PRELIMINARY DRAFT

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CHAPTER 543A. QUALITY-BASED OUTCOMES AND PAYMENTS UNDER MEDICAID AND CHILD HEALTH PLAN PROGRAM

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SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 543A.0001. DEFINITIONS. In this chapter:

(1) "Alternative payment system" includes:

(A) a global payment system;

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

(C) a blended payment system.

(2) "Blended payment system" means a system for compensating a physician or other health care provider that:

(A) includes at least one feature of a global payment system and an episode-based bundled payment system; and

(B) may include a system under which a portion of

the compensation paid to a physician or other health care provider is based on a fee-for-service payment arrangement.

(3) "Enrollee" means an individual enrolled in the child health plan program.

(4) "Episode-based bundled payment system" means a system for compensating a physician or other health care provider for providing or arranging for health care services to an enrollee or recipient that is based on a flat payment for all services provided in connection with a single episode of medical care.

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

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

(7) "Global payment system" means a system for compensating a physician or other health care provider for providing or arranging for a defined set of covered health care services to an enrollee or recipient for a specified period that is based on a predetermined payment per enrollee or recipient for the specified period, without regard to the quantity of services actually provided.

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

(9) "HIV" has the meaning assigned by Section 81.101, Health and Safety Code.

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

(11) "Managed care organization" means a person that is authorized or otherwise permitted by law to arrange for or

provide a managed care plan. The term includes a health maintenance organization and an exclusive provider organization.

(12) "Managed care plan" means a plan, including an exclusive provider benefit plan, under which a person undertakes to provide, arrange or pay for, or reimburse any part of the cost of health care services. The plan must include arranging for or providing health care services as distinguished from indemnification against the cost of those services on a prepaid basis through insurance or otherwise. The term does not include a plan that indemnifies a person for the cost of health care services through insurance.

(13) "Physician" means an individual licensed to practice medicine in this state under Subtitle B, Title 3, Occupations Code.

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

(15) "Potentially preventable ancillary service" means a health care service that:

(A) a physician or other health care provider provides or orders to supplement or support evaluating or treating a patient, including a diagnostic test, laboratory test, therapy service, or radiology service; and

(B) might not be reasonably necessary to provide quality health care or treatment.

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

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

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

underlying disease.

(17) "Potentially preventable emergency room visit" means an individual's treatment in a hospital emergency room or freestanding emergency medical care facility for a condition that might not require emergency medical attention because the condition could be treated, or could have been prevented, by a physician or other health care provider in a nonemergency setting.

(18) "Potentially preventable event" means a:

(A) potentially preventable admission;

(B) potentially preventable ancillary service;

(C) potentially preventable complication;

(D) potentially preventable emergency room visit;

(E) potentially preventable readmission; or

(F) combination of those events.

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

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

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

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

(D) another condition or procedure of a similar nature that the executive commissioner determines.

(20) "Quality-based payment system" means a system, including an alternative payment system, for compensating a

physician or other health care provider that:

(A) provides incentives to the physician or other health care provider to provide high-quality, cost-effective care; and

(B) bases some portion of the payment made to the physician or other health care provider on quality-of-care outcomes, which may include the extent to which the physician or other health care provider reduces potentially preventable events.

(21) "Recipient" means a Medicaid recipient. (Gov. Code, Secs. 536.001, 536.003(h); New.)

Source Law

Sec. 536.001. DEFINITIONS. In this chapter:

(2) "Alternative payment system" includes:

(A) a global payment system;

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

(C) a blended payment system.

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

(5) "Episode-based bundled payment system" means a system for compensating a physician or other health care provider for arranging for or providing health care services to child health plan program enrollees or Medicaid recipients that is based on a flat payment for all services provided in connection with a single episode of medical care.

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

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

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

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

employment or contractual relationship.

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

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

(12) "Managed care plan" means a plan, including an exclusive provider benefit plan, under which a person undertakes to provide, arrange for, pay for, or reimburse any part of the cost of any health care services. A part of the plan must consist of arranging for or providing health care services as distinguished from indemnification against the cost of those services on a prepaid basis through insurance or otherwise. The term does not include a plan that indemnifies a person for the cost of health care services through insurance.

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

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

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

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

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

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

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

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

(20) "Potentially preventable readmission" means a return hospitalization of a person within a period specified by the commission that may have resulted from deficiencies in the care or

treatment provided to the person during a previous hospital stay or from deficiencies in post-hospital discharge follow-up. The term does not include a hospital readmission necessitated by the occurrence of unrelated events after the discharge. The term includes the readmission of a person to a hospital for:

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

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

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

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

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

[Sec. 536.003]

(h) In this section, "HIV" has the meaning assigned by Section 81.101, Health and Safety Code.

Revisor's Note

(1) The revised law adds definitions of "enrollee" and "recipient" for drafting convenience and to avoid frequent, unnecessary repetition of the substance of the definitions.

(2) Section 536.001(9), Government Code, refers to "any person, partnership, professional association, corporation, facility, or institution." The revised law omits the references to "partnership," "professional association," and "corporation" as unnecessary because the definition of "person" provided by Section 311.005(2), Government Code (Code Construction Act), which applies to the revised law, expressly includes those terms.

(3) Section 536.001(10), Government Code, refers to a "public or private institution." The revised law omits "public or private" because an institution is necessarily either public or private.

