BILL ANALYSIS

Senate Research Center
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C.S.S.B. 7
By: Nelson
Health & Human Services
4/9/2009
Committee Report (Substituted)

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

The goal of S.B. 7 is to improve the quality, safety, and efficiency of Medicaid and the Children's Health Insurance Program (CHIP) in Texas. S.B. 7 achieves this through improving health information technology, quality-based hospital payments, a standardized patient identification system, increased equity in uncompensated hospital care reporting and reimbursement, and the use of pilot programs designed to promote innovation in the delivery of health care. This legislation also ensures that stakeholders participate in an advisory role throughout the implementation process.

This legislation lays the groundwork for changes in the way the state pays for health care. Currently, hospitals and providers are paid a "fee-for-service" based on the number of treatments, as opposed to the outcome of treatment, de-incentivizing efficiency and quality. S.B. 7 aims to move closer to a system that will allow health care payments based on quality of care and outcomes as opposed to quantity of services.

C.S.S.B. 7 relates to strategies for and improvements in quality of health care and care management provided through health care facilities and through the child health plan and medical assistance programs designed to improve health outcomes.

RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to the executive commissioner of the Health and Human Services Commission (HHSC) in SECTION 1 (Section 531.0993, Government Code), SECTION 3 (Section 531.551, Government Code), SECTION 4 (Sections 531.904 and 531.910, Government Code), SECTION 5 (Section 531.953, Government Code), SECTION 6 (Section 531.983, Government Code), SECTION 8 (Section 32.0283, Human Resources Code), SECTION 9 (Section 32.0312, Human Resources Code), and SECTION 10 (Section 311.004, Health and Safety Code) of this bill.

Rulemaking authority previously granted to the executive commissioner of HHSC is modified in SECTION 3 (Section 531.551, Government Code) and SECTION 7 (Section 98.108, Health and Safety Code) of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1. CHILD HEALTH PLAN AND MEDICAID PILOT PROGRAMS. Amends Subchapter B, Chapter 531, Government Code, by adding Sections 531.0993 and 531.0994, as follows:

> Sec. 531.0993. OBESITY PREVENTION PILOT PROGRAM. (a) Requires the Health and Human Services Commission (HHSC) and the Department of State Health Services (DSHS) to coordinate to establish a pilot program designed to decrease the rate of obesity in child health plan program enrollees and Medicaid recipients, improve the nutritional choices and increase physical activity levels by child health plan program enrollees and Medicaid recipients, and achieve long-term reductions in child health plan and Medicaid program costs incurred by the state as a result of obesity.
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> (b) Requires HHSC and DSHS to implement the pilot program in one or more health care service regions in this state, as selected by HHSC. Requires HHSC, in selecting the regions for participation, to consider the degree to which child health

plan program enrollees and Medicaid recipients in the region are at higher than average risk of obesity.

(c) Requires HHSC and DSHS, in consultation with the Health Care Quality Advisory Committee (HCQ committee) established under Section 531.0995, in developing the pilot program, to identify measurable goals and specific strategies for achieving those goals. Authorizes the specific strategies to be evidence-based to the extent evidence-based strategies are available for the purposes of the program.

(d) Requires HHSC, not later than November 1, 2011, to submit a report to the standing committees of the senate and house of representatives having primary jurisdiction over the child health plan and Medicaid programs regarding the results of the pilot program under this section. Requires that the report include a summary of the identified goals for the program and the strategies used to achieve those goals, an analysis of the data collected in the program and the capability of the data to measure achievement of the identified goals, a recommendation regarding the continued operation of the pilot program, and a recommendation regarding whether the program should be implemented statewide.

(e) Authorizes the executive commissioner of HHSC (executive commissioner) to adopt rules to implement this section.

Sec. 531.0994. MEDICAL HOME FOR CHILD HEALTH PLAN PROGRAM ENROLLEES AND MEDICAID RECIPIENTS. (a) Defines "medical home."

(b) Requires HHSC to establish a pilot program in one or more health care service regions in this state designed to establish a medical home for each child health plan program enrollee and Medicaid recipient participating in the pilot program. Authorizes a primary care provider participating in the program to designate a care coordinator to support the medical home concept.

(c) Requires HHSC to develop in consultation with the HCQ committee established under Section 531.0995 the pilot program in a manner that bases payments made, or incentives provided, to a participant's medical home on factors that include measurable wellness and prevention criteria, use of best practices, and outcomes.

(d) Requires HHSC, not later than January 1, 2011, to submit a report to the standing committees of the senate and the house of representatives having primary jurisdiction over the child health plan and Medicaid programs regarding the status of the pilot program under this section. Requires that the report include recommendations regarding the continued operation of the pilot program or whether the program should be implemented statewide or if HHSC cannot make the recommendations described by Subdivision (1) (relating to pilot program recommendations regarding continued operation or statewide implementation) due to an insufficient amount of data having been collected at the time of the report, statements regarding the time frames within which HHSC anticipates collecting sufficient data and making those recommendations.

