BILL ANALYSIS

Senate Research Center
82R17462 KFF-F

C.S.S.B. 7
By: Nelson
Health & Human Services
3/30/2011
Committee Report (Substituted)

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

The existing fee-for-service payment system is based on quantity of services rather than quality, incentivizing inefficiency and driving up health care costs.

The goal of C.S.S.B. 7 is to improve the quality, safety, and efficiency of Medicaid and the Children's Health Insurance Program (CHIP) in Texas. C.S.S.B 7 achieves this goal by transitioning the way the state pays for health care services under these programs to a performance-based payment system.

C.S.S.B. 7 amends current law relating to strategies for and improvements in quality of health care provided through and care management in the child health plan and medical assistance programs designed to achieve healthy outcomes and efficiency.

RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to the executive commissioner of the Health and Human Services Commission (executive commissioner) in SECTION 1 (Sections 536.003 and 536.203, Government Code) and SECTION 2 (Section 531.0861, Government Code) of this bill.

Rulemaking authority previously granted to the executive commissioner is modified in SECTION 1 (Section 536.151, Government Code) and SECTION 3 (Section 531.912, Government Code) of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1. QUALITY-BASED OUTCOME AND PAYMENT INITIATIVES. (a) Amends Subtitle I, Title 4, Government Code, by adding Chapter 536, and transfers Section 531.913, Government Code, to Subchapter D, Chapter 536, Government Code, redesignates it as Section 536.151, Government Code, and amends it, as follows:

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

SUBCHAPTER A: GENERAL PROVISIONS

Sec. 536.001. DEFINITIONS. Defines "advisory committee," "alternative payment system," "blended payment system," "child health plan program," "commission," "executive commissioner," "health and human services agencies," "episode-based bundled payment system," "exclusive provider benefit plan," "global payment system," "hospital," "managed care organization," "managed care plan," "Medicaid program," "potentially preventable admission," "potentially preventable ancillary service," "potentially preventable complication," "potentially preventable event," "potentially preventable hospital emergency room visit," "potentially preventable readmission," and "quality-based payment system" in this chapter.

Sec. 356.002. MEDICAID AND CHIP QUALITY-BASED PAYMENT ADVISORY COMMITTEE. (a) Establishes the Medicaid and the Children's

Health Insurance Program (CHIP) Quality-Based Payment Advisory Committee (advisory committee) to advise the Texas Health and Human Services Commission (HHSC) on establishing, for purposes of the child health plan and Medicaid programs administered by HHSC or a health and human services agency:

(1) reimbursement systems used to compensate health care providers and facilities 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 health care providers and facilities;

(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) Requires the executive commissioner of HHSC (executive commissioner) to appoint the members of the advisory committee. Requires that the committee consist of 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 a consumer representative; and

(6) at least one member who is a member of the Advisory Panel and Health Care-Associated Infections and Preventable Adverse Events who meets the qualifications prescribed by Section 98.052(a)(4) (relating to four additional professionals in quality assessment and performance improvement to be included as members of the advisory panel), Health and Safety Code.

(c) Requires the executive commissioner to appoint the presiding officer of the advisory committee.

Sec. 536.003. DEVELOPMENT OF QUALITY-BASED OUTCOME AND PROCESS MEASURES. (a) Requires HHSC, in consultation with the advisory committee, to develop quality-based outcome and process measures that promote the provision of efficient, quality health care and that can be used in the child health plan and Medicaid programs to implement quality-based payments for acute and long-term care services across all delivery models and payment

systems, including fee-for-service and managed care payment systems. Requires HHSC, in developing outcome measures under this section, to consider measures addressing potentially preventable events.

(b) Requires HHSC, to the extent feasible, to 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) Authorizes HHSC to 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) Authorizes the executive commissioner by rule to require managed care organizations and health care providers and facilities participating in the child health plan and Medicaid programs to report to HHSC in a format specified by the executive commissioner information necessary to develop outcome and process measures under this section.

