GOVERNMENT CODE

TITLE 4. EXECUTIVE BRANCH

SUBTITLE I. HEALTH AND HUMAN SERVICES

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

SUBCHAPTER A. GENERAL PROVISIONS

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.

Added by Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 1.01, eff. April 1, 2025.

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.

Added by Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 1.01, eff. April 1, 2025.

The following section was amended by the 89th Legislature. Pending publication of the current statutes, see H.B. 4666, 89th Legislature, Regular Session, for amendments affecting the following section.

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.

Added by Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 1.01, eff. April 1, 2025.

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 funds 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.

Added by Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 1.01, eff. April 1, 2025.

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.

Added by Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 1.01, eff. April 1, 2025.

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 525.0206, 525.0207, and 525.0208.

Added by Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 1.01, eff. April 1, 2025.

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.

Added by Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 1.01, eff. April 1, 2025.

The following section was amended by the 89th Legislature. Pending publication of the current statutes, see H.B. 4666, 89th Legislature, Regular Session, for amendments affecting the following section.

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.

Added by Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 1.01, eff. April 1, 2025.

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

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.

Added by Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 1.01, eff. April 1, 2025.

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 540.0204 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).

Added by Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 1.01, eff. April 1, 2025.

SUBCHAPTER C. QUALITY-BASED HEALTH HOME PAYMENT SYSTEMS

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.

Added by Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 1.01, eff. April 1, 2025.

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.

Added by Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 1.01, eff. April 1, 2025.

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).

Added by Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 1.01, eff. April 1, 2025.

SUBCHAPTER D. QUALITY-BASED HOSPITAL REIMBURSEMENT SYSTEM

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.

Added by Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 1.01, eff. April 1, 2025.

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.

Added by Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 1.01, eff. April 1, 2025.

SUBCHAPTER E. QUALITY-BASED PAYMENT INITIATIVES

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.

Added by Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 1.01, eff. April 1, 2025.

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.

Added by Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 1.01, eff. April 1, 2025.

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.

Added by Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 1.01, eff. April 1, 2025.

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.

Added by Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 1.01, eff. April 1, 2025.

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

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.

Added by Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 1.01, eff. April 1, 2025.

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.

Added by Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 1.01, eff. April 1, 2025.

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.

Added by Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 1.01, eff. April 1, 2025.