



2023 New Health Care Laws

From the 88th Texas Legislature



Texas
Hospital
Association

1108 Lavaca, Suite 700
Austin, Texas 78701
www.tha.org

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1108 Lavaca, Suite 700
Austin, Texas 78701
www.tha.org



Written by:

Jennifer Banda
Heather De La Garza
Cameron Duncan
Sara González
Carrie Kroll
Cesar Lopez
Erika Ramirez
Michael Sipes
Anna Stelter
Matt Turner
Steve Wohleb

Edited by:

Joey Berlin
Minh Ly
Michael Sipes
Steve Wohleb

Layout by:

Brian Nicols

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During its 140-day regular legislative session in 2023, the 88th Texas Legislature passed more than 1,000 bills. Many of those impact hospitals and health systems.

Written by THA’s legal, advocacy and policy teams, this reference manual contains an overview of health care and hospital-related legislation passed during the 2023 regular session. The brief analysis provided for each bill is not a detailed synopsis. Some bills have an operational impact on hospitals and health systems. THA has included an “operational impact” section where applicable, and has provided a list of bills to ensure that member hospitals can implement them appropriately. The full text of each bill may be obtained from the Texas Capitol website at www.capitol.state.tx.us. Questions regarding compliance with any new law should be directed to your facility’s legal counsel. Questions about the manual or requests for additional information may be directed to THA’s legal staff at 512/465-1030.

All member CEOs and chief legal officers each receive a complimentary copy as a benefit of THA membership. Hospital governing board members, medical staff leaders and administrative team and department leaders also will find the manual to be a valuable resource. Additional copies of 2023 New Health Care Laws may be purchased for \$50 for THA members and \$200 for non-members. An order form is provided at the back of the manual. THA members also may access the manual online at www.tha.org/2023HLM.





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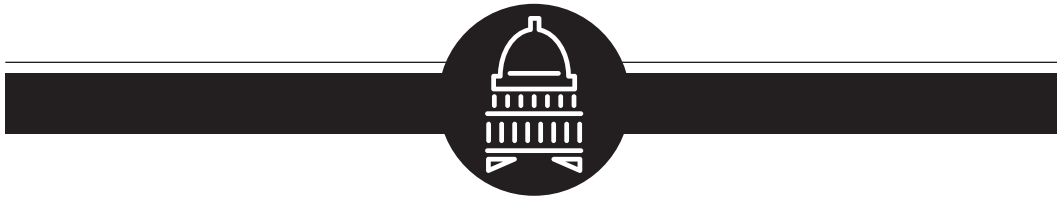
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BEHAVIORAL HEALTH



HOUSE BILL 3808

Author:
Rep. Terry Wilson

Effective Date: 9/1/23

Changing the Membership of the Pediatric Acute-Onset Neuropsychiatric Syndrome Advisory Council

ANALYSIS

HB 3808 deletes the following three membership qualifications out of the 14 members appointed by the governor for the Pediatric Acute-Onset Neuropsychiatric Syndrome Advisory Council:

- An osteopathic physician with experience treating persons with pediatric acute onset neuropsychiatric syndrome, including pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections.
- An immunologist with experience treating people with pediatric acute onset neuropsychiatric syndrome, including pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and the use of intravenous immunoglobulin.
- A dietician or nutritionist who provides services to children with autism spectrum disorders, attention deficit/hyperactivity disorders and other neurodevelopmental conditions.

The bill replaces the three membership qualifications above with three members who are health care providers, defined as a person who is authorized by the laws of this state to provide health care in the ordinary course of business or practice of a profession.

HB 3808 also revises the membership qualification for a social worker on the Council, deleting that the social worker has to be licensed by this state to practice and makes other minor procedural changes.

The total number of council members remains at 19.



SENATE BILL 1677

Author:
Sen. Charles Perry

Effective Date: 9/1/23

Mental Health Grant Program Requirements

ANALYSIS

SB 1677 adds additional funding guidance for certain mental health grant programs administered by the Health and Human Services Commission (HHSC) and creates a new program to fund the expansion or establishment of regional behavioral health centers and jail diversion centers. It also requires the Office of the State Auditor to conduct an audit of the forensic waitlist for competency restoration.

Section 1 of SB 1677 amends Section 531.0991, Government Code, which codifies the mental health grant program. The bill adds that if HHSC is awarded more funding for the mental health grant program in a state fiscal year than the total amount of grants awarded in the previous state fiscal year, in selecting grant recipients for the excess amount, HHSC must accept:

- Applications from applicants that were not selected as grant recipients the previous fiscal year, or
- Applications from applicants that were selected as grant recipients but require additional funding for their program.

Section 2 of SB 1677 amends Section 531.0993, Government Code, which codifies the grant program to reduce recidivism, arrest, and incarceration among individuals with mental illness and to reduce the wait time for forensic commitment. The bill adds the following:

- Subsection (d-1) requiring HHSC to establish procedures to help community collaboratives that include a county with a population of less than 250,000 to submit a petition seeking a grant.
- Subsection (d-2) requiring that, in the instance that HHSC is awarded more funding for the grant program in a state fiscal year than the total amount of grants awarded in the previous state fiscal year, in selecting grant recipients for the excess amount, HHSC must accept:
 - Petitions from community collaboratives that were not selected as grant recipients the previous fiscal year; or
 - Petitions from community collaboratives that were selected as grant recipients but require additional funding for their program.

Section 3 of HB 1677 establishes another grant program through which HHSC, in coordination with local mental health authorities, can fund nonprofits or governmental entities in rural areas to establish or expand behavioral health centers



or jail diversion centers. HHSC must develop criteria for application evaluation.

Section 4 of HB 1677 requires the state auditor’s office to conduct an audit of the forensic waitlist for competency restoration across county jails and publish a report by Dec. 1, 2024.

HOUSE BILL 400

Author:
Rep. Stephanie Klick

Effective Date: 9/1/23

New Grant Programs for Psychiatric Residency Programs and Behavioral Health Workforce Development

ANALYSIS

HB 400 creates the Psychiatric Specialty Innovation Grant Program at the Texas Higher Education Coordinating Board (THECB). The grant allows incentive payments to medical schools that administer innovative residency training programs in both adult and pediatric psychiatric care. In addition to funds appropriated by the legislature, THECB is also allowed to seek and apply for federal funds and solicit and accept gifts, grants and donations from any public or private source.

THECB is required to adopt rules in consultation with each medical school that adhere to the following guidelines (see Sec. 58A.073):

- The rules must include eligibility criteria that require medical schools to demonstrate regional and state workforce needs.
- There must be procedures for evaluating grant applications, grant amounts and monitoring the use of grant dollars.
- There must be methods for tracking the effectiveness of grants by using data regarding career paths of graduates and length of practice in the field of psychiatry.
- In awarding grants, THECB is required to allocate 60% to medical schools with innovative residency programs that specialize in pediatric psychiatric care and 40% to schools with innovative residency programs in adult psychiatric care.
- Within each category of grants, THECB must give priority to medical schools with innovative residency programs based in rural or underserved areas.
- Each grant must not exceed \$1 million.

HB 400 also creates the Behavioral Health Innovation Grant Program. Under the bill, THECB is directed to establish an innovation grant program to award incentive payments to institutions of higher education that administer innovative recruitment, training and retention programs to increase the number of mental health



professionals or professionals in related fields.

The programs may provide salary increase or stipends to faculty members who provide instruction to additional students in a mental health related degree or certificate program.

Under the program, THECB may seek and apply for any available federal funds and solicit gifts, grants, and donations from any other source. Additionally, THECB is required to establish eligibility criteria for institutions that must include:

- Demonstrated regional and state workforce needs.
- Grant application procedures.
- Grant amounts.
- Procedures to evaluate applications, use and effectiveness of grants.

In awarding grants, THECB is required to prioritize:

- Programs that enhance or leverage existing mental health professional degree programs.
- Programs in rural or underserved areas.
- Programs that partner with institutions of higher education or public schools.
- Programs that establish or maintain a program that incentivizes mental health professionals to serve in their field of study for at least three consecutive years following graduation in an inpatient or outpatient behavioral health facility or program that receives state funding.
- Programs that maintain a degree or certificate program for professionals in specialties that face significant workforce shortages, including mental health professionals.
- Programs that establish or maintain psychiatric fellowship programs that serve correctional facilities or inpatient psychiatric facilities.

Grant amounts may not be over \$1 million.

OPERATIONAL IMPACT

The bill may help create more mental health professionals that practice in both inpatient psychiatric hospitals and acute care hospitals who employ mental health professionals.

The program must be established by THECB by Sept. 1, 2024.



HOUSE BILL 4085

Author:
Rep. David Spiller, et al.

Effective Date: 9/1/23

Allowing Psychiatric Hospitals to be Refunded Certain Court Costs in Mental Health Proceedings

ANALYSIS

HB 4085 amends Section 571.018 of the Health and Safety Code to require a judge conducting a hearing or proceeding under the Mental Health Code to order the clerk of the court to refund court costs paid or advanced for a person by an inpatient mental health facility on the filing of an affidavit with the clerk of the court certifying that:

- The facility has received no compensation or reimbursement for the treatment of the person;
- The facility provided treatment for the person under a contract with a local mental health authority; or
- The facility provided treatment for the person and only received reimbursement under Medicaid.

Previously the statute only required a refund if the facility received no compensation for the treatment provided.

Note that an “inpatient mental health facility” includes, for purposes of this section, the following:

- A facility operated by the Department of State Health Services.
- A private mental hospital licensed by the Health and Human Services Commission.
- A local mental health authority or a facility operated by or under contract with a local mental health authority.
- An identifiable part of a general hospital licensed by HHSC in which diagnosis, treatment and care for persons with mental illness is provided.

OPERATIONAL IMPACT

Inpatient mental health facilities should consider requesting a refund of court costs if one of the circumstances outlined above applies.



HOUSE BILL 492

Author:
Rep. Tom Craddick

Effective Date: 9/1/2023

Creation of the Midland and Ector County Mental Health District

ANALYSIS

HB 492 creates the authority for Ector and Midland County hospital districts to create a special district to provide mental health services to the residents of the district. The bill makes the following changes:

- Under the bill, the two hospital districts may create a mental health services district if each governing body creates concurrent orders with identical provisions and defines the boundaries of the district to be coextensive with the combined boundaries of each hospital district.
- Under the contract terms, each hospital district must contract with the mental health district to provide mental health services to the hospital district's residents and specify the contract terms.
- The bill outlines processes for dissolution.
- The board of directors shall consist of six appointed directors, with each hospital district appointing three members to serve two-year staggered terms.
- Directors must be a resident or an officer of the hospital district and employees of the district may not serve.
- Under the powers and duties outlined in Subchapter D, Section 579.151, each hospital district may transfer to the special mental health district management and operation of any real property, improvements, and equipment located wholly in the district and used to provide mental health services, as well as operating funds and reserves for operating expenses and funds that have been budgeted by the creating hospital districts. See further provisions on page 5, Subchapter D.
- HB 492 allows the district to create rules and appoint a qualified individual to serve as district administrator, as well as an assistant.
- Each creating hospital district shall provide funding for the special district, but the district may not impose a tax or issue bonds or other obligations.
- The board is further required to hold a public hearing on the proposed annual budget.
- Lastly, the bill specifies that although the district may provide mental health services, other political subdivisions are not prohibited from providing, or taxing to provide for, mental health services inside the boundaries of the district.



SENATE BILL 1045

Author:

Sen. Joan Huffman

Effective Date: 9/1/23

Creating a New Intermediate Court of Appeals with Jurisdiction Over Mental Health Cases

ANALYSIS

SB 1045 creates a new intermediate appellate court, the Court of Appeals for the Fifteenth Court of Appeals District. The court's district is composed of all of the counties of the state. The court is held in the City of Austin and may transact its business in any county in the district as the court determines is necessary and convenient. It consists of a chief justice and four justices.

Under SB 1045, the Court has exclusive intermediate appellate jurisdiction over a number of matters relating to civil cases no matter where the case originates, including "a proceeding relating to a mental health commitment."

**SENATE BILL 1624**

Author:
Sen. Judith Zaffirini, et al.

Effective Date: 9/1/2023

Enabling Electronic Emergency Detention Warrant Applications and Making Changes to Guardianship Procedures**ANALYSIS**

SB 1624 makes several changes to processes around guardianship services and emergency detention warrants.

Emergency Detention Orders

Section 18 contains language related to Emergency Detention Orders issued under Section 573.012, Health and Safety Code. The bill requires judges or magistrates to permit physician applicants for emergency detention orders to apply by email or another secure electronic means, a change from the current permissive standard.

The bill further states a person may be detained even if they are physically located in a facility to perform the preliminary examination in accordance with Section 573.021 if the judge or magistrate transmits a warrant to the facility for the detention of the person, eliminating any perceived need for the warrant to be transmitted to and served by a peace officer.

The bill further adds language indicating that a person for whom a warrant is issued “who is not physically located in a mental health facility at the time the warrant is issued” may be transported to a facility for the preliminary examination. The language clarifies that transport is required only if the person is not already located in a facility.

An electronic emergency detention order may not be issued for an individual currently under the same order or under an order of protective custody, under Chapter 574, Health and Safety Code.

Additionally, SB 1624 requires the Office of Court Administration to develop and implement a process for an applicant for emergency detention to electronically present the application and for a judge or magistrate to electronically transmit a warrant.

Changes to Guardianships

SB 1624 also makes changes to guardianship services regarding access to records, appointment of attorney ad litem, etc., as outlined in Sections 1-6 and not detailed here.



Section 7 of the bill makes changes to the determination of incapacity of certain adults by allowing psychologists to perform examinations for these determinations. The bill specifies that physicians licensed in this state may present the certificate regarding incapacity if the proposed ward's alleged incapacity results from a physical condition or mental condition; or a psychologist licensed or certified if the proposed ward's alleged incapacity results from a mental condition.

The physician or psychologist who provides the letter or certificate must have experience examining individuals with the physical or mental condition resulting in the proposed ward's alleged incapacity or have an established patient-provider relationship with the proposed ward. The bill makes further conforming changes to accommodate the addition of psychologists as entities allowed to make these determinations.

SB 1624 additionally allows wards to have private communications with their physician or other medical professionals, unless the court limits communications due to risk of substantial harm to the ward or the communication is unduly burdensome to the physician or medical professional.

The bill makes further edits to the Estates Code that are beyond the scope of this publication.

OPERATIONAL IMPACT

Hospitals that apply for or utilize the emergency detention warrant application process may benefit from an electronic filing system, as peace officers are not always readily available to execute warrantless detentions for patients who are a danger to themselves or others. Hospitals should follow the development of the electronic application process by the Office of Court Administration in that it may provide another option for the detention of mentally ill patients in appropriate and urgent circumstances.



SENATE BILL 2479

Author:
Sen. Judith Zaffirini

Effective Date: 9/1/23

**Clarifying Procedures Related to Emergency Detention Warrant
Transports and Court-Ordered Psychoactive Medications**

ANALYSIS

SB 2479 amends the Texas Mental Health Code procedures related to emergency detention warrants and court-ordered psychiatric medications, in addition to revisions to the Code of Criminal Procedure not described here.

Section 3 amends Section 573.012, Health and Safety Code related to Emergency Detention Warrants by adding a new subsection (d-1) and modifying subsection (h). New Section (d-1) indicates that a peace officer who transports an apprehended person to a facility in accordance with Section 573.012:

- Is not required to remain at the facility while the person is medically screened or treated or while the person’s insurance coverage is verified.
- May leave the facility immediately after the person is taken into custody by appropriate facility staff and the peace officer provides the required documentation to the facility.

Note that Section 573.001, the section of the chapter that governs warrantless detentions initiated by a peace officer, was not similarly amended in SB 2479.

Subsection (h) is the subsection that allows a physician to request an emergency detention warrant electronically. The subsection was revised to add “a licensed mental health professional employed by a local mental health authority” as authorized to request a warrant by electronic means.

Section 4 amends Section 574.106, Health and Safety Code, to add a provision that indicates that an order for the administration of psychoactive medications issued under that section authorizes the taking of a patient’s blood sample to conduct reasonable and medically necessary evaluations and laboratory tests to safely administer a psychoactive medication authorized by the order.

OPERATIONAL IMPACT

Hospitals should note the statutory language in 573.012(d-1) related to a person transported under an emergency detention warrant, to avoid confusion or conflict in those potentially volatile situations.



SENATE BILL 26

Author:
Sen. Lois Kolkhorst, et al.

Effective Date: 9/1/2023

Mental Health Matching Grants and LMHA Oversight

ANALYSIS

SB 26 allows local mental health authorities to use licensed master social workers or licensed professional counselors under a waiver approved by the commissioner of the Health and Human Services Commission (HHSC). Under current law, local mental health authorities (LMHA) are required to employ a non-physician mental health professional to serve as a mental health and substance use resource for school districts.

SB 26 also creates the Innovation Matching Grant Program for Mental Health Early Intervention and Treatment. The grant program functions as follows:

- HHSC is required to establish a matching grant program to support community-based initiatives that promote identification of mental health issues and improve access to early intervention and treatment for children and families. The initiatives may include the following evidence-based initiatives as outlined in Sec. 531.09915.
- The following entities are eligible to apply for the grant:
 - A hospital licensed under Section 241, Health and Safety Code.
 - A mental health hospital licensed under Section 577, Health and Safety Code.
 - A hospital district.
 - A local mental health authority.
 - A child-care facility, as defined by Chapter 42, Human Resources Code.
 - A county or municipality.
 - A non-profit organization.
- HHSC is required to prioritize entities that work with children and family members of children with high risk of experiencing a crisis or developing a mental health condition.
- Entities applying must provide funds matching at least 10% of the grant amount.
- Grant dollars cannot be used to reimburse expenses that other sources, such as public or private payers, are obligated to pay.



