BILL ANALYSIS

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S.B. 7
By: Nelson
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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.

As proposed, S.B. 7 directs the Health and Human Services Commission (HHSC) and the Department of State Health Services (DSHS) to develop an obesity prevention pilot program, and to develop a pilot program to establish a medical home for Medicaid and CHIP recipients. The bill requires hospitals to submit data to DSHS relating to uncompensated care, and to develop an electronic health information exchange system that is compatible with existing information technology systems. The bill authorizes HHSC to develop a quality-based payment pilot program and a quality-based payment system within the Medicaid program. Health care facilities are required to report preventable adverse events to DSHS and prohibits or reduces Medicaid reimbursement to a hospital for never events consistent with Medicaid's payment methodologies for such events. The bill authorizes HHSC to develop a long-term care pay-for-performance program and requires all hospitals to use a standardized patient identification protocol based on patients' medical characteristics.

RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to the executive commissioner of the Health and Human Services Commission (HHSC) in SECTION 1 (Sections 531.0993 and 531.0994, Government Code), SECTION 3 (Sections 531.904 and 531.909, Government Code) and SECTION 4 (Section 531.953, Government Code), SECTION 5 (Section 531.983, Government Code), SECTION 7 (Section 32.0283, Human Resources Code), SECTION 8 (Section 32.0312, Human Resources Code), and SECTION 9 (Section 311.004, Health and Safety Code) of this bill.

Rulemaking authority previously granted to the executive commissioner of HHSC is modified in SECTION 2 (Section 531.551, Government Code) and in SECTION 6 (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 PILOT PREVENTION 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 nutritional choices by child health plan program enrollees and Medicaid recipients; and achieve reductions in child health plan and Medicaid program costs incurred by the state as a result of obesity.

(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 developing the pilot program, to identify measurable goals and specific strategies for achieving those goals.

(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, 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 any physician practice group providing services to participants under the pilot program to meet the Physician Practice Connections--Patient--Centered Medical Home Standards established by the National Committee for Quality Assurance, as those standards existed on January 1, 2009.

(d) Requires HHSC to develop 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.

(e) Requires HHSC, not later than November 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 results of the pilot program under this section. Requires that the report include a recommendation regarding the continued operation of the pilot program and a recommendation regarding whether the program should be implemented statewide.

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

SECTION 2. 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 by 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.

(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 in an amount equal to the costs incurred in conducting the audit.

(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 3. MEDICAL TECHNOLOGY; ELECTRONIC HEALTH INFORMATION EXCHANGE PROGRAM. (a) Amends Section 531.02411, Government Code, as follows:

Sec. 531.02411. STREAMLINING ADMINISTRATIVE PROCESSES. (a) Creates Subsection (a) from existing text.

(b) Requires HHSC to develop and implement a plan designed to encourage the increased use by Medicaid providers of the medical technology described by Subsection (a)(6)(B) (relating to the increased use of electronic prescribing tools). Requires that the plan include a goal of achieving by September 1, 2014, a specified percentage increase in the use of electronic prescribing by Medicaid providers. Requires HHSC, not later than January 1, 2010, to submit a report to the legislature describing the plan developed by HHSC in accordance with this subsection. Requires HHSC, not later than January 1, 2011, and January 1, 2013, to submit a report to the legislature regarding the implementation and results of the plan. Provides that this subsection expires September 1, 2014.

(b) Amends Chapter 531, Government Code, by adding Subchapter V, as follows:

SUBCHAPTER V. ELECTRONIC HEALTH INFORMATION EXCHANGE PROGRAM

Sec. 531.901. DEFINITIONS. Defines "health care provider" and "health information exchange system."

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 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.

(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 as its members 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; and at least one representative of a major provider association.

(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 the specific issues of 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 and incentives for increasing provider adoption and usage of an electronic health record and the health information exchange system.

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 an Internet-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 physicians and health care providers; a record of each visit to a physician or health care provider, including diagnoses, procedures performed, and laboratory test results; an immunization record; a prescription history; a list of pending and past due appointments based on Texas Health Steps program guidelines; and any other available health history that physicians and health care providers who provide care for the person determine is important.