(4) Section 536.001(14), Government Code, refers to a "person" licensed to practice medicine, and Sections 536.001(15), (17), (19), and (20), Government Code, refer to a "person" who receives health care services. Throughout this chapter, the revised law substitutes "individual" for "person" for clarity and consistency where the context makes clear that the referenced person is a natural person and not an entity described by the definition of "person" provided by Section 311.005(2), Government Code (Code Construction Act), which applies to the revised law.

Revised Law

Sec. 543A.0002. DEVELOPMENT OF OUTCOME AND PROCESS MEASURES; CORRELATION WITH INCREASED REIMBURSEMENT RATES. (a) The commission shall develop quality-based outcome and process measures that:

(1) promote the provision of efficient, quality health care; and

(2) can be used in the child health plan program and Medicaid to implement quality-based payments for acute care services and long-term services and supports across all delivery models and payment systems, including fee-for-service and managed care payment systems.

(b) The commission, in coordination with the Department of State Health Services, shall develop and implement a quality-based outcome measure for the child health plan program and Medicaid to annually measure the percentage of enrollees or recipients with HIV infection, regardless of age, whose most recent viral load test indicates a viral load of less than 200 copies per milliliter of blood.

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

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

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

(3) that will have the greatest effect on improving quality of care and the efficient use of services, including acute care services and long-term services and supports;

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

(5) that reflect effective coordination of acute care services and long-term services and supports;

(6) that can be tied to expenditures; and

(7) that reduce preventable health care utilization and costs.

(d) In developing the outcome and process measures, the commission must include measures that are based on potentially preventable events and advance quality improvement and innovation. The outcome measures based on potentially preventable events must:

(1) allow for a rate-based determination of health care provider performance compared to statewide norms; and

(2) be risk-adjusted to account for the severity of the illnesses of patients a provider serves.

(e) The commission may modify the outcome and process measures to:

(1) promote continuous system reform, improved quality, and reduced costs; and

(2) account for managed care organizations added to a service area.

(f) To the extent feasible, the commission shall align the outcome and process measures with measures required or recommended under reporting guidelines established by:

(1) the Centers for Medicare and Medicaid Services;

(2) the Agency for Healthcare Research and Quality; or

(3) another federal agency.

(g) The executive commissioner by rule may require

physicians, other health care providers, and managed care organizations participating in the child health plan program and Medicaid to report information necessary to develop the outcome and process measures to the commission in a format the executive commissioner specifies.

(h) If the commission increases physician and other health care provider reimbursement rates under the child health plan program or Medicaid as a result of an increase in the amounts appropriated for those programs for a state fiscal biennium as compared to the preceding state fiscal biennium, the commission shall, to the extent permitted under federal law and to the extent otherwise possible considering other relevant factors, correlate the increased reimbursement rates with the quality-based outcome and process measures. (Gov. Code, Secs. 536.003(a), (a-1), (b), (c), (d), (e), (f).)

Source Law

Sec. 536.003. DEVELOPMENT OF QUALITY-BASED OUTCOME AND PROCESS MEASURES. (a) The commission shall develop quality-based outcome and process measures that promote the provision of efficient, quality health care and that can be used in the child health plan program and Medicaid to implement quality-based payments for acute care services and long-term services and supports across all delivery models and payment systems, including fee-for-service and managed care payment systems. Subject to Subsection (a-1), the commission, in developing outcome and process measures under this section, must include measures that are based on potentially preventable events and that advance quality improvement and innovation. The commission may change measures developed:

(1) to promote continuous system reform, improved quality, and reduced costs; and

(2) to account for managed care organizations added to a service area.

(a-1) The outcome measures based on potentially preventable events must:

(1) allow for rate-based determination of health care provider performance compared to statewide norms; and

(2) be risk-adjusted to account for the severity of the illnesses of patients served by the provider.

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

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

(2) in a manner that takes into account appropriate patient risk factors, including the burden

of chronic illness on a patient and the severity of a patient's illness;

(3) that will have the greatest effect on improving quality of care and the efficient use of services, including acute care services and long-term services and supports;

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

(5) that reflect effective coordination of acute care services and long-term services and supports;

(6) that can be tied to expenditures; and

(7) that reduce preventable health care utilization and costs.

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

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

(e) If the commission increases physician and other health care provider reimbursement rates under the child health plan program or Medicaid as a result of an increase in the amounts appropriated for the programs for a state fiscal biennium as compared to the preceding state fiscal biennium, the commission shall, to the extent permitted under federal law and to the extent otherwise possible considering other relevant factors, correlate the increased reimbursement rates with the quality-based outcome and process measures developed under this section.

(f) The commission, in coordination with the Department of State Health Services, shall develop and implement a quality-based outcome measure for the child health plan program and Medicaid to annually measure the percentage of child health plan program enrollees or Medicaid recipients with HIV infection, regardless of age, whose most recent viral load test indicates a viral load of less than 200 copies per milliliter of blood.

Revised Law

Sec. 543A.0003. USE OF QUALITY-BASED OUTCOME MEASURE FOR ENROLLEES OR RECIPIENTS WITH HIV INFECTION. (a) The commission shall include aggregate, nonidentifying data collected using the quality-based outcome measure described by Section 543A.0002(b) in the annual report required by Section 543A.0008. The commission may include the data in any other report required by this chapter.