SB 26 also creates a transition of care program to be developed in consultation with long-term care providers to facilitate the transition of patients from behavioral health inpatient care to a nursing facility for patients who require a level of care provided by a nursing facility and a high level of behavioral health services and supports. The plan must include:

- Recommendations for providing incentives to providers to create capacity that serves patients with the above needs, including assessing the feasibility of including incentive payments under the Quality Incentive Payment Program (QIPP).
- Recommendations for methods to create capacity.
- Fiscal estimates, including estimated costs to nursing facilities and savings to hospitals that result from transitioning behavioral health patients.

The plan may only be implemented if HHSC determines the plan would increase the amount of general revenue. This provision expires on Sept. 1, 2025.

Under Section 531.1025, the HHSC Office of Inspector General is directed to conduct performance audits and require financial audits of each local behavioral health authorities and local mental health authorities. Performance audits must be scheduled at least once every 5 years; financial audits must be conducted every 3 years. Additional audits must be conducted as necessary based on adverse findings or at the request of HHSC.

SB 26 also amends current law related to discharge planning between state hospitals and LMHAs by allowing the commission to amend rules related to discharge planning. Additionally, the rules must specify that LMHA's responsibility for ensuring the successful transition of patients who are ready for hospital discharge and requires the LMHA to participate in the joint-discharge planning. State hospitals are required to designate at least one employee to provide transition support services. Transition support services provided by the LMHA must complement joint discharge planning efforts and may include enhanced services and support, and discharge monitoring for up to one year. State hospitals are further required to concentrate provisions of transition support services for patients who have been admitted to and discharged from a facility multiple times in a 30-day period or have been in the facility for longer than 365 consecutive days.

SB 26 specifies that voluntary admission at state hospitals may only take place if there is available space at the facility.

**SENATE BILL 52**

Author:
Sen. Judith Zaffirini

Effective Date: 9/1/23

Establishing a Right to In-Person Visitation by an Essential Caregiver for Patients in a State Hospital**ANALYSIS**

SB 52 enacts new Subchapter F to Chapter 552, Health and Safety Code, to establish the right of a patient, the patient's guardian or the patient's legally authorized representative to designate an essential caregiver with whom a state hospital may not prohibit in-person visitation.

"Essential caregiver" is defined as a family member, friend, guardian, or another person the patient, patient's guardian or patient's legally authorized representative selects for in-person visits. If a patient is a minor, the patient's parent, guardian or managing conservator may designate both of the minor patient's parents as essential caregivers.

Under SB 52, the Health and Human Services Commission (HHSC) must by rule develop guidelines to assist state hospitals in establishing essential caregiver visitation policies and procedures. The guidelines must require the state hospitals to:

- Allow a patient, patient's guardian, or patient's legally authorized representative or, for a minor patient, the patient's parent, guardian, or managing conservator to designate an essential caregiver for in-person visitation.
- Establish a visitation schedule allowing the essential caregiver to visit the patient for at least two hours each day.
- Establish procedures to enable physical contact between the patient and essential caregiver.
- Obtain the signature of the essential caregiver certifying the caregiver will follow the hospital's safety protocols and any other policies, procedures or rules established under SB 52.

A state hospital may not establish safety protocols that are more stringent than the safety protocols the hospital establishes for hospital staff.

A state hospital may revoke an individual's designation as an essential caregiver if the individual violates the hospital's policies, procedures, or safety protocols. If a state hospital revokes an individual's designation as an essential caregiver, the patient, patient's guardian or patient's legally authorized representative or, for a minor patient, the patient's parent, guardian or managing conservator, has the right to immediately



designate another individual as the patient’s essential caregiver. By rule, HHSC must establish an appeals process to evaluate the revocation of an individual’s designation as an essential caregiver.

A state hospital may petition HHSC to suspend in-person essential caregiver visits for not more than seven days if in-person visitation poses a serious community health risk. HHSC may deny the hospital’s request to suspend in-person essential caregiver visitation if HHSC determines that in-person visitation does not pose a serious community health risk. A state hospital may request an extension from HHSC to suspend in-person essential caregiver visitation for more than seven days. HHSC may not approve an extension for a period that exceeds seven days, and the hospital must separately request each extension. A state hospital may not suspend in-person essential caregiver visitation in any year for more than 14 consecutive days or 45 days total.

Finally, SB 52 provides that the requirements may not be construed as requiring an essential caregiver to provide necessary care to a patient, and a state hospital may not require an essential caregiver to provide the necessary care.

OPERATIONAL IMPACT

State hospitals should follow the rulemaking process and be prepared to comply with the rules and procedures adopted thereunder requiring the facility to allow in-person visitation by a designated essential caregiver.

**SENATE BILL 532**

Author:
Sen. Royce West, et al.

Effective Date: 9/1/23

Loan Repayment Program Revisions and Mental Health and Suicide Prevention Efforts**ANALYSIS**

SB 532 revises the mental health loan repayment program, the Math and Science Scholars Loan Repayment Program and includes provisions related to mental health and suicide prevention services at institutions of higher education.

SB 532 requires institutions of higher education to provide mental health and suicide prevention services as follows:

- Higher education institutions must provide a campus map identifying any location in which mental health services are provided to students on campus and information regarding how to access the services.
- Campuses are further required to identify at least one location that provides mental health services during on-campus orientation tours for incoming students.

SB 532 makes changes to the mental health loan repayment program as follows:

- Regarding eligibility criteria for loan repayment, the bill shortens the amount of time the mental health professional is required to practice in a mental health professional shortage area from up to five consecutive years to up to three consecutive years.
- The bill further allows professionals to establish eligibility for repayment if they provide services to patients in state hospitals or are receiving community-based services from local mental health authorities (LMHAs), regardless of whether the state hospital or the LMHA is located in a mental health professional shortage area.
- SB 532 removes the board certification requirement for physicians to be eligible for loan repayment.
- The bill amends the percentages of repayment assistance allowable per year from 10% in year one to 33.33%, from 15% in year two to 33.33%, and from 20% in year three to 33.33%.
- Finally, the bill requires the Texas Higher Education Coordinating Board to administer the program in a manner that ensures continuous approval or disapproval of applications, eligibility determinations, and acceptance of applications into the program.



SB 532 also amends the Math and Science Scholars Loan Repayment Program.

OPERATIONAL IMPACT

Mental health professionals will have more access to loan repayment due to the changes made in the required years of services and expansion of eligibility criteria. Hospitals who employ or contract with mental health professionals should consider promoting the benefits of the loan repayment program to prospective and current staff as a retention and recruitment tool.

SENATE BILL 850

Author:
Sen. Cesar Blanco

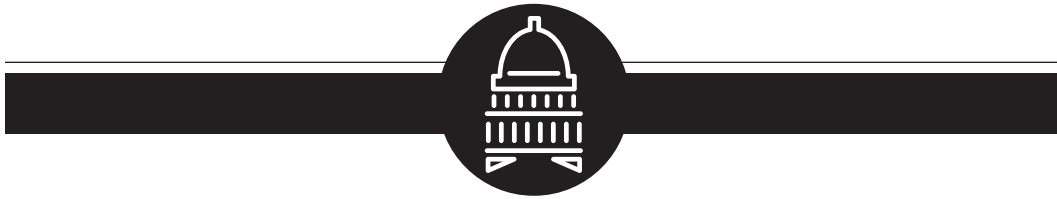
Effective Date: 9/1/23

Modifying the Composition of the Texas Children’s Mental Health Care Consortium**ANALYSIS**

SB 850 makes changes to the composition of the Texas Children’s Mental Health Care Consortium (TCMHCC). The consortium was created by the legislature in 2019 to address urgent mental health challenges throughout the state by leveraging the expertise and capacity of mental health-related institutions. Under current law, membership on the TCMHCC includes 13 universities, the Health and Human Services Commission (HHSC), the Texas Higher Education Coordinating Board, three mental health-related nonprofits and any other entity deemed necessary by the consortium’s executive committee. However, a permanent seat for an educational service center does not exist.

SB 850 adds to the composition of the consortium “each regional education service center established under Chapter 8, Education Code, that the HHSC executive commissioner identifies as a center predominately serving school districts classified as rural by the National Center for Education Statistics of the United States Department of Education.” It also adds one seat on the executive committee to a representative selected from among the regional education service centers.

Finally, SB 850 removes The University of Texas M.D. Anderson Cancer Center from the composition of the consortium.



BILLING AND PRICE TRANSPARENCY

**HOUSE BILL 3414**

Author:
Rep. Tom Oliverson

Effective Date: 6/11/23

Changes to Accessing the Texas All Payor Claims Database**ANALYSIS**

The Texas All Payer Claims Database (APCD) was created in 2021 and is operated by the Center for Healthcare Data at The University of Texas Health Science Center at Houston (the Center) and overseen by the Texas Department of Insurance. HB 3414 revises the enabling legislation of the APCD by:

- Including the University of Texas and Texas A&M University health plans.
- Adding a representative from an institution of higher education to the APCD stakeholder advisory group.
- Permitting data to be aggregated by metropolitan statistical or zip-code.

HB 3414 also sets new application parameters for entities seeking access to data not available in the public portal. These entities are required to identify their sources of funding for research, and the names of all individuals who will have access to the data and their affiliations, describe the parameters of the proposed study, demonstrate how the proposed research will improve the quality of care or reduce the cost of care, provide a description of the proposed methodology, including a description of how the research will be shared, and submit an institutional review board determination letter that is an approval, or approval with modifications. The Center must review and make determinations in a timely manner. Denials must describe the specific deficiencies in the application.

Entities may not sell data or information obtained from the Center and may publish data or information that identifies one or more health care providers, health benefit plans, health benefit plan issuers, or other mandatory payers only if the report or publication is made available to the public at no cost. However, the bill strikes the prohibition on using the data for a commercial purpose. The bill clarifies that all data identifying patients is confidential and not subject to disclosure.

**SENATE BILL 2476**

Author:
Sen. Judith Zaffirini

Effective Date: 9/1/23

Balance Billing Prohibition and Notice for EMS and Other Transportation Services and Supplies**ANALYSIS**

SB 2476 provides state balance billing protections to bills submitted by ground emergency medical services providers and for other transportation services and supplies. SB 2476 applies EMS and transport balance billing protections and notice requirements to each of the balance billing prohibition statutes: chapters 1271, 1275, 1301, 1551, 1575 and 1579 of the Texas Insurance Code, so the legislation applies to Texas Department of Insurance- (TDI) regulated HMOs, PPOs and EPOs, as well as plans administered by TRS and ERS. The changes to the law made by the bill apply on Jan. 1, 2024, and expire on Sept. 1, 2025.

Under the bill, health benefit plan issuers are required to pay for covered services and supplies provided by out-of-network EMS providers at:

- The lesser of the provider's billed charge or 325 percent of the current Medicare rate, including any applicable extenders and modifiers; or
- A rate set by the political subdivision in which the EMS provider operates that is submitted to the Texas Department of Insurance (TDI) and posted on TDI's website, which must be increased each subsequent plan year by the lesser of the Medicare Inflation Index or 10 percent of the provider's previous calendar year rates.

TDI is required to create a public internet database for political subdivisions that set and submit rates to TDI for emergency medical services by Jan. 1, 2024. Health benefit plan issuers are required to pay electronic claims to EMS providers within 30 days and non-electronic claims within 45 days after receipt of all information required for payment.

In addition to EMS services, under SB 2476, an out-of-network provider may not bill an enrollee receiving a health care transport, and the enrollee does not have financial responsibility for an amount greater than an applicable copayment, coinsurance, and deductible under the enrollee's managed care plan that is based on:

- The amount initially determined payable by the administrator; or
- If applicable, the modified amount as determined under the administrator's internal appeal process.



In addition, by Jan. 1, 2024, SB 2476 requires all health benefit plan issuers to provide notice to the insured and the physician or provider related to transport provided by an out-of-network provider that includes:

- A statement of the balance billing prohibition.
- The total amount the physician or provider may bill the insured under the insured's health benefit plan and an itemization of copayments, coinsurance, deductibles and other amounts included in that total.
- For an explanation of benefits provided to the physician or provider, information required by commissioner rule advising the physician or provider of the availability of mediation or arbitration.

The notice must be provided by the time of payment.

OPERATIONAL IMPACT

SB 2476 applies state balance billing protections to EMS services and supplies as well as transport provided to enrollees. For EMS services and supplies, the bill sets a minimum payment threshold. The political subdivision can set a payment rate and submit it to TDI for internet publication or, if a rate is not set by the political subdivision, the health benefit plan issuer must pay the lesser of 325 percent of Medicare or the provider's billed charge. SB 2476 also adds all transport services to the state balance billing law (emergency and non-emergency). The changes to the law made by the legislation are effective on Jan. 1, 2024, but sunset on Sept. 1, 2025. Hospitals may not balance bill for emergent or nonemergency transportation services beginning on Jan. 1, 2024, and should modify their policies and procedures to conform with the notice requirements and billing prohibitions added by SB 2476.

**SENATE BILL 490**

Author:
Sen. Bryan Hughes

Effective Date: 9/1/23

Requiring an Itemized Bill to Be Provided to Patients When Requesting Payment**ANALYSIS**

SB 490 creates a new Chapter 185 in the Health and Safety Code and will result in significant and possibly costly changes in how hospitals and other health care providers bill and collect from patients for providing health care services.

SB 490 applies to hospitals, ambulatory surgical centers, birthing centers, free-standing emergency centers and other health care facilities that are required to be licensed in Texas to provide health care services. Individual physicians with their own practice and federally qualified health centers are excluded from the legislation.

Beginning on Sept. 1, 2023, hospitals will be required to provide an itemized bill when they request payment from patients after services or supplies have been provided. For uninsured/self-pay patients, hospitals are required to provide this itemization in conjunction with any request for payment from the patient. For insured/third-party payer patients, hospitals are required to provide the itemized bill within 30 days from the date the hospital receives final payment from the insurer or third party. The bill does not define “final payment.” Hospitals and other providers should note that this itemization is not required when collecting copays or any upfront cost-sharing or other payments made the day of or prior to appointments for health care services.

More specifically, SB 490 requires a health care provider that requests payment from a patient after providing a health care service or related supply to the patient to submit with the request a written, itemized bill of the alleged cost of each service and supply provided to the patient during the visit. The itemized bill must contain the following elements:

- A plain language description of each distinct health care service or supply provided to the patient.
- Any billing code submitted to a third party and the amounts billed to and paid by that third party, if the hospital is seeking or sought reimbursement from that third party.
- The amount the hospital is seeking from the patient for each service and supply provided.



Hospitals can provide the itemized bill either via paper or electronic copy, including through a patient portal available on the hospital’s website. The law also mandates that patients are entitled to obtain additional copies of the itemized bill on request at any time after the initial copy is issued.

Penalties and Enforcement

A hospital that fails to comply with SB 490 is prohibited from pursuing debt collection against a patient. SB 490’s authors both provided legislative intent recorded in the Senate and House journals, respectively, that “debt collection” is only intended to apply to third-party debt collection. However, the new law defines “debt collection” as having the same meaning as defined in Section 392.001, Finance Code, which is defined as “an action, conduct, or practice in collecting, or soliciting, in collection, consumer debts that are due or alleged to be due a creditor.”

In addition to the prohibition on debt collection, the appropriate licensing authority is required to take disciplinary action against hospitals for violations of SB 490 as if the hospital had violated a hospital licensing law.

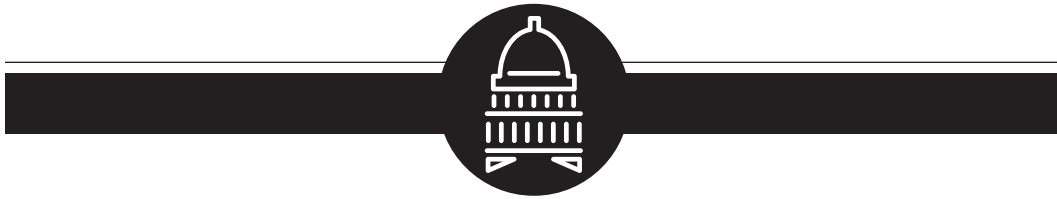
OPERATIONAL IMPACT

Given the short timeline for compliance, hospitals need to immediately engage their finance, billing and legal departments, in addition to third-party vendors to begin the process towards compliance with SB 490.

Hospitals should take note that the existing requirement that hospitals provide an “itemized statement,” found in Chapter 311, Health and Safety Code, and the new law as codified in SB 490, are not the same document. Hospitals should be prepared to comply with both statutes and attempt to reconcile the requirements in order to ensure compliance.

Given the lack of definitions for many terms in SB 490 and the conflict between the legislative intent and the bill’s text, hospital legal counsel may consider reviewing the Code Construction Act found in the Texas Government Code to research and craft arguments that will justify and support any actions taken by their hospital clients with respect to itemized bills.

Hospitals should also consider how to ensure verification for a provided itemized bill to a patient in order to defend against claims of noncompliance.



CHILDREN'S HEALTH CARE

**HOUSE BILL 3550**

Author:
Rep. Toni Rose

Effective Date: 9/1/23

Standards for Pediatric Extended Care Centers**ANALYSIS**

HB 3550 directs the Health and Human Services Commission (HHSC) to develop rules for minimum transportation standards for pediatric extended care centers as follows:

- The center is authorized, in coordination with the minor client's parent/guardian/legally authorized representative, to determine the client's schedule of transportation services.
- The center is authorized, in coordination with the minor client's prescribing physician, to determine the necessary type of provider who must be present during transportation.
- The minor client's parent/guardian/legally authorized representative can decline a center's transportation services entirely or only on a specific date.
- Centers may not require a plan of care or physician's order to document a client's need for transportation services to access a center's transportation services.
- Centers may not consider transportation services as nursing services included in a client's plan of care.

HHSC rules may limit the maximum number of authorized services provided to a client but otherwise cannot interfere with the authority of a parent, guardian or legally authorized representative of a minor client to make decisions regarding the treatment provided to the child.

