioner believes
 47-30 that a health care collaborative or another person is violating or
 47-31 has violated this chapter or a rule adopted under this chapter, the
 47-32 attorney general at the request of the commissioner may bring an
 47-33 action in a Travis County district court to enjoin the violation and
 47-34 obtain other relief if the court considers appropriate.

47-35 Sec. 848.204. NOTICE. The commissioner shall:

47-36 (1) report any action taken under this subchapter to:

47-37 (A) the relevant state licensing or certifying
 47-38 agency or board; and

47-39 (B) the United States Department of Health and
 47-40 Human Services National Practitioner Data Bank; and

47-41 (2) post notice of the action on the department's
 47-42 Internet website.

47-43 Sec. 848.205. INDEPENDENT AUTHORITY OF ATTORNEY GENERAL.

47-44 (a) The attorney general may:

47-45 (1) investigate a health care collaborative with
 47-46 respect to anticompetitive behavior that is contrary to the goals
 47-47 and requirements of this chapter; and

47-48 (2) request that the commissioner:

47-49 (A) impose a penalty or sanction;

47-50 (B) issue a cease and desist order; or

47-51 (C) suspend or revoke the health care
 47-52 collaborative's certificate of authority.

47-53 (b) This section does not limit any other authority or power
 47-54 of the attorney general.

47-55 SECTION 4.02. Paragraph (A), Subdivision (12), Subsection
 47-56 (a), Section 74.001, Civil Practice and Remedies Code, is amended
 47-57 to read as follows:

47-58 (A) "Health care provider" means any person,
 47-59 partnership, professional association, corporation, facility, or
 47-60 institution duly licensed, certified, registered, or chartered by
 47-61 the State of Texas to provide health care, including:

47-62 (i) a registered nurse;

47-63 (ii) a dentist;

47-64 (iii) a podiatrist;

47-65 (iv) a pharmacist;

47-66 (v) a chiropractor;

47-67 (vi) an optometrist; ~~or~~

47-68 (vii) a health care institution; or

47-69 (viii) a health care collaborative

48-1 certified under Chapter 848, Insurance Code.

48-2 SECTION 4.03. Subchapter B, Chapter 1301, Insurance Code,
48-3 is amended by adding Section 1301.0625 to read as follows:

48-4 Sec. 1301.0625. HEALTH CARE COLLABORATIVES. (a) Subject
48-5 to the requirements of this chapter, a health care collaborative
48-6 may be designated as a preferred provider under a preferred
48-7 provider benefit plan and may offer enhanced benefits for care
48-8 provided by the health care collaborative.

48-9 (b) A preferred provider contract between an insurer and a
48-10 health care collaborative may use a payment methodology other than
48-11 a fee-for-service or discounted fee methodology. A reimbursement
48-12 methodology used in a contract under this subsection is not subject
48-13 to Chapter 843.

48-14 (c) A contract authorized by Subsection (b) must specify
48-15 that the health care collaborative and the physicians or providers
48-16 providing health care services on behalf of the collaborative will
48-17 hold an insured harmless for payment of the cost of covered health
48-18 care services if the insurer or the health care collaborative do not
48-19 pay the physician or health care provider for the services.

48-20 (d) An insurer issuing an exclusive provider benefit plan
48-21 authorized by another law of this state may limit access to only
48-22 preferred providers participating in a health care collaborative if
48-23 the limitation is consistent with all requirements applicable to
48-24 exclusive provider benefit plans.

48-25 SECTION 4.04. Subtitle F, Title 4, Health and Safety Code,
48-26 is amended by adding Chapter 315 to read as follows:

48-27 CHAPTER 315. ESTABLISHMENT OF HEALTH CARE COLLABORATIVES

48-28 Sec. 315.001. AUTHORITY TO ESTABLISH HEALTH CARE
48-29 COLLABORATIVE. A public hospital created under Subtitle C or D or a
48-30 hospital district created under general or special law may form and
48-31 sponsor a nonprofit health care collaborative that is certified
48-32 under Chapter 848, Insurance Code.

48-33 SECTION 4.05. Section 102.005, Occupations Code, is amended
48-34 to read as follows:

48-35 Sec. 102.005. APPLICABILITY TO CERTAIN ENTITIES. Section
48-36 102.001 does not apply to:

48-37 (1) a licensed insurer;
48-38 (2) a governmental entity, including:
48-39 (A) an intergovernmental risk pool established
48-40 under Chapter 172, Local Government Code; and
48-41 (B) a system as defined by Section 1601.003,
48-42 Insurance Code;

48-43 (3) a group hospital service corporation; [~~or~~]
48-44 (4) a health maintenance organization that
48-45 reimburses, provides, offers to provide, or administers hospital,
48-46 medical, dental, or other health-related benefits under a health
48-47 benefits plan for which it is the payor; or

48-48 (5) a health care collaborative certified under
48-49 Chapter 848, Insurance Code.

