

GOVERNMENT CODE

TITLE 4. EXECUTIVE BRANCH

SUBTITLE I. HEALTH AND HUMAN SERVICES

CHAPTER 536. MEDICAID AND THE CHILD HEALTH PLAN PROGRAM:

QUALITY-BASED OUTCOMES AND PAYMENTS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 536.001. DEFINITIONS. In this chapter:

(1) Repealed by Acts 2015, 84th Leg., R.S., Ch. 837, Sec. 3.40(a)(21), and Ch. 946, Sec. 2.37(b)(20), eff. January 1, 2016.

(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.

(4) Repealed by Acts 2015, 84th Leg., R.S., Ch. 1, Sec. 2.287(18), eff. April 2, 2015.

(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.

(13) Repealed by Acts 2015, 84th Leg., R.S., Ch. 1, Sec. 2.287(18), eff. April 2, 2015.

(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. Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 1.12(a), eff. September 28, 2011.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.287(18), eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 3.21, eff. January 1, 2016.

Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 3.40(a)(21), eff. January 1, 2016.

Acts 2015, 84th Leg., R.S., Ch. 946 (S.B. 277), Sec. 2.21, eff. January 1, 2016.

Acts 2015, 84th Leg., R.S., Ch. 946 (S.B. 277), Sec. 2.37(b)(20), eff. January 1, 2016.

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.

(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](#).

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

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. [7](#)), Sec. 1.12(a), eff. September 28, 2011.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 1310 (S.B. 7), Sec. 4.07, eff. September 1, 2013.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.261, eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 3.22, eff. January 1, 2016.

Acts 2015, 84th Leg., R.S., Ch. 946 (S.B. 277), Sec. 2.22, eff. January 1, 2016.

Acts 2017, 85th Leg., R.S., Ch. 1030 (H.B. 1629), Sec. 1, eff. June 15, 2017.

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.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 1.12(a), eff. September 28, 2011.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 1310 (S.B. 7), Sec. 4.08, eff. September 1, 2013.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.262, eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 3.23, eff. January 1, 2016.

Acts 2015, 84th Leg., R.S., Ch. 946 (S.B. 277), Sec. 2.23, eff. January 1, 2016.

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.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 1.12(a), eff. September 28, 2011.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 1310 (S.B. 7), Sec. 4.09, eff. September 1, 2013.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.263, eff. April 2, 2015.

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.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 1.12(a), eff. September 28, 2011.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 1310 (S.B. 7), Sec. 4.10, eff.

September 1, 2013.

Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 3.24, eff. January 1, 2016.

Acts 2015, 84th Leg., R.S., Ch. 946 (S.B. 277), Sec. 2.24, eff. January 1, 2016.

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.

(b) Repealed by Acts 2015, 84th Leg., R.S., Ch. 946, Sec. 2.37(b)(24), and Ch. 837, Sec. 3.40(a)(23), eff. January 1, 2016. Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 1.12(a), eff. September 28, 2011.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 3.40(a)(23), eff. January 1, 2016.

Acts 2015, 84th Leg., R.S., Ch. 946 (S.B. 277), Sec. 2.37(b)(24), eff. January 1, 2016.

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.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 1.12(a), eff. September 28, 2011.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 1310 (S.B. 7), Sec. 4.11, eff. September 1, 2013.

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

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.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 1.12(a), eff. September 28, 2011.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 1310 (S.B. 7), Sec. 4.12, eff. September 1, 2013.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.264, eff. April 2, 2015.

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.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 1.12(a), eff. September 28, 2011.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 1310 (S.B. 7), Sec. 4.13, eff. September 1, 2013.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.265, eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 3.25, eff. January 1, 2016.

Acts 2015, 84th Leg., R.S., Ch. 946 (S.B. 277), Sec. 2.25, eff. January 1, 2016.

SUBCHAPTER C. QUALITY-BASED HEALTH HOME PAYMENT SYSTEMS

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.

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

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 1.12(a), eff. September 28, 2011.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.266, eff. April 2, 2015.

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.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 1.12(a), eff. September 28, 2011.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 3.26, eff. January 1, 2016.

Acts 2015, 84th Leg., R.S., Ch. 946 (S.B. 277), Sec. 2.26, eff. January 1, 2016.

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).

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 1.12(a), eff. September 28, 2011.

SUBCHAPTER D. QUALITY-BASED HOSPITAL REIMBURSEMENT SYSTEM

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.

Added by Acts 2009, 81st Leg., R.S., Ch. 1120 (H.B. 1218), Sec. 1, eff. September 1, 2009.

Transferred, redesignated and amended from Government Code, Section 531.913 by Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 1.12(a), eff. September 28, 2011.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 1310 (S.B. 7), Sec. 4.14, eff. September 1, 2013.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.267, eff. April 2, 2015.

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.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 1.12(a), eff. September 28, 2011.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 1310 (S.B. 7), Sec. 4.15, eff. September 1, 2013.

Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 3.27, eff. January 1, 2016.

Acts 2015, 84th Leg., R.S., Ch. 946 (S.B. 277), Sec. 2.27, eff. January 1, 2016.

SUBCHAPTER E. QUALITY-BASED PAYMENT INITIATIVES

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

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 1.12(a), eff. September 28, 2011.

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.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 1.12(a), eff. September 28, 2011.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 1310 (S.B. 7), Sec. 4.16, eff. September 1, 2013.

Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 3.28, eff. January 1, 2016.

Acts 2015, 84th Leg., R.S., Ch. 946 (S.B. 277), Sec. 2.28, eff. January 1, 2016.

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.

(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.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 1.12(a), eff. September 28, 2011.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.268, eff. April 2, 2015.

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.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 1.12(a), eff. September 28, 2011.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 3.29, eff. January 1, 2016.

Acts 2015, 84th Leg., R.S., Ch. 946 (S.B. 277), Sec. 2.29, eff. January 1, 2016.

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.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 1.12(a), eff. September 28, 2011.

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

PAYMENT SYSTEMS

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.

Added by Acts 2013, 83rd Leg., R.S., Ch. 1310 (S.B. 7), Sec. 4.17, eff. September 1, 2013.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 3.30, eff. January 1, 2016.

Acts 2015, 84th Leg., R.S., Ch. 946 (S.B. 277), Sec. 2.30, eff. January 1, 2016.

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.

Added by Acts 2013, 83rd Leg., R.S., Ch. 1310 (S.B. 7), Sec. 4.17, eff. September 1, 2013.

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.

Added by Acts 2013, 83rd Leg., R.S., Ch. 1310 (S.B. 7), Sec. 4.17, eff. September 1, 2013.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.269, eff. April 2, 2015.