HB 3550 also:

- Allows a center to provide nursing services in a group setting, consistent with appropriate staffing ratios as HHSC determines.
- Allows a center to obtain all required parent or legal guardian signatures for a patient on one consent document.
- Requires the consent document to illustrate the involvement of the parent or legal guardian in developing and establishing the care and treatment to be provided to the patient in the center.



- Requires HHSC in its rulemaking to clearly identify the necessary documents a center must obtain and maintain to be eligible for reimbursement under the Medicaid program. The rules may not:
 - Authorize a center to combine documentation for transportation with documentation for other services provided by the center.
 - Condition reimbursement of non-transportation services on a recipient's decision to use transportation services on a specific date or on an ongoing basis, or a center's obtaining and maintaining transportation documentation.

**HOUSE BILL 1649**

Author:
Rep. Angie Chen Button

Effective Date: 9/1/23

Notification When Cancer Treatment May Impair Fertility; Mandatory Coverage for Fertility Preservation Services Provided to Certain Cancer Patients**ANALYSIS**

HB 1649 creates Subchapter X within Chapter 161, Health and Safety Code. Under this new subchapter, health care facilities must, prior to a child's initial treatment with radiation or chemotherapy, notify the child's parents or legal guardians of the risk of impaired fertility. The Department of State Health Services is required to develop and make available to facilities a written notice for use in compliance with this required notification.

Additionally, HB 1649 requires health benefit plans providing benefits for medical or surgical expenses incurred because of a health condition, accident, or sickness to provide coverage for fertility preservation services (collection and preservation, but not storage) for people receiving medically necessary treatment for cancer that the American Society of Clinical Oncology (ASCO) or the American Society for Reproductive Medicine (ASRM) has established may cause impaired fertility. This requirement applies to an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document. The collection and preservation services must be standard procedures to preserve fertility consistent with medical practices or professional guidelines published by the ASCO or the ASRM.

The bill applies to plans issued by:

- An insurance company.
- A group hospital service corporation operating under Chapter 842, Insurance Code.
- A health maintenance organization operating under Chapter 843.
- An approved nonprofit health corporation that holds a certificate of authority under Chapter 844.
- A multiple employer welfare arrangement that holds a certificate of authority under Chapter 846.
- A stipulated premium company operating under Chapter 884.
- A fraternal benefit society operating under Chapter 885.



- A Lloyd's plan operating under Chapter 941.
- An exchange operating under Chapter 942.

The bill does apply to small employer health benefit plans subject to Chapter 1501, Insurance Code and standard health benefit plans under Chapter 1507, Insurance Code.

However, the bill does not apply to:

- Plans providing coverage for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury.
- Plans providing coverage only for hospital expenses.
- The Texas Medicaid Program, including managed care.
- The Texas Children's Health Insurance Program.

OPERATIONAL IMPACT

Prior to providing a child's initial treatment for chemotherapy or radiation, hospitals and other providers must inform parents or legal guardians of the treatment's risk of impaired fertility. Providers may use the written notice developed by DSHS to comply with this requirement.

**HOUSE BILL 2478**

Author:
Rep. Stephanie Klick

Effective Date: 9/1/23

Requiring a Newborn Screening Annual Report, Expansion of State Laboratory Hours, and Testing for Congenital Cytomegalovirus**ANALYSIS**

Under HB 2478, the Department of State Health Services (DSHS) is required to prepare a written report outlining each newborn screening test that screens for a disorder included in the Recommended Uniform Screening Panel of the U.S. Health and Human Services Secretary's Advisory Committee on Heritable Disorders in Newborns and Children but not required by DSHS. This report is due to the governor, lieutenant governor, speaker of the House of Representatives and each standing committee of the legislature having primary jurisdiction over the department no later than Sept. 1 of each year.

Current law stipulates that to the extent that funding is available, DSHS must require newborn screening to test for disorders listed as core and secondary conditions in the Recommended Uniform Screening Panel of the U.S. Health and Human Services Secretary's Advisory Committee on Heritable Disorders in Newborns and Children or another report determined by DSHS to provide more stringent newborn screening guidelines to protect the health and welfare of the state's newborns. The written report must:

- Identify any additional program capacity or resources the department would need to implement the additional newborn screening test and require each newborn in the state to receive the additional newborn screening test.
- Summarize any potential barriers to implementation and the anticipated implementation date.

As part of the summary of potential barriers to implementation, the report must include information on whether DSHS is capable of implementing the required additional newborn screening test within a 24-month period.

HB 2478 allows DSHS to use money appropriated to the Newborn Screening Preservation Account to ensure that the state laboratory or a laboratory approved by DSHS is available seven days a week to perform screening tests required by DSHS. The state lab is currently processing tests six days a week. They are closed on Sundays.



Finally, HB 2478 requires that newborns that do not pass their initial, required hearing screening performed in the hospital setting before discharge must be screened for congenital cytomegalovirus (CMV) unless their parent declines the test. The screen is required to be performed by the same entity that conducts the initial screen or they must, alternatively, cause the test to be performed.

If a newborn or infant receives a positive test for CMV, the entity performing the screen must provide the child's parents with the results of the test, information on the potential effects of congenital cytomegalovirus and the available treatment options as well as a referral to an appropriate physician or facility for the treatment of congenital cytomegalovirus.

OPERATIONAL IMPACT

Key obstetric and newborn medical care leadership and staff should be made aware of the inclusion of CMV to the state's newborn screening program. Policies, procedures and relevant education items must be updated to address the addition of a CMV screen for infants or babies that fail their first newborn hearing screen.

CMV does not appear on the Recommended Uniform Screening Panel of the U.S. Health and Human Services Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, possibly because there isn't a standard of care or routine protocols for screening children for CMV. Considerable review and coordination with genetic counselors and individuals with backgrounds in heritable disorders will be needed to determine how best to screen newborns or infants for CMV, as well as how best to counsel parents and refer the newborn or infants for treatment.

Once DSHS implements lab operations seven days a week, hospitals should conduct a review of hospital policies and procedures related to newborn screening specimen collection and submission including timeliness to determine how best to incorporate the increased availability of testing into hospital operations.

**HOUSE BILL 63**

Author:
Rep. Valoree Swanson, et al.

Effective Date: 9/1/23

Requiring Identifying Information to be Collected from People who Report Child Abuse/Neglect, and Governing Access to Such Identifying Information by DFPS Employees**ANALYSIS**

HB 63 makes changes to the process by which the Department of Family and Protective Services (DFPS) receives information related to suspected child abuse or neglect. Specifically, it adds elements to the information that must be collected by DFPS, including:

- The facts that caused the individual making the report to believe the child has been abused or neglected and the source of the information.
- The reporter's name and telephone number.
- The reporter's home address or, if the individual is a professional, the individual's business address and profession.

If the individual making a report of child abuse or neglect uses the toll-free telephone number DFPS operates for reporting child abuse or neglect and the person is unwilling to provide their name and telephone number, DFPS must notify the reporter that:

- The department is not authorized to accept an anonymous report of abuse or neglect.
- The report of abuse or neglect may be made to any local or state law enforcement agency.
- The reporter's identity is confidential and may be disclosed only as provided by Section 261.201 (see below) or to a law enforcement officer for the purposes of conducting a criminal investigation of the report.

The DFPS representative or other person receiving a report of child abuse or neglect must use the person's best efforts to obtain the identifying information described above. If a report is made orally, DFPS or local or state law enforcement agency receiving the report must:

- Notify the individual making the report that the report is being recorded and that making a false report is a criminal offense under Section 261.107, Family Code, punishable as a state jail felony or a third-degree felony.



- Make an audio recording of the report.

Additionally, HB 63 adds new provisions related to who has access to identifying information of a person making a report of suspected child abuse or neglect. It specifies that an employee of DFPS may only have access to the identity of the person making a report if:

- The employee is directly involved with an investigation, case or other process involving the child who is the subject of the report or the child's parent or other person having legal custody of the child;
- The employee supervises, directly or indirectly, an employee described immediately above; or
- The employee has any other legitimate professional interest in an investigation, case or other process involving the child who is the subject of the report or the child's parent or other person having legal custody of the child that necessitates access to the identity of the person who made the report.

DFPS must adopt rules to implement these requirements.

**SENATE BILL 14**

Author:
Sen. Donna Campbell

Effective Date: 9/1/23

Prohibiting Procedures, Treatment and Payment for Gender Transitioning, Gender Reassignment or Gender Dysphoria**ANALYSIS**

SB 14 prohibits the Children's Health Insurance Program from providing coverage of gender transitioning or gender reassignment procedures and treatments to children as well as payment for those procedures and treatments. It also prohibits the Health and Human Services Commission from providing Medicaid coverage of, or reimbursement to, a physician or health care provider for the provision of a procedure or treatment to a child that is prohibited as a component of gender transitioning or gender reassignment procedures and treatments to children.

Additionally, SB 14 adds a new subchapter X to Chapter 161 of the Health and Safety Code, Public Health Provisions, titled Gender Transitioning and Gender Reassignment Procedures and Treatments for Certain Children. Subchapter X defines a child as an individual who is younger than 18.

New language prohibits, for the purpose of transitioning a child's biological sex, as determined by the sex organs, chromosomes and endogenous profiles of the child or affirming the child's perception of the child's sex if that perception is inconsistent with the child's biological sex, a physician or health care provider from knowingly:

- Performing a surgery that sterilizes the child, including:
 - Castration.
 - Vasectomy.
 - Hysterectomy.
 - Oophorectomy.
 - Metoidioplasty.
 - Penectomy.
 - Phalloplasty.
 - Vaginoplasty.
 - Performing a mastectomy.
- Providing, prescribing, administering or dispensing any of the following prescription drugs that induce transient or permanent infertility:
 - Puberty suppression or blocking prescription drugs to stop or delay normal puberty;



- Supraphysiologic doses of testosterone to females; or
- Supraphysiologic doses of estrogen to males; or

- Removing any otherwise healthy or non-diseased body part or tissue.

Exceptions may be made for the provision by a physician or health care provider, with the consent of the child's parent or legal guardian, of:

- Puberty suppression or blocking prescription drugs for the purpose of normalizing puberty for a minor experiencing precocious puberty.
- Appropriate and medically necessary procedures or treatments to a child who:
 - Is born with medically verifiable genetic disorder of sex development, including:
 - 46, XX chromosomes with virilization;
 - 46, XY chromosomes with undervirilization; or
 - Both ovarian and testicular tissue; or
 - Does not have the normal sex chromosome structure for male or female as determined by a physician through genetic testing.

The prohibition on gender transitioning medical care does not apply to the provision of a prescription drug to a child if the prescription drug is part of a continuing course of treatment that the child began before June 1, 2023, and if the child attended 12 or more sessions of mental health counseling or psychotherapy during a period of at least six months before the date the course of treatment began.

SB 14 stipulates, however, that the children who are receiving drugs must wean off the prescription drug over a period of time and in a manner that is safe, medically appropriate and that minimizes the risk of complications. Additionally, the child may not switch to or begin a course of treatment that physicians or health care providers are prohibited from providing.

Public money may not directly or indirectly be used, granted, paid or distributed to any health care provider, medical school, hospital, physician, or any other entity, organization or person that provides or facilitates the provision of a procedure or treatment to a child for the purposes of gender transition.



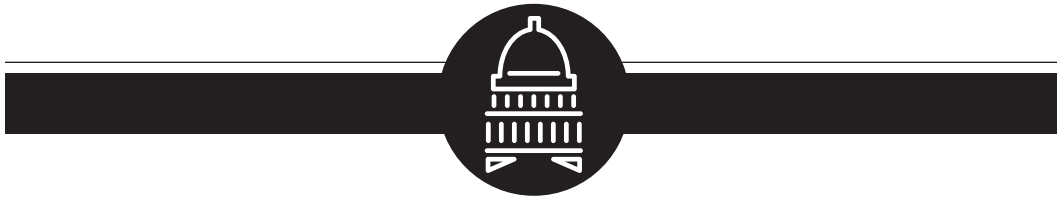
The Texas Attorney General is given the ability to bring an action to enforce Subchapter X to restrain or enjoin the person from committing, continuing to commit or repeating the violation. The venue for such an action is the district court of Travis County or the county where the violation occurred or is about to occur.

Performing a gender transitioning or gender reassignment procedure or treatment is now listed as prohibited practice by a physician or license applicant in the Occupations Code. Additionally, the Texas Medical Board (TMB) is now required to revoke the license or other authorization to practice medicine for any physician who violates this new statute. The TMB must also refuse to admit to examination or refuse to issue a license or renew a license to a person who commits a violation on top of any other grounds for revocation.

OPERATIONAL IMPACT

Hospitals providing gender transitioning medical services should review SB 14 and ensure that their processes comply with the requirements and prohibitions in SB 14 as necessary. All related policies and procedures should be updated to reflect this new prohibition. Time should be taken to clearly communicate any changes to all patients and families receiving any level of gender transitioning service as well as all employees and staff that have a role in providing gender transitioning care. Given heightened awareness and scrutiny, any changes or clarity regarding a facility's role in providing gender transitioning care should be well-communicated to every employee or affiliated staff on each campus so that they can in turn communicate accurately or know how to refer someone for more information should they be asked about the medical services provided.

Legal teams should take a close look at how this statute might impact the continuity of medical care provided to hospitalized patients who may be going through gender transition legally in another state. A dialogue between Rep. Tom Oliverson, MD (R-Cypress), the House sponsor for SB 14, and Rep. Donna Howard (D-Austin) on the House floor when the bill was being debated on third reading, and that is memorialized in the House Journal beginning on page 4237, may provide pertinent legislative intent on this issue of continuity of care. Process and procedures should be established so it is clear how to address such patient scenarios.



EMERGENCY CARE/TRAUMA

**HOUSE BILL 617**

Author:
Rep. Drew Darby, et al.

Effective Date: 9/1/23

Establishing a Pilot Program to Provide EMS and Prehospital Care Instruction in Rural Areas**ANALYSIS**

HB 617 requires the Health and Human Services Commission (HHSC), with the Texas Tech University Health Sciences Center (TTUHSC), to establish a pilot project to provide emergency medical services instruction and emergency prehospital care instruction through telemedicine or telehealth services provided by regional trauma resource centers to (1) providers in rural-area trauma centers, and (2) EMS providers in rural areas.

TTUHSC and HHSC will staff, design, and define criteria for the pilot program, specifically to determine when a tele-service that provides instruction for EMS, emergency prehospital care, and trauma care should be transferred to an emergency medical resource center for intervention, and will collect the data necessary to evaluate the pilot project.

A facility participating in the pilot project must agree to successfully complete any required training and to provide all reports required by the center for the project.

A trauma facility cannot be selected to participate in the pilot program, unless the facility:

- Has a quality assurance program that measures each health care provider's compliance with the medical protocol;
- Uses emergency medical services and emergency prehospital care protocols approved by a physician medical director knowledgeable in emergency medical services and emergency prehospital care;
- Has experience in providing emergency medical services and emergency prehospital care that the center determines is sufficient; and
- Has resources sufficient to provide the additional telemedicine medical services or telehealth services and related instruction required for the project in addition to the health care services the facility already provides.

The ability for a facility to maintain records and produce reports to measure the effectiveness of the pilot program must be a consideration of a facility's ability to serve in the program.



Grants may be provided to fund the pilot program, but a political subdivision with a trauma facility that participates in the pilot program may pay part of the program costs. If a sufficient number of political subdivisions in a region that may be served by the pilot project agree to pay an amount that, together with other funding received, is sufficient to fund the project for the region, the center must:

- Contract with the political subdivisions for each subdivision to pay an appropriate share of the cost.
- Implement the project for the region when the amounts agreed to in the contracts and any other funding received under this section are sufficient to fund the project for the region.

A report to the governor and each house of the legislature must result from the pilot project. The operations of a regional trauma resource center must be considered the provision of 911 services under Section 771.053, Health and Safety Code. Employees of and volunteers at the regional trauma resource center have the same protection from liability as a member of the governing body of a public agency under Section 771.053, Health and Safety Code.

A member of the project's work group is not entitled to compensation for serving on the project work group and may not be reimbursed for travel or expenses incurred as part of the project work group. The work group is not subject to Chapter 2110, Government Code.

"Emergency Medical Services" means services used to respond to an individual's perceived need for immediate medical care and to prevent death or aggravation of physiological or psychological illness or injury.

"Emergency Medical Services Provider" means a person who uses or maintains emergency medical services vehicles, medical equipment and emergency medical services personnel to provide emergency medical services.

"Emergency Prehospital Care" means care provided to a sick or injured individual before or during transportation of the individual to a medical facility and includes any necessary stabilization of the individual in connection with that transportation.

"Regional Trauma Resource Center" means a trauma facility the center selects to participate in the pilot project.



“Rural Area” means a county with a population of 50,000 or less or a large, isolated and sparsely populated area of a county with a population of more than 50,000.

“Telehealth Service” and “Telemedicine Medical Service” have the meanings assigned by Section 111.001, Occupations Code.

“Trauma Facility” means a health care facility equipped and staffed to provide comprehensive treatment of seriously injured individuals as part of an emergency medical services and trauma care system.

OPERATIONAL IMPACT

Hospitals that desire to join the pilot program should review the requirements and elements of the pilot program and contact HHSC or TTUHSC for additional information after determining eligibility to participate.



HOUSE BILL 624

Author:
Rep. Cody Harris, et al.

Effective Date: 9/1/23

Allowing Emergency Medical Transport of Certain Patients by Firefighters

ANALYSIS

HB 624 provides authority to a firefighter, as defined under Section 419.021, Government Code, or who is a volunteer firefighter certified by the Texas Commission on Fire Protection or the State Firefighters' and Fire Marshals' Association of Texas, regardless of whether they are licensed as an EMS provider, to transport a sick or injured patient to a health care facility, in a vehicle other than an EMS vehicle, if:

- The appropriate emergency medical services provider is notified of the patient's clinical condition and is unable to provide emergency medical services imminently at the patient's location; and
- The medical treatment and transport operating guidelines for the patient's apparent clinical condition authorize transport of the patient in a vehicle other than an emergency medical services vehicle.