48-50 SECTION 4.06. Subdivision (5), Subsection (a), Section
48-51 151.002, Occupations Code, is amended to read as follows:

48-52 (5) "Health care entity" means:
48-53 (A) a hospital licensed under Chapter 241 or 577,
48-54 Health and Safety Code;

48-55 (B) an entity, including a health maintenance
48-56 organization, group medical practice, nursing home, health science
48-57 center, university medical school, hospital district, hospital
48-58 authority, or other health care facility, that:

48-59 (i) provides or pays for medical care or
48-60 health care services; and

48-61 (ii) follows a formal peer review process
48-62 to further quality medical care or health care;

48-63 (C) a professional society or association of
48-64 physicians, or a committee of such a society or association, that
48-65 follows a formal peer review process to further quality medical
48-66 care or health care; [~~or~~]

48-67 (D) an organization established by a
48-68 professional society or association of physicians, hospitals, or
48-69 both, that:

49-1 (i) collects and verifies the authenticity
 49-2 of documents and other information concerning the qualifications,
 49-3 competence, or performance of licensed health care professionals;
 49-4 and

49-5 (ii) acts as a health care facility's agent
 49-6 under the Health Care Quality Improvement Act of 1986 (42 U.S.C.
 49-7 Section 11101 et seq.); or

49-8 (E) a health care collaborative certified under
 49-9 Chapter 848, Insurance Code.

49-10 SECTION 4.07. Not later than September 1, 2012, the
 49-11 commissioner of insurance and the attorney general shall adopt
 49-12 rules as necessary to implement this article.

49-13 SECTION 4.08. As soon as practicable after the effective
 49-14 date of this Act, the commissioner of insurance shall designate or
 49-15 employ staff with antitrust expertise sufficient to carry out the
 49-16 duties required by this Act.

49-17 ARTICLE 5. PATIENT IDENTIFICATION

49-18 SECTION 5.01. Subchapter A, Chapter 311, Health and Safety
 49-19 Code, is amended by adding Section 311.004 to read as follows:

49-20 Sec. 311.004. STANDARDIZED PATIENT RISK IDENTIFICATION
 49-21 SYSTEM. (a) In this section:

49-22 (1) "Department" means the Department of State Health
 49-23 Services.

49-24 (2) "Hospital" means a general or special hospital as
 49-25 defined by Section 241.003. The term includes a hospital
 49-26 maintained or operated by this state.

49-27 (b) The department shall coordinate with hospitals to
 49-28 develop a statewide standardized patient risk identification
 49-29 system under which a patient with a specific medical risk may be
 49-30 readily identified through the use of a system that communicates to
 49-31 hospital personnel the existence of that risk. The executive
 49-32 commissioner of the Health and Human Services Commission shall
 49-33 appoint an ad hoc committee of hospital representatives to assist
 49-34 the department in developing the statewide system.

49-35 (c) The department shall require each hospital to implement
 49-36 and enforce the statewide standardized patient risk identification
 49-37 system developed under Subsection (b) unless the department
 49-38 authorizes an exemption for the reason stated in Subsection (d).

49-39 (d) The department may exempt from the statewide
 49-40 standardized patient risk identification system a hospital that
 49-41 seeks to adopt another patient risk identification methodology
 49-42 supported by evidence-based protocols for the practice of medicine.

49-43 (e) The department shall modify the statewide standardized
 49-44 patient risk identification system in accordance with
 49-45 evidence-based medicine as necessary.

49-46 (f) The executive commissioner of the Health and Human
 49-47 Services Commission may adopt rules to implement this section.

49-48 ARTICLE 6. REPORTING OF HEALTH CARE-ASSOCIATED INFECTIONS

49-49 SECTION 6.01. Section 98.001, Health and Safety Code, as
 49-50 added by Chapter 359 (S.B. 288), Acts of the 80th Legislature,
 49-51 Regular Session, 2007, is amended by adding Subdivisions (8-a) and
 49-52 (10-a) to read as follows:

49-53 (8-a) "Health care professional" means an individual
 49-54 licensed, certified, or otherwise authorized to administer health
 49-55 care, for profit or otherwise, in the ordinary course of business or
 49-56 professional practice. The term does not include a health care
 49-57 facility.

49-58 (10-a) "Potentially preventable complication" and
 49-59 "potentially preventable readmission" have the meanings assigned
 49-60 by Section 1002.001, Health and Safety Code.

49-61 SECTION 6.02. Subsection (c), Section 98.102, Health and
 49-62 Safety Code, as added by Chapter 359 (S.B. 288), Acts of the 80th
 49-63 Legislature, Regular Session, 2007, is amended to read as follows:

49-64 (c) The data reported by health care facilities to the
 49-65 department must contain sufficient patient identifying information
 49-66 to:

49-67 (1) avoid duplicate submission of records;

49-68 (2) allow the department to verify the accuracy and
 49-69 completeness of the data reported; and

50-1 (3) for data reported under Section 98.103 [~~or~~
50-2 ~~98.104~~], allow the department to risk adjust the facilities'
50-3 infection rates.