(e) Requires HHSC, if HHSC increases 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, to the extent permitted under federal law and to the extent otherwise possible considering other relevant factors, to 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) Requires HHSC, using quality-based outcome and process measures developed under Section 536.003 and subject to this section, after consulting with the advisory committee, to develop quality-based payment systems for compensating a health care provider or facility 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 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) Requires HHSC to develop quality-based payment systems in the manner specified by this chapter. Requires HHSC, to the extent necessary, to coordinate the timeline for the development and implementation of a payment system with 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) Requires HHSC, in developing quality-based payment systems under this chapter, to 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 reduce unnecessary administrative burdens, and align quality-based payment incentives for health care providers or facilities 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) Requires HHSC, in developing quality-based payment systems under this chapter, to ensure that a managed care organization, health care provider, or health care facility will not be rewarded by the system for withholding or delaying the provision of medically necessary care.

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

(b) Provides that Subsection (a) does not authorize HHSC to direct a managed care organization regarding how the organization compensates health care providers and facilities providing services under the organization's managed care plan.

Sec. 536.006. TRANSPARENCY. Requires HHSC and the advisory committee to:

(1) ensure transparency in the development and establishment of 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 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 actionable valid information to, and receiving input from, managed care organizations, health care providers, including physicians and experts in the various medical specialty fields, health care facilities, 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, health care provider, or health care facility 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) Requires HHSC, at least once every two-year period, to evaluate the outcomes and cost-effectiveness of any quality-based payment system or other payment initiative implemented under this chapter.

(b) Requires HHSC to:

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

(2) provide a process by which managed care organizations and health care providers and facilities are authorized to comment and provide input into the advisory committee's recommendations under Subdivision (1).

Sec. 536.008. ANNUAL REPORT. (a) Requires HHSC to submit an annual report to the legislature regarding:

(1) the quality-based outcome and process measurers 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) Requires HHSC to report outcome and process measures under Subsection (a)(1) by health care service region and service delivery model.

[Reserves Sections 536.009-536.050 for expansion.]

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

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

(b) Requires HHSC to report 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) Authorizes HHSC to allow a managed care organization participating in the child health plan or Medicaid program increased flexibility to implement quality initiatives in a managed care plan offered by the organization, including flexibility with respect to network requirements and 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) Requires HHSC, after consulting with the advisory committee, to develop quality of care and cost-efficiency benchmarks, including benchmarks based on a managed care organization's performance with respect to reducing potentially preventable events and containing the growth rate of health care costs.

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

(d) Requires HHSC, in awarding contracts to managed care organizations under the child health plan and Medicaid programs, in addition to considerations under Section 533.003 of this code and Section 62.155 (Health Plan Providers), Health and Safety Code, to give preference to an organization that offers a managed care plan that implements quality initiatives under Subsection (a) or meets quality of care and cost-efficiency benchmarks under Subsection (b).

(e) Authorizes HHSC to implement financial incentives under this section only if implementing the incentives would not require additional state funding because the cost associated with implementation would be offset by expected savings or additional federal funding.

[Reserves Sections 536.053-536.100 for expansion.]

SUBCHAPTER C. QUALITY-BASED HEALTH HOME PAYMENT SYSTEMS

Sec. 536.101. DEFINITIONS. Defines "health home" and "participating enrollee" in this subchapter.

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

(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.

(b) Authorizes HHSC to 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. Requires a provider, to be eligible to receive reimbursement under a quality-based payment system under this subchapter, to:

(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 HHSC that the provider meets the requirement of Subdivision (1).

[Reserves Sections 536.104-536.150 for expansion.]

SUBCHAPTER D. QUALITY-BASED HOSPITAL REIMBURSEMENT SYSTEM

Sec. 536.151. New heading: COLLECTION AND REPORTING OF CERTAIN INFORMATION. Redesignates existing Section 531.913 as Section 536.151. (a) Redesignates existing Subsection (b) as Subsection (a). Requires the executive commissioner to adopt rules for identifying preventable readmissions of child health plan program enrollees and Medicaid recipients and potentially preventable complications experience by child health plan program enrollees and Medicaid recipients. Requires HHSC to collect data from hospitals, rather than exchange data with hospitals, on present-on-admission indicators for purposes of this section. Deletes existing Subsection (a) defining "potentially preventable readmission."

