Amend **CSSB 23** (house committee printing) as follows:

(1) In SECTION 10 of the bill, immediately following the heading to the section (page 34, line 18), between "PROGRAMS." and "Subchapter", insert "(a)".

(2) In SECTION 10 of the bill, in added Section 531.086(b)(2), Government Code (page 35, lines 11 and 12), strike "or primary care case management" and substitute "payment".

(3) In SECTION 10 of the bill, in added Section 531.086(c), Government Code (page 35, line 13), strike "August 31, 2012" and substitute "August 31, 2013".

(4) In SECTION 10 of the bill, in added Section 531.086(d), Government Code (page 35, line 17), strike "September 1, 2013" and substitute "September 1, 2014".

(5) In SECTION 10 of the bill, in added Section 531.0861(a), Government Code (page 35, line 19), strike "The" and substitute "If cost-effective, the".

(6) At the end of SECTION 10 of the bill (page 36, between lines 5 and 6), insert the following:

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

Sec. 32.0641. RECIPIENT ACCOUNTABILITY PROVISIONS; COST-SHARING REQUIREMENT TO IMPROVE APPROPRIATE UTILIZATION OF [~~COST-SHARING FOR CERTAIN HIGH-COST MEDICAL~~] SERVICES. (a) To [~~If the department determines that it is feasible and cost-effective, and to~~] the extent permitted under and in a manner that is consistent with Title XIX, Social Security Act (42 U.S.C. Section 1396 et seq.) and any other applicable law or regulation, including Sections 1916 and 1916A, Social Security Act (42 U.S.C. Sections 1396o and 1396o-1), or under a federal waiver or other authorization, the executive commissioner of the Health and Human Services Commission shall adopt, after consulting with the Medicaid and CHIP Quality-Based Payment Advisory Committee established under Section 536.002, Government Code, cost-sharing provisions that encourage personal accountability and appropriate utilization of health care services, including a cost-sharing provision applicable to [~~require~~] a recipient who chooses to receive a nonemergency [~~a high-cost~~] medical service [~~provided~~] through a

hospital emergency room [~~to pay a copayment, premium payment, or other cost-sharing payment for the high-cost medical service~~] if:

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

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

(B) informs the recipient:

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

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

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

(C) offers to provide the recipient with a referral to the nonemergency provider to facilitate scheduling of the service; and

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

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

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

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

(c) <u>The</u> [~~If the~~] executive commissioner of the Health and Human Services Commission <u>shall adopt</u> [~~adopts a copayment or other~~] cost-sharing <u>provisions</u> [~~payment~~] under Subsection (a), <u>other than provisions applicable to recipients who choose to receive nonemergency medical services through a hospital emergency room, in</u>

a manner that is consistent with Section 1916 or 1916A, Social Security Act (42 U.S.C. Section 1396o or 1396o-1) [~~the commission may not reduce hospital payments to reflect the potential receipt of a copayment or other payment from a recipient receiving medical services provided through a hospital emergency room~~].

(7) Add the following appropriately numbered SECTIONS to the bill and renumber subsequent SECTIONS of the bill accordingly:

SECTION ____. QUALITY-BASED OUTCOME AND PAYMENT INITIATIVES. (a) Subtitle I, Title 4, Government Code, is amended by adding Chapter 536, and Section 531.913, Government Code, is transferred to Subchapter D, Chapter 536, Government Code, redesignated as Section 536.151, Government Code, and amended to read as follows:

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

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 536.001. DEFINITIONS. In this chapter:

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

(2) "Alternative payment system" includes:

(A) a global payment system;

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

(C) a blended payment system.

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

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

(5) "Episode-based bundled payment system" means a system for compensating a physician or other health care provider for arranging for or providing health care services to child health

plan program enrollees or Medicaid recipients that is based on a flat payment for all services provided in connection with a single episode of medical care.

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

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

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

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

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

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

(12) "Managed care plan" means a plan, including an exclusive provider benefit plan, under which a person undertakes to provide, arrange for, pay for, or reimburse any part of the cost of any health care services. A part of the plan must consist of arranging for or providing health care services as distinguished from indemnification against the cost of those services on a

prepaid basis through insurance or otherwise. The term does not include a plan that indemnifies a person for the cost of health care services through insurance.