50-4 SECTION 6.03. Section 98.103, Health and Safety Code, as
50-5 added by Chapter 359 (S.B. 288), Acts of the 80th Legislature,
50-6 Regular Session, 2007, is amended by amending Subsection (b) and
50-7 adding Subsection (d-1) to read as follows:

50-8 (b) A pediatric and adolescent hospital shall report the
50-9 incidence of surgical site infections, including the causative
50-10 pathogen if the infection is laboratory-confirmed, occurring in the
50-11 following procedures to the department:

50-12 (1) cardiac procedures, excluding thoracic cardiac
50-13 procedures;

50-14 (2) ventricular [~~ventriculo~~peritoneal] shunt
50-15 procedures; and

50-16 (3) spinal surgery with instrumentation.

50-17 (d-1) The executive commissioner by rule may designate the
50-18 federal Centers for Disease Control and Prevention's National
50-19 Healthcare Safety Network, or its successor, to receive reports of
50-20 health care-associated infections from health care facilities on
50-21 behalf of the department. A health care facility must file a report
50-22 required in accordance with a designation made under this
50-23 subsection in accordance with the National Healthcare Safety
50-24 Network's definitions, methods, requirements, and procedures. A
50-25 health care facility shall authorize the department to have access
50-26 to facility-specific data contained in a report filed with the
50-27 National Healthcare Safety Network in accordance with a designation
50-28 made under this subsection.

50-29 SECTION 6.04. Section 98.1045, Health and Safety Code, as
50-30 added by Chapter 359 (S.B. 288), Acts of the 80th Legislature,
50-31 Regular Session, 2007, is amended by adding Subsection (c) to read
50-32 as follows:

50-33 (c) The executive commissioner by rule may designate an
50-34 agency of the United States Department of Health and Human Services
50-35 to receive reports of preventable adverse events by health care
50-36 facilities on behalf of the department. A health care facility
50-37 shall authorize the department to have access to facility-specific
50-38 data contained in a report made in accordance with a designation
50-39 made under this subsection.

50-40 SECTION 6.05. Subchapter C, Chapter 98, Health and Safety
50-41 Code, as added by Chapter 359 (S.B. 288), Acts of the 80th
50-42 Legislature, Regular Session, 2007, is amended by adding Sections
50-43 98.1046 and 98.1047 to read as follows:

50-44 Sec. 98.1046. PUBLIC REPORTING OF CERTAIN POTENTIALLY
50-45 PREVENTABLE EVENTS FOR HOSPITALS. (a) In consultation with the
50-46 Texas Institute of Health Care Quality and Efficiency under Chapter
50-47 1002, the department, using data submitted under Chapter 108, shall
50-48 publicly report for hospitals in this state risk-adjusted outcome
50-49 rates for those potentially preventable complications and
50-50 potentially preventable readmissions that the department, in
50-51 consultation with the institute, has determined to be the most
50-52 effective measures of quality and efficiency.

50-53 (b) The department shall make the reports compiled under
50-54 Subsection (a) available to the public on the department's Internet
50-55 website.

50-56 (c) The department may not disclose the identity of a
50-57 patient or health care professional in the reports authorized in
50-58 this section.

50-59 Sec. 98.1047. STUDIES ON LONG-TERM CARE FACILITY REPORTING
50-60 OF ADVERSE HEALTH CONDITIONS. (a) In consultation with the Texas
50-61 Institute of Health Care Quality and Efficiency under Chapter 1002,
50-62 the department shall study which adverse health conditions commonly
50-63 occur in long-term care facilities and, of those health conditions,
50-64 which are potentially preventable.

50-65 (b) The department shall develop recommendations for
50-66 reporting adverse health conditions identified under Subsection
50-67 (a).

50-68 SECTION 6.06. Section 98.105, Health and Safety Code, as
50-69 added by Chapter 359 (S.B. 288), Acts of the 80th Legislature,

51-1 Regular Session, 2007, is amended to read as follows:

51-2 Sec. 98.105. REPORTING SYSTEM MODIFICATIONS. Based on the
51-3 recommendations of the advisory panel, the executive commissioner
51-4 by rule may modify in accordance with this chapter the list of
51-5 procedures that are reportable under Section 98.103 [~~or 98.104~~].
51-6 The modifications must be based on changes in reporting guidelines
51-7 and in definitions established by the federal Centers for Disease
51-8 Control and Prevention.

51-9 SECTION 6.07. Subsections (a), (b), and (d), Section
51-10 98.106, Health and Safety Code, as added by Chapter 359 (S.B. 288),
51-11 Acts of the 80th Legislature, Regular Session, 2007, are amended to
51-12 read as follows:

51-13 (a) The department shall compile and make available to the
51-14 public a summary, by health care facility, of:

51-15 (1) the infections reported by facilities under
51-16 Section [Sections] 98.103 [~~and 98.104~~]; and

51-17 (2) the preventable adverse events reported by
51-18 facilities under Section 98.1045.