(b) Redesignates existing Subsection (c) as Subsection (b). Requires HHSC to establish a program to provide a confidential report to each hospital in the 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. Requires that a report provided under this section, to the extent possible, include potentially preventable readmissions and potentially preventable complications information across all child health plan and Medicaid program payment systems. Requires that a hospital distribute the information contained in the report to health care providers providing services at the hospital.

Deletes existing text requiring HHSC to establish a health information exchange program to exchange confidential information with each hospital in this state regarding the hospital's performance with respect to potentially preventable readmissions. Deletes existing text requiring a hospital to distribute the information received from HHSC to health care providers providing services at the hospital.

(c) Provides that a report provided to a hospital under this section is confidential and is not subject to Chapter 552 (Public Information).

Sec. 536.152. REIMBURSEMENT ADJUSTMENTS. (a) Requires HHSC, subject to Subsection (b), using the data collected under Section 136.151 and the diagnosis-related groups (DRG) methodology implemented under Section 536.005, after consulting with the advisory committee, to the extent feasible to adjust child health plan and Medicaid reimbursements to hospitals, including payments made under the disproportionate share hospitals and upper payment limit supplemental payment programs, in a manner that may reward or penalize a hospital based on the hospital's performance with respect to exceeding, or failing to achieve, outcome and process measures developed under Section 536.003 that address potentially preventable readmissions and potentially preventable complications.

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

[Reserves Sections 536.153-536.200 for expansion.]

SUBCHAPTER E. QUALITY-BASED PAYMENT INITIATIVES

Sec. 536.201. DEFINITION. Defines, in this subchapter, "payment initiative."

Sec. 536.202. PAYMENT INITIATIVES; DETERMINATION OF BENEFIT TO STATE. (a) Requires HHSC, after consulting with the advisory committee, to establish payment initiatives to test the effectiveness of quality-based payment systems, alternative payment methodologies, and high-quality, cost-effective health care delivery models that provide incentives to health care providers and facilities 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 provider collaboration; and

(6) contain costs.

(b) Requires HHSC to establish a process by which managed care organizations and health care providers and facilities may submit proposals for payment initiatives described by Subsection (a), and 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) Requires HHSC to establish one or more payment initiatives as provided by this chapter if HHSC determines under Section 536.202 that implementation of one or more payment initiatives is feasible and cost-effective for this state.

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

(c) Authorizes HHSC to limit a payment initiative to:

(1) one or more regions in this state;

(2) one or more organized networks of health care providers and facilities; 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) Requires that a payment initiative implemented under this subchapter be operated for at least one calendar year.

Sec. 536.204. STANDARDS; PROTOCOLS. (a) Requires the executive commissioner to:

(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) Authorizes the executive commissioner, in addition to the benchmarks and goals under Subsection (a), to approve efficiency performance that may include the sharing of realized cost savings with health care providers and facilities that provide health care services that exceed the efficiency performance standards. Prohibits the efficiency performance standards from creating any financial incentive for or involve making a payment to a health care provider or facility that directly or indirectly induces the limitation of medically necessary services.

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

(b) Requires HHSC, as soon as practicable after the effective date of this Act, but not later than September 1, 2012, to convert the reimbursement systems used under the child health plan program under Chapter 62 (Child Health Plan for Certain Low-Income Children), Health and Safety Code, and medical assistance program under Chapter 32 (Medical Assistance Program), 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.

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

(d) Requires HHSC, subject to Section 536.004(b), Government Code, as added by this section, to 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 2. APPROPRIATE UTILIZATION OF CERTAIN HEALTH CARE SERVICES. (a) Amends Subchapter B, Chapter 531 Government Code, by adding Sections 531.086 and 531.0861, as follows:

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

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

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

(b) Requires that the study conducted under Subsection (a) evaluate:

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

(2) any change in statute required to implement each component within the Medicaid fee-for-service or primary care case management model.