SECTION 2. HEALTH CARE QUALITY ADVISORY COMMITTEE. (a) Amends Subchapter B, Chapter 531, Government Code, by adding Section 531.0995, as follows:

Sec. 531.0995. HEALTH CARE QUALITY ADVISORY COMMITTEE. (a) Requires HHSC to establish the HCQ committee to assist HHSC as specified by Subsection (d) with defining the best practices and quality performance with respect to health care services and setting standards for quality performance by heath care providers and facilities for purposes of programs administered by HHSC or a health and human services agency.

(b) Requires the executive commissioner to appoint the members of the HCQ committee. Requires the HCQ committee to consist of health care providers, representatives of health care facilities, and other stakeholders interested in health care services provided in this state. Requires at least one member to be a physician who has clinical practice expertise, and at least one member to be 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) Requires the executive commissioner to appoint the presiding officer of the HCQ committee.

(d) Requires the HCQ committee to advise HHSC on measurable goals for the obesity prevention pilot program under Section 531.0993; measureable wellness and prevention criteria and best practices for the medical home pilot program under Section 531.0994; quality of care standards, evidence-based protocols, and measurable goals for quality-based payment initiatives pilot programs implemented under Subchapter W; and any other quality of care standards, evidence-based protocols, measurable goals, or other related issues with respect to which a law or the executive commissioner specifies that the HCQ committee is required to advise.

(b) Requires the executive commissioner of HHSC to appoint the members of the HCQ committee not later than November 1, 2009.

SECTION 3. UNCOMPENSATED HOSPITAL CARE DATA. (a) Amends the heading to Section 531.551, Government Code, to read as follows:

Sec. 531.551. UNCOMPENSATED HOSPITAL CARE REPORTING AND ANALYSIS; HOSPITAL AUDIT FEE.

(b) Amends Section 531.551, Government Code, by amending Subsections (a) and (d) and adding Subsections (a-1), (a-2), and (m), as follows:

(a) Requires the executive commissioner, using data submitted to DSHS under Subsection (a-1), to adopt rules providing for a standard definition of "uncompensated hospital care" that reflects unpaid costs incurred by hospitals and accounts for actual hospital costs and hospital charges and revenue sources, among other provisions.

(a-1) Requires DSHS, to assist the executive commissioner in adopting and amending the rules required by Subsection (a), to require each hospital in this state to provide to DSHS, not later than a date specified by DSHS, uncompensated hospital care data prescribed by HHSC. Requires each hospital to submit complete and adequate data, as determined by DSHS, not later than the specified date.

(a-2) Requires DSHS to notify HHSC of each hospital in this state that fails to submit complete and adequate data required by DSHS under Subsection (a-1) on or before the date specified by DSHS. Authorizes HHSC, notwithstanding any other law and to the extent allowed by federal law, to withhold Medicaid program reimbursements owed to the hospital until the hospital complies with the requirement.

(d) Requires HHSC, if HHSC determines through the procedures adopted under Subsection (b) that a hospital submitted a report described by Subsection (a)(3) with incomplete or inaccurate information, to notify the hospital of the specific information the hospital is required to submit and prescribe a date by which the hospital is required to provide that information.

(m) Authorizes HHSC to require each hospital that is required under 42 C.F.R. Section 455.304 to be audited to pay a fee to offset the cost of the audit in an amount determined by HHSC. Prohibits the total amount of fees imposed on hospitals as authorized by this subsection from exceeding the total cost incurred by HHSC in conducting the required audits of the hospitals.

(c) Requires the executive commissioner, as soon as possible after the date DSHS requires each hospital in this state to initially submit uncompensated hospital care data under Section 531-551(a-1), Government Code, as added by this section, to adopt rules or amendments to existing rules that conform to the requirements of Section 531.551(a), Government Code, as amended by this section.

SECTION 4. MEDICAL TECHNOLOGY; ELECTRONIC HEALTH INFORMATION EXCHANGE PROGRAM. (a) Amends Chapter 531, Government Code, by adding Subchapter V, as follows:

SUBCHAPTER V. ELECTRONIC HEALTH INFORMATION EXCHANGE PROGRAM

Sec. 531.901. DEFINITIONS. Defines "electronic health record," "health information exchange system," and "local or regional health information exchange."

Sec. 531.902. ELECTRONIC HEALTH INFORMATION EXCHANGE SYSTEM. (a) Requires HHSC to develop an electronic health information system to improve the quality, safety, and efficiency of health care services provided under the child health plan and Medicaid programs. Requires HHSC, in developing the system, to ensure that the confidentiality of patients' health information is protected and the privacy of those patients is maintained, appropriate information technology systems used by HHSC and health and human services agencies are interoperable, and the system and external information technology systems are interoperable in receiving and exchanging appropriate electronic health information as necessary to enhance the comprehensive nature of the information contained in electronic health records.

