THCA’s Legislative Report is intended to provide general information about the subject matter covered. It is not meant to provide legal opinions, offer advice, or serve as a substitute for advice by licensed, legal professionals. Laws and interpretations of those laws change frequently and the subject matter of this report has important legal consequences. If not understood, legal, tax, or other counsel should be consulted.
OVERVIEW

The start of the 84th Session of the Texas Legislature was labeled “a new day in Texas.” The session ushered in many changes. Texas had a new governor (Greg Abbott) for the first time since 2000 and a new lieutenant governor (Dan Patrick) for the first time since 2003. The State Comptroller told legislators they had a record high $18 billion in new money for the budget.

But the 2014 elections had also brought in a new crop of legislators who had pledged to cut taxes and tighten the state’s spending in most areas. Legislators also heard warnings about how falling oil prices and a slowing economy could mean a less rosy revenue outlook than originally projected. Those warnings seemed to build as the session progressed.

The legislature adjourned on June after passing a budget that left many healthcare providers and advocates disappointed. The budget covered caseload growth across Medicaid, but not cost growth. No increase was given to long term care providers. The only group with a significant increase was the hospitals. That was due to the concerns with the 1115 Federal Waiver Program proceedings.

Health care did not receive much attention from most legislators during the session. The biggest story was a state contracting scandal within the Health and Human Services Commission (HHSC) that led to a personnel shakeup and an investigation of the agency. Despite questions about the performance of the agency, the Legislature voted to merge the Department of Aging and Disability Services (DADS) and others into HHSC starting in 2016.

There was also a well-publicized effort to increase penalties on nursing facilities. Senator Charles Schwertner, R-Georgetown, introduced legislation that would require license revocation for any provider who was tagged with three Level 4 violations within a two-year period. A modified version of the bill, SB 304, eventually passed.

It was also a session with an unusual (even for Texas) enthusiasm for gun rights. Long term care was not untouched by this as bills were introduced and heard in committee that would have allowed the carrying of guns in nursing facilities. No bill with such a provision was passed into law, however.

Throughout the session, THCA members worked the halls of the Capitol. More than 13 different providers came to Austin, throughout the legislative session, to discuss the critical needs of long term care in Texas. THCA nurses also came out in big numbers for their Legislative Day while our Business Coalition visited the Capitol to explain the impact of nursing facilities on the economy. THCA also offered Virtual Dementia tours and blood pressure screenings to members and staff.

Here is a summary of the actions taken by the 84th Legislature affecting long term care. If you have any questions or suggestions, please do not hesitate to contact Scot Kibbe, THCA Director of Government Relations (skibbe@txhca.org).
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**FUNDING**

**HB 1 - General Appropriations Act**

Author: Otto
Sponsor: Nelson
Effective Date: September 1, 2015

**Article II**

The Legislature appropriated $77.1 billion in all funds for the Health & Human Services budget for the 2016-17 biennium.

Medicaid funding equaled $61.2 billion in All Funds (which includes federal dollars), including $25.0 billion in General Revenue Funds (state dollars only) and $0.2 billion in General Revenue–Dedicated Funds, This an increase of $2.1 billion in All Funds, including $2.0 billion in General Revenue Funds and General Revenue–Dedicated Funds. Approximately $1.7 billion in General Revenue Funds is provided for items including projected caseload growth, including the transition of certain children from CHIP to Medicaid; maintaining fiscal year 2015 average costs for most programs, including fiscal year 2015 rate increases; replacing $0.3 billion in Interagency Contracts with General Revenue Funds; and full biennial funding of the Community First Choice program. This increase is offset by a reduction of $0.3 billion in General Revenue Funds from not continuing state funding for the non-federal portion of the Disproportionate Share Hospital (DSH) program in the 2016–17 biennium.

A less favorable Federal Medical Assistance Percentage (FMAP) results in a higher proportion of the program being funded with General Revenue Funds.

The Legislature funded caseload growth but not cost growth. Rates for nursing facility and most other health care providers remained flat.