(c) Requires the executive commissioner, not later than August 31, 2012, to submit to the governor and the Legislative Budget Board a report summarizing the findings of the study required by this section.

(d) Provides that this section expires September 1, 2013.

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

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

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

(b) Amends Section 32.0641, Human Resources Code, as follows:

Sec. 32.0641. New heading: RECIPIENT ACCOUNTABILITY PROVISIONS; COST-SHARING REQUIREMENT TO IMPROVE APPROPRIATE UTILIZATION OF SERVICES. (a) Requires the executive commissioner, to the

extent permitted under Title XIX, Social Security Act (42 U.S.C. Section 1396 et seq.) and any other applicable law or regulation or under a federal waiver or other authorization, after consulting with the Medicaid and the advisory committee established under Section 536.002, Government Code, to adopt cost-sharing provisions, that encourage personal accountability and appropriate utilization of health care services, including a cost-sharing provision applicable to a recipient who chooses to receive a nonemergency medical services through a hospital emergency room, rather than requiring the executive commissioner to adopt cost-sharing provisions that require a recipient who chooses a high-cost medical service provided through a hospital emergency room to pay a copayment, premium payment, or other cost-sharing payment for the high-cost medical services, 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 that the recipient does not have a condition requiring emergency medical services; 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 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 medical services, rather than emergency medical services, through the hospital emergency room despite having access to medically acceptable, appropriate medical services, rather than medically acceptable, lower-cost medical services.

(b) Prohibits HHSC from seeking a federal waiver or other authorization under this section, rather than under Subsection (a), that would prevent a Medicaid recipient who has a condition requiring emergency medical services from receiving care through a hospital emergency room, or waive any provision under Section 1867, Social Security Act (42 U.S.C. Section 1395dd).

Deletes existing Subsection (c), prohibiting HHSC from reducing 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 if the executive commissioner adopts a copayment or other cost-sharing payment under Subsection (a).

SECTION 3. LONG-TERM CARE PAYMENT INCENTIVE INITIATIVES. (a) Amends the heading to Section 531.912, Government Code, to read as follows:

Sec. 531.912. PAY-FOR-PERFORMANCE INCENTIVES FOR CERTAIN NURSING FACILITIES.

(b) Amends Sections 531.912(b), (c), and (f), Government Code, as follows:

(b) Requires the executive commissioner, if feasible, by rule to establish an incentive payment program for nursing facilities, rather than a quality of care health information exchange with nursing facilities that choose to participate in a program designed for a certain purpose, that choose to participate. Requires that the program be designed to improve the quality of care and services provided to medical assistance recipients. Authorizes the program, subject to Subsection (f), to provide incentive payments in accordance with this section to encourage facilities to participate in the program.

(c) Requires the executive commissioner, in establishing an incentive payment program, rather than a quality of care health information exchange program, under this section, subject to Subsection (d), to adopt outcome-based performance measures, rather than to exchange information with participating nursing facilities regarding performance measures. Sets forth the required and authorized criteria for those performance measures.

(f) Authorizes HHSC to make incentive payments under the program only if money is appropriated for that purpose, rather than specifically appropriated for that purpose.

(c) Requires the Department of Aging and Disability Services (DADS) to 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 certain types of providers of long-term care services as defined by Section 22.0011 (Definition), Human Resources Code, under the medical assistance program. Sets forth the types of providers of long-term care services.

(d) Requires DADS, not later than September 1, 2012, to submit to the legislature a written report containing the findings of the study conducted under Subsection (c) of this section and DADS's recommendations.

SECTION 4. FEDERAL AUTHORIZATION. Requires a state agency, if necessary for implementation of a provision of this Act, to request a waiver or authorization from a federal agency, and authorizes delay of implementation until such waivers or authorizations are granted.

SECTION 5. Effective date: September 1, 2011.