(b) The commission shall determine the appropriateness of including the quality-based outcome measure described by Section

543A.0002(b) in the quality-based payments and payment systems developed under Sections 543A.0004 and 543A.0051. (Gov. Code, Sec. 536.003(g).)

Source Law

> (g) The commission shall include aggregate, nonidentifying data collected using the quality-based outcome measure described by Subsection (f) in the annual report required by Section 536.008 and may include the data in any other report required by this chapter. The commission shall determine the appropriateness of including the quality-based outcome measure described by Subsection (f) in the quality-based payments and payment systems developed under Sections 536.004 and 536.051.

Revised Law

Sec. 543A.0004. DEVELOPMENT OF QUALITY-BASED PAYMENT SYSTEMS. (a) Using the quality-based outcome and process measures developed under Section 543A.0002 and after consulting with appropriate stakeholders with an interest in the provision of acute care and long-term services and supports under the child health plan program and Medicaid, the commission shall develop and require managed care organizations to develop quality-based payment systems for compensating a physician or other health care provider participating in the child health plan program or Medicaid that:

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

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

(3) promote health care coordination;

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

(5) promote effective health care delivery models; and

(6) take into account the specific needs of the enrollee and recipient populations.

(b) The commission shall develop the quality-based payment systems in the manner specified by this chapter. To the extent necessary to maximize the receipt of federal money or reduce administrative burdens, the commission shall coordinate the timeline for developing and implementing a payment system with the

implementation of other initiatives such as:

(1) the Medicaid Information Technology Architecture (MITA) initiative of the Center for Medicaid and State Operations;

(2) the ICD-10 code sets initiative; or

(3) the ongoing Enterprise Data Warehouse (EDW) planning process.

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

(1) an alternative payment system;

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

(A) reduce unnecessary administrative burdens; and

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

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

(d) In developing the quality-based payment systems, the commission shall ensure that a system will not reward a physician, other health care provider, or managed care organization for withholding or delaying medically necessary care.

(e) The commission may modify a quality-based payment system to account for:

(1) programmatic differences between the child health plan program and Medicaid; and

(2) delivery systems under those programs. (Gov. Code, Sec. 536.004.)

Source Law

Sec. 536.004. DEVELOPMENT OF QUALITY-BASED PAYMENT SYSTEMS. (a) Using quality-based outcome and process measures developed under Section 536.003 and subject to this section, the commission, after consulting with appropriate stakeholders with an interest in the provision of acute care and long-term services and supports under the child health plan program and Medicaid, shall develop quality-based payment systems, and require managed care organizations to develop quality-based payment systems, for compensating a physician or other health care provider participating in the child health plan program or Medicaid that:

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

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

(3) promote the coordination of health care;

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

(5) promote effective health care delivery models; and

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

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

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

(1) an alternative payment system;

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

(A) reduce unnecessary administrative burdens; and

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

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

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

(e) The commission may modify a quality-based

payment system developed under this chapter to account for programmatic differences between the child health plan program and Medicaid and delivery systems under those programs.

Revisor's Note

(1) Section 536.004(a), Government Code, provides that "subject to this section," meaning Section 536.004, Government Code, the Health and Human Services Commission shall develop certain payment systems. The revised law omits the quoted language as unnecessary because the requirements of that section, which is revised as this section, apply by their own terms.

(2) Section 536.004(b), Government Code, refers to federal "funds." The revised law substitutes "money" for "funds" because, in context, the meaning is the same and "money" is the more commonly used term.

Revised Law

Sec. 543A.0005. PAYMENT METHODOLOGY CONVERSION. (a) To the extent possible, the commission shall convert hospital reimbursement systems under the child health plan program and Medicaid to a diagnosis-related groups (DRG) methodology that will allow the commission to more accurately classify specific patient populations and account for the severity of patient illness and mortality risk.

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

(c) Notwithstanding Subsection (a) and to the extent possible, the commission shall convert outpatient hospital reimbursement systems under the child health plan program and Medicaid to an appropriate prospective payment system that will allow the commission to:

(1) more accurately classify the full range of

outpatient service episodes;

(2) more accurately account for the intensity of services provided; and

(3) motivate outpatient service providers to increase efficiency and effectiveness. (Gov. Code, Sec. 536.005.)

Source Law

> Sec. 536.005. CONVERSION OF PAYMENT METHODOLOGY. (a) To the extent possible, the commission shall convert hospital reimbursement systems under the child health plan program and Medicaid to a diagnosis-related groups (DRG) methodology that will allow the commission to more accurately classify specific patient populations and account for severity of patient illness and mortality risk.
>
> (b) Subsection (a) does not authorize the commission to direct a managed care organization to compensate physicians and other health care providers providing services under the organization's managed care plan based on a diagnosis-related groups (DRG) methodology.
>
> (c) Notwithstanding Subsection (a) and to the extent possible, the commission shall convert outpatient hospital reimbursement systems under the child health plan program and Medicaid to an appropriate prospective payment system that will allow the commission to:
>
> (1) more accurately classify the full range of outpatient service episodes;
>
> (2) more accurately account for the intensity of services provided; and
>
> (3) motivate outpatient service providers to increase efficiency and effectiveness.