Funding for rural and safety net hospitals received a $573.3 million increase (All Funds). Mental health services were given a $150 million bump.

Primary care physicians, who had asked for a 2% increase in Medicaid reimbursements and were granted it in the House budget, receive no increase in the final budget. Some therapy providers saw a $350 million cut over the biennium while managed care organizations had their profit margins reduced by half a percent.
According to the *Texas Tribune*:

*Experts on both sides agree that lawmakers probably shortchanged Medicaid, even after increasing the two-year budget by $2.1 billion, leaving a budget hole that will have to be filled later. They didn’t allow for inflation and used rosy estimates of projected “cost containment” savings, they said, all but ensuring that the program will require some shoring up in the form of a supplemental budget when lawmakers return in 2017.*

**Relevant Long Term Care Riders**

**Health and Human Services Commission (HHSC)**

46. **Quality-Based Payment and Delivery Reforms in the Medicaid and Children's Health Insurance Programs.** Out of funds appropriated to the Health and Human Services Commission (HHSC) in Goal B, Medicaid, and Goal C, Children's Health Insurance Program, HHSC may implement the following quality-based reforms in the Medicaid and CHIP programs:

a. develop quality-based outcome and process measures that promote the provision of efficient, quality health care and that can be used to implement quality-based payments for acute and long-term care services across delivery models and payment systems;

b. implement quality-based payment systems for compensating a health care provider or facility participating in the Medicaid and CHIP programs;

c. implement quality-based payment initiatives to reduce potentially preventable readmissions and potentially preventable complications; and

d. implement a bundled payment initiative in the Medicaid program, including a shared savings component for providers that meet quality-based outcomes. The executive commissioner may select high-cost and/or high-volume services to bundle and may consider the experiences of other payers and other state of Texas programs that purchase healthcare services in making the selection.

e. Under the Health and Human Services Commission's authority in 1 T.A.C. Sec. 355.307(c), the commission may implement a Special Reimbursement Class for long term care commonly referred to as "small house facilities." Such a class may include a rate reimbursement model that is cost neutral and that adequately addresses the cost differences that exist in a nursing facility constructed and operated as a small house facility, as well as the potential for off-setting cost savings through decreased utilization of higher cost institutional and ancillary services. The payment increment may be based upon a provider incentive payment rate.
Required Reporting: The commission shall provide annual reports to the Governor’s Office of Budget, Planning, and Policy and Legislative Budget Board on December 1, 2015 and December 1, 2016 that include (1) the quality-based outcome and process measures developed; (2) the progress of the implementation of quality-based payment systems and other related initiatives; (3) outcome and process measures by health service region; and (4) cost-effectiveness of quality-based payment systems and other related initiatives.

81. Medicaid Managed Care Organization Network Adequacy Action Report. Out of funds appropriated above, the Health and Human Services Commission shall report to the Legislature and the public no later than September 1, 2016 containing the number of final disciplinary orders or corrective action plans imposed by the Commission over the last five years based upon violations of the Commission’s Medicaid managed care program network adequacy requirements under 1 Tex. Admin. Code § 353.411. For each final disciplinary order or corrective action plan imposed by the Commission based upon a violation of the Commission’s Medicaid managed care program network adequacy requirements or accessibility of services standards provisions, the report shall include: the name of the managed care organization, date of the disciplinary order or corrective action plan, disciplinary or corrective action taken, and ground for the violation.

92. Report on STAR+PLUS Program Expenditures. The Texas Health and Human Services Commission shall report, no later than September 1, 2015 and October 15, 2016, all specific and projected program expenditures for STAR+PLUS to the Lieutenant Governor, Speaker of the House, Legislative Budget Board members, Texas Health and Human Services Committee members, and the Texas Human Services Committee members. The expenditures will include FY2016 budgetary expenditures and estimated expenditures for each program in STAR+PLUS and projected expenditures for FY 2017.

