By: Nelson S.B. No. 7

A BILL TO BE ENTITLED

AN ACT

relating to strategies for and improvements in quality of health care provided through and care management in the child health plan and medical assistance programs designed to achieve healthy outcomes and efficiency.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. QUALITY-BASED OUTCOME AND PAYMENT INITIATIVES. (a) Subtitle I, Title 4, Government Code, is amended by adding Chapter 536, and Section 531.913, Government Code, is transferred to Subchapter D, Chapter 536, Government Code, redesignated as Section 536.151, Government Code, and amended to read as follows:

CHAPTER 536. MEDICAID AND CHILD HEALTH PLAN PROGRAMS: QUALITY-BASED OUTCOMES AND PAYMENTS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 536.001. DEFINITIONS. In this chapter:

(1) "Advisory committee" means the Medicaid and CHIP Quality-Based Payment Advisory Committee established under Section 536.002.

(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 health care provider or facility that includes one

or more features of a global payment system and an episode-based bundled payment system.

(4) "Child health plan program," "commission," "executive commissioner," and "health and human services agencies" have the meanings assigned by Section 531.001.

(5) "Episode-based bundled payment system" means a system for compensating a health care provider or facility 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) "Global payment system" means a system for compensating a health care provider or facility 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.

(7) "Managed care organization" means a person who 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.

(8) "Managed care plan" means a 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 includes a primary care case management provider network. The term does not include a plan that indemnifies a person for the cost of health care services through insurance.

(9) "Medicaid program" means the medical assistance program established under Chapter 32, Human Resources Code.

(10) "Potentially preventable admission" means an admission of a person to a hospital or long-term care facility that could reasonably have been prevented if care and treatment had been provided by a health care provider in accordance with accepted standards of care.

(11) "Potentially preventable ancillary service" means a health care service provided or ordered by a 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 is not reasonably necessary for the provision of quality health care or treatment.

(12) "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;

(B) results from the care, lack of care, or treatment provided during the hospital or long-term care facility stay, as applicable, rather than from a natural progression of an underlying disease; and

(C) could reasonably have been prevented if care

and treatment had been provided in accordance with accepted standards of care.

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

(14) "Potentially preventable hospital emergency room visit" means treatment of a person in a hospital emergency room for a condition that does not require emergency medical attention because the condition could be treated by a health care provider in a nonemergency setting.

(15) "Potentially preventable readmission" means a return hospitalization of a person within a period specified by the commission that results 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.

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

Sec. 536.002. MEDICAID AND CHIP QUALITY-BASED PAYMENT ADVISORY COMMITTEE. (a) The Medicaid and CHIP Quality-Based Payment Advisory Committee is established to assist the commission with, for purposes of the child health plan and Medicaid programs administered by the commission or a health and human services agency:

(1) ensuring that the reimbursement system used to compensate health care providers and facilities under those programs rewards the provision of high-quality, cost-effective health care and quality performance and quality of care outcomes with respect to health care services;

(2) setting standards and benchmarks for quality performance, quality of care outcomes, efficiency, and accountability by managed care organizations and health care providers and facilities; and

(3) ensuring that programs and reimbursement policies encourage high-quality, cost-effective health care delivery models

that increase provider collaboration, promote wellness and prevention, and improve health outcomes.

(b) The executive commissioner shall appoint the members of the advisory committee. The committee must consist of health care providers, representatives of health care facilities, and other stakeholders interested in health care services provided in this state. At least one member must be a physician who has clinical practice expertise, and at least one member must be a member of the Advisory Panel on Health Care-Associated Infections and Preventable Adverse Events who meets the qualifications prescribed by Section 98.052(a)(4), Health and Safety Code.

(c) The executive commissioner shall appoint the presiding officer of the advisory committee.

(d) The advisory committee shall advise the commission on developing outcome and process measures under Section 536.003.

Sec. 536.003. DEVELOPMENT OF QUALITY-BASED OUTCOME AND PROCESS MEASURES. (a) The commission, in consultation with the advisory committee, 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 and Medicaid programs to implement quality-based payments for acute and long-term care services across all delivery models and payment systems, including fee-for-service and managed care payment systems. The commission, in developing outcome measures under this section, must consider measures addressing potentially preventable events.