Revised Law

Sec. 543A.0006. TRANSPARENCY; CONSIDERATIONS. (a) The commission shall:

(1) ensure transparency in developing and establishing:

(A) quality-based payment and reimbursement systems under Section 543A.0004 and Subchapters B, C, and D, including in developing outcome and process measures under Section 543A.0002; and

(B) quality-based payment initiatives under Subchapter E, including developing quality-of-care and cost-efficiency benchmarks under Section 543A.0203(a) and approving efficiency performance standards under Section 543A.0203(b); and

(2) for developing and establishing the quality-based payment and reimbursement systems and initiatives described by Subdivision (1), develop guidelines that establish procedures to provide notice and information to and receive input from managed care organizations, health care providers, including physicians and experts in the various medical specialty fields, and other stakeholders, as appropriate.

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

(c) The commission shall develop web-based capability that:

(1) provides health care providers and managed care organizations with data on their clinical and utilization performance, including comparisons to peer organizations and providers located in this state and in the provider's respective region; and

(2) supports the requirements of the electronic health information exchange system under Sections ___, ___, and ___ [[[Sections 531.907, 531.908, and 531.909]]]. (Gov. Code, Sec. 536.006.)

Source Law

Sec. 536.006. TRANSPARENCY. (a) The commission shall:

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

(A) quality-based payment and reimbursement systems under Section 536.004 and Subchapters B, C, and D, including the development of outcome and process measures under Section 536.003; and

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

(2) develop guidelines establishing

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

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

(4) develop web-based capability to provide managed care organizations and health care providers with data on their clinical and utilization performance, including comparisons to peer organizations and providers located in this state and in the provider's respective region.

(b) The web-based capability required by Subsection (a)(4) must support the requirements of the electronic health information exchange system under Sections 531.907 through 531.909.

Revised Law

Sec. 543A.0007. PERIODIC EVALUATION. At least once each two-year period, the commission shall evaluate the outcomes and cost-effectiveness of any quality-based payment system or other payment initiative implemented under this chapter. (Gov. Code, Sec. 536.007.)

Source Law

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

Revised Law

Sec. 543A.0008. ANNUAL REPORT. (a) The commission shall submit to the legislature and make available to the public an annual report on:

(1) the quality-based outcome and process measures developed under Section 543A.0002, including measures based on each potentially preventable event; and

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

(b) The commission shall, as appropriate, report outcome

and process measures under Subsection (a)(1) by:

(1) geographic location, which may require reporting by county, health care service region, or another appropriately defined geographic area;

(2) enrollee or recipient population or eligibility group served;

(3) type of health care provider, such as acute care or long-term care provider;

(4) number of enrollees and recipients who relocated to a community-based setting from a less integrated setting;

(5) quality-based payment system; and

(6) service delivery model.

(c) The report may not identify a specific health care provider. (Gov. Code, Sec. 536.008.)

Source Law

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

(1) the quality-based outcome and process measures developed under Section 536.003, including measures based on each potentially preventable event; and

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

(b) As appropriate, the commission shall report outcome and process measures under Subsection (a)(1) by:

(1) geographic location, which may require reporting by county, health care service region, or other appropriately defined geographic area;

(2) recipient population or eligibility group served;

(3) type of health care provider, such as acute care or long-term care provider;

(4) number of recipients who relocated to a community-based setting from a less integrated setting;

(5) quality-based payment system; and

(6) service delivery model.

(c) The report required under this section may not identify specific health care providers.

Revisor's Note

Sections 536.008(b)(2) and (4), Government Code, refer to "recipient population" and "recipients," respectively, to whom certain outcome and process measures relate. The revised law in Section 543A.0001

of this chapter adds a definition of "recipient" to mean a Medicaid recipient. That revised law also adds a definition of "enrollee" to mean an individual enrolled in the child health plan program. Because the outcome and process measures to which Section 536.008, Government Code, refers relate to both the child health plan program and Medicaid, it is clear that the term "recipient" as used in Sections 536.008(b)(2) and (4) is intended to mean both Medicaid recipients and child health plan program enrollees, rather than the more restrictive definition of "recipient" as added in the revised law. Therefore, the revised law substitutes "enrollee or recipient population" and "enrollees and recipients" for the references to "recipient population" and "recipients," respectively.

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

Revised Law

Sec. 543A.0051. QUALITY-BASED PREMIUM PAYMENTS; PERFORMANCE REPORTING. (a) Subject to Section 1903(m)(2)(A), Social Security Act (42 U.S.C. Section 1396b(m)(2)(A)), and other federal law, the commission shall base a percentage of the premiums paid to a managed care organization participating in the child health plan program or Medicaid on the organization's performance with respect to outcome and process measures developed under Section 543A.0002 that address potentially preventable events. The percentage may increase each year.

(b) The commission shall make available information relating to a managed care organization's performance with respect to outcome and process measures under this subchapter to an enrollee or recipient before the enrollee or recipient chooses a managed care plan. (Gov. Code, Sec. 536.051.)

Source Law

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

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

Revised Law

Sec. 543A.0052. FINANCIAL INCENTIVES AND CONTRACT AWARD PREFERENCES. (a) The commission may allow a managed care organization participating in the child health plan program or Medicaid increased flexibility to implement quality initiatives in a managed care plan offered by the organization, including flexibility with respect to financial arrangements, to:

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

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

(3) reduce the incidence of unnecessary institutionalization and potentially preventable events; and

(4) in collaboration with physicians and other health care providers, increase the use of alternative payment systems, including shared savings models.