96. NAIP/MPAP Payments Informational Listing. The following is an informational listing of estimated Network Access Improvement Program (NAIP) and Nursing Facility Minimum Payment Amounts Program (MPAP) payments. This rider is informational only and does not make any appropriations. The actual amounts will vary dependent upon the amount of non-state funds used as intergovernmental transfers and upon the number of entities choosing to participate. The funds are not included in this Act.

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97. Nursing Facility Minimum Payment Amounts Program. It is the intent of the Legislature that not later than September 1, 2016, the Commission shall fully transition the Nursing Facility Minimum Payment Amounts Program (MPAP) program from a program solely based on enhanced payment rates to publically-owned nursing facilities to a Quality Incentive Payment Program (QIPP) for all nursing facilities that have a source of public funding for the non-federal share, whether those facilities are publically- or privately-owned. No state General Revenue is
to be expended under the QIPP. The additional payments to nursing facilities through the QIPP should be based upon improvements in quality and innovation in the provision of nursing facility services, including but not limited to payment incentives to establish culture change, small house models, staffing enhancements and outcome measures to improve the quality of care and life for nursing facility residents.

Department of Aging and Disability Resources (DADS)

9. Pediatric Care in Nursing Facilities. When using funds appropriated above in addition to consideration of expense in determining the appropriate placement for children who currently receive care in nursing facilities, the department shall, within the requirements of state and federal law, consider the requests of parents concerning either a continued stay in a nursing facility providing skilled pediatric care or an alternate placement.


a. Nursing Home Income Eligibility Cap. It is the intent of the Legislature that the income eligibility cap for nursing home care shall be maintained at the federal maximum level of 300 percent of Supplemental Security Income (SSI).

b. Nursing Home Bed Capacity Planning. It is the intent of the Legislature that the department shall control the number of Medicaid beds, and decertify unused Medicaid beds, and reallocate some or all of the decertified Medicaid beds, taking into account a facility's occupancy rate.

Special Provisions Related to all Health Agencies

Sec. 43. Rate Limitations and Reporting Requirements. Notwithstanding other provisions of this Act, the use of appropriated funds for a rate paid by a health and human services agency in Article II of this Act shall be governed by the specific limitations included in this provision. For purposes of this provision, "rate" is defined to include all provider reimbursements (regardless of methodology), including for oral medications, that account for significant expenditures made by a health and human services agency in Article II of this Act. "Fiscal impact" is defined as an increase in expenditures due to either a rate change or establishment of a new rate, including the impact on all affected programs. Additionally, estimates of fiscal impacts should be based on the most current caseload forecast submitted by the Health and Human Services Commission (HHSC) pursuant to other provisions in this Act and should specify General Revenue-related Funds, TANF Federal Funds, and All Funds. Fiscal estimates that impact multiple risk groups may be reported at an aggregate level and acute care services may be reported by rate category.
a. Notification of Change to Managed Care Rates.

(1) No later than 45 calendar days prior to implementation of a change to premium rates for managed care organizations (MCO) contracting with HHSC, the Executive Commissioner of the HHSC shall submit the following information in writing to the Legislative Budget Board, the Governor, and the State Auditor:
   (i) a schedule showing the original and revised rate, which should include information on the rate basis for the MCO reimbursements to providers;
   (ii) a schedule and description of the rate-setting process for all rates listed for subsection (1); and
   (iii) an estimate of the fiscal impact, by agency and by fiscal year, including the amount of General Revenue Funds, TANF Federal Funds, and All Funds for each rate change listed for subsection (1).

(2) Within seven days of the submission requirements listed above in subsections (i) through (iii), the Executive Commissioner of the HHSC shall submit a schedule identifying an estimate of the amount of General Revenue Funds, TANF Federal Funds, and All Funds by which expenditures at such rate levels would exceed appropriated funding.