51-19 (b) Information included in the departmental summary with
51-20 respect to infections reported by facilities under Section
51-21 [Sections] 98.103 [~~and 98.104~~] must be risk adjusted and include a
51-22 comparison of the risk-adjusted infection rates for each health
51-23 care facility in this state that is required to submit a report
51-24 under Section [Sections] 98.103 [~~and 98.104~~].

51-25 (d) The department shall publish the departmental summary
51-26 at least annually and may publish the summary more frequently as the
51-27 department considers appropriate. Data made available to the
51-28 public must include aggregate data covering a period of at least a
51-29 full calendar quarter.

51-30 SECTION 6.08. Subchapter C, Chapter 98, Health and Safety
51-31 Code, as added by Chapter 359 (S.B. 288), Acts of the 80th
51-32 Legislature, Regular Session, 2007, is amended by adding Section
51-33 98.1065 to read as follows:

51-34 Sec. 98.1065. STUDY OF INCENTIVES AND RECOGNITION FOR
51-35 HEALTH CARE QUALITY. The department, in consultation with the
51-36 Texas Institute of Health Care Quality and Efficiency under Chapter
51-37 1002, shall conduct a study on developing a recognition program to
51-38 recognize exemplary health care facilities for superior quality of
51-39 health care and make recommendations based on that study.

51-40 SECTION 6.09. Section 98.108, Health and Safety Code, as
51-41 added by Chapter 359 (S.B. 288), Acts of the 80th Legislature,
51-42 Regular Session, 2007, is amended to read as follows:

51-43 Sec. 98.108. FREQUENCY OF REPORTING. (a) In consultation
51-44 with the advisory panel, the executive commissioner by rule shall
51-45 establish the frequency of reporting by health care facilities
51-46 required under Sections 98.103[~~, 98.104,~~] and 98.1045.

51-47 (b) Except as provided by Subsection (c), facilities
51-48 [Facilities] may not be required to report more frequently than
51-49 quarterly.

51-50 (c) The executive commissioner may adopt rules requiring
51-51 reporting more frequently than quarterly if more frequent reporting
51-52 is necessary to meet the requirements for participation in the
51-53 federal Centers for Disease Control and Prevention's National
51-54 Healthcare Safety Network.

51-55 SECTION 6.10. Subsection (a), Section 98.109, Health and
51-56 Safety Code, as added by Chapter 359 (S.B. 288), Acts of the 80th
51-57 Legislature, Regular Session, 2007, is amended to read as follows:

51-58 (a) Except as provided by Sections 98.1046, 98.106, and
51-59 98.110, all information and materials obtained or compiled or
51-60 reported by the department under this chapter or compiled or
51-61 reported by a health care facility under this chapter, and all
51-62 related information and materials, are confidential and:

51-63 (1) are not subject to disclosure under Chapter 552,
51-64 Government Code, or discovery, subpoena, or other means of legal
51-65 compulsion for release to any person; and

51-66 (2) may not be admitted as evidence or otherwise
51-67 disclosed in any civil, criminal, or administrative proceeding.

51-68 SECTION 6.11. Section 98.110, Health and Safety Code, as
51-69 added by Chapter 359 (S.B. 288), Acts of the 80th Legislature,

52-1 Regular Session, 2007, is amended to read as follows:

52-2 Sec. 98.110. DISCLOSURE AMONG CERTAIN AGENCIES.
 52-3 (a) Notwithstanding any other law, the department may disclose
 52-4 information reported by health care facilities under Section
 52-5 98.103[~~98.104~~] or 98.1045 to other programs within the
 52-6 department, to the Health and Human Services Commission, [~~and~~] to
 52-7 other health and human services agencies, as defined by Section
 52-8 531.001, Government Code, and to the federal Centers for Disease
 52-9 Control and Prevention, or any other agency of the United States
 52-10 Department of Health and Human Services, for public health research
 52-11 or analysis purposes only, provided that the research or analysis
 52-12 relates to health care-associated infections or preventable
 52-13 adverse events. The privilege and confidentiality provisions
 52-14 contained in this chapter apply to such disclosures.

52-15 (b) If the executive commissioner designates an agency of
 52-16 the United States Department of Health and Human Services to
 52-17 receive reports of health care-associated infections or
 52-18 preventable adverse events, that agency may use the information
 52-19 submitted for purposes allowed by federal law.

52-20 SECTION 6.12. Section 98.104, Health and Safety Code, as
 52-21 added by Chapter 359 (S.B. 288), Acts of the 80th Legislature,
 52-22 Regular Session, 2007, is repealed.