(b) Requires HHSC to implement the health information exchange system in stages as described by this subchapter, except that HHSC is authorized to deviate from those stages if technological advances make a deviation advisable or more efficient.

(c) Requires that the health information exchange system be developed in accordance with the Medicaid Information Technology Architecture (MITA) initiative of the Center for Medicaid and State Operations.

Sec. 531.903. ELECTRONIC HEALTH INFORMATION EXCHANGE SYSTEM ADVISORY COMMITTEE. (a) Requires HHSC to establish the Electronic Health Information Exchange System Advisory Committee (committee) to assist HHSC in the performance of HHSC's duties under this subchapter.

(b) Requires the executive commissioner to appoint to the committee at least 12 and not more than 15 members who have an interest in health information technology and who have experience in serving persons receiving health care through the child health plan and Medicaid programs.

(c) Requires the committee to include certain members, including Medicaid providers; child health plan program providers; fee-for-service providers; at least one representative of the Texas Health Services Authority established under Chapter 182 (Texas Health Services Authority), Health and Safety Code; at least one representative of each health and human services agency; at least one representative of a major

provider association; at least one representative of a health care facility; at least one representative of a managed care organization; at least one representative of the pharmaceutical industry; and at least one representative of a local or regional health information exchange.

(d) Requires the members of the committee to represent the geographic and cultural diversity of the state.

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

(f) Requires the committee to advise HHSC on issues regarding the development and implementation of the electronic health information exchange system, including any issue specified by HHSC and certain specific issues, including data to be included in an electronic health record; presentation of data; useful measures for quality of service and patient health outcomes; federal and state laws regarding privacy and management of private patient information; incentives for increasing health care provider adoption and usage of an electronic health record and the health information exchange system; and data exchange with local or regional health information exchanges to enhance the comprehensive nature of the information contained in electronic health records.

(g) Requires the committee to collaborate with the Texas Health Services Authority to ensure that the health information exchange system is interoperable with, and not an impediment to, the electronic health information infrastructure that the authority assists in developing.

Sec. 531.904. STAGE ONE: ELECTRONIC HEALTH RECORD. (a) Requires HHSC, in stage one of implementing the health information exchange system, to develop and establish a claims-based electronic health record for each person who receives medical assistance under the Medicaid program. Requires that the electronic health record be available through a browser-based format.

(b) Requires the executive commissioner to adopt rules specifying the information required to be included in the electronic health record. Authorizes the required information to include, as appropriate, the name and address of each of the person's health care providers; a record of each visit to a health care provider, including diagnoses, procedures performed, and laboratory test results; an immunization record; a prescription history; a list of due and overdue Texas Health Steps medical and dental checkup appointments; and any other available health history that health care providers who provide care for the person determine is important.

(c) Authorizes information under Subsection (b) to be added to any existing electronic health record or health information technology and to be exchanged with local and regional health information exchanges.

(d) Requires HHSC to make an electronic health record for a patient available to the patient through the Internet.

Sec. 531.9041. STAGE ONE: ENCOUNTER DATA. Requires HHSC, in stage one of implementing the health information exchange system, to require for purposes of the implementation each managed care organization with which HHSC contracts under Chapter 533 (Powers and Duties) for the provision of Medicaid managed care services to submit to HHSC complete encounter data for each month that includes all paid and processed claims for the month not later than the 30th day after the last day of the month to which the data relates.

Sec. 531.905. STAGE ONE: ELECTRONIC PRESCRIBING. (a) Requires HHSC, in stage one of implementing the health information exchange system, to

develop and coordinate electronic prescribing tools for use by health care providers and health care facilities under the child health plan and Medicaid programs.

(b) Requires the electronic prescribing tools, to the extent feasible, to provide current payer formulary information at the time a health care provider writes a prescription and support the electronic transmission of a prescription.

(c) Authorizes HHSC to take any reasonable action to comply with this section, including establishing information exchanges with national electronic prescribing networks or providing health care providers with access to an Internet-based prescribing tool developed by HHSC.

(d) Requires HHSC to apply for and actively pursue any waiver to the child health plan program or the state Medicaid plan from the federal Centers for Medicare and Medicaid Services or any other federal agency as necessary to remove an identified impediment to the implementation of electronic prescribing tools under this section. Requires HHSC, if HHSC with assistance from the Legislative Budget Board determines that the implementation of operational modifications in accordance with a waiver obtained as required by this subsection has resulted in cost increases in the child health plan or Medicaid program, to take the necessary actions to reverse the operational modifications.