(b) The commission shall develop quality-of-care and cost-efficiency benchmarks, including benchmarks based on a managed care organization's performance with respect to:

(1) reducing potentially preventable events; and

(2) containing the growth rate of health care costs.

(c) The commission may include in a contract between a managed care organization and the commission financial incentives that are based on the organization's successful implementation of

quality initiatives under Subsection (a) or success in achieving quality-of-care and cost-efficiency benchmarks under Subsection (b). The commission may implement the financial incentives only if implementing the incentives would be cost-effective.

(d) In awarding contracts to managed care organizations under the child health plan program and Medicaid, the commission shall, in addition to considerations under Section ____ [[[Section 533.003]]] of this code and Section 62.155, Health and Safety Code, give preference to an organization that offers a managed care plan that:

(1) successfully implements quality initiatives under Subsection (a) as the commission determines based on data or other evidence the organization provides; or

(2) meets quality-of-care and cost-efficiency benchmarks under Subsection (b). (Gov. Code, Sec. 536.052.)

Source Law

> Sec. 536.052. PAYMENT AND CONTRACT AWARD INCENTIVES FOR MANAGED CARE ORGANIZATIONS. (a) The commission may allow a managed care organization participating in the child health plan program or Medicaid increased flexibility to implement quality initiatives in a managed care plan offered by the organization, including flexibility with respect to financial arrangements, in order to:
>
> (1) achieve high-quality, cost-effective health care;
>
> (2) increase the use of high-quality, cost-effective delivery models;
>
> (3) reduce the incidence of unnecessary institutionalization and potentially preventable events; and
>
> (4) increase the use of alternative payment systems, including shared savings models, in collaboration with physicians and other health care providers.
>
> (b) The commission shall develop quality of care and cost-efficiency benchmarks, including benchmarks based on a managed care organization's performance with respect to reducing potentially preventable events and containing the growth rate of health care costs.
>
> (c) The commission may include in a contract between a managed care organization and the commission financial incentives that are based on the organization's successful implementation of quality initiatives under Subsection (a) or success in achieving quality of care and cost-efficiency benchmarks under Subsection (b).
>
> (d) In awarding contracts to managed care organizations under the child health plan program and Medicaid, the commission shall, in addition to

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

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

SUBCHAPTER C. QUALITY-BASED HEALTH HOME PAYMENT SYSTEMS

Revised Law

Sec. 543A.0101. DEFINITION. In this subchapter, "health home" means a primary care provider practice or, if appropriate, a specialty care provider practice, incorporating several features, including comprehensive care coordination, family-centered care, and data management, that are focused on improving outcome-based quality of care and increasing patient and provider satisfaction under the child health plan program and Medicaid. (Gov. Code, Sec. 536.101(1).)

Source Law

Sec. 536.101. DEFINITIONS. In this subchapter:

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

Revisor's Note

Section 536.101(2), Government Code, defines "participating enrollee" for purposes of Subchapter C, Chapter 536, Government Code, which is revised as this subchapter. For clarity, the revised law incorporates the substance of the definition into the revised law in each place the term appears and omits the definition. The omitted law reads:

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

Revised Law

Sec. 543A.0102. QUALITY-BASED HEALTH HOME PAYMENTS. (a)

The commission may develop and implement quality-based payment systems for health homes designed to improve quality of care and reduce the provision of unnecessary medical services. A quality-based payment system must:

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

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

(b) The commission may develop a quality-based payment system for health homes only if implementing the system would be feasible and cost-effective. (Gov. Code, Sec. 536.102.)

Source Law

> Sec. 536.102. QUALITY-BASED HEALTH HOME PAYMENTS. (a) Subject to this subchapter, the commission may develop and implement quality-based payment systems for health homes designed to improve quality of care and reduce the provision of unnecessary medical services. A quality-based payment system developed under this section must:
>
> (1) base payments made to a participating enrollee's health home on quality and efficiency measures that may include measurable wellness and prevention criteria and use of evidence-based best practices, sharing a portion of any realized cost savings achieved by the health home, and ensuring quality of care outcomes, including a reduction in potentially preventable events; and
>
> (2) allow for the examination of measurable wellness and prevention criteria, use of evidence-based best practices, and quality of care outcomes based on the type of primary or specialty care provider practice.
>
> (b) The commission may develop a quality-based payment system for health homes under this subchapter only if implementing the system would be feasible and cost-effective.

Revisor's Note

Section 536.102(a), Government Code, provides

that "[s]ubject to this subchapter," meaning Subchapter C, Chapter 536, Government Code, the Health and Human Services Commission may develop and implement certain payment systems. The revised law omits the quoted language for the reason stated in Revisor's Note (1) to Section 543A.0004 of this chapter.

Revised Law

Sec. 543A.0103. HEALTH HOME ELIGIBILITY. To be eligible to receive reimbursement under a quality-based payment system under this subchapter, a health home must:

(1) directly or indirectly provide enrollees or recipients who have a health home with access to health care services outside of regular business hours;

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

(3) provide evidence satisfactory to the commission that the health home meets the requirement of Subdivision (1). (Gov. Code, Sec. 536.103.)

Source Law

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

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

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

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

Revisor's Note

Section 536.103, Government Code, refers to a "health home provider." The revised law substitutes "health home" for "health home provider" because "health home" is the defined term under Section 536.101(1), Government Code, revised in this

subchapter as Section 543A.0101, and a health home is defined as a type of provider.