52-23 SECTION 6.13. Not later than December 1, 2012, the
 52-24 Department of State Health Services shall submit a report regarding
 52-25 recommendations for improved health care reporting to the governor,
 52-26 the lieutenant governor, the speaker of the house of
 52-27 representatives, and the chairs of the appropriate standing
 52-28 committees of the legislature outlining:

52-29 (1) the initial assessment in the study conducted
 52-30 under Section 98.1065, Health and Safety Code, as added by this Act;

52-31 (2) based on the study described by Subdivision (1) of
 52-32 this subsection, the feasibility and desirability of establishing a
 52-33 recognition program to recognize exemplary health care facilities
 52-34 for superior quality of health care;

52-35 (3) the recommendations developed under Section
 52-36 98.1065, Health and Safety Code, as added by this Act; and

52-37 (4) the changes in existing law that would be
 52-38 necessary to implement the recommendations described by
 52-39 Subdivision (3) of this subsection.

52-40 ARTICLE 7. INFORMATION MAINTAINED BY DEPARTMENT OF STATE HEALTH
 52-41 SERVICES

52-42 SECTION 7.01. Section 108.002, Health and Safety Code, is
 52-43 amended by adding Subdivisions (4-a) and (8-a) and amending
 52-44 Subdivision (7) to read as follows:

52-45 (4-a) "Commission" means the Health and Human Services
 52-46 Commission.

52-47 (7) "Department" means the [~~Texas~~] Department of State
 52-48 Health Services.

52-49 (8-a) "Executive commissioner" means the executive
 52-50 commissioner of the Health and Human Services Commission.

52-51 SECTION 7.02. Chapter 108, Health and Safety Code, is
 52-52 amended by adding Section 108.0026 to read as follows:

52-53 Sec. 108.0026. TRANSFER OF DUTIES; REFERENCE TO COUNCIL.

52-54 (a) The powers and duties of the Texas Health Care Information
 52-55 Council under this chapter were transferred to the Department of
 52-56 State Health Services in accordance with Section 1.19, Chapter 198
 52-57 (H.B. 2292), Acts of the 78th Legislature, Regular Session, 2003.

52-58 (b) In this chapter or other law, a reference to the Texas
 52-59 Health Care Information Council means the Department of State
 52-60 Health Services.

52-61 SECTION 7.03. Subsection (h), Section 108.009, Health and
 52-62 Safety Code, is amended to read as follows:

52-63 (h) The department [~~council~~] shall coordinate data
 52-64 collection with the data submission formats used by hospitals and
 52-65 other providers. The department [~~council~~] shall accept data in the
 52-66 format developed by the American National Standards Institute
 52-67 [~~National Uniform Billing Committee (Uniform Hospital Billing Form~~
 52-68 ~~UB 92) and HCFA-1500] or its successor [~~their successors~~] or other
 52-69 nationally [~~universally~~] accepted standardized forms that~~

53-1 hospitals and other providers use for other complementary purposes.
 53-2 SECTION 7.04. Section 108.013, Health and Safety Code, is
 53-3 amended by amending Subsections (a) through (d), (g), (i), and (j)
 53-4 and adding Subsections (k) through (n) to read as follows:

53-5 (a) The data received by the department under this chapter
 53-6 [council] shall be used by the department and commission [council]
 53-7 for the benefit of the public. Subject to specific limitations
 53-8 established by this chapter and executive commissioner [council]
 53-9 rule, the department [council] shall make determinations on
 53-10 requests for information in favor of access.

53-11 (b) The executive commissioner [council] by rule shall
 53-12 designate the characters to be used as uniform patient identifiers.
 53-13 The basis for assignment of the characters and the manner in which
 53-14 the characters are assigned are confidential.

53-15 (c) Unless specifically authorized by this chapter, the
 53-16 department [council] may not release and a person or entity may not
 53-17 gain access to any data obtained under this chapter:

53-18 (1) that could reasonably be expected to reveal the
 53-19 identity of a patient;

53-20 (2) that could reasonably be expected to reveal the
 53-21 identity of a physician;

53-22 (3) disclosing provider discounts or differentials
 53-23 between payments and billed charges;

53-24 (4) relating to actual payments to an identified
 53-25 provider made by a payer; or

53-26 (5) submitted to the department [council] in a uniform
 53-27 submission format that is not included in the public use data set
 53-28 established under Sections 108.006(f) and (g), except in accordance
 53-29 with Section 108.0135.

53-30 (d) Except as provided by this section, all [All] data
 53-31 collected and used by the department [and the council] under this
 53-32 chapter is subject to the confidentiality provisions and criminal
 53-33 penalties of:

53-34 (1) Section 311.037;

53-35 (2) Section 81.103; and

53-36 (3) Section 159.002, Occupations Code.

53-37 (g) Unless specifically authorized by this chapter, the
 53-38 department [The council] may not release data elements in a manner
 53-39 that will reveal the identity of a patient. The department
 53-40 [council] may not release data elements in a manner that will reveal
 53-41 the identity of a physician.