Sec. 531.906. STAGE TWO: EXPANSION. Authorizes HHSC, based on the recommendations of the committee established under Section 531.903 and feedback provided by interested parties, in stage two of implementing the health information exchange system, to expand the system by providing an electronic health record for each child enrolled in the child health plan program; including state laboratory results information in an electronic health record, including the results of newborn screenings and tests conducted under the Texas Health Steps program, based on the system developed for the health passport under Section 266.006 (Health Passport), Family Code; improving data-gathering capabilities for an electronic health record so that the record may include basic health and clinical information in addition to available claims information, as determined by the executive commissioner; using evidence-based technology tools to create a unique health profile to alert health care providers regarding the need for additional care, education, counseling, or health management activities for specific patients; and continuing to enhance the electronic health record created under Section 531.904 as technology becomes available and interoperability capabilities improve.

Sec. 531.907. STAGE THREE: EXPANSION. Authorizes HHSC, in stage three of implementing the health information exchange system, to expand the system by developing evidence-based benchmarking tools that can be used by health care providers to evaluate their own performances on health care outcomes and overall quality of care as compared to aggregated performance data regarding peers and expanding the system to include state agencies, additional health care providers, laboratories, diagnostic facilities, hospitals, and medical offices.

Sec. 531.908. INCENTIVES. Requires HHSC and the committee established under Section 531.903 to develop strategies to encourage health care providers to use the health information exchange system, including incentives, education, and outreach tools to increase usage.

Sec. 531.909. REPORTS. (a) Requires HHSC to provide an initial report to the Senate Health and Human Services Committee or its successor, the House Committee on Human Services or its successor, and the House Committee on Public Health or its successor regarding the health information exchange system not later than January 1, 2011, and to provide a subsequent report to those

committees not later than January 1, 2013. Requires that each report describe the status of the implementation of the system, specify utilization rates for each health information technology implemented as a component of the system, and identify goals for utilization rates described by Subdivision (2) (relating to requiring the report to specify utilization rates) and actions HHSC intends to take to increase utilization rates.

(b) Provides that this section expires September 2, 2013.

Sec. 531.910. RULES. Authorizes the executive commissioner to adopt rules to implement this subchapter.

(b) Amends Subchapter B, Chapter 62, Health and Safety Code, by adding Section 62.060, as follows:

Sec. 62.060. HEALTH INFORMATION TECHNOLOGY STANDARDS. (a) Defines "health information technology."

(b) Requires HHSC to ensure that any health information technology used in the child health plan program conforms to nationally recognized standards.

(c) Amends Subchapter B, Chapter 32, Human Resources Code, by adding Section 32.073, as follows:

Sec. 32.073. HEALTH INFORMATION TECHNOLOGY STANDARDS. (a) Defines "health information technology."

(b) Requires HHSC to ensure that any health information technology used in the medical assistance program conforms to nationally recognized standards.

(d) Requires the executive commissioner, as soon as practicable after the effective date of this Act, to adopt rules to implement the electronic health record and electronic prescribing system required by Subchapter V, Chapter 531 (Health and Human Services Commission), Government Code, as added by this section.

(e) Requires the executive commissioner to appoint the members of the committee established under Section 531.903, Government Code, as added by this section, as soon as practicable after the effective date of this Act.

SECTION 5. QUALITY-BASED PAYMENT INITIATIVES. (a) Amends Chapter 531, Government Code, by adding Subchapter W, as follows:

SUBCHAPTER W. QUALITY-BASED PAYMENT INITIATIVES PILOT PROGRAMS FOR PROVISION OF HEALTH CARE SERVICES

Sec. 531.951. DEFINITIONS. Defines "pay-for-performance system" and "pilot program."

Sec. 531.952. PILOT PROGRAM PROPOSALS; DETERMINATION OF BENEFIT TO STATE. (a) Authorizes health care providers and facilities to submit proposals to HHSC for the implementation through pilot programs of quality-based payment initiatives that provide incentives to the providers and facilities, as applicable, to develop health care interventions for child health plan program enrollees or Medicaid recipients, or both, that are cost-effective to this state and will improve the quality of health care provided to the enrollees or recipients.

(b) Requires HHSC to determine whether it is feasible and cost-effective to implement one or more of the proposed pilot programs. Requires HHSC, in addition, to examine alternative payment methodologies used in the Medicare

program and consider whether implementing one or more of the methodologies, modified as necessary to account for programmatic differences, through a pilot program under this subchapter would achieve cost savings in the Medicaid program while ensuring the use of best practices.

Sec. 531.953. PURPOSE AND IMPLEMENTATION OF PILOT PROGRAMS. (a) Requires HHSC, if HHSC determines under Section 531.952 that implementation of one or more quality-based payment initiatives pilot programs is feasible and cost-effective for this state, to establish one or more programs as provided by this subchapter to test pay-for-performance payment system alternatives to traditional fee-for-service or other payments made to health care providers or facilities participating in the child health plan or Medicaid program, as applicable, that are based on best practices, outcomes, and efficiency, but ensure high-quality, effective health care services.