SUBCHAPTER D. QUALITY-BASED HOSPITAL REIMBURSEMENT SYSTEM

Revised Law

Sec. 543A.0151. COLLECTING CERTAIN INFORMATION; REPORTS TO CERTAIN HOSPITALS. (a) The executive commissioner shall adopt rules for identifying:

(1) potentially preventable admissions and readmissions of enrollees and recipients, including preventable admissions to long-term care facilities;

(2) potentially preventable ancillary services provided to or ordered for enrollees and recipients;

(3) potentially preventable emergency room visits by enrollees and recipients; and

(4) potentially preventable complications experienced by enrollees and recipients.

(b) The commission shall collect data from hospitals on present-on-admission indicators for purposes of this section.

(c) The commission shall establish a program to provide to each hospital in this state that participates in the child health plan program or Medicaid a report regarding the hospital's performance with respect to each potentially preventable event described by Subsection (a). To the extent possible, the report should include all potentially preventable events across all child health plan program and Medicaid payment systems. A hospital shall distribute the information in the report to physicians and other health care providers providing services at the hospital.

(d) Except as provided by Subsection (e), a report provided to a hospital under Subsection (c) is confidential and not subject to Chapter 552.

(e) The commission may release information in a report described by Subsection (c):

(1) not earlier than one year after the date the report is provided to the hospital; and

(2) only after deleting any data that relates to a hospital's performance with respect to a particular diagnosis-related group or an individual patient. (Gov. Code, Sec. 536.151.)

Source Law

> Sec. 536.151. COLLECTION AND REPORTING OF CERTAIN INFORMATION. (a) The executive commissioner shall adopt rules for identifying:
>
> (1) potentially preventable admissions and readmissions of child health plan program enrollees and Medicaid recipients, including preventable admissions to long-term care facilities;
>
> (2) potentially preventable ancillary services provided to or ordered for child health plan program enrollees and Medicaid recipients;
>
> (3) potentially preventable emergency room visits by child health plan program enrollees and Medicaid recipients; and
>
> (4) potentially preventable complications experienced by child health plan program enrollees and Medicaid recipients.
>
> (a-1) The commission shall collect data from hospitals on present-on-admission indicators for purposes of this section.
>
> (b) The commission shall establish a program to provide a confidential report to each hospital in this state that participates in the child health plan program or Medicaid regarding the hospital's performance with respect to each potentially preventable event described under Subsection (a). To the extent possible, a report provided under this section should include all potentially preventable events across all child health plan program and Medicaid payment systems. A hospital shall distribute the information contained in the report to physicians and other health care providers providing services at the hospital.
>
> (c) Except as provided by Subsection (d), a report provided to a hospital under this section is confidential and is not subject to Chapter 552.
>
> (d) The commission may release the information in the report described by Subsection (b):
>
> (1) not earlier than one year after the date the report is submitted to the hospital; and
>
> (2) only after deleting any data that relates to a hospital's performance with respect to particular diagnosis-related groups or individual patients.

Revised Law

Sec. 543A.0152. REIMBURSEMENT ADJUSTMENTS. (a) The commission shall use the data collected under Section 543A.0151 and the diagnosis-related groups (DRG) methodology implemented under Section 543A.0005, if applicable, to adjust, to the extent feasible, child health plan program and Medicaid reimbursements to hospitals, including payments made under the disproportionate

share hospitals and upper payment limit supplemental payment programs. The commission shall base an adjustment for a hospital on the hospital's performance with respect to exceeding or failing to achieve outcome and process measures developed under Section 543A.0002 that address the rates of potentially preventable readmissions and potentially preventable complications.

(b) The commission must provide the report required by Section 543A.0151(c) to a hospital at least one year before adjusting child health plan program and Medicaid reimbursements to the hospital under this section. (Gov. Code, Sec. 536.152.)

Source Law

Sec. 536.152. REIMBURSEMENT ADJUSTMENTS. (a) Subject to Subsection (b), using the data collected under Section 536.151 and the diagnosis-related groups (DRG) methodology implemented under Section 536.005, if applicable, the commission shall to the extent feasible adjust child health plan and Medicaid reimbursements to hospitals, including payments made under the disproportionate share hospitals and upper payment limit supplemental payment programs, based on the hospital's performance with respect to exceeding, or failing to achieve, outcome and process measures developed under Section 536.003 that address the rates of potentially preventable readmissions and potentially preventable complications.

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

Revisor's Note

Section 536.152(a), Government Code, provides that "[s]ubject to Subsection (b)," meaning Section 536.152(b), Government Code, the Health and Human Services Commission shall adjust certain hospital reimbursements. The revised law omits the quoted language for the reason stated in Revisor's Note (1) to Section 543A.0004 of this chapter.

SUBCHAPTER E. QUALITY-BASED PAYMENT INITIATIVES

Revised Law

Sec. 543A.0201. PAYMENT INITIATIVES; DETERMINATION OF BENEFIT TO STATE. (a) The commission shall establish payment initiatives to test the effectiveness of quality-based payment

systems, alternative payment methodologies, and high-quality, cost-effective health care delivery models that provide incentives to physicians and other health care providers to develop health care interventions for enrollees or recipients that will:

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

(2) reduce potentially preventable events;

(3) promote prevention and wellness;

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

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

(6) contain costs; and

(7) improve integration of acute care services and long-term services and supports, including discharge planning from acute care services to community-based long-term services and supports.