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

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

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

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

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

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

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

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

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

other health care provider in a nonemergency setting.

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

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

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

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

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

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

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

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

to health care services;

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

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

(4) outcome and process measures under Section 536.003.

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

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

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

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

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

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

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

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

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

Sec. 536.003. DEVELOPMENT OF QUALITY-BASED OUTCOME AND

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

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

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

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

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

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

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

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

(e) If the commission increases physician and other health care provider reimbursement rates under the child health plan or Medicaid program as a result of an increase in the amounts appropriated for the programs for a state fiscal biennium as

compared to the preceding state fiscal biennium, the commission shall, to the extent permitted under federal law and to the extent otherwise possible considering other relevant factors, correlate the increased reimbursement rates with the quality-based outcome and process measures developed under this section.

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

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

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

(3) promote the coordination of health care;

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

(5) promote effective health care delivery models; and

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

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

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

(1) an alternative payment system;

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

differences, if implementing the system would:

(A) reduce unnecessary administrative burdens; and

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

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

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

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

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

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

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

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

(A) quality-based payment and reimbursement

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

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

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

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

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

(b) The commission shall:

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

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

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

(1) the quality-based outcome and process measures

developed under Section 536.003; and

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

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

[Sections 536.009-536.050 reserved for expansion]

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

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

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

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

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

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

(3) reduce potentially preventable events.

(b) The commission, after consulting with the advisory committee, shall develop quality of care and cost-efficiency

benchmarks, including benchmarks based on a managed care organization's performance with respect to reducing potentially preventable events and containing the growth rate of health care costs.

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

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

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

[Sections 536.053-536.100 reserved for expansion]

SUBCHAPTER C. QUALITY-BASED HEALTH HOME PAYMENT SYSTEMS

Sec. 536.101. DEFINITIONS. In this subchapter:

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

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

Sec. 536.102. QUALITY-BASED HEALTH HOME PAYMENTS. (a) Subject to this subchapter, the commission, after consulting with the advisory committee, may develop and implement

quality-based payment systems for health homes designed to improve quality of care and reduce the provision of unnecessary medical services. A quality-based payment system developed under this section must:

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

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

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

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

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

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

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

[Sections 536.104-536.150 reserved for expansion]

SUBCHAPTER D. QUALITY-BASED HOSPITAL REIMBURSEMENT SYSTEM

Sec. 536.151 [~~531.913~~]. COLLECTION AND REPORTING OF CERTAIN [~~HOSPITAL HEALTH~~] INFORMATION [~~EXCHANGE~~]. (a) [~~In this section, "potentially preventable readmission" means a return hospitalization of a person within a period specified by the commission that results from deficiencies in the care or treatment provided to the person during a previous hospital stay or from~~

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

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

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

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

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

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

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

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

Sec. 536.152. REIMBURSEMENT ADJUSTMENTS. (a) Subject to Subsection (b), using the data collected under Section 536.151 and

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

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

[Sections 536.153-536.200 reserved for expansion]

SUBCHAPTER E. QUALITY-BASED PAYMENT INITIATIVES

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

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

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

(2) reduce potentially preventable events;

(3) promote prevention and wellness;

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

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

(6) contain costs.

(b) The commission shall:

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

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

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

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

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

(1) one or more regions in this state;

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

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

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

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

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

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

(b) In addition to the benchmarks and goals under Subsection

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

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

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

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

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

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

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

(1) not later than September 1, 2012, based on the

hospitals' performances with respect to reducing potentially preventable readmissions; and

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

SECTION ____. LONG-TERM CARE PAYMENT INCENTIVE INITIATIVES. (a) The heading to Section 531.912, Government Code, is amended to read as follows:

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

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

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

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

(1) must be:

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

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

(2) may include measures of:

(A) quality of care, as determined by clinical

performance ratings published by the federal Centers for Medicare and Medicaid Services, the Agency for Healthcare Research and Quality, or another federal agency [~~life~~];

(B) direct-care staff retention and turnover;

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

(D) employee satisfaction and engagement;

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

(F) regulatory compliance;

(G) level of person-centered care; and

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

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

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

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

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

(d) Not later than September 1, 2012, the Department of Aging and Disability Services shall submit to the legislature a

written report containing the findings of the study conducted under Subsection (c) of this section and the department's recommendations.