(b) Requires HHSC to administer any pilot program 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 pilot program to one or more regions in this state, one or more organized networks of health care facilities and providers, or 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 pilot program implemented under this subchapter be operated for at least one state fiscal year.

Sec. 531.954. STANDARDS; PROTOCOLS. (a) Requires the executive commissioner, in consultation with the HCQ committee established under Section 531.0995, to approve quality of care standards, evidence-based protocols, and measurable goals for a pilot program to ensure high-quality and effective health care services.

(b) Authorizes the executive commissioner to approve, in addition to the standards approved under Subsection (a), efficiency performance standards that are authorized to include the sharing of realized cost savings with health care providers and facilities that provide health care services that exceed the efficiency performance standards.

Sec. 531.955. QUALITY-BASED PAYMENT INITIATIVES. (a) Authorizes the executive commissioner to contract with appropriate entities, including qualified actuaries, to assist in determining appropriate payment rates for a pilot program implemented under this subchapter.

(b) Authorizes the executive commissioner to increase a payment rate, including a capitation rate, adopted under this section as necessary to adjust the rate for inflation.

(c) Requires the executive commissioner to ensure that services provided to a child health plan program enrollee or Medicaid recipient, as applicable, meet the quality of care standards required under this subchapter and are at least equivalent to the services provided under the child health plan or Medicaid program, as applicable, for which the enrollee or recipient is eligible.

Sec. 531.956. TERMINATION OF PILOT PROGRAM; EXPIRATION OF SUBCHAPTER. Provides that the pilot program terminates and this subchapter expires September 2, 2013.

(b) Requires HHSC, not later than November 1, 2012, to present a report to the governor, the lieutenant governor, the speaker of the house of representatives, and the members of each legislative committee having jurisdiction over the child health plan and Medicaid programs. Requires that the report, for each pilot

program implemented under Subchapter W, Chapter 531, Government Code, as added by this section, describe the operation of the pilot program, analyze the quality of health care provided to patients under the pilot program, compare the per-patient cost under the pilot program to the per-patient cost of the traditional fee-for-service or other payments made under the child health plan and Medicaid programs, and make recommendations regarding the continuation or expansion of the pilot program.

SECTION 6. QUALITY-BASED HOSPITAL PAYMENTS. Amends Chapter 531, Government Code, by adding Subchapter X, as follows:

SUBCHAPTER X. QUALITY- BASED HOSPITAL REIMBURSEMENT SYSTEM

Sec. 531.981. DEFINITIONS. Defines "potentially preventable complication" and "potentially preventable readmission."

Sec. 531.982. DEVELOPMENT OF QUALITY-BASED HOSPITAL REIMBURSEMENT SYSTEM. (a) Requires HHSC, subject to Subsection (b), to develop a quality-based hospital reimbursement system for paying Medicaid reimbursements to hospitals. Provides that the system is intended to align Medicaid provider payment incentives with improved quality of care, promote coordination of health care, and reduce potentially preventable complications and readmissions.

(b) Requires HHSC to develop the quality-based hospital reimbursement system in phases as provided by this subchapter. Requires HHSC, to the extent possible, to coordinate the timeline for the development and implementation with the implementation of the Medicaid Information Technology Architecture (MITA) initiative of the Center for Medicaid and State Operations and the ICD-10 code sets initiative and with the ongoing Enterprise Data Warehouse (EDW) planning process to maximize receipt of federal funds.

Sec. 531.983. PHASE ONE: COLLECTION AND REPORTING OF CERTAIN INFORMATION. (a) Provides that the first stage of the development of the quality-based hospital reimbursement system consists of the elements described by this section.

(b) Requires the executive commissioner to adopt rules for identifying potentially preventable readmissions of Medicaid recipients and requires HHSC to collect data on present-on-admission indicators for purposes of this section.

(c) Requires HHSC to establish a program to provide a confidential report to each hospital in this state regarding the hospital's performance with respect to potentially preventable readmissions. Requires a hospital to provide the information contained in the report provided to the hospital to health care providers providing services at the hospital

(d) Provides that after HHSC provides the reports to hospitals as provided by Subsection (c), each hospital will be afforded a period of two years during which the hospital is authorized to adjust its practices in an attempt to reduce its potentially preventable readmissions. Provides that during that period, reimbursements paid to the hospital may not be adjusted on the basis of potentially preventable readmissions.

(e) Requires HHSC to convert the hospital Medicaid reimbursement system to a diagnoses-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.

Sec. 531.984. PHASE TWO: REIMBURSEMENT ADJUSTMENTS. (a) Provides that the second phase of the development of the quality-based hospital reimbursement system consists of the elements described by this section and is required to be based on the

information reported, and the DRG methodology implemented, during phase one of the development.