53-42 (i) Notwithstanding any other law and except as provided by
 53-43 this section, the [council and the] department may not provide
 53-44 information made confidential by this section to any other agency
 53-45 of this state.

53-46 (j) The executive commissioner [council] shall by rule [,
 53-47 with the assistance of the advisory committee under Section
 53-48 108.003(g)(5),] develop and implement a mechanism to comply with
 53-49 Subsections (c)(1) and (2).

53-50 (k) The department may disclose data collected under this
 53-51 chapter that is not included in public use data to any department or
 53-52 commission program if the disclosure is reviewed and approved by
 53-53 the institutional review board under Section 108.0135.

53-54 (l) Confidential data collected under this chapter that is
 53-55 disclosed to a department or commission program remains subject to
 53-56 the confidentiality provisions of this chapter and other applicable
 53-57 law. The department shall identify the confidential data that is
 53-58 disclosed to a program under Subsection (k). The program shall
 53-59 maintain the confidentiality of the disclosed confidential data.

53-60 (m) The following provisions do not apply to the disclosure
 53-61 of data to a department or commission program:

53-62 (1) Section 81.103;

53-63 (2) Sections 108.010(g) and (h);

53-64 (3) Sections 108.011(e) and (f);

53-65 (4) Section 311.037; and

53-66 (5) Section 159.002, Occupations Code.

53-67 (n) Nothing in this section authorizes the disclosure of
 53-68 physician identifying data.

53-69 SECTION 7.05. Section 108.0135, Health and Safety Code, is

54-1 amended to read as follows:

54-2 Sec. 108.0135. INSTITUTIONAL [SCIENTIFIC] REVIEW BOARD
 54-3 [PANEL]. (a) The department [council] shall establish an
 54-4 institutional [a scientific] review board [panel] to review and
 54-5 approve requests for access to data not contained in [information
 54-6 other than] public use data. The members of the institutional
 54-7 review board must [panel shall] have experience and expertise in
 54-8 ethics, patient confidentiality, and health care data.

54-9 (b) To assist the institutional review board [panel] in
 54-10 determining whether to approve a request for information, the
 54-11 executive commissioner [council] shall adopt rules similar to the
 54-12 federal Centers for Medicare and Medicaid Services' [Health Care
 54-13 Financing Administration's] guidelines on releasing data.

54-14 (c) A request for information other than public use data
 54-15 must be made on the form prescribed [created] by the department
 54-16 [council].

54-17 (d) Any approval to release information under this section
 54-18 must require that the confidentiality provisions of this chapter be
 54-19 maintained and that any subsequent use of the information conform
 54-20 to the confidentiality provisions of this chapter.

54-21 SECTION 7.06. Effective September 1, 2014, Subdivisions (5)
 54-22 and (18), Section 108.002, Section 108.0025, and Subsection (c),
 54-23 Section 108.009, Health and Safety Code, are repealed.

54-24 ARTICLE 8. ADOPTION OF VACCINE PREVENTABLE DISEASES POLICY BY
 54-25 HEALTH CARE FACILITIES

54-26 SECTION 8.01. The heading to Subtitle A, Title 4, Health and
 54-27 Safety Code, is amended to read as follows:

54-28 SUBTITLE A. FINANCING, CONSTRUCTING, REGULATING, AND INSPECTING
 54-29 HEALTH FACILITIES

54-30 SECTION 8.02. Subtitle A, Title 4, Health and Safety Code,
 54-31 is amended by adding Chapter 224 to read as follows:

54-32 CHAPTER 224. POLICY ON VACCINE PREVENTABLE DISEASES

54-33 Sec. 224.001. DEFINITIONS. In this chapter:

54-34 (1) "Covered individual" means:

54-35 (A) an employee of the health care facility;

54-36 (B) an individual providing direct patient care
 54-37 under a contract with a health care facility; or

54-38 (C) an individual to whom a health care facility
 54-39 has granted privileges to provide direct patient care.

54-40 (2) "Health care facility" means:

54-41 (A) a facility licensed under Subtitle B,
 54-42 including a hospital as defined by Section 241.003; or

54-43 (B) a hospital maintained or operated by this
 54-44 state.

54-45 (3) "Regulatory authority" means a state agency that
 54-46 regulates a health care facility under this code.

54-47 (4) "Vaccine preventable diseases" means the diseases
 54-48 included in the most current recommendations of the Advisory
 54-49 Committee on Immunization Practices of the Centers for Disease
 54-50 Control and Prevention.

54-51 Sec. 224.002. VACCINE PREVENTABLE DISEASES POLICY
 54-52 REQUIRED. (a) Each health care facility shall develop and
 54-53 implement a policy to protect its patients from vaccine preventable
 54-54 diseases.