Sec. 46. Coordination of Interagency Nursing Facility Resident Complaint Data and Information.

a. The Office of the Long Term Care Ombudsman shall be the state entity designated to collect, monitor, and analyze data related to all Medicaid managed care nursing facility resident complaint data regardless of the payer of services, and shall include in their annual report information and data that identifies Medicaid managed care organizations' performance at the facility level that is related to nursing facility resident complaints, including, but not limited to: (1) the source and location of the complaint, (2) the nature of complaint, (3) the disposition of complaint, (4) the length of time required to resolve the complaint, and (5) any other information and data that the Long Term Care Ombudsman identifies as relevant.

b. Out of the funds appropriated elsewhere in the Act, the Department of Aging and Disability Services and the Health and Human Services Commission shall establish an interagency workgroup to facilitate the exchange of data and any other related information about Medicaid managed care nursing facility resident complaint data and to determine standard definitions for the data to be shared.

c. Out of the funds appropriated to the Health and Human Services Commission (HHSC), in Goal A, Strategy A.1.2, Integrated Eligibility and Enrollment:

   1. HHSC shall collect information and data related to Medicaid managed care nursing facility resident complaint data from Medicaid managed care organizations including, but not limited to: (1) the source and location of the complaint and/or appeal, (2) the
nature or category of complaint and/or appeal, (3) the disposition of complaint and/or appeal, (4) the complaint and/or appeal resolution length and entity that resolved complaint and/or appeal, (5) type of service or procedure-related to complaint and/or appeal, and other information the HHSC Office of the Ombudsman, in consultation with the Department of Aging and Disability Services Long Term Care Ombudsman, identifies as relevant.

2. HHSC shall quarterly provide the above information to the Department of Aging and Disability Services Office of the Long Term Care Ombudsman in a format the Long Term Care Ombudsman specifies.

3. The HHSC Office of the Ombudsman shall annually report the above Medicaid managed care nursing facility resident complaint information, including analysis of complaint data trends, and comparison of performance between managed care organizations and across time, to the executive commissioner of HHSC and the Health and Human Services Council.

4. HHSC’s Office of the Ombudsman shall prepare information that identifies a Medicaid managed care organization's (MCO) performance related to Medicaid managed care nursing facility resident complaints including, but not limited to: (1) the source and location of the complaint and/or appeal, (2) the nature or category of complaint and/or appeal, (3) the disposition of complaint and/or appeal, (4) the complaint and/or appeal resolution length and entity that resolved complaint and/or appeal, (5) type of service or procedure-related to complaint and/or appeal, and other information identified as relevant to a MCO beneficiary. The information shall be prepared in a consumer friendly, printed format that allows beneficiaries to compare Medicaid managed care nursing facility resident complaint resolution performance by MCO, services provided, geographic location, and across time. The printed information shall be distributed to all respective beneficiaries of health and human service programs provided by a MCO. The information shall be distributed to beneficiaries via postal mail annually during enrollment or other predetermined mailing period.
MANAGED CARE

**HB 3523**- Relating to improving the delivery and quality of Medicaid acute care services and long-term care services and supports.

**Author:** Raymond  
**Sponsor:** Perry  
**Effective Date:** September 1, 2015

Last session, residents of nursing facilities who rely on Medicaid were moved to managed care by SB 7. That legislation provided that HHSC would set Medicaid rates until Sept. 1, 2019. HB 3523 extends that date to September 1, 2021.

Also extended from 2019 to 2021 are the requirements that facilities be paid not later than the 10th day following submission of a clean claim; that managed care organizations assist in collecting applied income from residents; that HHSC establish minimum credentialing and minimum performance standards; and prohibition against an MCO requiring prior authorization for a nursing facility resident in need of emergency services.

It will also continue the state’s setting of the methodology for the staff enhancement rate through September 1, 2021. At that time, managed care organizations will set the rates with the approval of HHSC.

The requirement that managed care organizations contract with any facility approved to accept Medicaid on September 1, 2013, was not extended. This “any willing provider” clause remains set to expire on September 1, 2017.

**SB 760**- Relating to access and assignment requirements for, support and information regarding, and investigations of certain providers of health care and long-term services.