(b) Requires HHSC, using the information reported and the DRG methodology implemented during phase one of the development of the quality-based hospital reimbursement system, to adjust Medicaid reimbursements to hospitals based on performance in reducing potentially preventable readmissions. Provides that the adjustment is prohibited from being applied to a hospital if the patient's readmission to that hospital is classified as a potentially preventable readmission, but that hospital is not the same hospital to which the person was previously admitted and is required to be focused on addressing potentially preventable readmissions that are continuing, significant problems, as determined by HHSC.

Sec. 531.985. PHASE THREE: STUDY OF POTENTIALLY PREVENTABLE COMPLICATIONS. (a) Requires HHSC, in phase three of the development of the quality-based hospital reimbursement system, to study the feasibility of collecting data from hospitals concerning potentially preventable complications and adjusting Medicaid reimbursements based on performance in reducing those complications.

(b) Requires HHSC to provide a report to the standing committees of the senate and house of representatives having primary jurisdiction over the Medicaid program concerning the results of the study conducted under this section when the study is completed.

SECTION 7. PREVENTABLE ADVERSE EVENT REPORTING. (a) Amends the heading to Chapter 98, Health and Safety Code, as added by Chapter 359 (S.B. 288), Acts of the 80th Legislature, Regular Session, 2007, to read as follows:

CHAPTER 98. REPORTING OF HEALTH CARE-ASSOCIATED INFECTIONS AND PREVENTABLE ADVERSE EVENTS

(b) Amends Sections 98.001(1) and (11), Health and Safety Code, as added by Chapter 359 (S.B. 288), Acts of the 80th Legislature, Regular Session, 2007, to redefine "advisory panel" and "reporting system."

(c) Amends Section 98.051, Health and Safety Code, as added by Chapter 359 (S.B. 288), Acts of the 80th Legislature, Regular Session, 2007, as follows:

Sec. 98.051. ESTABLISHMENT. Requires the executive commissioner to establish the Advisory Panel on Health Care-Associated Infections and Preventable Adverse Effects within DSHS, rather than within the infectious disease surveillance and epidemiology branch of DSHS, to guide the implementation, development, maintenance, and evaluation of the reporting system.

(d) Amends Section 98.052(a), Health and Safety Code, as added by Chapter 359 (S.B. 288), Acts of the 80th Legislature, Regular Session, 2007, as follows:

(a) Provides that the advisory panel is composed of 18, rather than 16, members, including three board-certified or board-eligible physicians who are licensed to practice medicine in this state under Chapter 155, Occupations Code, at least two of whom have active medical staff privileges at a hospital in this state and at least one of whom is an active member of the Society for Healthcare Epidemiology of America and who have demonstrated expertise in quality assessment and performance improvement or infection control in health care facilities; and four additional professionals in quality assessment and performance improvement, among certain other members. Deletes existing text requiring that one of the three board-certified or board-eligible physicians be a pediatric infectious disease physician with expertise and experience in pediatric health care epidemiology, that all three physicians are active members of the Society for Healthcare Epidemiology of America; and that one of the two professionals in quality

assessment and performance improvement, be employed by a general hospital and the other by an ambulatory surgical center.

(e) Amends Sections 98.102(a) and (c), Health and Safety Code, as added by Chapter 359 (S.B. 288), Acts of the 80th Legislature, Regular Session, 2007, as follows:

(a) Requires DSHS to establish the Texas Health Care-Associated Infection and Preventable Adverse Events Reporting System within DSHS, rather than within the infectious disease surveillance and epidemiology branch of DSHS. Provides that the purpose of the reporting system is to provide for the reporting of health care-associated preventable adverse events by health care facilities to DSHS and the public reporting of information regarding health care-associated preventable adverse events by DSHS, among other purposes. Makes nonsubstantive changes.

(c) Requires that the data reported by health care facilities to DSHS contain sufficient patient identifying information to allow DSHS, for data reported under Section 98.103 or 98.104, to risk adjust the facilities' infection rates, among other purposes.

(f) Amends Subchapter C, Chapter 98, Health and Safety Code, as added by Chapter 359 (S.B. 288), Acts of the 80th Legislature, Regular Session, 2007, by adding Section 98.1045, as follows:

Sec. 98.1045. REPORTING OF PREVENTABLE ADVERSE EVENTS. (a) Requires each health care facility to report to DSHS the occurrence of any of the following preventable adverse events involving the facility's patient:

(1) a health care-associated adverse condition or event for which the Medicare program will not provide additional payment to the facility under a policy adopted by the federal Centers for Medicare and Medicaid Services; and

(2) subject to Subsection (b), an event included in the list of adverse events identified by the National Quality Forum that is not included under Subdivision (1).

(b) Authorizes the executive commissioner to exclude an adverse event described by Subsection (a)(2) from the reporting requirement of Subsection (a) if the executive commissioner, in consultation with the advisory panel, determines that the adverse event is not an appropriate indicator of a preventable adverse event.