(b) The commission shall:

(1) establish a process through which a physician, other health care provider, or managed care organization may submit a proposal for a payment initiative; and

(2) determine whether implementing one or more proposed payment initiatives is feasible and cost-effective.

(c) If the commission determines that implementing one or more payment initiatives is feasible and cost-effective for this state, the commission shall establish one or more payment initiatives as provided by this subchapter. (Gov. Code, Secs. 536.202, 536.203(a).)

Source Law

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

(1) improve the quality of health care

provided to the enrollees or recipients;

(2) reduce potentially preventable events;

(3) promote prevention and wellness;

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

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

(6) contain costs; and

(7) improve integration of acute care services and long-term services and supports, including discharge planning from acute care services to community-based long-term services and supports.

(b) The commission shall:

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

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

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

Revisor's Note

Section 536.202(a), Government Code, provides that the Health and Human Services Commission "shall" establish payment initiatives to test certain payment systems, payment methodologies, and health care delivery models. In contrast, Section 536.203(a), Government Code, requires the commission to establish one or more of those payment initiatives if the commission determines that implementing the initiatives is feasible and cost-effective. The requirements imposed on the commission by the two provisions appear to conflict, and the revised law preserves the ambiguity.

Revised Law

Sec. 543A.0202. PAYMENT INITIATIVE ADMINISTRATION. (a) The commission shall administer any payment initiative the commission establishes under this subchapter. The executive commissioner may adopt rules, plans, and procedures and enter into contracts and other agreements as the executive commissioner considers appropriate and necessary to administer this subchapter.

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

(1) one or more regions in this state;

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

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

(c) An implemented payment initiative must be operated for at least one calendar year. (Gov. Code, Secs. 536.203(b), (c), (d).)

Source Law

> (b) The commission shall administer any payment initiative established under this subchapter. The executive commissioner may adopt rules, plans, and procedures and enter into contracts and other agreements as the executive commissioner considers appropriate and necessary to administer this subchapter.
>
> (c) The commission may limit a payment initiative to:
>
> (1) one or more regions in this state;
>
> (2) one or more organized networks of physicians and other health care providers; or
>
> (3) specified types of services provided under the child health plan program or Medicaid, or specified types of enrollees or recipients under those programs.
>
> (d) A payment initiative implemented under this subchapter must be operated for at least one calendar year.

Revised Law

Sec. 543A.0203. QUALITY-OF-CARE AND COST-EFFICIENCY BENCHMARKS AND GOALS; EFFICIENCY PERFORMANCE STANDARDS. (a) The executive commissioner shall develop quality-of-care and cost-efficiency benchmarks and measurable goals that a payment initiative must meet to ensure high-quality and cost-effective health care services and healthy outcomes.

(b) In addition to the benchmarks and goals described by Subsection (a), the executive commissioner may approve efficiency performance standards that may include the sharing of realized cost savings with physicians and other health care providers who provide health care services that exceed the standards. The standards may not create a financial incentive for or involve making a payment to

a physician or other health care provider that directly or indirectly induces limiting medically necessary services. (Gov. Code, Sec. 536.204.)

Source Law

> Sec. 536.204. STANDARDS; PROTOCOLS. (a) The executive commissioner shall develop quality of care and cost-efficiency benchmarks and measurable goals that a payment initiative must meet to ensure high-quality and cost-effective health care services and healthy outcomes.
>
> (b) In addition to the benchmarks and goals under Subsection (a), the executive commissioner may approve efficiency performance standards that may include the sharing of realized cost savings with physicians and other health care providers who provide health care services that exceed the efficiency performance standards. The efficiency performance standards may not create any financial incentive for or involve making a payment to a physician or other health care provider that directly or indirectly induces the limitation of medically necessary services.

Revised Law

Sec. 543A.0204. PAYMENT RATES UNDER PAYMENT INITIATIVES. The executive commissioner may contract with appropriate entities, including qualified actuaries, to assist in determining appropriate payment rates for an implemented payment initiative. (Gov. Code, Sec. 536.205.)

Source Law

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

Revisor's Note
(End of Subchapter)

Section 536.201, Government Code, defines "payment initiative" for purposes of Subchapter E, Chapter 536, Government Code, as "a quality-based payment initiative established under" that subchapter.

The revised law omits the definition in part because it is misleading and therefore does not add to the clear meaning of the law. Throughout the

subchapter, the term is not consistently used in the manner in which it is defined. For example, Section 536.202(b)(1), Government Code, which is revised in this subchapter as Section 543A.0201(b)(1), authorizes certain persons to submit "proposals for payment initiatives," and Section 536.202(b)(2), Government Code, which is revised in this subchapter as Section 543A.0201(b)(2), refers to "proposed payment initiatives." A proposed payment initiative is not an initiative that necessarily has been or will be "established" as specified by the definition in Section 536.201.

The revised law also omits the definition as unnecessary. In each occurrence of the term, the meaning is clear from the context in which it is used.