No later than Jan. 1, 2024, each trauma service area regional advisory council (RAC) must develop the medical treatment and transport operating guidelines necessary to implement this section for the area served by the RAC and provide notice of the guidelines to the EMS providers and firefighters in that area.

OPERATIONAL IMPACT

Hospitals should be aware that firefighters may transport patients to the facility and should update relevant policies and procedures to account for this. Coordination with the local RAC may assist in preparing appropriate guidance.

These requirements take effect for any transportation provided on or after Jan. 1, 2024.



SENATE BILL 1526

Author:
Sen. Cesar Blanco

Effective Date: 9/1/23

**Authorizing Big Bend Regional Hospital District to Provide Mobile
Emergency Services**

ANALYSIS

Under SB 1526, Big Bend Regional Hospital District is given the authority to provide mobile emergency medical services within the district's boundaries.

OPERATIONAL IMPACT

The operational impact is limited to Big Bend Regional Hospital District.

SENATE BILL 1588

Author:
Sen. Cesar Blanco

Effective Date: 9/1/23

**Relating to Allowable Variances from Rules Governing Emergency
Services Providers**

ANALYSIS

SB 1588 relates to an application for a rule variance requested by an emergency medical services provider, and makes the following changes to section 773.052, Health and Safety Code:

- It removes a \$30 application fee for a hardship variance request.
- It removes language requiring the Department of State Health Services to grant a request from a sole provider for a variance from minimum equipment standards, but SB 1588 maintains the required variance for staffing standards. It also removes language requiring the provider to be exempt from the payment of fees under Section 773.0581, Health and Safety Code, in order to be eligible for this variance.

OPERATIONAL IMPACT

Hospitals operating emergency medical services who have utilized the variance process under this amended section should take note of the limitations on requesting a variance related to minimum equipment standards.



SENATE BILL 2133

Author:
Sen. Borris Miles

Effective Date: 9/1/23

Requiring Emergency Planning for Transportation of End Stage Renal Disease Patients During a Disaster

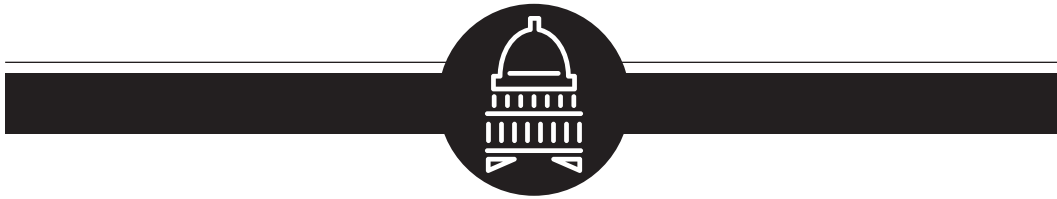
ANALYSIS

SB 2133 requires the Health and Human Services Commission to require that applicable EMS providers enact a plan for providing a dialysis patient, who places an emergency 9-1-1 telephone call during a declared disaster, an alternative mode of transportation directly to and from an outpatient end stage renal disease facility if the patient's normal and alternative modes of transportation cannot be used during the disaster.

An EMS provider's plan may prioritize providing transportation for a patient suffering from an acute emergency condition over transportation for a dialysis patient.

OPERATIONAL IMPACT

Hospitals should be minimally affected by these changes but should be aware that EMS may require updated policies regarding transportation of dialysis patients during a disaster. Of note: patients suffering from acute emergency conditions can be prioritized during the disaster.



HEALTH CARE COVERAGE



HOUSE BILL 1337

Author:
Rep. Lacey Hull

Effective Date: 9/1/23

New Requirements Relating to Step Therapy Protocols by Health Plans Covering Prescription Drugs for Serious Mental Illnesses

ANALYSIS

HB 1337 adds Section 1369.0547 to Chapter 1369 of the Insurance Code which lays out requirements for step therapy protocols specific to prescription drugs to treat serious mental illnesses prescribed to enrollees 18 years of age or older.

Under Section 1355.001 of the Insurance Code, “serious mental illness” means the following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM):

- Bipolar disorders (hypomanic, manic, depressive, and mixed).
- Depression in childhood and adolescence.
- Major depressive disorders (single episode or recurrent).
- Obsessive-compulsive disorders.
- Paranoia and other psychotic disorders.
- Schizo-affective disorders (bipolar or depressive).
- Schizophrenia.

HB 1337 specifies that in providing coverage of a prescribed drug approved by the U.S. Food and Drug Administration, health benefit plans that cover prescription drugs to treat serious mental illness are prohibited from requiring an enrollee to:

- Fail to respond successfully to more than one different drug for each one prescribed, excluding the generic or pharmaceutical equivalents.
- Provide proof of a history of failure of more than one different drug for each one prescribed, excluding the generic or pharmaceutical equivalents.

Section 1369.0547(d) does allow health benefit plan issuers to implement a step therapy protocol to require a trial of a generic or pharmaceutical equivalent of a prescribed drug as a condition of continued coverage of that prescribed drug in the instances that it is only done once in a plan year; and only if the generic or pharmaceutical equivalent drug is added to the plan’s drug formulary.

The prohibitions and requirements in HB 1337 only apply to health benefit plans delivered, issued for delivery, or renewed on or after Jan. 1, 2024.



HOUSE BILL 109

Author:
Rep. Julie Johnson

Effective Date: 9/1/23

Prohibition on Denying Claims Based Solely on the Price of the Hearing Aid Exceeding Plan Benefits

ANALYSIS

HB 109 prohibits a health benefit plan that provides coverage for hearing aids from denying an enrollee's claim for one solely on the basis that the price is more than the benefit available under the health benefit plan.

The bill applies to health benefit plans providing benefits for medical or surgical expenses incurred because of a health condition, accident or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract or an individual or group evidence of coverage or similar coverage document offered by:

- An insurance company.
- A group hospital service corporation operating under Chapter 842, Insurance Code.
- A health maintenance organization operating under Chapter 843, Insurance Code.
- An approved nonprofit health corporation that holds a certificate of authority under Chapter 844, Insurance Code.
- A multiple employer welfare arrangement that holds a certificate of authority under Chapter 846, Insurance Code.
- A stipulated premium company operating under Chapter 884, Insurance Code.
- A fraternal benefit society operating under Chapter 885, Insurance Code.
- A Lloyd's plan operating under Chapter 941, Insurance Code.
- An exchange operating under Chapter 942, Insurance Code.

Additionally, the bill applies to:

- A small employer health benefit plan subject to Chapter 1501, Insurance Code, including coverage provided through a health group cooperative under Subchapter B of that chapter.
- A standard health benefit plan issued under Chapter 1507, Insurance Code.
- A basic coverage plan under Chapter 1551, Insurance Code.



- A basic plan under Chapter 1575, Insurance Code.
- A primary care coverage plan under Chapter 1579, Insurance Code.
- A plan providing basic coverage under Chapter 1601, Insurance Code.
- A regional or local health care program operated under Section 75.104, Health and Safety Code.
- A self-funded health benefit plan sponsored by a professional employer organization under Chapter 91, Labor Code.
- A health benefit plan subject to Subchapter F, Chapter 1367, Insurance Code.

HB 109 does not apply to:

- Plans providing coverage for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury.
- Plans providing coverage only for hospital expenses.
- The Texas Medicaid Program, including managed care.

Under HB 109, a health benefit plan is not required to pay an enrollee's claim for a hearing aid in an amount that is more than the benefit available.



HOUSE BILL 1592

Author:
Rep. Tom Oliverson

Effective Date: 9/1/23

Opt-In to State Balance Billing Law for Employer-Sponsored ERISA Health Benefit Plans

ANALYSIS

HB 1592 allows plan sponsors (employers) of self-insured or self-funded health benefit plans operating under the Employee Retirement Income Security Act of 1974 (ERISA) to elect to use the state’s balance billing dispute resolution law instead of the federal balance billing dispute resolution law – the federal No Surprises Act – to resolve out of network medical bills. HB 1592 requires the Texas Department of Insurance (TDI) to implement rules by Dec. 1, 2023, governing the form and manner of the opt-in.

OPERATIONAL IMPACT

Currently, there are separate federal and state balance billing laws governing out-of-network surprise medical bills. The state balance billing law applies to plans dependent on TDI, and ERISA plans are subject to the federal No Surprises Act. HB 1592 allows employers utilizing ERISA plans to voluntarily elect to resolve out-of-network claims under Texas law for the plan year. Hospitals should monitor rulemaking at the Texas Department of Insurance and adjust their policies and procedures to account for ERISA plans that elect to use TDI’s dispute resolution mechanism.

**HOUSE BILL 1647**

Author:
Rep. Cody Harris

Effective Date: 9/1/23

White Bagging Prohibition for Certain Clinician-Administered Drugs Administered in Certain Settings**ANALYSIS**

HB 1647 creates a new Subchapter O under Chapter 1369, Insurance Code in Title 8 of the Insurance Code to prohibit “white bagging” by certain health insurers for clinician-administered drugs prescribed to enrollees with a chronic, complex, rare or life-threatening medical condition. However, the bill does allow for white bagging to continue for these drugs if they are administered in a hospital, hospital facility-based practice setting, or hospital outpatient infusion center. **To put it simply, the white bagging prohibitions under HB 1647 do not apply to hospitals.**

The term “white bagging” is not used or defined in HB 1647. It is a colloquial term used to describe the following actions taken by health benefit plans or pharmacy benefit managers, now prohibited by HB 1647: requiring clinician-administered drugs to be dispensed only by certain pharmacies or only pharmacies participating in the health benefit plan’s network, OR limiting coverage of otherwise covered clinician-administered drugs based on an enrollee’s choice of pharmacy or because the dispensing pharmacy was not in-network.

HB 1647 also prohibits requiring in-network physicians or individual health care providers to bill for or be reimbursed for delivery and administration of clinician administered drugs under the pharmacy benefit instead of a medical benefit. However, a clinician-administered drug could be reimbursed under the pharmacy benefit if the insurer obtains the patient’s informed consent, and the physician provides a written attestation that any delay in the drug’s administration will not place the patient at an increased health risk.

The law also prohibits health benefit plans from charging any additional fees to enrollees based on their pharmacy choice or because the dispensing pharmacy was not in-network. This includes applying higher copays, coinsurance, second copays, second coinsurance or any other price increase.

In order for the law’s prohibitions to apply, certain conditions must exist. The “white bagging” prohibitions only apply if the patient’s physician or health care provider determines that a delay of care would cause disease progression or if the use of an in-network pharmacy for these drugs would likely cause death or patient harm, cause a barrier to the patient’s compliance with their plan of care or the timeliness of dispensation requires the use of a different pharmacy.



The law defines “clinician administered drug” specifically as an outpatient prescription drug that (a) cannot be reasonably self-administered by the patient or by an individual assisting the patient with the administration and (b) is typically administered by a physician (including through delegation or supervision) or other health care provider in a physician’s office. This definition does not include vaccines. The definition of health care provider is limited to individuals and does not include hospitals.

HB 1647 applies to most health benefit plans. Specifically the law applies to health benefit plans offered by insurance companies, HMOs, small employer plans (including health group cooperatives), plans issued by Chapter 842 group hospital service corporations, multiple employer welfare arrangements, Chapter 844 nonprofit health corporations with a certificate of authority, stipulated premium companies, fraternal benefit societies, Lloyd’s plans, Chapter 942 reciprocal exchanges, consumer choice benefit plans, group health coverage provided through school districts, professional employer organization self-funded plans and a regional or local health care program operated under Section 75.104, Health & Safety Code.

The law does not apply to an issuer/provider of health benefits or a pharmacy benefit manager administering pharmacy benefits under Medicaid, Medicaid managed care, CHIP, the TRICARE military health system; or a worker’s compensation policy that provides medical benefits.

Finally, the law is not to be construed to authorize a person to administer a drug that is not authorized to do so under federal or Texas law or to modify drug administration requirements, including delegation and supervision, under Texas law.

The law applies only to a health benefit plan delivered, issued for delivery or renewed on or after Jan. 1, 2024.



HOUSE BILL 2002

Author:
Rep. Tom Oliverson, et al.

Effective Date: 9/1/23

New Requirements for PPO Plans to Credit Direct Payments Made to Physicians and Health Care Providers Towards an Enrollee’s Out-of-Pocket Expenses

ANALYSIS

HB 2002 amends Subchapter C-1 of Chapter 1301, Insurance Code to require insurers offering preferred provider benefit plans to credit toward an enrollee’s deductible or out-of-pocket maximum expense limit any direct payment amount made by an enrollee to a physician or health care provider for a medically necessary covered health care service or supply. However, the amount paid by the enrollee must be less than the average discounted rate for the same service or supply paid to an equivalently licensed preferred provider under the benefit plan.

The law requires insurers to create procedures to allow an enrollee to submit these claims and to outline any required documentation that must be provided to support the claim. These procedures and accompanying information must be readily accessible on an insurer’s website.

These laws apply to health benefit plans delivered, issued for delivery, or renewed on or after Jan. 1, 2024.

**HOUSE BILL 3359**

Author:
Rep. Greg Bonnen

Effective Date: 9/1/23

Omnibus PPO and EPO Network Adequacy Legislation, Clarification of Applicability of Surprise Billing Law to Post-Emergency Stabilizing Care, and Limitations on Unilateral Contract Changes**ANALYSIS**

HB 3359 is an omnibus health benefit plan network adequacy bill. The changes in law apply only to an insurance policy that is delivered, issued for delivery, or renewed on or after Sept. 1, 2024. The bill sets network parameters for preferred provider benefit organizations and exclusive provider benefit organizations operating under Chapter 1301, Texas Insurance Code, and requires the Texas Department of Insurance (TDI) to implement rules to:

- Monitor ongoing compliance with network adequacy standards and require health benefit plans to report material deviations from network adequacy standards within 30 days of the date of the deviation.
- Promptly take action against PPOs within 90 days of the material violation unless there are no uncontracted licensed physicians or health care providers in the affected county or the insurer requests a waiver through a new process.
- Require insurers to ensure the availability of in-network providers based on current and projected utilization for adults and minors.
- Require public hearings at TDI for health benefit plans that are seeking waivers to network adequacy standards.
- Limit network adequacy waivers to one year after a public hearing showing good cause.
- Require disclosure of active waivers to insureds.
- Limit renewals of waivers to two consecutive years unless good faith efforts are shown by the insurer to bring the plan into compliance based on provider availability.

TDI is required to implement rules setting defined parameters on time and distance set through a detailed table and ensure adequate appointment availability. In addition, TDI's rules must:

- Ensure access to specialty and pediatric care.
- Require an adequate number of preferred provider physicians who have admitting privileges at one or more preferred provider hospitals located within the insurer's designated service area.



- Ensure access to general, pediatric, specialty and psychiatric hospitals (with exceptions for exclusive provider benefit plans that demonstrate the ability to meet demand at specific contracted hospitals), and 24-hour access to urgent care and emergency care.
- Require preferred provider organizations and exclusive provider organizations to demonstrate an adequate network to TDI prior to offering a plan to insureds.

HB 3359 also clarifies an open question in the state surprise billing law that post-emergency stabilization care is subject to the state law prohibition on balance billing and facility mediation or non-facility arbitration for disputes between providers and health benefit plans.

HB 3359 also prohibits unilateral adverse material changes to current contracts between a preferred provider organization and a physician, health care practitioner or organization of both that would decrease the preferred provider's payment or compensation, change the provider's tier to a less preferred tier or change the administrative procedures in a way that may reasonably be expected to significantly increase the provider's administrative expenses or decrease the provider's payment or compensation. This prohibition does not apply to hospitals.



HOUSE BILL 4500

Author:
Rep. Caroline Harris

Effective Date: 1/1/24

New Coverage Verification Website Requirements for Health Insurers

ANALYSIS

HB 4500 creates a new Chapter 1223 in Title 8 of the Insurance Code to require most health benefit plans to maintain and make available a secure website system that allows a physician or health care provider for a hospital or freestanding ER to determine if a patient is covered under a health benefit plan and the patient's deductible, copayment or coinsurance responsibility.

A health insurer can comply with this law by providing the information through an existing internet portal or a portal administered by a third-party contractor that is available 24/7.

HB 4500 applies to most health benefit plans. Specifically the law applies to health benefit plans issued by insurance companies, HMOs, state health benefit plans (ERS/TRS/UT/A&M), small employer plans (including health group cooperatives), plans issued by Chapter 842 group hospital service corporations, multiple employer welfare arrangements, Chapter 844 nonprofit health corporations with a certificate of authority, stipulated premium companies, fraternal benefit societies, Lloyd's plans, Chapter 942 reciprocal exchanges, consumer choice benefit plans, group health coverage provided through school districts, professional employer organization self-funded plans, alternative benefit coverage offered by a Texas Mutual Insurance Company subsidiary and a regional or local health care program operated under Section 75.104, Health and Safety Code. The law does not apply to Medicaid, Medicaid managed care, or CHIP.

OPERATIONAL IMPACT

While this law has no direct impact on hospitals, the bill seeks to ease the burden encountered by health care providers, including hospitals, in verifying a patient's insurance and coverage information. Hospitals should begin engaging with any third-party payers subject to the law to determine the location of these websites/portals and ensure that admissions, billing and administrative staff are aware of their existence and use.

**HOUSE BILL 711**

Author:
Rep. James Frank, et al.

Effective Date: 6/12/23

Prohibition on Certain Contract Clauses in Contracts for Health Care Services**ANALYSIS**

HB 711 amends Chapter 1458, Insurance Code, to prohibit certain providers from requiring in their direct contracts with any, “general contracting entity” any provision that is considered an “anti-tiering,” “anti-steering,” “gag” and “most-favored nations” clause.