(b) To the extent feasible, the commission shall develop

outcome and process measures:

(1) consistently across all child health plan and Medicaid program 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; and

(3) that will have the greatest effect on improving quality of care and the efficient use of services.

(c) The commission may 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 health care providers and facilities participating in the child health plan and Medicaid programs 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 provider reimbursement rates under the child health plan or Medicaid program 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, correlate the increased reimbursement rates with the quality-based outcome and process measures developed under this section.

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 the advisory committee, shall develop quality-based payment systems for compensating a health care provider or facility participating in the child health plan or Medicaid program 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 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 any administrative burden; and

(B) align quality-based payment incentives for health care providers or facilities 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 or improve quality of care in the child health plan and Medicaid programs.

Sec. 536.005. CONVERSION OF PAYMENT METHODOLOGY. To the extent possible, the commission shall convert reimbursement systems under the child health plan and Medicaid programs 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.

Sec. 536.006. 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) The commission shall present the results of its evaluation under Subsection (a) to the advisory committee for the committee's input and recommendations.

Sec. 536.007. ANNUAL REPORT. (a) The commission shall

submit an annual report to the legislature regarding:

(1) the quality-based outcome and process measures developed under Section 536.003; and

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

(b) The commission shall report outcome and process measures under Subsection (a)(1) by county and service delivery model.

[Sections 536.008-536.050 reserved for expansion]

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

Sec. 536.051. DEVELOPMENT OF QUALITY-BASED PREMIUM PAYMENTS; PERFORMANCE REPORTING. (a) The commission shall base a percentage of the premiums paid to a managed care organization participating in the child health plan or Medicaid program on the organization's performance with respect to outcome and process measures developed under Section 536.003, including outcome measures addressing potentially preventable events.

(b) The commission shall report 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.

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 or

Medicaid program increased flexibility to implement quality initiatives in a managed care plan offered by the organization, including flexibility with respect to network requirements and financial arrangements, in order to:

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

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

(3) reduce potentially preventable events.

(b) The commission, after consulting with the advisory committee, 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 and Medicaid programs, 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 implements quality initiatives under Subsection (a) 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 not require additional state funding because the cost associated with the implementation would be offset by expected savings or additional federal funding.

[Sections 536.053-536.100 reserved for expansion]

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 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 and Medicaid programs.

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

Sec. 536.102. QUALITY-BASED HEALTH HOME PAYMENTS. (a) Subject to this subchapter, the commission, after consulting with the advisory committee, 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.

(b) The commission may develop a quality-based payment system for health homes under this subchapter only if implementing the system would not require additional state funding because the costs associated with the implementation would be offset by expected savings or additional federal funding.

Sec. 536.103. PROVIDER ELIGIBILITY. To be eligible to receive reimbursement under a quality-based payment system under this subchapter, a 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).

[Sections 536.104-536.150 reserved for expansion]

SUBCHAPTER D. QUALITY-BASED HOSPITAL REIMBURSEMENT SYSTEM

Sec. 536.151 [~~531.913~~]. COLLECTION AND REPORTING OF CERTAIN [~~HOSPITAL HEALTH~~] INFORMATION [~~EXCHANGE~~]. (a) [~~In this~~

~~section, "potentially preventable readmission" means a return hospitalization of a person within a period specified by the commission that results 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:~~

~~[(1) the same condition or procedure for which the person was previously admitted;~~

~~[(2) an infection or other complication resulting from care previously provided;~~

~~[(3) a condition or procedure that indicates that a surgical intervention performed during a previous admission was unsuccessful in achieving the anticipated outcome; or~~

~~[(4) another condition or procedure of a similar nature, as determined by the executive commissioner.~~

[~~(b)~~] The executive commissioner shall adopt rules for identifying potentially preventable readmissions of child health plan program enrollees and Medicaid recipients and potentially preventable complications experienced by child health plan program enrollees and Medicaid recipients. The [~~and the~~] commission shall collect [~~exchange~~] data from [~~with~~] hospitals on present-on-admission indicators for purposes of this section.