(g) Amends Sections 98.106(a), (b), and (g), Health and Safety Code, as added by Chapter 359 (S.B. 288), Acts of the 80th Legislature, Regular Session, 2007, as follows:

(a) Requires DSHS to compile and make available to the public a summary, by health care facility, of the infections reported by facilities under Sections 98.103 and 98.104 and the preventable adverse events reported by facilities under Section 98.1045.

(b) Requires that information included in the DSHS summary with respect to infections reported by facilities under Sections 98.103 and 98.104 be risk adjusted and include a comparison of the risk-adjusted infection rates for each health care facility in this state that is required to submit a report under Sections 98.103 and 98.104.

(g) Requires DSHS to make the DSHS summary available on an Internet website administered by DSHS and authorizes DSHS to make the summary available through other formats accessible to the public. Requires that the website contain a statement informing the public of the option to report suspected health care-associated infections and preventable adverse events to DSHS.

(h) Amends Section 98.108, Health and Safety Code, as added by Chapter 359 (S.B. 288), Acts of the 80th Legislature, Regular Session, 2007, as follows:

Sec. 98.108. FREQUENCY OF REPORTING. Requires the executive commissioner by rule to establish, in consultation with the advisory panel, the frequency of reporting by health care facilities required under Sections 98.103, 98.104, and 98.1045.

(i) Amends Section 98.109, Health and Safety Code, as added by Chapter 359 (S.B. 288), Acts of the 80th Legislature, Regular Session, 2007, by adding Subsection (b-1) and amending Subsection (e), as follows:

(b-1) Prohibits a state employee or officer from being examined in a civil, criminal, or special proceeding, or any other proceeding, regarding the existence or contents of information or materials obtained, compiled, or reported by DSHS under this chapter.

(e) Prohibits a DSHS summary or disclosure from containing information identifying a patient and certain other persons in connection with a specific incident, rather than a facility patient and certain other persons in connection with a specific infection incident.

(j) Amends Sections 98.110 and 98.111, Health and Safety Code, as added by Chapter 359 (S.B. 288), Acts of the 80th Legislature, Regular Session, 2007, as follows:

Sec. 98.110. New heading: DISCLOSURE AMONG CERTAIN AGENCIES. Authorizes DSHS, notwithstanding any other law, to disclose information reported by health care facilities under Sections 98.103, 98.104, or 98.1045 to other programs within DSHS, to HHSC, and to other health and human services agencies, as defined by Section 531.001 (Definitions), Government Code, for public health research or analysis purposes only, provided that the research or analysis relates to health care-associated infections or preventable adverse events.

Sec. 98.111. CIVIL ACTION. Prohibits published infection rates or preventable adverse events from being used in a civil action to establish a standard of care applicable to a health care facility.

(k) Requires the commissioner of state health services to appoint a person who meets the qualifications prescribed by Section 98.052(a)(3), Health and Safety Code, as amended by this section, to serve as a member of the advisory panel established under Section 98.051, Health and Safety Code, on each expiration date of the term of a member serving on that panel who met the qualifications prescribed by Section 98.052(a)(3), Health and Safety Code, as that section existed immediately preceding the effective date of this Act, and who was appointed before that date. Requires the commissioner, in addition, as soon as possible after the effective date of this Act, to appoint two additional members to the advisory panel who meet the qualifications prescribed by Section 98.052(a)(4), Health and Safety Code, as amended by this section.

(l) Requires the executive commissioner, not later than February 1, 2010, to adopt rules and procedures necessary to implement the reporting of health care-associated preventable adverse events as required under Chapter 98 (Reporting of Health Care-Associated Infections), Health and Safety Code, as amended by this section.

SECTION 8. LONG-TERM CARE INCENTIVES. (a) Amends Subchapter B, Chapter 32, Human Resources Code, by adding Section 32.0283, as follows:

Sec. 32.0283. PAY-FOR-PERFORMANCE INCENTIVES FOR CERTAIN NURSING FACILITIES. (a) Defines "nursing facility."

(b) Requires the executive commissioner by rule to establish, if feasible, an incentive payment program for nursing facilities that is designed to improve the quality of care and services provided to medical assistance recipients. Requires that the program provide additional payments in accordance with this section to the facilities that meet or exceed performance standards established by the executive commissioner.

(c) Requires the executive commissioner, in establishing an incentive payment program under this section, subject to Subsection (d), to adopt outcome-based performance measures. Requires that the performance measures be recognized by the executive commissioner as valid indicators of the overall quality of care received by medical assistance recipients and be designed to encourage and reward evidence-based practices among nursing facilities; and authorizes the performance measures to include measures of quality of life, direct-care staff retention and turnover, recipient satisfaction, employee satisfaction and engagement, the incidence of preventable acute care emergency room services use, regulatory compliance, level of person-centered care, and level of occupancy or of facility utilization.