Applicability

HB 711 amends Section 1458.001 to add definitions for all of the aforementioned quoted terms. Any term not defined by HB 711 has the meaning set forth in Section 1458.001. HB 711 did not modify the definition of “provider,” therefore HB 711’s prohibitions only apply and are limited to the following providers:

- Hospitals licensed under Chapter 241, Health and Safety Code.
- Advanced Practice Nurses (APRNs).
- Optometrists.
- Therapeutic optometrists.
- Physicians.
- Physician assistants.
- Professional association composed solely of physicians, optometrists, or therapeutic optometrists.
- Entities owned by two or more physicians who are licensed to practice medicine.
- Partnerships composed solely of physicians, optometrists, or therapeutic optometrists.
- Physician-hospital organizations that act exclusively as an administrator for the other aforementioned providers to facilitate the provider’s participation in health care contracts.

Section 1458.001 specifically excludes physician-hospital organizations that lease or rent their organization’s network to another party. Additionally, since the definition of “provider” only lists hospitals that are required to be licensed as hospitals under Chapter 241, Health and Safety Code, any other institution that is licensed or authorized to operate under a different Health and Safety Code chapter, such as



(but not limited to) state-owned hospitals, federally owned hospitals and private mental hospitals, are not subject to HB 711.

“General Contracting Entity” is defined to include any person that directly contracts with the above-listed providers for the delivery of health care services to covered individuals, whether that person has, in the ordinary course of business, an established provider network that can be accessed by another party. Providers that administer or own a health benefit plan can be included in this definition but not if they are acting in their capacity as a provider.

Prohibited Contracting Clauses

HB 711 prohibits physicians and providers from entering into or from offering a written provider network contract that includes the following contract clauses:

- “Anti-tiering” meaning a provision that (a) restricts the ability of a general contracting entity from introducing or modifying a tiered network plan or from assigning providers into tiers or (b) requires a general contracting entity to place all the provider’s members in the same tier of a tiered network plan.

Example: Requiring a payment increase if an entity moves a provider into a lower tier during the term of a provider network contract.

- “Anti-steering” meaning a provision that restricts a general contracting entity’s ability to encourage enrollees to obtain health care services from the provider’s competitors, including offering incentives to encourage an enrollee’s use of a specific provider.

Examples: Prohibiting deductible waivers that encourage enrollees to use one provider over another; prohibiting the provision of informational materials to enrollees encouraging them to seek health care services from certain providers.

- “Gag clause” is a provision that restricts the ability of a general contracting entity or the provider from disclosing price or quality information including the allowed amount, negotiated rate or discount, fees for services or other claim-related financial obligations included in the contract to:
 - Governmental entities that are authorized by law to receive this information; or



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- An enrollee or potential eligible enrollees, treating provider of an enrollee, plan sponsor or potentially eligible plan sponsors.

“Gag clause” also includes any provisions that would prohibit disclosing out-of-pocket costs to enrollees.

Example: Prohibiting the disclosure of the discount agreed to by a provider with a general contracting entity for providing specific health care services.

- “Most-favored nation clause” meaning a provision that:
 - Prohibits or grants an option to prohibit (a) a provider from contracting with another general contracting entity to provide health care services at lower rates or (b) a general contracting entity from contracting with another provider to provide health care services at a higher rate;
 - Requires or grants an option to require (a) a provider to accept a lower rate for health care services if the provider agrees with another general contracting entity to accept a lower rate for the services or (b) a general contracting entity to pay a higher rate for health care services if the entity agrees with another provider to pay a higher rate for services;
 - Requires or grants an option to require (a) termination or renegotiation of an existing provider network contract if a provider agrees with another general contracting entity to accept a lower rate for providing health care services or (b) a general contracting entity agrees to pay a provider a higher rate for health care services; or
 - Requires (a) the provider to disclose the provider’s contractual reimbursement rates with other general contracting entities or (b) a general contracting entity to disclose the entity’s contractual reimbursement rates with other providers.

Example: A contract may be terminated or must be renegotiated if, during the term of the contract, the general contracting entity agrees to a higher rate of reimbursement with another provider for the same or a substantially similar health care service.

HB 711 also prohibits amending or renewing an existing provider network contract with a general contracting entity that contains any of the four prohibited clauses.



Timing

Any gag or most-favored nations clause that is currently in a provider network contract is void and enforceable as of June 12 – the date HB 711 became effective. However, any anti-tiering or anti-steering provisions currently in provider network contracts are still valid until the earlier of:

- The effective date of an amendment that eliminates the anti-tiering or anti-steering provision from the contract and is entered into in accordance with the contract’s terms; or
- Dec. 31, 2023.

Finally, HB 711 imposes upon health benefit plan issuers a fiduciary duty to their enrollees or policyholders when the issuers engage in tiering or steering conduct requiring that issuers only engage in tiering and steering for the primary benefit of the enrollee or policyholder and not for the issuer’s profits.

OPERATIONAL IMPACT

Physicians and applicable hospitals must immediately review their provider network contracts with any person that qualifies as a “general contracting entity” to determine if such contracts contain any of the four prohibited provisions.

- If the contracts contain gag or most-favored nations clauses, physicians and applicable hospitals must educate their staff and, if practicable, their governing bodies, that such clauses can no longer be enforced.
- If the contracts contain anti-tiering or anti-steering clauses, physicians and hospitals are strongly encouraged to assess those provisions and determine whether they should seek amendments or renegotiate these contracts with the general contracting entities in accordance with the contract’s terms. If physicians and hospitals wait too long to address these matters with the general contracting entities, these provisions will be void on Jan. 1, 2024, regardless if negotiations are still ongoing.
- Physicians and hospitals must read this legislation carefully. For example, the inclusion of the phrase “restricts the ability of” in the definition of anti-tiering, anti-steering, and gag clauses reflects the intent of the author that these definitions be interpreted broadly and can apply to a variety of contractual clauses, in addition to direct or clear prohibitions not to tier, steer or disclose.

**HOUSE BILL 755**

Author:
Rep. Julie Johnson, et al.

Effective Date: 9/1/23

New Prior Authorization Prohibitions for Certain Autoimmune Diseases and Blood Disorders**ANALYSIS**

HB 755 creates a new Subchapter N under Chapter 1369 of the Insurance Code which prohibits most health benefit plans from requiring more than one annual prior authorization for coverage of prescription drugs used to treat an autoimmune disease, hemophilia, or Von Willebrand disease.

HB 755 defines “prescription drug” as having the same meaning as set forth in Section 551.003(36) of the Occupations Code. The definition includes most substances that federal or state law requires a prescription before the substance may be legally dispensed, drugs or devices that require certain labeling set forth in the statute and any drug or device that a federal or state law restricts use to a practitioner.

The following prescription drugs are excluded by HB 755, even if they are prescribed to treat autoimmune diseases, hemophilia or Von Willebrand disease:

- Opioids.
- Benzodiazepines.
- Barbiturates.
- Carisoprodol.
- Prescription drugs that have a typical treatment period of less than 12 months.
- Prescription drugs that have an FDA boxed warning and specific provider assessment.
- Prescription drugs approved by the FDA but not approved for the treatment of autoimmune diseases, hemophilia or Von Willebrand disease.

Only certain health benefit plans are subject to this new law. HB 755 applies to health benefit plans issued by insurance companies, HMOs, state health benefit plans (ERS/TRS/UT/A&M), small employer plans, plans issued by Chapter 842 group hospital service corporations, multiple employer welfare arrangements, Chapter 844 nonprofit health corporations with a certificate of authority, stipulated premium companies, fraternal benefit societies, Lloyd’s plan, Chapter 942 exchanges, consumer choice benefit plans, group health coverage provided through school districts and professional employer organization self-funded plans.



The bill does not apply to Medicaid plans, CHIP, plans that only provide coverage for hospital expenses and plans that provide wage or payments in lieu of wages to employees while they are sick or absent due to a work-related illness or injury.

Finally, HB 755 does not apply to grandfathered individual health plans issued on or before March 23, 2010, unless that plan has reduced benefits or increased costs to the individual since that date.

These requirements take effect on Sept. 1, 2023, but only apply to applicable health benefit plans delivered, issued for delivery, or renewed on or after Jan. 1, 2024.

HOUSE BILL 916

Author:
Rep. Claudia Ordaz, et al.

Effective Date: 9/1/23

New Coverage Requirements for Prescription Contraceptives

ANALYSIS

HB 916 amends Subchapter C of Chapter 1369 of the Insurance Code to require most health benefit plans to provide coverage for enrollees to obtain a one-time three-month supply of a covered prescription contraceptive the first time the enrollee fills this prescription and, subsequently, a one-time 12-month supply of a covered prescription contraceptive for each 12-month period.

HB 916 applies to most health benefit plans. Specifically the law applies to health benefit plans issued by insurance companies, state health benefit plans (ERS/TRS/UT/A&M), small employer plans, plans issued by Chapter 842 group hospital service corporations, multiple employer welfare arrangements, Chapter 844 nonprofit health corporations with a certificate of authority, stipulated premium companies, fraternal benefit societies, Lloyd's plan, Chapter 942 reciprocal exchanges, consumer choice benefit plans, group health coverage provided through school districts and professional employer organization self-funded plans. The bill does apply to Medicaid plans, including plans offered under the Medicaid managed care program.

The 12-month supply of prescription contraceptive must be covered even if the enrollee was not enrolled in the benefit plan when they first obtained the drug.

Enrollees can only obtain one 12-month supply of the covered prescription contraceptive drug within a 12-month period.

These requirements only apply to applicable health benefit plans delivered, issued for delivery, or renewed on or after Jan. 1, 2024.

**HOUSE BILL 999**

Author:
Rep. Four Price, et al.

Effective Date: 9/1/23

New Requirements for Insurers to Apply Certain Credits to Enrollee Deductibles, Cost-Sharing or Out-of-Pocket Maximums for Certain Prescription Drugs**ANALYSIS**

HB 999 amends Subchapter B of Chapter 1369, Insurance Code, to require health benefit plans covering prescription drugs or pharmacy benefit managers to apply any payment assistance for out-of-pocket expenses (discount, coupon, product voucher or any other financial reduction) provided to an enrollee by a third party to the enrollee's deductible, copayment, cost-sharing responsibility or out-of-pocket maximum under their health benefit plan.

According to the bill analysis, the purpose of HB 999 is to ensure that, for example, any copay assistance coupons provided to patients from drug manufacturers are applied to a patient's cost-sharing responsibilities (as listed above) by insurance companies.

These requirements only apply to prescription drugs for which:

- A generic equivalent does not exist;
- A generic equivalent exists but the patient has obtained access to the drug through their health plan using prior authorization, step therapy protocol, or an expectations and appeals process;
- An interchangeable biological product does not exist; or
- An interchangeable biological product does exist but the patient has obtained access to the drug through their health plan using prior authorization, step therapy protocol or an expectations and appeals process.

This law only applies to applicable health benefit plans delivered, issued for delivery, or renewed on or after Jan. 1, 2024.



SENATE BILL 1003

Author:

Sen. Nathan Johnson

Effective Date: 9/1/23

New Provider Directory Requirements for Health Benefit Plans

ANALYSIS

Senate Bill 1003 requires health benefit plan issuers to revise their provider directories to include the additional categories of nurse anesthetists, anesthesiologist assistants, nurse midwives, surgical assistants, physical therapists, occupational therapists, speech-language pathologists and any other specialty identified by the Texas Department of Insurance by rule. Provider directories are still required to list radiologists, anesthesiologists, pathologists, emergency department physicians and neonatologists. However, under SB 1003, assistant surgeons are no longer required to be included in provider directories. In addition, provider directories are no longer required to list facility-based physicians or health care providers employed by the facility based on the rationale that the in-network facility bills for their services.

Health benefit plan issuers must update their provider directories to conform to SB 1003 by Jan. 1, 2024.



SENATE BILL 1040

Author:
Sen. Lois Kolkhorst

Effective Date: 9/1/23

Prohibition on Coverage of Human Organ Transplant Care Performed in or Procured from China or Other Country Engaged in Forced Organ Harvesting

ANALYSIS

Senate Bill 1040 prohibits a health benefit plan issuer from covering a human organ transplant or post-transplant care if:

- The transplant operation is performed in China or another country known to have participated in forced organ harvesting as designated by the Commissioner of the Department of State Health Services (DSHS); or
- The human organ to be transplanted was procured by a sale or donation originating in China or another country known to have participated in forced organ harvesting as designated by the Commissioner of DSHS.

The Commissioner of DSHS may designate additional countries of governments that fund, sponsor or otherwise facilitate forced organ harvesting and must provide written notice to the Commissioners of the Teacher Retirement System of Texas, Employees Retirement System of Texas and the Health and Human Services Commission when additional countries are designated.

SB 1040 applies to the following health benefit plans operating under their corresponding chapters in the Texas Insurance Code:

- An insurance company.
- A group hospital service corporation operating under Chapter 842, Insurance Code.
- A health maintenance organization operating under Chapter 843.
- An approved nonprofit health corporation that holds a certificate of authority under Chapter 844.
- A multiple employer welfare arrangement that holds a certificate of authority under Chapter 846.
- A stipulated premium company operating under Chapter 884.
- A fraternal benefit society operating under Chapter 885.
- A Lloyd's plan operating under Chapter 941.



- An exchange operating under Chapter 942.
- A small employer health benefit plan subject to Chapter 1501, including coverage provided through a health group cooperative under Subchapter B of that chapter.
- A standard health benefit plan issued under Chapter 1507.
- A basic coverage plan under Chapter 1551.
- A basic plan under Chapter 1575.
- A primary care coverage plan under Chapter 1579.
- A plan providing basic coverage under Chapter 1601.

SB 1040 also applies to:

- Health benefits provided by or through a church benefits board under Subchapter I, Chapter 22, Business Organizations Code.
- The state Medicaid program, including the Medicaid managed care program operated under Chapter 533, Government Code.
- The child health plan program under Chapter 62, Health & Safety Code.
- A regional or local health care program operated under Section 75.104, Health & Safety Code.
- A self-funded health benefit plan sponsored by a professional employer organization under Chapter 91, Labor Code.
- County employee group health benefits provided under Chapter 157, Local Government Code.
- Health and accident coverage provided by a risk pool created under Chapter 172, Local Government Code.

**SENATE BILL 1286**

Author:
Sen. Charles Schwertner

Effective Date: 9/1/23

Clarification of Prompt Payment Deadlines for Certain Health Benefit Plan Claims Impacted by a Catastrophic Event**ANALYSIS**

SB 1286 revises sections of the Insurance Code applicable to health maintenance organizations and insurers offering preferred provider benefit plans to clarify when deadlines for submitting claims by providers to HMOs/PPOs are extended as a result of a catastrophic event and when HMOs/PPOs are not subject to penalties for failure to meet prompt payment deadlines as a result of a catastrophic event.

Specifically, SB 1286 amends Sections 843.337(b)-(c) and 1301.102(d)-(e), Insurance Code, to clarify that health care providers (which includes hospitals) and physicians who fail to submit claims to the HMOs or PPOs in compliance with state law forfeit their right to payment. However, the new law clarifies that health care providers and physicians can receive extensions to submit their claims if the Texas Department of Insurance (TDI) commissioner publishes a notice allowing for extension of prompt payment deadlines and approved by TDI as a result of a catastrophic event or TDI approves a physician's or provider's request for an extension due to a catastrophic event that interferes with normal business operations.

Additionally, SB 1286 relieves HMOs and PPOs from being assessed penalties when they fail to promptly pay claims if the failure is a result of a catastrophic event and TDI publishes notice allowing an extension of prompt payment deadlines due to the event or TDI approved the HMO's/PPO's request for an extension as a result of substantial interference of the catastrophic event with normal business operations.

SB 1286 allows TDI to promulgate rules to establish requirements for physicians, health care providers, HMOs and PPOs to submit extension requests of prompt claim submission and payment deadlines.

OPERATIONAL IMPACT

Hospitals must be aware that the law was revised to remove the old catastrophic event exception for failure to submit claims promptly, given that payment will be forfeited unless the new conditions for claiming an exception exist or are met. Hospitals should expect HMOs and PPOs to strictly enforce this requirement.

Hospitals, however, should also strictly enforce demands for penalty payments. This could include filing complaints with TDI or considering legal recourse, should HMOs and PPOs fail to pay any applicable penalties allowed by Insurance Code



Sections 843.342 and 1301.137, respectively, when failure to pay occurs during a catastrophic event and the HMO or PPO has not met the criteria for a penalty waiver resulting from a catastrophic event.

SENATE BILL 1342

Author:
Sen. Charles Perry

Effective Date: 9/1/23

Binding Third-Party Insurers to Prior Authorizations for Medicaid Beneficiaries When Medicaid is the Payer of Last Resort

ANALYSIS

SB 1342 makes updates to the Medicaid third-party recovery statute found at Human Resources Code section 32.0424 to align with federal law and to ensure that Medicaid is the payer of last resort when a Medicaid beneficiary has another source of payment for covered Medicaid services. The bill provides that aside from certain exceptions (described below), for an item or service provided to an individual entitled to medical assistance that was previously paid for by the Health and Human Services Commission (HHSC) or HHSC's designee and for which a third-party health insurer is responsible for payment, the third-party health insurer must accept authorization provided by HHSC or HHSC's designee that the item or service is covered under the medical assistance program as if that authorization is a prior authorization made by the third-party health insurer for the item or service.

For purposes of this requirement, "third-party health insurer" means a health insurer or other person or arrangement that is legally responsible by state or federal law or private agreement to pay some or all claims for health care items or services provided to an individual. The term includes:

- A self-insured plan.
- A group health plan as defined by Section 607 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1167).
- A service benefit plan.
- A managed care organization.
- A pharmacy benefit manager.