(b) [~~(c)~~] The commission shall establish a [~~health information exchange~~] program to provide a [~~exchange~~] confidential report to [~~information with~~] each hospital in this state that

participates in the child health plan or Medicaid program regarding the hospital's performance with respect to potentially preventable readmissions and potentially preventable complications. To the extent possible, a report provided under this section should include potentially preventable readmissions and potentially preventable complications information across all payment systems. A hospital shall distribute the information contained in the report [~~received from the commission~~] to health care providers providing services at the hospital.

(c) A report provided to a hospital under this section is confidential and is not subject to Chapter 552.

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, the commission, after consulting with the advisory committee, 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, in a manner that rewards or penalizes a hospital based on the hospital's performance in reducing 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.

[Sections 536.153-536.200 reserved for expansion]

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.

Sec. 536.202. PAYMENT INITIATIVES; DETERMINATION OF BENEFIT TO STATE. (a) The commission shall, after consulting with health care providers and facilities and disease and care management organizations, 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 the providers and facilities, as applicable, 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; and

(5) increase provider collaboration.

(b) The commission shall:

(1) establish a process by which health care providers and facilities and disease and care management organizations 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.

(c) For purposes of Subsection (b), an initiative is cost-effective if implementing the initiative would not require additional state funding because the costs associated with the implementation would be offset by expected savings or additional federal funding.

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 health care facilities and providers; or

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

Sec. 536.204. STANDARDS; PROTOCOLS. (a) The executive commissioner shall:

(1) consult with the advisory committee to 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; and

(2) approve benchmarks and goals developed as provided by Subdivision (1).

(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 health care providers and facilities that 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 health care provider or facility that directly or indirectly induces the limitation of medically necessary services.

Sec. 536.205. PROVISION OF SERVICES AND PAYMENT RATES UNDER PAYMENT INITIATIVES. (a) 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.

(b) The executive commissioner shall ensure that services provided to a child health plan program enrollee or Medicaid recipient, as applicable, meet or exceed the quality of care and cost-efficiency benchmarks required under this subchapter and are at least equivalent to the services provided under the child health

plan or Medicaid program, as applicable, for which the enrollee or recipient is eligible.

(b) As soon as practicable after the effective date of this Act, but not later than September 1, 2012, the Health and Human Services Commission shall convert the reimbursement systems used under the child health plan program under Chapter 62, Health and Safety Code, and medical assistance program under Chapter 32, Human Resources Code, to the diagnosis-related groups (DRG) methodology to the extent possible as required by Section 536.005, Government Code, as added by this Act.

(c) Not later than September 1, 2012, the Health and Human Services Commission shall begin providing performance reports to hospitals regarding the hospitals' performances with respect to potentially preventable complications as required by Section 536.151, Government Code, as transferred, redesignated, and amended by this Act.

(d) Subject to Section 536.004(b), Government Code, as added by this Act, the Health and Human Services Commission shall begin making adjustments to child health plan and Medicaid reimbursements to hospitals as required by Section 536.152, Government Code, as added by this Act:

(1) not later than September 1, 2012, based on the hospitals' performances with respect to reducing potentially preventable readmissions; and

(2) not later than September 1, 2013, based on the hospitals' performances with respect to reducing potentially preventable complications.

SECTION 2. COST SHARING FOR CERTAIN HEALTH CARE SERVICES. Section 32.0641, Human Resources Code, is amended to read as follows:

Sec. 32.0641. RECIPIENT ACCOUNTABILITY PROVISIONS; COST-SHARING REQUIREMENT TO IMPROVE APPROPRIATE UTILIZATION OF [~~COST-SHARING FOR CERTAIN HIGH-COST MEDICAL~~] SERVICES. (a) To [~~If the department determines that it is feasible and cost-effective, and to~~] the extent permitted under Title XIX, Social Security Act (42 U.S.C. Section 1396 et seq.) and any other applicable law or regulation or under a federal waiver or other authorization, the executive commissioner of the Health and Human Services Commission shall adopt, after consulting with the Medicaid and CHIP Quality-Based Payment Advisory Committee established under Section 536.002, Government Code, cost-sharing provisions that encourage personal accountability and appropriate utilization of health care services, including a cost-sharing provision applicable to [~~require~~] a recipient who chooses to receive a nonemergency [~~a high-cost~~] medical service [~~provided~~] through a hospital emergency room [~~to pay a copayment, premium payment, or other cost-sharing payment for the high-cost medical service~~] if:

(1) the hospital from which the recipient seeks service:

(A) performs an appropriate medical screening and determines that the recipient does not have a condition requiring emergency medical services;

(B) informs the recipient:

(i) that the recipient does not have a

condition requiring emergency medical services;

(ii) that, if the hospital provides the nonemergency service, the hospital may require payment of a copayment, premium payment, or other cost-sharing payment by the recipient in advance; and

(iii) of the name and address of a nonemergency Medicaid provider who can provide the appropriate medical service without imposing a cost-sharing payment; and

(C) offers to provide the recipient with a referral to the nonemergency provider to facilitate scheduling of the service; and

(2) after receiving the information and assistance described by Subdivision (1) from the hospital, the recipient chooses to obtain [~~emergency~~] medical services through the hospital emergency room despite having access to medically acceptable, appropriate [~~lower-cost~~] medical services.

(b) The department may not seek a federal waiver or other authorization under this section [~~Subsection (a)~~] that would:

(1) prevent a Medicaid recipient who has a condition requiring emergency medical services from receiving care through a hospital emergency room; or

(2) waive any provision under Section 1867, Social Security Act (42 U.S.C. Section 1395dd).

[~~(c) If the executive commissioner of the Health and Human Services Commission adopts a copayment or other cost-sharing payment under Subsection (a), the commission may not reduce hospital payments to reflect the potential receipt of a copayment~~

~~or other payment from a recipient receiving medical services provided through a hospital emergency room.~~]

SECTION 3. LONG-TERM CARE PAYMENT INCENTIVE INITIATIVES. (a) The heading to Section 531.912, Government Code, is amended to read as follows:

Sec. 531.912. PAY-FOR-PERFORMANCE INCENTIVES FOR [~~QUALITY OF CARE HEALTH INFORMATION EXCHANGE WITH~~] CERTAIN NURSING FACILITIES.

(b) Sections 531.912(b), (c), and (f), Government Code, are amended to read as follows:

(b) If feasible, the executive commissioner by rule shall establish an incentive payment program for [~~a quality of care health information exchange with~~] nursing facilities that choose to participate. The [~~in a~~] program must be designed to improve the quality of care and services provided to medical assistance recipients. Subject to Subsection (f), the program may provide incentive payments in accordance with this section to encourage facilities to participate in the program.

(c) In establishing an incentive payment [~~a quality of care health information exchange~~] program under this section, the executive commissioner shall, subject to Subsection (d), adopt outcome-based [~~exchange information with participating nursing facilities regarding~~] performance measures. The performance measures:

(1) must be:

(A) recognized by the executive commissioner as valid indicators of the overall quality of care received by medical

assistance recipients; and

(B) designed to encourage and reward evidence-based practices among nursing facilities; and

(2) may include measures of:

(A) quality of life;

(B) direct-care staff retention and turnover;

(C) recipient satisfaction;

(D) employee satisfaction and engagement;

(E) the incidence of preventable acute care emergency room services use;

(F) regulatory compliance;

(G) level of person-centered care; and

(H) level of occupancy or of facility utilization.

(f) The commission may make incentive payments under the program only if money is [~~specifically~~] appropriated for that purpose.

(c) The Department of Aging and Disability Services shall conduct a study to evaluate the feasibility of expanding any incentive payment program established for nursing facilities under Section 531.912, Government Code, as amended by this Act, by providing incentive payments for the following types of providers of long-term care services, as defined by Section 22.0011, Human Resources Code, under the medical assistance program:

(1) intermediate care facilities for persons with mental retardation licensed under Chapter 252, Health and Safety Code; and

(2) providers of home and community-based services, as described by 42 U.S.C. Section 1396n(c), who are licensed or otherwise authorized to provide those services in this state.

(d) Not later than September 1, 2012, the Department of Aging and Disability Services shall submit to the legislature a written report containing the findings of the study conducted under Subsection (c) of this section and the department's recommendations.

SECTION 4. FEDERAL AUTHORIZATION. If before implementing any provision of this Act a state agency determines that a waiver or authorization from a federal agency is necessary for implementation of that provision, the agency affected by the provision shall request the waiver or authorization and may delay implementing that provision until the waiver or authorization is granted.

SECTION 5. EFFECTIVE DATE. This Act takes effect September 1, 2011.