**Author:** Schwertner  
**Sponsor:** Price  
**Effective Date:** September 1, 2015

Requires HHSC to set minimum provider access standards for a Medicaid managed care organization’s provider network. If an MCO fails to comply with those standards, HHSC will suspend default enrollment for at least a quarter of the year. HHSC could also require the MCO to pay liquidated damages or refuse to retain or renew their contract.
SB 760 also requires a Medicaid MCO to establish and implement an expedited credentialing process to allow providers to apply for eligibility to provide services on a provisional basis.

SB 760 requires a Medicaid MCO to post its provider network directory on the MCO’s website along with a phone number and e-mail address offering help in identifying in-network health care providers, scheduling appointments, and accessing available in-network services.

The bill directs HHSC to establish a program to monitor an MCO’s provider network to ensure they are meeting contractual obligations.

Contracts with a Medicaid MCO will have to require an MCO to develop and submit a comprehensive plan describing how they will comply with provider access standards.
REGULATORY

HB 1337 - Relating to requiring institutions and assisted living facilities to maintain guardianship orders of residents.

Author: Naishtat
Sponsor: Zaffirini
Effective Date: September 1, 2015

HB 1337 requires nursing homes and assisted living facilities to maintain a copy of any court order appointing a guardian of a resident or a resident's estate in the resident's medical records. During an investigation of alleged abuse, neglect, or exploitation, DADS investigators will be required to inspect any order maintained in the resident's medical record appointing a guardian for the resident who is the subject of an investigation.

HB 2588 - Relating to disclosures by nursing facilities and assisted living facilities regarding certification or classification to provide specialized care, treatment, or personal care services to residents with Alzheimer's disease or related disorders and the authority of the executive commissioner of the Health and Human Services Commission to adopt rules defining those conditions; adding requirements for an occupational license.

Author: Naishtat
Sponsor: Zaffirini
Effective Date: Immediate but applies only to disclosures made on or after January 1, 2016.

Requires nursing homes and assisted living facilities that provide specialized care and treatment to residents with Alzheimer's and related disorders to disclose if a facility is certified for the provision of personal care and treatment of Alzheimer's and other disorders in the facility's disclosure statement. Also requires the executive commissioner of HHSC to adopt any rules prescribing for the disclosures required in the bill.

In addition, the bill requires the executive commissioner of HHSC to adopt in rule a definition of "Alzheimer's disease and related disorders," to apply to facilities that advertise, market, or otherwise promote that they provide personal care services to residents who have Alzheimer's disease or related disorders and are certified by the state to provide specialized care and treatment of persons with Alzheimer's disease and related disorders and modifies the definition as necessary to conform to changes in medical practice.
SB 200 - Relating to the continuation and functions of the Health and Human Services Commission and the provision of health and human services in this state.

Author: Nelson  
Sponsor: Price
Effective Date: September 1, 2015 unless otherwise provided

This is the Sunset bill for HHSC. It extends the agency to 2027. It rolls the Department of Assistive and Rehabilitative Services (DARS) and DADS into HHSC starting on September 1, 2016. The consolidation will be completed by September 1, 2017. Functions of DADS that remained with the agency will transfer to HHSC along with the regulatory functions of DFPS and DSHS and functions related to DSHS’ state-operated institutions. DADS will be abolished after all its functions have transferred.

The bill requires the HHSC commissioner to establish divisions with HHSC along functional lines with a director. Nursing facilities would be governed under a regulatory division. The commissioner will define the duties of the directors and delegate decision making and budget authority to them.

A transition oversight committee will work to facilitate transfer of functions with minimal negative effect on the delivery of services.

The bill also mandates that HHSC develop a single, consolidated Medicaid provider enrollment and credentialing process and create a centralized Interne portal through which providers can enroll in the program.

Numerous advisory committees are abolished with this legislation, including the STAR + PLUS Nursing Facility Advisory Committee and the state Medicaid managed care advisory committee.

SB 207 - Relating to the authority and duties of the office of inspector general of the Health and Human Services Commission.