The omitted law reads:

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

SUBCHAPTER F. QUALITY-BASED LONG-TERM SERVICES AND SUPPORTS PAYMENT SYSTEMS

Revised Law

Sec. 543A.0251. QUALITY-BASED PAYMENT SYSTEMS FOR LONG-TERM SERVICES AND SUPPORTS. (a) The commission, after consulting with appropriate stakeholders representing nursing facility providers with an interest in providing long-term services and supports, may develop and implement quality-based payment systems for Medicaid long-term services and supports providers designed to improve quality of care and reduce the provision of unnecessary services. A quality-based payment system must base payments made to providers on quality and efficiency measures that may include measurable wellness and prevention criteria and the use of evidence-based best practices, sharing a portion of any realized cost savings the provider achieves, and ensuring quality of care

outcomes, including a reduction in potentially preventable events.

(b) The commission may develop a quality-based payment system for Medicaid long-term services and supports providers only if implementing the system would be feasible and cost-effective. (Gov. Code, Sec. 536.251.)

Source Law

> Sec. 536.251. QUALITY-BASED LONG-TERM SERVICES AND SUPPORTS PAYMENTS. (a) Subject to this subchapter, the commission, after consulting with appropriate stakeholders representing nursing facility providers with an interest in the provision of long-term services and supports, may develop and implement quality-based payment systems for Medicaid long-term services and supports providers designed to improve quality of care and reduce the provision of unnecessary services. A quality-based payment system developed under this section must base payments to providers on quality and efficiency measures that may include measurable wellness and prevention criteria and use of evidence-based best practices, sharing a portion of any realized cost savings achieved by the provider, and ensuring quality of care outcomes, including a reduction in potentially preventable events.
>
> (b) The commission may develop a quality-based payment system for Medicaid long-term services and supports providers under this subchapter only if implementing the system would be feasible and cost-effective.

Revisor's Note

Section 536.251(a), Government Code, provides that "[s]ubject to this subchapter," meaning Subchapter F, Chapter 536, Government Code, the Health and Human Services Commission may develop and implement certain payment systems. The revised law omits the quoted language for the reason stated in Revisor's Note (1) to Section 543A.0004 of this chapter.

Revised Law

Sec. 543A.0252. DATA SET EVALUATION. To ensure that the commission is using the best data to inform developing and implementing quality-based payment systems under Section 543A.0251, the commission shall evaluate the reliability, validity, and functionality of post-acute and long-term services and supports data sets. The commission's evaluation should assess:

(1) to what degree data sets on which the commission relies meet a standard:

(A) for integrating care;

(B) for developing coordinated care plans; and

(C) that would allow for the meaningful development of risk adjustment techniques;

(2) whether the data sets will provide value for outcome or performance measures and cost containment; and

(3) how classification systems and data sets used for Medicaid long-term services and supports providers can be standardized and, where possible, simplified. (Gov. Code, Sec. 536.252.)

Source Law

> Sec. 536.252. EVALUATION OF DATA SETS. To ensure that the commission is using the best data to inform the development and implementation of quality-based payment systems under Section 536.251, the commission shall evaluate the reliability, validity, and functionality of post-acute and long-term services and supports data sets. The commission's evaluation under this section should assess:
>
> (1) to what degree data sets relied on by the commission meet a standard:
>
> (A) for integrating care;
>
> (B) for developing coordinated care plans; and
>
> (C) that would allow for the meaningful development of risk adjustment techniques;
>
> (2) whether the data sets will provide value for outcome or performance measures and cost containment; and
>
> (3) how classification systems and data sets used for Medicaid long-term services and supports providers can be standardized and, where possible, simplified.

Revised Law

Sec. 543A.0253. COLLECTING CERTAIN INFORMATION; REPORTS TO CERTAIN PROVIDERS. (a) The executive commissioner shall adopt rules for identifying the incidence of potentially preventable admissions, potentially preventable readmissions, and potentially preventable emergency room visits by Medicaid long-term services and supports recipients.

(b) The commission shall establish a program to provide to each Medicaid long-term services and supports provider in this

state a report regarding the provider's performance with respect to potentially preventable admissions, potentially preventable readmissions, and potentially preventable emergency room visits. To the extent possible, the report should include applicable potentially preventable events information across all Medicaid payment systems.

(c) Except as provided by Subsection (d), a report provided to a provider under Subsection (b) is confidential and not subject to Chapter 552.

(d) The commission may release information in a report described by Subsection (b):

(1) not earlier than one year after the date the report is provided to the provider; and

(2) only after deleting any data that relates to a provider's performance with respect to a particular resource utilization group or an individual recipient. (Gov. Code, Sec. 536.253.)

Source Law

Sec. 536.253. COLLECTION AND REPORTING OF CERTAIN INFORMATION. (a) The executive commissioner shall adopt rules for identifying the incidence of potentially preventable admissions, potentially preventable readmissions, and potentially preventable emergency room visits by Medicaid long-term services and supports recipients.

(b) The commission shall establish a program to provide a report to each Medicaid long-term services and supports provider in this state regarding the provider's performance with respect to potentially preventable admissions, potentially preventable readmissions, and potentially preventable emergency room visits. To the extent possible, a report provided under this section should include applicable potentially preventable events information across all Medicaid payment systems.

(c) Subject to Subsection (d), a report provided to a provider under this section is confidential and is not subject to Chapter 552.

(d) The commission may release the information in the report described by Subsection (b):

(1) not earlier than one year after the date the report is submitted to the provider; and

(2) only after deleting any data that relates to a provider's performance with respect to particular resource utilization groups or individual recipients.