(d) Requires the executive commissioner to maximize the use of available information technology and limit the number of performance measures adopted under Subsection (c) to achieve administrative cost efficiency and avoid an unreasonable administrative burden on nursing facilities, and for each performance measure adopted under Subsection (c), establish a performance threshold for purposes of determining eligibility for an incentive payment under the program.

(e) Requires a nursing facility, to be eligible for an incentive payment under the program, to meet or exceed applicable performance thresholds in at least two of the performance measures adopted under Subsection (c), at least one of which is an indicator of quality of care.

(f) Authorizes the executive commissioner to determine the amount of an incentive payment under the program based on a performance index that gives greater weight to performance measures that are shown to be stronger indicators of a nursing facility's overall performance quality and to enter into a contract with a qualified person, as determined by the executive commissioner, for the following services related to the program: data collection, data analysis, and reporting of nursing facility performance on the performance measures adopted under Subsection (c).

(b) Amends Section 32.060(a), Human Resources Code, as added by Section 16.01, Chapter 204 (H.B. 4), Acts of the 78th Legislature, Regular Session, 2003, as follows:

(a) Provides that any information obtained or used by DSHS to determine the eligibility of a nursing facility for an incentive payment, or to determine the facility's performance rating, under Section 32.028(g) or 32.0283(f), is not admissible as evidence in a civil action, among other findings and facts.

(c) Requires HHSC to conduct a study to evaluate the feasibility of providing an incentive payment program 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 similar to the incentive payment program established for nursing facilities under Section 32.0283, Human Resources Code, as added by this section.

(d) Requires HHSC, not later than September 1, 2010, to submit to the legislature a written report containing the findings of the study conducted under Subsection (c) of this section and HHSC's recommendations.

(e) Requires the executive commissioner, as soon as practicable after the effective date of this Act, to adopt the rules required by Section 32.0283, Human Resources Code, as added by this section.

SECTION 9. PREVENTABLE ADVERSE EVENT REIMBURSEMENT. (a) Amends Subchapter B, Chapter 32, Human Resources Code, by adding Section 32.0312, as follows:

Sec. 32.0312. REIMBURSEMENT FOR SERVICES ASSOCIATED WITH PREVENTABLE ADVERSE EVENTS. Requires the executive commissioner to adopt rules regarding the denial or reduction of reimbursement under the medical assistance program for preventable adverse events that occur in a hospital setting. Provides that the executive commissioner, in adopting rules under this subsection, is required to ensure that HHSC imposes the same reimbursement denials or reductions for preventable adverse events as the Medicare program imposes for the same types of health care-associated adverse conditions and the same types of health care providers and facilities under a policy adopted by the federal Centers for Medicare and Medicaid Services; is required to consult with the HCQ committee established under Section 531.0995, Government Code, to obtain the advice of that committee regarding denial or reduction of reimbursement claims for any other preventable adverse events that cause patient death or serious disability in health care settings, including events on the list of adverse events identified by the National Quality Forum; and is authorized to allow HHSC to impose reimbursement denials or reductions for preventable events described by Subdivision (2) (relating to requiring the executive commissioner to consult with the committee to obtain the advice of that committee regarding denial or reduction of reimbursement claims).

(b) Requires the executive commissioner, not later than September 1, 2010, to adopt rules required by Section 32.0312, Human Resources Code, as added by this section.

(c) Authorizes rules adopted by the executive commissioner under Section 32.0312, Human Resources Code, as added by this section, to apply only to a preventable adverse event occurring on or after the effective date of the rules.

SECTION 10. PATIENT RISK IDENTIFICATION SYSTEM. Amends Subchapter A, Chapter 311, Health and Safety Code, by adding Section 311.004, as follows:

Sec. 311.004. STANDARDIZED RISK IDENTIFICATION SYSTEM. (a) Defines "department" and "hospital."

(b) Requires DSHS to coordinate with hospitals to develop a statewide standardized patient risk identification system under which a patient with a specific medical risk may be readily identified through the use of a system that communicates to hospital personnel the existence of that risk. Requires the executive commissioner to appoint an ad hoc committee of hospital representatives to assist DSHS in developing the statewide system.

(c) Requires DSHS to require each hospital to implement and enforce the statewide standardized patient risk identification system developed under Subsection (b) unless DSHS authorizes an exemption for the reason stated in Subsection (d).

(d) Authorizes DSHS to exempt from the statewide standardized patient risk identification system a hospital that seeks to adopt another patient risk identification methodology supported by evidence-based protocols for the practice of medicine.

(e) Requires DSHS to modify the statewide standardized patient risk identification system in accordance with evidence-based medicine as necessary.

(f) Authorizes the executive commissioner to adopt rules to implement this section.

SECTION 11. 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 12. EFFECTIVE DATE. Effective date: September 1, 2009.