Author: Hinojosa  
Sponsor: Gonzales
Effective Date: September 1, 2015

Modifies the rulemaking, duties and operations of the Office of Inspector General (OIG) for HHSC. The bill will require the OIG to undergo special review by Sunset Advisory Commission in six years. The bill would require the OIG to establish priorities to guide its investigation processes, change the timelines for different phases of the investigation process, define OIG’s role in managed care oversight, and require the OIG to conduct quality assurance reviews and
require a peer review of sampling methodology used in its investigative process. Additionally, the bill would streamline the credible allegation of fraud (CAF) hold hearing process, clarify good cause exceptions for OIG’s application of a CAF hold, require the OIG to pay all costs for CAF hold hearings at State Office of Administrative Hearings (SOAH), and change pharmacies’ rights when under an OIG audit.

The bill would require the OIG and HHSC to coordinate audit and oversight activities of managed care organizations. Additionally, the bill would prohibit the OIG from performing duplicative criminal history background checks.

**SB 304**- Relating to certain violations committed by long-term care facilities, including violations that constitute the abuse and neglect of residents.

**Author:** Schwertner  
**Sponsor:** Raymond  
**Effective Date:** September 1, 2016

Known as the “three strikes bill”, this legislation calls for the revocation of the license of a facility that has three Immediate Jeopardy violations related to the abuse or neglect of a resident within a 24 month period at the discretion of the HHSC commissioner. Findings of Immediate Jeopardy violations included as cause for license revocation are based upon separate and distinct visits to the facility for survey, inspections or investigation visits. The determination of immediate threat to health and safety must be included in the notification to the facility at exit, and not some later time period.

Negotiated rule making must be used by HHSC in setting the rules that implement this bill.

SB 304 requires monitoring visits to be given to long-term care facilities with a history of patient care deficiencies or that are identified as medium risk through DADS' early warning system. The bill authorizes a long-term care facility may request a monitoring visit. The bill includes among the conditions required to be assessed by a quality-of-care monitor conditions identified through the long-term care facility’s quality measure reports based on Minimum Data Set Resident Assessments. The bill requires DADS to schedule a follow-up visit not later than the 45th day after the date of an initial monitoring visit.

A rapid response program for facilities is established following the finding of three Immediate Jeopardy violations. The rapid response team will work with the facility on improving the quality of care as well as providing reporting input to the commissioner on the facility’s efforts on ensuring the health and safety of the residents.

The commissioner may stay revocation of a license if the facility is cooperating in such program and improving the quality of care as determined by the rapid response team.
SB 304 also moves Informal Dispute Resolution (IDR) process from HHSC. The Commission will now have to contract with a third party non-profit organization to carry out the process.

ASSISTED LIVING

**HB 1769**- Relating to requirements for assisted living facility license applicants

Author: Zerwas/Faircloth  
Sponsor: Uresti  
Effective Date: September 1, 2015

HB 1769 would change the current licensing practice for assisted living facilities in good standing with DADS. The applicant would be considered in good standing if it had operated an Assisted Living facility in Texas for six consecutive years, during which time none of the applicant’s facilities:

- had a violation resulting in harm or an immediate threat of harm to a resident likely to cause serious injury, impairment, or death; and
- had sanctions of any kind imposed against them, including civil or administrative penalties, denial, suspension, or revocation of a license, or emergency closure.

An assisted living facility in good standing could request an initial license that did not require an on-site health inspection. An inspection will still need to take place within 90 days after the license is granted, however.

The bill prohibits DADS from requiring an assisted living facility to admit residents before DADS issued the license. Providers would be required to submit policies and procedures to DADS for approval and to verify employee background checks and credentials.
WORKGROUPS AND ADVISORY COUNCILS

**HB 2696** — Relating to a study on reducing workplace violence against nurses.

**Author:** Howard/Coleman/Collier/Klick/Price  
**Sponsor:** Zaffirini

**Effective date:** Immediate

Authorizes the statewide health coordinating council to conduct a study on workplace violence against nurses in health facilities. The study must:

1) distinguish between verbal and physical violence;  
2) determine the practice areas, environments, and settings in which verbal or physical violence is likely to occur;  
3) identify practices that prevent or reduce verbal and physical violence against nurses;  
4) survey nurses regarding the type and frequency of verbal and physical violence the nurses have experienced in the preceding year and throughout the nurses’ careers; and  
5) survey health facilities regarding the occurrence of verbal and physical violence against nurses and specific strategies implemented to prevent verbal and physical violence, including:
   a. required reporting of verbal and physical violence;  
   b. reporting of physical assaults to law enforcement; and  
   c. implementation of a violence prevention plan and the contents of and personnel covered by the plan.