(c) Authorizes information under Subsection (b) be added to any existing electronic health record or health information technology.

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

Sec. 531.905. STAGE ONE: ELECTRONIC PRESCRIBING. (a) Requires HHSC, in stage one of implementing the health information exchange system, develop and coordinate electronic prescribing tools for use by physicians and health care providers under the child health plan and Medicaid programs.

(b) Requires that the electronic prescribing tools, to the extent feasible, to provide current payer formulary information at the time a physician or 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 physicians and health care providers with access to an Internet-based prescribing tool developed by HHSC.

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; or using predictive modeling techniques and medical profiling capabilities to create a unique health profile for a person to be included in the person's electronic health record to alert physicians and health care providers regarding the need for education, counseling, or health management activities.

Sec. 531.907. STAGE THREE: EXPANSION. Authorizes HHSC, in stage three of implementing the health information exchange system, to expand the system by continuing to enhance the electronic health record created under Section 531.904 as technology becomes available and interoperability capabilities improve; developing benchmarking tools that can be used to evaluate the performance of physicians and health care providers and overall health care quality; or expanding the system to include state agencies, additional physicians, 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 physicians and health care providers to use the health information exchange system, including incentives, education, and outreach tools to increase usage.

Sec. 531.909. RULES. Authorizes the executive commissioner to adopt rules to implement this subchapter.

(c) 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 the standards adopted by the Healthcare Information Technology Standards Panel sponsored by the American National Standards Institute.

(d) 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 the standards adopted by the Healthcare Information Technology Standards Panel sponsored by the American National Standards Institute.

(e) 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.

(f) 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 4. 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 physicians and other health care providers to submit proposals to HHSC for the implementation through pilot programs of quality-based payment initiatives that provide incentives to the physicians or other health care providers 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 the bundled payment system used in the

Medicare program and consider whether implementing the system, 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 physicians and other health care providers 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 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 physicians, hospitals, and other health care providers or specified types of services provided under the health care 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 to approve quality of care standards and evidence-based protocols 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 physicians and other 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 5. 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, 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 MITA 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 requiring hospitals in this state to collect data with respect to Medicaid recipients regarding any indicators that are present at the time of a recipient's admission to the hospital that the recipient may experience potentially preventable complications on discharge from the hospital. Requires that the rules be consistent with policies established for the Medicare program for the collection of present-on-admission indicators and require each hospital to report data on the indicators to the Texas Health Care Information Collection maintained by DSHS.

(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 of Medicaid recipients. Requires HHSC to select a method for identifying potentially preventable readmissions for purposes of this subsection.

(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 an all patient refined diagnoses related groups (APR-DRG) payment system 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 APR-DRG payment system implemented, during phase one of the development.

(b) Requires HHSC, using the information reported and the APR-DRG payment system 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. Authorizes the adjustment to be a partial reduction of the reimbursement, but prohibit the adjustment from entirely eliminating the reimbursement.

(c) Requires HHSC to review present-on-admission indicator data reported by hospitals under Section 531.983(b) to determine the feasibility of establishing a program related to potentially preventable complications. Authorizes HHSC, if the program is determined feasible, to establish a program to provide confidential reports to each hospital in this state regarding the hospital's performance with respect to potentially preventable complications experienced by Medicaid recipients. Requires HHSC to select a method for identifying potentially preventable complications for purposes of this subsection.

(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 complications. Prohibits reimbursements paid to the hospital from being adjusted during this period, on the basis of potentially preventable complications.

Sec. 531.985. PHASE THREE: ADDITIONAL REIMBURSEMENT ADJUSTMENTS. (a) Provides that the third phase of the development of the quality-based hospital reimbursement system consists of the elements described by this section, and is based on the information reported during phase two of the development.

(b) Requires HHSC to use the information reported during phase two of the development of the quality-based hospital reimbursement system to guide decision-making on the option of adjusting Medicaid reimbursements to hospitals based on performance in reducing potential preventable complications. Authorizes the adjustment, if HHSC adjusts the reimbursement, to be in the amount of a portion of the reimbursement, but prohibit the adjustment from entirely eliminating the reimbursement.