Under Subsection 32.0424(b-2) the requirement referenced above does not apply to a third-party health insurer with respect to providing:

- Hospital insurance benefits or supplementary insurance benefits under Part A or B of Title XVIII of the Social Security Act (42 U.S.C. Section 1395c et seq. or 1395j et seq.);



- A health care prepayment plan under Section 1833(a)(1)(A), Social Security Act (42 U.S.C. Section 1395l(a)(1)(A));
- A Medicare Advantage plan under Part C of Title XVIII of the Social Security Act (42 U.S.C. Section 1395w-21 et seq.);
- A prescription drug plan as a prescription drug plan sponsor under Part D of Title XVIII of the Social Security Act (42 U.S.C. Section 1395w-101 et seq.); or
- A reasonable cost reimbursement plan under Section 1876, Social Security Act (42 U.S.C. Section 1395mm).

SENATE BILL 622

Author:
Sen. Tan Parker

Effective Date: 9/1/23

Requirement for Health Benefit Plans to Disclose Prescription Drug Information on Request**ANALYSIS**

A health care provider prescribing medication may not have information regarding the financial impact that filling a prescription might have on the patient. SB 622 permits a prescribing provider or an enrollee to request, for a drug covered under a plan's pharmacy benefit, the following information from the health benefit plan issuer regarding the drug formulary and any formulary alternative:

- The enrollee's eligibility.
- Accurate cost-sharing information based on the dispensing location.
- Applicable utilization management requirements.

The health benefit plan issuer must respond in real time for a request made through a standard API; allow the use of an integrated technology or service to provide the information; ensure the information is current and provide the information if the request is made using the drug's unique billing code and National Drug Code. A health benefit plan issuer may not deny or delay a request to attempt to block the information; restrict the prescribing provider from communicating information about the cost of the drug or lower-cost alternatives; or except as required by law, interfere with access to the information by charging a fee, not responding timely, requiring the enrollee to consent to the release of the information or penalize the provider for disclosing the information or ordering a clinically appropriate alternative drug.



SB 622 applies to a health benefit plan delivered, issued for delivery, or renewed on or after Jan. 1, 2025. However, a health benefit plan issuer with fewer than 10,000 enrollees may request a one-year delay in implementation from the Texas Department of Insurance (TDI) and, after the first year, request a temporary exception from one or more requirements of the bill by submitting a report to TDI that demonstrates that compliance would impose an unreasonable cost relative to the public value that would be gained from full compliance.

SB 622 applies to the following health benefit plans operating under their corresponding chapters in the Texas Insurance Code:

- An insurance company.
- A group hospital service corporation operating under Chapter 842.
- A health maintenance organization operating under Chapter 843.
- An approved nonprofit health corporation that holds a certificate of authority under Chapter 844.
- A multiple employer welfare arrangement that holds a certificate of authority under Chapter 846.
- A stipulated premium company operating under Chapter 884.
- A fraternal benefit society operating under Chapter 885.
- A Lloyd's plan operating under Chapter 941.
- An exchange operating under Chapter 942.
- A small employer health benefit plan subject to Chapter 1501, including coverage provided through a health group cooperative under Subchapter B of that chapter.
- A standard health benefit plan issued under Chapter 1507.
- A basic coverage plan under Chapter 1551.
- A basic plan under Chapter 1575.
- A primary care coverage plan under Chapter 1579.
- A plan providing basic coverage under Chapter 1601.
- Alternative health benefit coverage offered by a subsidiary of the Texas Mutual Insurance Company under Subchapter M, Chapter 2054.
- A regional or local health care program operated under Section 75.104, Health and Safety Code.
- A self-funded health benefit plan sponsored by a professional employer organization under Chapter 91, Labor Code.



The bill does not apply to:

- The state Medicaid program, including the Medicaid managed care program operated under Chapter 533, Government Code.
- The child health plan program under Chapter 62, Health & Safety Code; the TRICARE military health system.
- A workers' compensation insurance policy or other form of providing medical benefits under Title 5, Labor Code.

SENATE BILL 833

Author:
Sen. Phil King, et al.

Effective Date: 9/1/23

Enacting New Prohibitions on Certain Rating Criteria Utilized by Certain Insurers**ANALYSIS**

SB 833 creates a new Chapter 565 under Title 5 of the Insurance Code to prohibit certain insurers from using an environmental, social, or governance model, score, factor or standard to charge a rate different than the rate charged to another business or risk in the same class for essentially the same hazard. However, if an insurer's actions are based on an ordinary insurance business purpose such as the use of sound actuarial principles or financial solvency considerations reasonably related to loss experience for the different types of risks and coverages made available by a particular insurer, then an insurer will not violate SB 833.

SB 833 clearly states that it is not intended to prohibit the use of information that is relevant and related to insurance risk even if that information may also be used or considered in developing an environmental, social, or governance model, score, factor or standard.

Applicability

SB 833 applies only to insurance policies issued and delivered by an insurer in Texas. This includes more than just health insurance policies and products. SB 833 defines "insurer" to include an insurance company or other entity authorized to engage in the business of insurance in Texas including:

- A stock or mutual property and casualty insurance company.
- A Lloyd's plan.



- A reciprocal or interinsurance exchange.
- A county mutual insurance company.
- A farm mutual insurance company.
- Any insurer writing a line of insurance regulated by Title 10 – Property & Casualty Insurance of the Insurance Code.
- All life, health, and accident insurance companies regulated by the Texas Department of Insurance (TDI) including a stock or mutual life, health, or accident insurance company, a fraternal benefit society, a nonprofit hospital, medical, or dental service corporation, including a group hospital service corporation operating under Chapter 842, Insurance Code, stipulated premium companies and HMOs operating under Chapter 843.

SB 833 does not apply to fidelity, guaranty, and surety bonds or crop insurance.

SB 833 also makes very clear that the new law should not be construed and applied to require an insurer to write any line or type of business that the insurer does not write, or a material change in the insurer’s current business plans. It also does not require the filing of rates for any line, type of insurer or type of insurance business that is not already specifically required by statute to file rates with TDI.

SB 833 does not create any new type of private cause of action or an independent basis in a civil or criminal proceeding.

Rulemaking

SB 833 specifically states that it is not intended to authorize TDI to adopt any rule, model, or standard requiring an insurer to use any environmental, social, or governance model law, regulation or other standard that has not been specifically authorized by statutes. This includes any federally required rule, model or standing that does not preempt state law under the McCarran-Ferguson Act (15 U.S.C. Section 1012(b)) or a rule, model, or standard required by any national organization, including the National Association of Insurance Commissioners, that has not been authorized by statute.

This law only applies to an insurance policy that is delivered, issued for delivery, or renewed in this state on or after Jan. 1, 2024.



SENATE BILL 989

Author:
Sen. Joan Huffman

Effective Date: 9/1/23

Mandatory Coverage for Biomarker Testing

ANALYSIS

SB 989 requires health benefit plan issuers to cover biomarker testing for the purpose of diagnosis, treatment, appropriate management or ongoing monitoring of an enrollee’s disease or condition to guide treatment when the test is supported by medical and scientific evidence.

A health benefit plan issuer must cover biomarker testing only when use of biomarker testing provides clinical utility because use of the test for the condition is evidence-based; is scientifically valid based on the medical and scientific evidence; informs a patient’s outcome and a provider’s clinical decision; and predominately addresses the acute or chronic issue for which the test is being ordered, except that a test may include some information that cannot be immediately used in the formulation of a clinical decision.

A health benefit plan must cover biomarker testing in a manner that limits disruptions to care, including limiting the number of biopsies and biospecimen samples.

SB 989 applies to the following health benefit plans operating under their corresponding chapters in the Texas Insurance Code:

- An insurance company.
- A group hospital service corporation operating under Chapter 842.
- A health maintenance organization operating under Chapter 843.
- An approved nonprofit health corporation that holds a certificate of authority under Chapter 844.
- A multiple employer welfare arrangement that holds a certificate of authority under Chapter 846.
- A stipulated premium company operating under Chapter 884.
- A fraternal benefit society operating under Chapter 885.
- A Lloyd’s plan operating under Chapter 941.
- An exchange operating under Chapter 942.
- A small employer health benefit plan subject to Chapter 1501, including coverage provided through a health group cooperative under Subchapter B of that chapter.



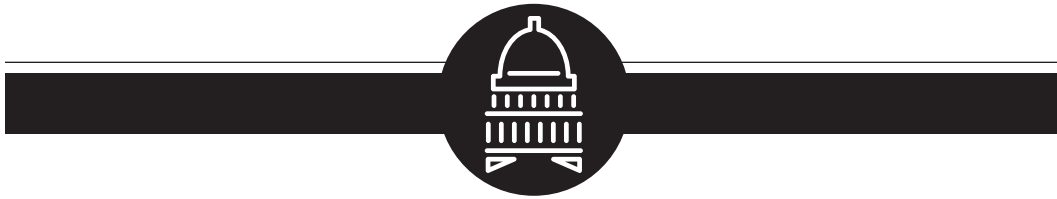
- A standard health benefit plan issued under Chapter 1507.
- A basic coverage plan under Chapter 1551.
- A basic plan under Chapter 1575.
- A primary care coverage plan under Chapter 1579.

The bill also applies to:

- The state Medicaid program, including the Medicaid managed care program operated under Chapter 533, Government Code.
- The child health plan program under Chapter 62, Health & Safety Code; and a self-funded health benefit plan sponsored by a professional employer organization under Chapter 91, Labor Code.

OPERATIONAL IMPACT

Hospitals should inform their providers and update their policies and procedures to reflect required coverage of clinically appropriate biomarker testing for commercial health plans, Employee Retirement Income Security Act plans and Medicaid plans. SB 989 applies to a health benefit plan that is delivered, issued for delivery or renewed on or after Jan. 1, 2024.



HEALTH CARE PROVIDERS



HOUSE BILL 1106

Author:
Rep. Vickie Goodwin, et al.

Effective Date: 9/1/23

Modifying the Regulatory Standards for the Practice of Acudetox

ANALYSIS

HB 1106 modifies the regulation of acudetox practice under Section 205.303 of the Texas Occupations Code in several ways:

- It expands the list of practitioners who are eligible to practice acudetox to include a professional counselor practicing under a temporary license, licensed marriage and family therapists, licensed marriage and family therapist associates, licensed physician assistant or other licensed or certified professional approved by the Texas Medical Board.
- It changes some of the terminology used in the section, including a new reference to auricular acudetox, and replacing “alcoholism, substance abuse, or chemical dependency” with “addiction, trauma, or physical, emotional, or psychological stress” when describing the types of conditions the specialist may treat.
- It requires informed consent prior to treatment and records of treatment to contain the signature and printed name of the specialist.
- It allows for a three-year renewal cycle, instead of the current one-year.
- It modifies the continuing education requirement from the current 6 hours to 3 hours annually.



HOUSE BILL 3009

Author:
Rep. Gary VanDeaver

Effective Date: 9/1/23

Providing the Authority for Health Care Providers to Examine a Person for Capacity in Certain Guardianship Proceedings

ANALYSIS

Under changes enacted in HB 3009, in guardianship proceedings under the Estates Code, an advanced practice registered nurse, in addition to a physician, may examine an individual for purposes of determining capacity, disability or probable cause for investigation. However, the advanced practice registered nurse may require delegation from and supervision by a physician, along with the supervising physician signing any written determination.

"Advanced practice registered nurse" has the meaning assigned by Section 301.152, Occupations Code.

"Physician" means an individual licensed by the Texas Medical Board to practice medicine in Texas.



HOUSE BILL 3130

Author:
Rep. Bobby Guerra, et al.

Effective Date: 9/1/23

Allowing Licensing Agencies to Keep Certain Information Confidential About Licensees Who Are Clients of Family Violence Shelters or Similar Services

ANALYSIS

HB 3130 amends the Texas Public Information Act (PIA) to prohibit a governmental body from selling or otherwise releasing the name, home or business address, place of employment, telephone number, electronic mail address, social security number, date of birth, driver's license or state identification number, passport number, emergency contact information, or numeric identifier of a person who holds, previously held or is an applicant for a license issued by the governmental body and notifies the governmental body on a form provided by the office of the attorney general or the governmental body that the person:

- Is a current or former client of a family violence shelter center, victims of trafficking shelter center, or sexual assault program or is a survivor of family violence, domestic violence or sexual assault.
- Chooses to restrict public access to the information.

It further allows a governmental body to redact the information described above from a response to a request for a list or directory of license holders, former license holders or license applicants without the necessity of requesting a decision from the attorney general under the PIA.

Finally, HB 3130 directs the office of the attorney general, as soon as practicable after the effective date, to prepare the form for making the request, to make the form available on the attorney general's website, and to notify family violence shelter centers, victims of trafficking shelter centers and sexual assault programs of the availability and purpose of the form.

OPERATIONAL IMPACT

Eligible individuals who hold a license issued by an agency covered by the Public Information Act will need to file the required form to ensure that the information covered by HB 3130 will be kept confidential.



SENATE BILL 1343

Author:
Sen. Morgan LaMantia

Effective Date: 9/1/23

Expansion of the Texas Board of Nursing and New Procedures for Expert Advanced Practice Registered Nurse Review

ANALYSIS

SB 1343 expands the Texas Board of Nursing (BON) to now include seven nurse members (instead of six), two of which must now be APRNs (instead of one) and five members of the public (instead of four). SB 1343 directs the governor to appoint the two new members as soon as possible with one person's term expiring on Jan. 31, 2025, and one on Jan. 31, 2029.

SB 1343 also creates new laws to address expert reviews of APRNs. Specifically, SB 1343 adds new requirements to Section 301.457, Occupations Code, that include:

- The BON adopting rules requiring them to appoint APRNs to act as expert reviewers to assist with complaints and investigations relating to alleged standard of care violations by APRNs.
- The BON referring complaints to one of the appointed expert reviewers who practices in the same APRN role and population focus as the subject APRN if the BON determines that an act by the subject falls below an acceptable standard of care.
 - The BON, however, may not refer the complaint to an expert reviewer if the alleged act is within the scope of practice applicable to a nurse who is not an APRN or the alleged act is considered unprofessional conduct.

SB 1343 creates a new Section 301.4575 under Chapter 301 of the Occupations Code to outline the procedures that must be followed by expert reviewers appointed by the BON to conduct reviews of APRNs that are referred pursuant to new Section 301.475(h). Expert APRN reviewers must:

- Determine whether the subject APRN violated the standard of care applicable to the complaint's circumstances.
- Issue a preliminary written report of that determination to the BON.

Finally, SB 1343 amends Section 301.464, Occupations Code, which governs informal disposition of contested cases and informal proceedings, both subject to the Administrative Procedures Act (Chapter 2001, Government Code), by requiring that the BON adopt additional rules requiring that a copy of the expert APRN



reviewer’s written report be included in a notice of informal proceeding for cases where the allegation includes a standard of care violation.

The BON must also adopt rules mandating that the report redacts any identifying information that could identify the expert reviewer. However, the role and population focus of the expert reviewer must not be redacted. The BON must adopt these rules no later than Feb. 1, 2024.

SENATE BILL 422

Author:
Sen. Angela Paxton

Effective Date: 9/1/23

Authorizing Recognition of Military Members’ Out-of-State Licenses

ANALYSIS

SB 422 amends Section 55.0041, Occupations Code, to now also allow military members to use their out-of-state license to engage in a business or occupation in Texas, so long as the member is in good standing in the out-of-state jurisdiction and the licensing requirements are substantially similar to those required in Texas. “License” includes a license, certificate, registration, permit or other form of authorization required by law or a state agency rule that must be obtained before the person can engage in a particular business.

Section 55.0041 currently only applies to military member spouses. SB 422 will ensure that the same benefits apply to military members.

SB 422 also clarifies what happens in the event of a divorce that changes the status of a person as a military spouse. Following the divorce, a military spouse can continue engaging in the occupation or business for three years from the date the spouse received confirmation about the agency’s verification of the out-of-state license and the spouse is still authorized to engage in the business or practice. Note this is not from the date of divorce, but from the date of agency confirmation meaning that the law does not allow such a person to continue practicing under the out-of-state license for an additional three years.

SB 422 also allows for rulemaking by applicable state agencies that now require the state agency to verify the member or spouse’s license is in good standing within 30 days from receipt of the information required by the law.



SB 422 also amends Section 55.004(d), Occupations Code to mandate any applicable state agency adopt rules to allow military service member applicants to establish residency by accepting a copy of the permanent change of station order. Prior to SB 422, the law only applied to military spouses.

OPERATIONAL IMPACT

Hospitals should be aware of this legislation in order to ensure that applicants for certain licensed required health care positions are not turned away or rejected by human resource departments.

SENATE BILL 510

Author:
Sen. Charles Perry

Effective Date: 9/1/23

Confidentiality of Licensing Applications and Other Information Held by State Licensing Agencies

ANALYSIS

SB 510 amends the Texas Public Information Act (PIA) in several respects.

Section 2 of SB 510 creates a new disclosure exception under the PIA, Section 552.11765, Government Code, and requires a licensing agency in the state to maintain as confidential license applications or information about its licensees that includes:

- Home address.
- Home telephone number.
- E-mail.
- Social Security number (SSN).
- Date of birth.
- Driver’s license number.
- State ID number.
- Passport number.
- Emergency contact.
- Payment information.



The requirement applies to individuals who applied, hold or previously held a license issued by a state governmental body. However, the name, license number, license status of an applicant, license holder or previous license holder is not confidential and may be disclosed under the PIA.

New Section 552.11765(c) also makes public certain information related to a laundry list of licenses issued under various sections of the Human Resources and Health and Safety Codes. This information includes:

- Last four digits of SSN in connection with verification of employability or employee misconduct registry search provided by Texas Health and Human Services Commission (HHSC).
- Home address where the licensing authority-regulated activity occurs.
- E-mails or phone numbers associated with licensing authority-regulated activity.