54-55 (b) The policy must:

54-56 (1) require covered individuals to receive vaccines
 54-57 for the vaccine preventable diseases specified by the facility
 54-58 based on the level of risk the individual presents to patients by
 54-59 the individual's routine and direct exposure to patients;

54-60 (2) specify the vaccines a covered individual is
 54-61 required to receive based on the level of risk the individual
 54-62 presents to patients by the individual's routine and direct
 54-63 exposure to patients;

54-64 (3) include procedures for verifying whether a covered
 54-65 individual has complied with the policy;

54-66 (4) include procedures for a covered individual to be
 54-67 exempt from the required vaccines for the medical conditions
 54-68 identified as contraindications or precautions by the Centers for
 54-69 Disease Control and Prevention;

55-1 (5) for a covered individual who is exempt from the
 55-2 required vaccines, include procedures the individual must follow to
 55-3 protect facility patients from exposure to disease, such as the use
 55-4 of protective medical equipment, such as gloves and masks, based on
 55-5 the level of risk the individual presents to patients by the
 55-6 individual's routine and direct exposure to patients;

55-7 (6) prohibit discrimination or retaliatory action
 55-8 against a covered individual who is exempt from the required
 55-9 vaccines for the medical conditions identified as
 55-10 contraindications or precautions by the Centers for Disease Control
 55-11 and Prevention, except that required use of protective medical
 55-12 equipment, such as gloves and masks, may not be considered
 55-13 retaliatory action for purposes of this subdivision;

55-14 (7) require the health care facility to maintain a
 55-15 written or electronic record of each covered individual's
 55-16 compliance with or exemption from the policy; and

55-17 (8) include disciplinary actions the health care
 55-18 facility is authorized to take against a covered individual who
 55-19 fails to comply with the policy.

55-20 (c) The policy may include procedures for a covered
 55-21 individual to be exempt from the required vaccines based on reasons
 55-22 of conscience, including a religious belief.

55-23 Sec. 224.003. DISASTER EXEMPTION. (a) In this section,
 55-24 "public health disaster" has the meaning assigned by Section
 55-25 81.003.

55-26 (b) During a public health disaster, a health care facility
 55-27 may prohibit a covered individual who is exempt from the vaccines
 55-28 required in the policy developed by the facility under Section
 55-29 224.002 from having contact with facility patients.

55-30 Sec. 224.004. DISCIPLINARY ACTION. A health care facility
 55-31 that violates this chapter is subject to an administrative or civil
 55-32 penalty in the same manner, and subject to the same procedures, as
 55-33 if the facility had violated a provision of this code that
 55-34 specifically governs the facility.

55-35 Sec. 224.005. RULES. The appropriate rulemaking authority
 55-36 for each regulatory authority shall adopt rules necessary to
 55-37 implement this chapter.

55-38 SECTION 8.03. Not later than June 1, 2012, a state agency
 55-39 that regulates a health care facility subject to Chapter 224,
 55-40 Health and Safety Code, as added by this Act, shall adopt the rules
 55-41 necessary to implement that chapter.

55-42 SECTION 8.04. Notwithstanding Chapter 224, Health and
 55-43 Safety Code, as added by this Act, a health care facility subject to
 55-44 that chapter is not required to have a policy on vaccine preventable
 55-45 diseases in effect until September 1, 2012.

55-46 ARTICLE 9. TEXAS EMERGENCY AND TRAUMA CARE EDUCATION

55-47 PARTNERSHIP PROGRAM

55-48 SECTION 9.01. Chapter 61, Education Code, is amended by
 55-49 adding Subchapter GG to read as follows:

55-50 SUBCHAPTER GG. TEXAS EMERGENCY AND TRAUMA CARE EDUCATION

55-51 PARTNERSHIP PROGRAM

55-52 Sec. 61.9801. DEFINITIONS. In this subchapter:

55-53 (1) "Emergency and trauma care education partnership"
 55-54 means a partnership that:

55-55 (A) consists of one or more hospitals in this
 55-56 state and one or more graduate professional nursing or graduate
 55-57 medical education programs in this state; and

55-58 (B) serves to increase training opportunities in
 55-59 emergency and trauma care for doctors and registered nurses at
 55-60 participating graduate medical education and graduate professional
 55-61 nursing programs.

55-62 (2) "Participating education program" means a
 55-63 graduate professional nursing program as that term is defined by
 55-64 Section 54.221 or a graduate medical education program leading to
 55-65 board certification by the American Board of Medical Specialties
 55-66 that participates in an emergency and trauma care education
 55-67 partnership.

55-68 Sec. 61.9802. PROGRAM: ESTABLISHMENT; ADMINISTRATION;
 55-69 PURPOSE. (a) The Texas emergency and trauma care education

56-1 partnership program is established.

56-2 (b) The board shall administer the program in accordance
56-3 with this subchapter and rules adopted under this subchapter.

56-4 (c) Under the program, to the extent funds are available
56-5 under Section 61.9805, the board shall make grants to emergency and
56-6 trauma care education partnerships to assist those partnerships to
56-7 meet the state's needs for doctors and registered nurses with
56-8 training in emergency and trauma care by offering one-year or
56-9 two-year fellowships to students enrolled in graduate professional
56-10 nursing or graduate medical education programs through
56-11 collaboration between hospitals and graduate professional nursing
56-12 or graduate medical education programs and the use of the existing
56-13 expertise and facilities of those hospitals and programs.