**SB 914** — Relating to a council on long-term care facility surveys and informal dispute resolution

**Author:** Kolkhorst  
**Sponsor:** Schubert/Raymond/Naishtat

**Effective Date:** September 1, 2015

SB 914 establishes the Long-Term Care Facility Survey and Informal Dispute Resolution Council to examine best practices and protocols for a survey and IDR process that are more consistent and efficient and less burdensome. The committee will make recommendations before the next Legislative Session.
The HHSC Commissioner will appoint the council and it will include:

1) two program managers from different Department of Aging and Disability Services regions;
2) one surveyor who has attained at least the level of investigator IV;
3) two members of an enforcement team from different Department of Aging and Disability Services regions;
4) three surveyors, each from a different Department of Aging and Disability Services region, at least one of whom must have a background in nursing, at least one of whom must have a background in social work, and at least one of whom must have a background in the provision of pharmacy services;
5) one informal dispute resolution team leader;
6) one informal dispute resolution reviewer;
7) two owners or regional vice presidents of operation who oversee multiple long-term care facilities;
8) two regional quality assurance nurses who oversee multiple long-term care facilities;
9) two active long-term care facility administrators; and
10) two active long-term care facility directors of nursing.
HB 1403- Relating to the definition of health care liability claim for the purposes of certain laws governing those claims.

Author: Sheets/Turner, Chris/Fallon
Sponsor: Estes
Effective Date: September 1, 2015

HB 1403 would exclude actions filed under the Texas Workers’ Compensation Act (TWCA) by employees who were not covered by workers’ compensation insurance for damages and exemplary damages for personal injury or death that occurred in the course and scope of employment from the definition of a “health care liability claim” under the Texas Medical Liability Act, Civil Practice and Remedies Code, ch. 74. Under the bill, the expert reports served on each defendant in a health care liability claim would be required to address at least one theory of direct liability asserted against each physician or health care provider against whom a theory of direct liability was asserted.

This legislation is a response to a recent ruling by the Texas Supreme Court in the case Texas West Oaks Hospital, LP v. Williams, 371 S.W.3d 171 (Tex. 2012). The Court ruled that a claim by an employee of a private mental health hospital who was injured in an altercation with a patient with a history of violent outbursts was a health care liability claim under the Texas Medical Liability Act (TMLA). The court dismissed the claimant’s suit on the grounds that he did not serve the defendant with an expert report, as required for health care liability claims under Civil Practice and Remedies Code, ch. 74.

Under Labor Code, sec. 406.033, employees who are not covered by workers’ compensation insurance could file claims against employers to recover damages for personal injury or death that are sustained in the course and scope of employment. Sec. 408.001 allows employees’ surviving spouses or heirs to seek exemplary damages for those claims if the employee’s death was caused by an intentional act or omission or gross negligence of the employer.
MEDICAL

HB 2641- Relating to the exchange of health information in this state; creating a criminal offense.

Author: Zerwas/Guillen/Shaheen
Sponsor: Schwertner
Effective Date: September 1, 2015

HB 2641 would set regulations for sending or receiving health information, including health information collected by the Department of State Health Services, through a health information exchange.