(c) Authorizes HHSC to expand the applicability of reimbursement adjustments to additional bases.

SECTION 6. 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 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 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. 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, allow DSHS to risk adjust the facilities' infection rates.

(e) 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) Defines "infant," "serious disability," and "serious injury."

(b) Requires each health care facility to report to DSHS certain preventable adverse events involving the facility's patients, if applicable.

(f) 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 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.

(g) 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.

(h) 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) Provides that a DSHS summary or disclosure may not contain information identifying patient, employee, and certain other persons in connection with a specific incident, rather than a facility patient, employee, and certain other persons in connection with a specific infection incident.

(i) 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.

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

SECTION 7. 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 LONG-TERM CARE PROVIDERS. (a) Defines "long-term care provider."

(b) Requires the executive commissioner by rule to establish, if feasible, an incentive payment program for long-term care providers that is designed to improve the quality of care provided to medical assistance recipients. Requires that the program provide additional reimbursement payments in accordance with this section to the providers that 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 indicators of whether a long-term care provider is providing evidence-based care and the overall quality of care received by medical assistance recipients; and authorizes the performance measures to include measures of quality of life, direct-care staff stability, recipient satisfaction, regulatory compliance, level of person-centered care, and level of occupancy.

(d) Requires the executive commissioner to limit the number of performance measures adopted under Subsection (c) to avoid an unreasonable administrative burden on long-term care providers and for each performance measure adopted under Subsection (c), establish a

performance threshold for purposes of determing eligibility for an incentive payment under the program.

(e) Requires a long-term care provider, to be eligible for an incentive payment under the program, to 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) Requires that the amount of an incentive payment under the program be based on a long-term care provider's ability to achieve each performance measure, with greater weight given to performance measures that are strong indicators of quality of care.

(g) Authorizes the executive commissioner to enter into a contract with a person for the following services related to the program: data collection, data analysis, and reporting of long-term care provider performance on the performance measures.

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

SECTION 8. NEVER EVENT REIMBURSEMENT. (a) Amends Subchapter B, Chapter 32, Human Resources Code, by adding Section 32.0312, as follows:

Sec. 32.0312. REIMBURSEMENT PROHIBITED FOR SERVICES ASSOCIATED WITH PREVENTABLE ADVERSE EVENTS. (a) Defines "health care provider."

(b) Prohibits DSHS from providing reimbursement under the medical assistance program to a health care provider for a health care service provided in association with a preventable adverse event involving a recipient of medical assistance while in the provider's care, including a health care service provided as a result of or to correct the consequences of a preventable adverse event.

(c) Requires the executive commissioner to adopt rules necessary to implement this section, including rules defining a preventable adverse event for purposes of Subsection (b). Requires the executive commissioner, in adopting rules under this subsection, to ensure that DSHS does not provide reimbursement for health care services provided in association with the same types of health care-associated adverse conditions for which the Medicare program will not provide additional payment under a policy adopted by the Centers for Medicare and Medicaid Services; consider the list of adverse events identified by the National Quality Forum; and consult with health care providers, including hospitals, physicians, and nurses, and representatives of health benefit plan issuers to obtain the recommendations of those providers and representatives regarding denial of reimbursement claims for any other preventable adverse events that cause patient death or serious disability in health care settings.

(b) Requires the executive commissioner, not later than November 1, 2009, to adopt rules necessary to implement Section 32.0312, Human Resources Code, as added by this section.

(c) Makes application of Section 32.0312, notwithstanding Section 32.0312, Human Resources Code, prospective.

SECTION 9. PATIENT WRISTBANDS. Amends Subchapter A, Chapter 311, Health and Safety Code, by adding Section 311.004, as follows:

Sec. 311.004. STANDARDIZED PATIENT WRISTBANDS. (a) Defines "department" and "hospital."

(b) Requires DSHS to coordinate with hospitals to develop a statewide standardized patient wristband identification system under which a patient with a specific medical characteristic may be readily identified through the use of a colored wristband that indicates to hospital personnel the existence of that characteristic. Requires the 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 wristband identification system developed under Subsection (b).

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

SECTION 10. 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 11. EFFECTIVE DATE. Effective date: September 1, 2009.