SENATOR JANE NELSON

SB 7 by Senator Nelson - 82nd (1st Called)

relating to the administration, quality, efficiency and funding of health care, health and human services, and health benefits programs in this state.

Key Provisions

- Removes the now defunct Health Opportunity Pool and allocates 100% of the revenue from the Adult Entertainment Fee to programs that help sexual assault victims.
- Adds additional entities eligible to receive revenue from the Adult Entertainment Fee (health science centers, Internet Crimes Against Children Task Force, Department of Family and Protective Services).
- Authorizes the Health and Human Services Commission to implement an objective client assessment process for acute nursing services.
- Implements Electronic Visit Verification technology in community care programs and for acute nursing services.
- Repeals the prohibition against managed care in Cameron, Hidalgo, and Maverick counties and agreed upon language by Hinojosa for certain protections.
- Requires the Health and Human Services Commission to consider certain factors when awarding managed care contracts, including if a pharmacy benefit manager (PBM) has been convicted of violating state or federal law, committed a breach of contract, or assessed a fine or penalty of $500,000 or more in the previous three years.
- Allows for the carve-in of prescription drugs into Medicaid managed care while ensuring that existing patient protections under fee for service are maintained:
  - Single state formulary
  - Any willing pharmacy
  - Prohibits mandated mail order
  - Prompt pay for pharmacy claims
- Requires that any person serving as a medical director for a managed care organization be licensed to practice medicine in Texas.
- Transfers children in the State Kids Insurance Program to the Children's Health Insurance Program.
- Eliminates the electronic finger imaging requirement for the Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF) and requires the Commission to implement appropriate technology to prevent duplicative benefits.
- Makes assisted living facility and nursing home licenses renewable every 3 years (instead of every 2 years) and directs HHSC to stagger license expiration dates.
- Directs DADS to conduct utilization reviews of services in all waiver programs and directs HHSC and DADS to explore ways to develop uniform licensing and contracting standards for all waiver programs.
- Exempts DSHS programs from assisted living facility licensure.

- Requires the Commission to study and implement physician incentive programs to reduce emergency room use for non-emergency conditions in Medicaid.
- Directs the Commission to implement copayments for Medicaid recipients who use the emergency room for non-emergency conditions.
- Allows the Commission to expand its existing Medicaid billing coordination system to process claims for other services provided through the Commission or another health and human services agency.
- Establishes the Medicaid/CHIP Quality-Based Payments Advisory Committee.
- Directs the Commission, in consultation with the advisory committee, to develop quality-based outcome measures that focus on reducing potentially preventable events (e.g., preventable hospital admissions, emergency room visits, ancillary services, readmissions, and complications).
- Requires the Commission to use these quality-based outcome measures to adjust Medicaid/CHIP reimbursements across all Medicaid/CHIP payment systems including fee-for-service and managed care.
- Requires HHSC to convert its current Medicaid/CHIP reimbursement systems to a diagnosis-related groups (DRG) methodology that will more accurately classify patient populations and account for the patient's severity of illness and mortality risk no later than September 1, 2012.
- Requires the Commission to use quality-based outcome measures to base a percentage of the premiums paid to managed care organizations participating in Medicaid/CHIP on the organization's performance.
- Requires HHSC to make information regarding managed care organizations' performance available to Medicaid/CHIP enrollees in managed care before they choose their managed care plan.
- Requires HHSC, when awarding contracts to managed care organizations, to give preference to an organization that implements quality-based payment initiatives or meets quality of care and cost-efficiency benchmarks.
- Allows HHSC to develop quality based payments, including shared savings, for Medicaid/CHIP providers who serve as a "health home" for recipients and provide high quality, efficient care.
- Requires HHSC to provide hospitals with a report regarding their performance on potentially preventable complications **(Last session we required HHSC to give hospitals a report on potentially preventable readmissions)**.
- Adjusts Medicaid/CHIP payments to hospitals based on a hospital's performance on potentially preventable readmissions and complications after hospitals have received performance reports for at least a year.
- Allows health care providers and facilities to submit proposals to HHSC for payment initiatives that improve quality and efficiency of Medicaid/CHIP and allows HHSC to implement initiatives that are feasible and cost-effective.
- Makes clean-up changes to the nursing facility pay-for-performance initiative passed last session.
- Directs DADS to study the feasibility of expanding the existing nursing facility pay-for-performance program to other long-term care services (e.g., ICF/MRs, home and community-based services).
- Allows a public hospital or hospital district that provides indigent care to a sponsored alien to recover the costs of the health care services from the sponsor.

- Allows the Commission to recover the costs of benefits (Medicaid, CHIP, food stamps, cash assistance) provided to a sponsored alien from the sponsor.
- Requires electronic submission for durable medical equipment under Medicaid.
- Creates tiers for family planning funding to ensure providers of comprehensive care are prioritized.
- Continues the women's health program prohibition currently in statute against funding abortion providers.
- Establishes a state action doctrine to provide certified health care collaborative safe harbor from state and federal anti-trust laws.
- Establishes the Texas Institute of Health Care Quality and Efficiency (administratively attached to HHSC) to improve health care quality, efficiency, accountability, education, and cost containment in this state by encouraging health care provider collaboration, effective health care delivery models, and coordination of health care services.
- Requires the Institute to complete an assessment of all health-related data currently collected by the state, and make recommendations for consolidating this data and improving health care transparency to the public.
- Requires the Institute to study the feasibility of establishing an "all payor" claims database.
- Abolishes the Texas Health Care Policy Council and transfers all unexpended balances to the Institute.
- Prohibits mandatory coverage under a health care collaborative.
- Establishes a governance structure for health care collaborative.
- Requires a collaborative to have a compensation advisory committee.
- Creates a "Health Care Collaborative" certification process at the Texas Department of Insurance.
- Requires the Attorney General's office to review applications for certification and either concur or not concur with the Department of Insurance's decision to grant a certificate.
- Requires a collaborative to renew its certificate annually.
- Requires a collaborative to have a complaint system in place to resolve complaints by patients and health care providers.
- Requires due process for a physician who is either not chosen to participate in a collaborative or de-selected from participation.
- Requires the Department of Insurance to collect application and renewal fees from the collaboratives **(offsets costs of certification and regulation)**.
- Allows the Insurance Commissioner to suspend, revoke, and impose sanctions and penalties on a collaborative who is non-compliant with the requirements for collaboratives.
- Allows a public hospital or hospital district to create a health care collaborative.
- Requires the Department of State Health Services to coordinate with hospitals to develop a statewide patient wristband protocol based on patient medical characteristics (e.g., DNR, allergies).
- Clarifies that the Department of State Health Services may designate the federal National Healthcare Safety Network for statewide healthcare-associated infections reporting and preventable adverse events and makes reporting frequency consistent with federal requirements **(this change is needed to implement SB 288 (80R), Nelson).**
- Requires the Department of State Health Services to publicly report hospital rates of potentially preventable readmissions and complications.

- Requires the Department of State Health Services to study and make recommendations on reporting potentially preventable adverse health conditions that occur in long-term care facilities.
- Requires the Department of State Health Services, in consultation with the Institute, to study how a recognition program that recognizes exemplary health facilities could be implemented.
- Allows the Department of State Health Services to share health-related data within the department and with the Health and Human Services Commission.
- Repeals rural hospital reporting exemption beginning September 1, 2014.
- Requires hospitals and health care facilities to develop and implement a policy to protect its patients from vaccine preventable diseases.
- Establishes the Texas emergency and trauma care education partnership program.