56-14 Sec. 61.9803. GRANTS: CONDITIONS; LIMITATIONS. (a) The
56-15 board may make a grant under this subchapter to an emergency and
56-16 trauma care education partnership only if the board determines
56-17 that:

56-18 (1) the partnership will meet applicable standards for
56-19 instruction and student competency for each program offered by each
56-20 participating education program;

56-21 (2) each participating education program will, as a
56-22 result of the partnership, enroll in the education program a
56-23 sufficient number of additional students as established by the
56-24 board;

56-25 (3) each hospital participating in an emergency and
56-26 trauma care education partnership will provide to students enrolled
56-27 in a participating education program clinical placements that:

56-28 (A) allow the students to take part in providing
56-29 or to observe, as appropriate, emergency and trauma care services
56-30 offered by the hospital; and

56-31 (B) meet the clinical education needs of the
56-32 students; and

56-33 (4) the partnership will satisfy any other requirement
56-34 established by board rule.

56-35 (b) A grant under this subchapter may be spent only on costs
56-36 related to the development or operation of an emergency and trauma
56-37 care education partnership that prepares a student to complete a
56-38 graduate professional nursing program with a specialty focus on
56-39 emergency and trauma care or earn board certification by the
56-40 American Board of Medical Specialties.

56-41 Sec. 61.9804. PRIORITY FOR FUNDING. In awarding a grant
56-42 under this subchapter, the board shall give priority to an
56-43 emergency and trauma care education partnership that submits a
56-44 proposal that:

56-45 (1) provides for collaborative educational models
56-46 between one or more participating hospitals and one or more
56-47 participating education programs that have signed a memorandum of
56-48 understanding or other written agreement under which the
56-49 participants agree to comply with standards established by the
56-50 board, including any standards the board may establish that:

56-51 (A) provide for program management that offers a
56-52 centralized decision-making process allowing for inclusion of each
56-53 entity participating in the partnership;

56-54 (B) provide for access to clinical training
56-55 positions for students in graduate professional nursing and
56-56 graduate medical education programs that are not participating in
56-57 the partnership; and

56-58 (C) specify the details of any requirement
56-59 relating to a student in a participating education program being
56-60 employed after graduation in a hospital participating in the
56-61 partnership, including any details relating to the employment of
56-62 students who do not complete the program, are not offered a position
56-63 at the hospital, or choose to pursue other employment;

56-64 (2) includes a demonstrable education model to:

56-65 (A) increase the number of students enrolled in,
56-66 the number of students graduating from, and the number of faculty
56-67 employed by each participating education program; and

56-68 (B) improve student or resident retention in each
56-69 participating education program;

57-1 (3) indicates the availability of money to match a
57-2 portion of the grant money, including matching money or in-kind
57-3 services approved by the board from a hospital, private or
57-4 nonprofit entity, or institution of higher education;

57-5 (4) can be replicated by other emergency and trauma
57-6 care education partnerships or other graduate professional nursing
57-7 or graduate medical education programs; and

57-8 (5) includes plans for sustainability of the
57-9 partnership.

57-10 Sec. 61.9805. GRANTS, GIFTS, AND DONATIONS. In addition to
57-11 money appropriated by the legislature, the board may solicit,
57-12 accept, and spend grants, gifts, and donations from any public or
57-13 private source for the purposes of this subchapter.

57-14 Sec. 61.9806. RULES. The board shall adopt rules for the
57-15 administration of the Texas emergency and trauma care education
57-16 partnership program. The rules must include:

57-17 (1) provisions relating to applying for a grant under
57-18 this subchapter; and

57-19 (2) standards of accountability consistent with other
57-20 graduate professional nursing and graduate medical education
57-21 programs to be met by any emergency and trauma care education
57-22 partnership awarded a grant under this subchapter.

57-23 Sec. 61.9807. ADMINISTRATIVE COSTS. A reasonable amount,
57-24 not to exceed three percent, of any money appropriated for purposes
57-25 of this subchapter may be used to pay the costs of administering
57-26 this subchapter.

57-27 SECTION 9.02. As soon as practicable after the effective
57-28 date of this article, the Texas Higher Education Coordinating Board
57-29 shall adopt rules for the implementation and administration of the
57-30 Texas emergency and trauma care education partnership program
57-31 established under Subchapter GG, Chapter 61, Education Code, as
57-32 added by this Act. The board may adopt the initial rules in the
57-33 manner provided by law for emergency rules.

57-34 ARTICLE 10. EFFECTIVE DATE

57-35 SECTION 10.01. Except as otherwise provided by this Act,
57-36 this Act takes effect on the 91st day after the last day of the
57-37 legislative session.

57-38 * * * * *