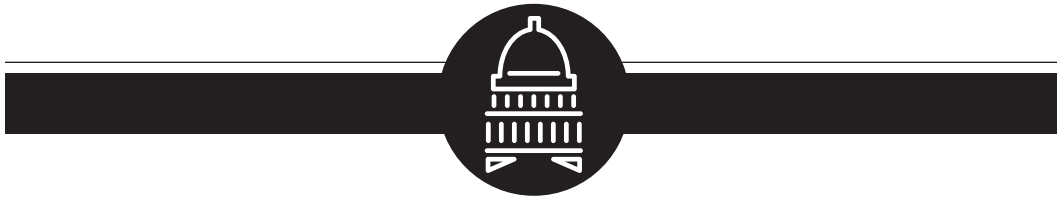
This new disclosure requirement applies to licenses issued under the following codes/sections:

Human Resources Code

- Chapter 42 – Facilities, Homes and Agencies That Provide Child Care Services.
- Chapter 43 – Regulation of Child Care and Child-Placing Agency Administrators.
- Chapter 103 – Day Activity and Health Services.
- Chapter 161 – Entities Subject to Oversight by the Department of Aging and Disability Services.

Health and Safety Code

- Chapter 142 – Home and Community Support Services.
- Chapter 242 – Convalescent, Nursing Facilities, and Related Institutions.
- Chapter 247 – Assisted Living Facilities.
- Chapter 248A – Prescribed Pediatric Extended Care Centers.
- Chapter 250 – Nurse Aid Registry and Criminal History Checks of Employees And Applicants for Employment in Certain Facilities Serving the Elderly, Persons with Disabilities, or Persons with Terminal Illness.
- Chapter 252 – Intermediate Care Facilities for Individuals with Intellectual Disability.



HEALTH CARE WORKFORCE



HOUSE BILL 4451

Author:
Rep. Salman Bhojani, et al.

Effective Date: 9/1/23

New Reporting by the Texas Workforce Commission on Apprenticeship Opportunities for High-Demand Industries

ANALYSIS

HB 4451 amends Subchapter A of Chapter 302, Labor Code to require the Texas Workforce Commission (TWC) to prepare and submit a report on available apprenticeship programs in Texas to the Legislature by Sept. 1 of each year. The law requires TWC to prepare the report in conjunction with local workforce development boards. TWC must also make recommendations on how to expand availability of the apprenticeship programs in emerging and high-demand industries, specifically with respect to high-demand industries that have higher employment demand relative to the total number of active apprenticeships and programs.

Apprenticeship programs include industry-recognized training programs that provide on-the-job training, preparatory, supplementary or related instruction for a recognized apprenticeable occupation by the Office of Apprenticeship of the U.S. Department of Labor or is a certified industry-recognized apprenticeship program.

Per the new law, health care and social services are considered “high-demand industries.” TWC must include specific data in the report as outlined by the law. TWC is allowed to collaborate with the Texas Workforce Investment Council (TWIC) or the Apprenticeship and Training Advisory Committee (ATAC), as recommended by the TWIC, to develop the required recommendations. Copies of the report sent to the legislature must also be sent to the TWIC and ATAC annually.

OPERATIONAL IMPACT

Hospitals should consider whether they provide any programs that meet the definition of an apprenticeship program and, if so, ensure that TWC is aware of their program’s existence so that the program’s availability is noted in the report. Inclusion in such reports will help ensure that the Legislature is aware of the continuing need to strengthen the healthcare workforce pipeline.

The TWC must submit its first report to the Legislature by Sept. 1, 2024.

**SENATE BILL 25**

Author:
Sen. Lois Kolkhorst

Effective Date: 6/18/2023

Omnibus Nursing Workforce Funding and Nursing Education Investment Legislation**ANALYSIS**

SB 25 is significant legislation that seeks to alleviate the nursing workforce bottleneck by increasing funding to expand the amount of nursing students and the number of nurses willing to serve as faculty to train these new students. SB 25 achieves this by authorizing the creation of a new scholarship program for nursing students, expanding the Nursing Faculty Loan Repayment Assistance Program to now include part-time faculty and extending the Nursing Innovation Grant Program to Aug. 31, 2027, as it was originally set to expire on Sept. 1, 2023.

Additionally, SB 25 creates a new subchapter in the Education Code to authorize the establishment of grant programs to support nursing education and training by providing funding to clinical sites. These include a clinical site nurse preceptor grant program, clinical site innovation and coordination program and grant programs for institutions that have qualified nursing staff that serve as part-time faculty at clinical sites and for training. While the Legislature did not appropriate any funds for these programs, it is a significant step forward to have the legislation in place so that once funding is available, the programs can be established and administered.

These programs are all administered by the Texas Higher Education Coordinating Board (THECB).

Specifically, SB 25 amends Subchapter L of Chapter 61, Education Code to:

- Expand the definition of “professional nursing student” (Section 61.651) to include students seeking a professional nursing degree in a public or private institution of higher education and non-profit, tax-exempt, regionally accredited colleges or universities that operate under a memorandum of understanding with the state of Texas under an executive order issued by the Governor.
- Require THECB to establish criteria to determine eligibility for a scholarship or loan repayment that includes requiring that persons be enrolled in and have outstanding student loans for education received at the aforementioned institutions (Section 61.655(c)).
- Require THECB adopt rules that require that not more than 10 percent of the total amount of scholarships or loan repayment assistance are awarded to individuals who are enrolled in or received an education from non-profit,



tax-exempt, regionally accredited colleges or universities that operate under a memorandum of understanding with the state of Texas under an executive order issued by the governor.

It also amends Sections 61.9822 and 61.9823, Subchapter JJ of Chapter 61, Education Code to:

- Expand eligibility to nurses who serve as part-time faculty of a nursing degree program at public or private institution of higher education.
- Remove the statutory maximum \$7,000 limit on loan repayment assistance received by a nurse and authorize the THECB to determine the maximum amount each year. THECB is required to base loan repayment assistance received by a part-time faculty nurse on the proportion of hours part-time faculty serve to the number worked by full-time faculty nurses.

Additionally, SB 25 amends Section 63.202 (f) and (g), Subchapter C of Chapter 63, Education Code to extend the life of the THECB's Nursing Innovation Grant Program which is funded through the Permanent Fund for Higher Education Nursing, Allied Health, and Other Health-Related Programs to Aug. 31, 2027, with an expiration of Sept. 1, 2027, instead of Sept. 1, 2023.

SB 25 also creates a new Subchapter Z-1 to:

- Authorize the establishment of grant program funding for clinical sites that provide clinical learning experiences for nursing students.
- Define “clinical site” to include acute care rehab facilities, primary care settings, long-term care settings, nursing homes, resident care settings and any other sites identified by THECB as providing clinical learning experiences.
- Create the Clinical Site Nurse Preceptor Grant Program to award to eligible clinical sites that support the use of nurse preceptors in providing clinical training to nursing students.
- Create the Clinical Site Innovation and Coordination Program which would award grants to eligible clinical sites that create and operate innovative pilot programs that will support nursing performed at the clinical sites by increasing number of nurses, improving nurse work environments, nurse retention, workplace safety and coordinating with other clinical sites on finding solutions to common nursing concerns.



- Create the Nursing Faculty Grant Program for Part-Time Positions to award to eligible public and private institutions of higher education so that they may provide funding for qualified nursing staff working at clinical sites who serve as part-time faculty for those institutions.
- Create the Nursing Faculty Grant Program for Training to award grants to eligible clinical sites so that these sites can fund qualified nursing faculty of institutions of higher education who seek to obtain additional clinical training by working part-time at a clinical site.
- Finally, SB 25 repeals Sections 61.653 (Matching Fund Program), 61.656(c) (related to THECB authority to adopt rules for the matching fund program), and 61.657 (related to advisory committees).

OPERATIONAL IMPACT

Hospitals that serve as clinical training sites for nursing should notify their education and nursing departments about this new legislation in order to determine how best to communicate to staff about the new scholarship, grant and funding opportunities.

**SENATE BILL 401**

Author:
Sen. Lois Kolkhorst

Effective Date: 9/1/23

Prohibition on Price Gouging for Medical Staffing Services During Declared Public Health Disaster Period**ANALYSIS**

SB 401 prohibits a medical staffing services agency from providing services to a health care organization or other entity in the state at an exorbitant price, especially during a public health disaster period. The bill applies to a designated public health disaster period based on a threat to public health as declared by the governor or the president beginning on the date of declaration and ending on the 30th day after the disaster declaration expires or is terminated. SB 401 applies to a medical staffing services agency that provides physician assistants, surgical assistants, nurses and nurse aids.

The Consumer Protection Division of the Office of Attorney General may bring an action in district court for injunctive relief against the medical staffing services agency and to collect a civil penalty of up to \$10,000 for each violation.

OPERATIONAL IMPACT

Hospitals that are charged excessive rates for medical staffing services during a declared public health disaster period may file complaints with the Consumer Protection Division of the Office of the Attorney General. Hospitals may file complaints online through the Office of the Attorney General Consumer Protection Division website and should include:

- The name of the business or individual.
- The business/individual's full address, including ZIP code.
- A detailed description of the complaint.
- An explanation of how the hospital came into contact with the business/individual.
- Transaction dates and amounts.
- Contract information (when appropriate) with payment details.
- How the hospital attempted to resolve the dispute, including the names of individuals contacted.

SB 401 does not define the terms of excessive or exorbitant prices, so hospitals should be prepared to demonstrate the differences in the cost of temporary contract labor.



SENATE BILL 840

Author:
Sen. Royce West

Effective Date: 9/1/23

Assault of Hospital Personnel on Hospital Property Now a Third-Degree Felony

ANALYSIS

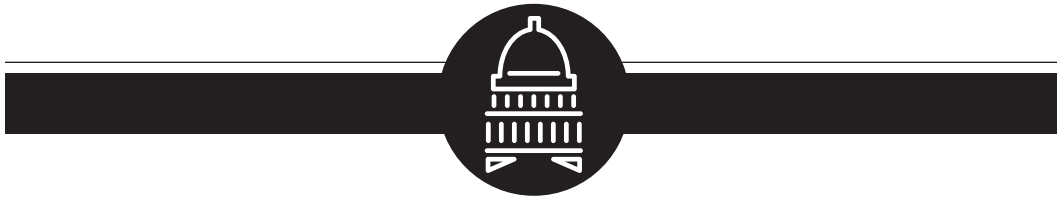
SB 840, also known as the Jacqueline “Jackie” Pokuaa and Katie “Annette” Flowers Act, amends Section 22.01(b), Penal Code, by making an assault of hospital personnel located on hospital property a third-degree felony instead of a Class A misdemeanor.

Local prosecutors now can charge someone with a felony for assaulting a person on hospital property who the perpetrator knows is hospital personnel. “Hospital property” includes all land and buildings owned or leased by the hospital. Thus this includes not just the hospital’s main building or campus, but also outpatient departments and other hospital-owned or leased facilities.

The bill adds a definition of “hospital personnel” to Section 22.01(b) which includes nurses, physicians, physician assistants, maintenance or janitorial staff, receptionists and any other hospital-employed individuals, or people who work in general or special hospitals as those terms are defined in Chapter 241, Health and Safety Code. This includes hospitals owned or operated by the state of Texas.

OPERATIONAL IMPACT

While not required, hospitals may consider signs or notifications in waiting rooms or other conspicuous locations of the hospital or hospital-owned or leased property to provide patients and visitors knowledge that they are located on hospital property. Such actions may assist local prosecutors in establishing any requisite knowledge required to charge a perpetrator with the enhanced penalty, a third-degree felony, instead of a Class A misdemeanor.



HOSPITAL OPERATIONS

**Senate Bill 1401**

Author:

Sen. Judith Zaffirini

Effective Date: 9/1/23

Rights of Sexual Assault Survivors and Reimbursement for Forensic Medical Exams**ANALYSIS**

SB 1401 makes changes to the requirement of a health care provider to conduct a forensic medical exam on a victim of sexual assault. The exam must be performed on a sexual assault victim who is a minor, regardless of when the victim presents to the provider, if the minor or a person authorized to act on behalf of the minor or an employee of the Department of Family and Protective Services consents to the exam. For a sexual assault victim who is not a minor, the exam must be performed if the victim presents to the provider within 120 hours after the assault occurred, or, under a new requirement, later than 120 hours if the victim was referred by a law enforcement agency or referred by a physician, sexual assault examiner or sexual assault nurse examiner who has conducted a preliminary medical evaluation and determined a forensic medical examination should be conducted.

SB 1401 also requires a law enforcement agency to refer a victim of sexual assault for a forensic medical exam if:

- The assault is reported within 120 hours after occurring; or
- If the victim is a minor.

A law enforcement agency may refer a victim of sexual assault for a forensic medical exam regardless of timing if it will further the investigation or prosecution.

SB 1401 also adds a requirement saying a health care provider who provides a forensic medical exam will be reimbursed for the reasonable costs of other medical care provided to the victim during the forensic medical examination. A request for this reimbursement must be supported by a complete and itemized bill of the reasonable costs of the additional medical care. The amount eligible for reimbursement is in accordance with the medical fee guidelines prescribed by Subtitle A, Title 5, Labor Code. A payment made as described above may not exceed \$25,000. Neither the attorney general nor a victim of a sexual assault is liable for costs incurred for medical care that exceed the medical fee guidelines described above or is not medically necessary. A sexual assault survivor may not be required to pay for these costs.



The attorney general may deny or reduce payment to the extent that reimbursement is recouped from a collateral source.

SB 1401 also establishes that sexual assault survivors who undergo a forensic medical exam have cooperated with law enforcement for purposes of accessing the Crime Victim's Compensation Fund.

Finally, the Texas Health and Human Services Commission must add to their standard information form for sexual assault survivors information regarding the crime victim's compensation and regarding the payment of costs and the reimbursements available for care, as well as the right of victims that are minors to receive forensic medical exams regardless of the timeframe of the assault.

OPERATIONAL IMPACT

All hospitals are required to be able to perform a sexual assault forensic exam (SAFE) on request. Hospitals should review SB 1401 and update their policies with regard to the availability of a SAFE, the timing of the exam and the procedures for obtaining consent and for requesting reimbursement for certain costs.

**Senate Bill 1402**

Author:

Sen. Judith Zaffirini

Effective Date: 9/1/23

Sexual Assault Task Force Updates and Required Sexual Assault Training**ANALYSIS*****Sexual Assault Task Force Updates***

SB 1402 updates the composition of the Sexual Assault Survivors' Task Force by:

- Adding a representative from the Department of Family and Protective Services.
- Removing the president of the Texas Society of Pathologists or the president's designee.
- Adding an adult survivor of child sexual abuse or the parent or guardian of a survivor of child sexual abuse.
- Adding a survivor of adult sexual assault.

SB 1402 clarifies in statute that Chapter 2110, Government Code (related to state agency advisory committees) does not apply to composition, duration or designation of the task force's presiding officer.

Sexual Assault Training for Hospital and Medical Staff

SB 1402 modifies the current requirement that anyone performing forensic medical examinations on sexual assault survivors complete basic forensic evidence collection training to specify the training must be at least two hours and lists two additional options that can also satisfy this requirement:

- Completing equivalent education that conforms to the evidence collection protocol described in Section 420.031, Government Code.
- Completing a continuing medical or nursing education course in forensic evidence collection described by Section 156.057 or 301.306, Occupations Code, that is approved by appropriate licensing board.

SB 1402 also requires a health care facility that has an emergency department to provide at least one hour of basic sexual assault response training to all facility employees who provide:

- Patient admission functions;



- Patient-related administrative support functions; or
- Direct patient care.

The basic sexual assault response training must include instruction on:

- The provision of survivor-centered, trauma-informed care to sexual assault survivors.
- The rights of sexual assault survivors under Chapter 56A, Code of Criminal Procedure, including:
 - Availability of a forensic medical examination, including an examination that is available when a sexual assault survivor does not report the assault to a law enforcement agency; and
 - The role of an advocate as defined by Section 420.003, Government Code, in responding to a sexual assault survivor.

If an employee has completed a continuing medical or nursing education course in forensic evidence collection described by Section 156.057 or 301.306, Occupations Code, that is approved by appropriate licensing board then this requirement is considered met.

Every health care facility with an emergency department that is not a sexual assault forensic exam-ready facility must develop a written policy to ensure the above training requirements for basic forensic evidence collection and for the specified employees on basic sexual assault response training are met.

Sexual Assault Training for Law Enforcement Officers

SB 1402 also contains education and training requirements for law enforcement officers that are not detailed here.

OPERATIONAL IMPACT

Health care facilities that have an emergency department must have written policies in place to implement the training requirements set forth in the bill by Dec. 1, 2023. Also, the training required for forensic medical exams only applies toward forensic medical exams that occur on or after that date.

**HOUSE BILL 1890**

Author:

Rep. Jacey Jetton

Effective Date: 5/27/23

State Waiver Authority Created for the CMS Hospital-at-Home Waiver Program**ANALYSIS**

The Hospital-at-Home program is a Centers for Medicare & Medicaid Services (CMS) waiver program that was established in November 2020 to allow hospitals to increase their inpatient capacity during the COVID-19 pandemic. Hospitals applied to CMS to be included in the program and were able to treat acute inpatients in their own homes. At the end of 2022, Congress authorized the continuation of the Hospital-at-Home waiver program through Dec. 31, 2024. At the state level, hospitals needed to obtain approval from the Health and Human Services Commission (HHSC) to operate a hospital-at-home program, granting compliance with state regulatory requirements. Authority for the HHSC waiver has been operationalized through an ongoing state emergency rule. To continue the program at HHSC, legislative authority was necessary. HB 1890 gives that legislative authority to HHSC.

The bill establishes the Acute Hospital Care at Home Waiver Program in the Texas hospital licensing law and grants HHSC the authority to establish standards for the program that are at least as stringent as the CMS rules. HHSC is required to adopt agency rules outlining minimum standards, procedures and criteria for the program. To operate the program, a hospital must be both CMS-approved and HHSC-approved. A hospital must submit an application to HHSC in the required form and pay any required application fee. The bill allows HHSC to waive or modify hospital state licensing requirements to facilitate a hospital-at-home program in the best interest of patients.