The bill would require the executive commissioner of HHSC to ensure that:

- all information systems available for use by HHSC or a health and human services agency for sending or receiving protected health information to or from a health care provider were capable of sending and receiving that information in accordance with the applicable data exchange standards developed by an organization accredited by the American National Standards Institute;
- all information systems for which planning or procurement began on or after September 1, 2015, were capable of sending and receiving protected health information in accordance with applicable data exchange standards;
- if national data exchange standards did not exist for sending and receiving health information, HHSC would make every effort to ensure the system was interoperable with national standards for electronic health record systems;
- HHSC and each health and human services agency would establish an interoperability standards plan for all information systems that exchanged protected health information with health care providers; by December 1 of each even-numbered year, the executive commissioner would report to the governor and the Legislative Budget Board on the commission’s and the health and human services agencies’ measurable progress in ensuring that the information systems were interoperable with one another and met appropriate standards;
- the report would include an assessment of the progress made in achieving HHSC goals related to the exchange of health information, including facilitating care coordination among the agencies, ensuring quality improvement, and realizing cost savings; and
- the executive commissioner by rule could develop and HHSC could implement a system to reimburse providers of health care services under the state Medicaid program for review and transmission of electronic health information if feasible and cost effective.
SB 1243-Relating to a pilot program for donation and redistribution of certain unused prescription medications; authorizing a fee.

Author: Burton
Sponsor: Sheffield/Klick
Effective Date: September 1, 2015

SB 1243 requires the Department of State Health Services (DSHS) to establish a pilot program for the donation and redistribution of certain prescription drugs. The program would be conducted in one or more municipalities with a population of more than 500,000 but less than 1 million (Austin, El Paso, Fort Worth).

Under the program, a charitable drug donor could donate certain unused prescription drugs to DSHS. The department would not accept the drugs unless the drugs were properly stored while in the donor’s possession, the department was provided with a verifiable address and phone number of the donor, and the person transferring the drugs presented photo identification.

Donated drugs would be required to be prescription drugs that had been approved by the U.S. Food and Drug Administration and were sealed in unopened, tamper-evident, unit dose packaging. Drugs packaged in single-unit doses would be acceptable if the outside packaging was opened but the single unit dose packaging was unopened.

The drugs could not be subject to a mandatory or voluntary recall, adulterated or misbranded, a controlled substance, a parenteral or injectable medication, require refrigeration, or expire less than 60 days after the date of donation.

DSHS would not be permitted to distribute the drugs without inspection by a licensed pharmacist. It also would not be permitted to charge a fee for the drugs other than a nominal handling fee, or resell the drugs.

DSHS would be required to establish a location to centrally store drugs for distribution to qualifying patients. The department also would be required to establish and maintain an electronic database in which the name and quantity of each drug was listed and a charitable medical clinic, physician, or other licensed health care professional could search for and request drugs donated under the pilot program.

Drugs would be administered to patients only by a charitable medical clinic, a licensed health care professional in a Texas penal institution, or a physician’s office using the drugs for indigent health care or for patients who receive Medicaid assistance.
A drug would be required to be prescribed for the patient. The clinic or physician administering the drug could not charge a fee for the drugs, other than a nominal handling fee, or resell the drugs.

Qualified individuals acting in good faith in administering drugs under the pilot program would not be civilly or criminally liable or subject to professional disciplinary action for harm caused by administering drugs unless the harm was caused by negligence, recklessness or indifference, or intentional conduct. DSHS would be required to establish rules governing the program.

DSHS would be required to report to the Legislature on the results of the pilot program. The report would be required to include:

- The program’s efficacy in expanding access to prescription medications;
- Any cost savings to the state or local government;
- An evaluation of the program’s database and system of distribution;
- Any health and safety issues;
- Recommended improvements; and
- An evaluation of potential expansion of the program.

The bill also would require DSHS to conduct a feasibility study on establishing a program under which hospitals, nursing facilities, or other health facilities could transfer unused drugs to the department or another entity designated by the department for distribution to public hospitals. The study would consider which rules would need to be adopted to implement such a program, including rules related to the types of drugs which might be transferred, the procedures for transferring and allocation the drugs and qualification for an entity designated to transfer and distribute drugs. DSHS would submit its findings to the Legislature no later than September 1, 2016.

The bill would apply only to a drug donated, accepted, provided or administered on or after January 1, 2016.