OPERATIONAL IMPACT

Hospitals that currently operate a hospital-at-home program are operating under HHSC authority granted by an emergency rule. HHSC will be adopting new rules outlining the minimum standards and requirements going forward for hospitals that want to continue operating a Hospital-at-Home program. It is possible that existing hospital-at-home hospitals will need to reapply under the new rules and pay a fee. THA will engage with HHSC in the rulemaking process and ensure THA members are updated as those rules and next steps are put in place.

**HOUSE BILL 1998**

Author:
Rep. Julie Johnson, et al.

Effective Date: 9/1/23

Increasing the Texas Medical Board's Oversight of Physicians and Modifying a Hospital's Requirement to Report Certain Peer Review Actions to the TMB**ANALYSIS**

HB 1998 was filed in response to several high-profile cases of alleged inadequate oversight of physicians who committed egregious acts of medical negligence. It imposes new requirements on the Texas Medical Board (TMB), and importantly for hospitals, modifies a reporting requirement applicable to medical peer review committees. Specifically, Section 9 of the bill requires a medical peer review committee or health care entity to report in writing to the TMB the results and circumstances of a medical peer review that adversely affects the clinical privileges of a physician for a period longer than 14 days. This is a change from the current requirement to report actions lasting longer than 30 days.

HB 1998 makes additional changes to the TMB's regulatory oversight of physicians. It imposes two surcharges on physicians that must be paid upon additional licensure and each renewal, including:

- A \$15 surcharge to fund and allow the TMB to administer the Texas Physician Health Program.
- An additional charge in an amount set by the TMB to cover the cost of administering a continuous query on the National Practitioner Data Bank, as described below.

HB 1998 also requires the TMB to run a continuous query on the National Practitioner Data Bank and, not later than the 10th working day after the date any new information is found, update a physician's profile to include any new report or correction to a report of disciplinary action against the physician and remove any report of disciplinary action against the physician that has been dismissed or otherwise voided. Information included in a physician's profile resulting from the query may not include any patient identifying information or information that may reasonably be used to identify any person or entity other than the physician.

Related to complaint investigations and disciplinary proceedings, HB 1998 allows physicians who are licensed in a state covered by the Interstate Medical Licensure Compact to serve on an expert panel in relation to a physician being investigated if there are no panel members licensed to practice medicine in Texas available to review the complaint in a timely manner. It further provides that an applicant for a Texas license is ineligible if the applicant held a license to practice medicine that has



been revoked by the licensing authority in another state or a province of Canada for a reason that would be grounds for the board to revoke a license to practice medicine in Texas.

Related to criminal background checks, HB 1998 requires each applicant for a new or renewal license to submit a complete set of fingerprints to the TMB (this only needs to be done once) with their application, and the TMB must submit the fingerprint set to the Texas Department of Public Safety.

Finally, Section 11 expands the list of criminal offenses that are grounds for suspending or restricting a physician's license, to include:

- Homicide.
- Human trafficking.
- Offenses under Chapter 21 or 22, Penal Code (sexual or assaultive offenses), if the offense is sexual, lewd or indecent in nature, not a misdemeanor punishable by fine only, and committed against a patient of the license holder, a child, an elderly individual or an individual with a disability.

OPERATIONAL IMPACT

Hospitals will need to review and likely revise their medical staff bylaws and processes to ensure that they are complying with the requirement for reporting the results and circumstances of a medical peer review that adversely affects the clinical privileges of a physician for a period longer than 14 days, a change from the current requirement of reporting actions lasting longer than 30 days.



HOUSE BILL 3161

Author:

Rep. Lacey Hull

Effective Date: 9/1/23

Duties Regarding Bodies of Unidentified Deceased Persons and Control of the Disposition of a Deceased Person's Remains

ANALYSIS

HB 3161 revises the Code of Criminal Procedures Chapter 49, Inquests Upon Dead Bodies, to clarify that a person or body is considered unidentified if the deceased person's legal name is unknown and there is no known person with the duty to inter the deceased person's remains.

Justices of the peace (JPs) and medical examiners (MEs) are now required to conduct an inquest into the death of a person who dies in the county served by the justice if the person is identified but the cause or circumstances of the death are unknown, or the person is unidentified regardless of whether the cause of the circumstances of death are known. The current statute only requires a JP to conduct an inquest if remains of a person are found and the cause of death is unknown, and the person is unidentified.

HB 3161 revises Chapter 711 Health and Safety Code (General Provisions Related to Cemeteries) clarifying that people with the duty to control the disposition of the decedent's remains may not act if that person has been arrested or an arrest warrant has been issued for the person for a crime under Chapter 19 of the Penal Code related to criminal homicide, that involves family violence against the decedent or the decedent had filed an application for a protective order against or with respect to the person.

A person regulated under Chapter 651 of the Occupations Code related to crematory services, funeral directing and embalming who knowingly allows a person who has been arrested or for whom an arrest warrant has been issued for criminal homicide involving family violence to control the disposition of a decedent's remains commits a prohibited practice. A court with jurisdiction over probate proceedings must expedite the proceedings to resolve any dispute over the right to control the disposition of a decedent's remains if the dispute involves the control of the disposition by a prohibited person.

OPERATIONAL IMPACT

Hospital employees that routinely process decedents should be made aware of these changes in statute and the higher bar set for investigations. Legal and compliance officers should also be aware of these changes and review any policies and procedures to ensure they are appropriately updated. Employees and staff



that coordinate with JPs, MEs or law enforcement for the purposes of identifying patients, releasing decedent's remains and/or assisting with investigations should be educated on the new requirements and how their role might be impacted.

HOUSE BILL 3162

Author:
Rep. Stephanie Klick

Effective Date: 9/1/23

Revising the Texas Advance Directives Act Provisions Related to Advance Directives, DNR Orders, and Health Care Treatment Decisions for Certain Patients; Revising the Consent to Medical Treatment Act

ANALYSIS

Revisions to the Texas Advance Directives Act

HB 3162 makes broad changes to the Texas Advance Directives Act (TADA) found at Chapter 166, Health and Safety Code. Because a full, detailed review of the changes to the TADA is beyond the scope of this publication, THA developed additional HB 3162 resources that are available through your THA contact.

The changes to the TADA include:

- Extending the statutory period for notice to a patient, or their appropriate decision-maker, in advance of a meeting held pursuant to the dispute resolution process set forth in Section 166.046, from 48 hours to 7 days, and specifying certain information that must be included in the notice.
- Requiring an ethics or medical committee to consider the patient's well-being in conducting its review under Section 166.046 but prohibiting any judgment on the patient's quality of life, and enumerating specific considerations the committee must make related to the continuation of life-sustaining treatment – such as whether the treatment will prolong the natural process of dying or hasten the patient's death.
- Specifying and expanding the rights of persons participating in a committee meeting under Section 166.046, before, during and after the meeting.
- Barring certain people from participating in an executive session of a committee meeting.



- Clarifying language regarding patients with disabilities, as well as how such disabilities may affect the process and decisions made under the TADA. Specifically, during the review process under Section 166.046(b), an ethics or medical committee is prohibited from considering a patient’s disability that existed before the patient’s current admission unless the disability is relevant in determining whether the medical or surgical intervention is medically appropriate.
- Extending the statutory period from 10 days to 25 days for continued attempts to transfer a patient and the provision of care and interventions to a patient after the meeting held pursuant to the dispute resolution process set forth in Section 166.046 deems that ongoing care and interventions are medically inappropriate.
- Expanding and specifying new requirements related to attempts to transfer a patient.
- Clarifying that Section 166.046 applies only to care and treatment decisions for patients who are deemed incompetent or otherwise mentally or physically incapable of communication.
- Introducing a requirement for facilities to report certain data, within 180 days of initiating the dispute resolution process under Section 166.046 and requiring HHSC to publish aggregated data related to these reports.
- Adding language to statute concerning the transfer of patients and the potential for a patient to receive limited surgical interventions to help facilitate a transfer, when necessary.
- Amending language in Chapter 166, Subchapter E, Health and Safety Code (“In-Patient DNR Orders”), to clarify and correct issues of concern made apparent since implementation in 2017, including those related to potential liability protection.

Revisions to the Consent to Medical Treatment Act

HB 3162 also amends the Consent to Medical Treatment Act (Chapter 313, Health and Safety Code) to more closely align its decision-making hierarchy with the TADA (found at Section 166.039, Health and Safety Code). Chapter 313 governs treatment decisions made on behalf of an adult patient of a home and community support services agency or in a hospital or nursing home, or an adult inmate of a county or municipal jail who is comatose, incapacitated or otherwise mentally or physically incapable of communication. HB 3162 indicates that Chapter 313 only applies if the patient does not have a legal guardian or an agent under medical power of attorney who is reasonably available after a reasonably diligent inquiry.



It also removes from the surrogate decision-making hierarchy “the individual clearly identified to act for the patient by the patient before the patient became incapacitated, the patient’s nearest living relative, or a member of the clergy.” Finally, under a new subsection added to Section 313.004, if the patient does not have a legal guardian, an agent under a medical power of attorney or a person listed in the hierarchy listed in Subsection (a) (i.e., spouse, adult children, parents, who is reasonably available after a reasonably diligent inquiry), another physician who is not involved in the medical treatment of the patient “may concur” with the proposed treatment.

OPERATIONAL IMPACT

Hospitals should review and understand the entire scope of the changes to the TADA, as the legislation is very broad, comparatively lengthy and may result in significant impact to current hospital processes. Applicable policies and procedures will require updates to align with the changes made by legislation. THA has developed additional resources on this legislation and the extensive changes to the processes contained in the TADA. These resources and THA personnel are available to THA members for consultation required for a successful implementation of these changes.

Review, consultation, disagreement, conduct or other action affected by the changes in statute which occurs prior to Sept. 1, 2023 is governed by the statute existing prior to the effective date.

Any review, consultation, disagreement, conduct or other action affected by the changes in statute that occurs on or after Sept. 1, 2023 is governed by the statute as modified by HB 3162.

**HOUSE BILL 4**

Author:

Rep. Giovanni Capriglione

Effective Date: 1/1/24

Texas Data Privacy and Security Act**ANALYSIS**

HB 4 adds Subtitle C to Title 11 of the Business and Commerce Code, at Chapter 541, and regulates the collection, use, processing and treatment of consumers' personal data by certain businesses, including biometric data and health care records. Affected data may include demographic, genetic, geolocation or any other information that is linked or reasonably linkable to a person.

The Act applies to all Texas businesses, except for state agencies and political subdivisions, institutions of higher education, most nonprofit organizations or covered entities or businesses associates governed by the federal Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health Act. Additionally, certain information is excluded from the Act, including protected health information covered by HIPAA, health records, certain patient identifying information, information created and protected by the federal Patient Safety and Quality Improvement Act, data that is de-identified, converted to a limited data set, or collected and used for public health activities pursuant to HIPAA and certain information connected to human subjects and other research.

A consumer may contact a covered business, through the person responsible for the covered data for the business, and among other rights request:

- Confirmation of the business's possession and access to covered data.
- Correction of inaccuracies in the covered data.
- Deletion of covered data.
- A copy of the covered data.
- An opt out of the processing of covered data for advertising, sale, or other related purposes.

The covered business must deny or comply with a request without undue delay and within 45 days of receiving such request. One 45-day extension may be provided. If denying a request, justification for the denial and instructions on how to appeal must also be provided. Information requested must be provided free of charge at least twice per year, unless the business can demonstrate the request is manifestly unfounded, excessive or repetitive.



A business must establish two or more secure and reliable methods for consumers to submit requests and may require a customer to utilize an existing account. If the business maintains a website, a mechanism on such site must be provided.

Among other things, businesses must limit the collection of personal data to what is adequate, relevant, and reasonably necessary and must maintain reasonable administrative, technical and physical data security practices.

Consumers must be provided with a reasonably accessible and clear privacy notice, as required by HB 4. This notice may require statutory language if the business engages in the sale of personal sensitive data or of personal biometric data, in addition to any other requirements.

A business must undertake and document a data protection assessment to, among other things, identify and weigh the benefits and risks of collecting, processing or selling consumer information. De-identified data must remain confidential and unidentifiable.

The Texas Attorney General has exclusive authority to enforce these requirements and must post additional information on its website. Civil penalties may not exceed \$7,500 per violation, and penalties may include recovery of attorney's fees and other reasonable expenses. There is no private right of action.

OPERATIONAL IMPACT

Hospitals should review the entire text of HB 4, as there will likely be an operational impact on all Texas hospitals, despite exceptions in the statute. The changes in law are broad and will likely have disparate consequences and effects across the state. These new requirements are multi-faceted and the individual or department responsible for IT and/or data collection within each facility should be familiar with these changes in law.

**HOUSE BILL 49**

Author:

Rep. Stephanie Klick, et al.

Effective Date: 9/1/23

Public Access to Certain Hospital Investigation Information and Materials**ANALYSIS**

HB 49 affects the type of information that is publicly available related to hospital investigations and enforcement actions. It applies to hospitals licensed under Chapter 241, Health and Safety Code (general and special hospitals) and Chapter 577, Health and Safety Code (mental health facilities). It requires the Health and Human Services Commission (HHSC) to publicly post additional information resulting from hospital investigations on HHSC's website from what is currently required. This information will be posted for a minimum of two years and includes:

- The notice of the hospital's alleged violation, which must include the provisions of the law(s) the hospital allegedly violated and a general statement of the nature of the alleged violation.
- The name of the hospital.
- The geographic location of the hospital.
- The date HHSC issued the final decision, investigative report or order.
- The outcome of HHSC's investigation of the hospital, which may include:
 - Issuance of a reprimand.
 - Denial or revocation of a license.
 - Adoption of a corrective action plan.
 - Imposition of an administrative penalty and the penalty amount.

To the extent information is disclosed pursuant to the Texas Public Information Act (Chapter 552, Government Code), all personally identifiable information must be redacted. However, HB 49 permits the following pursuant to an open-records request:

- A notice of the hospital's alleged violations, including the provisions of law allegedly violated.
- Number of investigations HHSC has conducted of the hospital.
- Pleadings in any administrative proceeding to impose a penalty against the hospital for the alleged violation.
- Outcome of HHSC's investigation of the hospital, which may include:



- Issuance of a reprimand.
- Denial or revocation of a license.
- Adoption of a corrective action plan.
- Imposition of an administrative penalty and the penalty amount.
- A final decision, investigative report or order issued by HHSC to address the alleged violation.

HB 49 clarifies that a hospital may release medical records in the hospital's possession (1) on the request of the patient who is the subject of the records, or (2) to the patient, the parent or guardian or a minor or incapacitated patient, or the personal representative of a deceased patient.



HOUSE BILL 915

Author:
Rep. Tom Craddick

Effective Date: 9/1/23

Employer Requirement to Post Notice for Reporting Workplace Violence or Suspicious Activity

ANALYSIS

HB 915 creates Chapter 104A, Labor Code to require employers to post a notice to employees providing them with the contact information of the Texas Department of Public Safety, to whom they may report instances of workplace violence or suspicious activity.

Employers are required to post this notice:

- In a conspicuous place in the employer's place of business.
- In sufficient locations to be convenient for all employees.
- In English and Spanish, as appropriate.

The Texas Workforce Commission (TWC), in consultation with DPS, will prescribe the form and content of this notice in rule and the forthcoming rules must require the notice to:

- Contain the contact information for reporting workplace violence and suspicious activity to DPS.
- Inform employees of the right to make a report to DPS anonymously.

OPERATIONAL IMPACT

Subsequent to TWC rulemaking, hospitals and other employers will be required to post the notice in the manner required by statute and rule.



SENATE BILL 186

Author:

Sen. Borris Miles, et al.

Effective Date: 9/1/23

Prohibiting Discharges to Unlicensed or Unpermitted Group-Centered Homes

ANALYSIS

SB 186 prohibits hospitals or other health facilities from discharging or otherwise releasing patients to the care of an unlicensed or unpermitted group home, boarding home facility or similar group-centered facility.

SB 186 further specifies the following exceptions, under which a facility may discharge a patient to an unlicensed or unpermitted group, boarding or group-centered facility:

- If there are no licensed group-centered facilities in the county in which the patient is discharged.
- If the patient voluntarily elects to reside in the unlicensed or unpermitted group-centered facility.

The bill specifies that hospitals and other health facilities are not liable for damages to the patient resulting from the patient's discharge or release to a group, boarding or group-centered facility or home.

SB 186 also prohibits local health authorities from issuing orders related to discharge that conflict with this bill.

OPERATIONAL IMPACT

Hospitals will need to ensure discharge planning procedures align with the specifics of the bill and may not discharge a patient to an unlicensed group home unless one of the exceptions applies.

**SENATE BILL 240**

Author:
Sen. Donna Campbell

Effective Date: 9/1/23

**New Requirements Related to Workplace Violence Prevention
Committee, Plan, and Policy****ANALYSIS**

SB 240 enacts new requirements for hospitals, among others, to establish and implement a workplace violence prevention committee, plan, and policy by Sept. 1, 2024. SB 240 creates a new Chapter 331 in the Health and Safety Code and has four main requirements for facilities, including hospitals. SB 240 also applies to home health, nursing homes, ambulatory surgical centers and freestanding emergency centers. A facility's state licensing agency is allowed to enforce this law by undertaking any disciplinary action for violations against any person in the same manner as if that person had violated an applicable licensing law for the facility.

Committee Required

Facilities must establish a workplace violence prevention committee or task an existing facility committee to take on the new workplace violence prevention duties. The committee must include at least one RN who provides direct care to facility patients, one physician who provides direct care to facility patients unless the facility does not have at least one physician on staff, and one employee who provides security services to the facility, if any and if practicable.

A health care system that owns or operates more than one facility may establish a single committee for all of the system's facilities but only if the committee develops a workplace violence prevention plan that can be implemented at each facility (this may or may not require more than one plan depending on the types of facility under the system umbrella) and any data gathered and collected on violence prevention remains distinctly identifiable by facility in the system.

Policy Required

The facility's governing body must adopt a workplace violence prevention policy to protect health care providers and employees from violent behavior and threats of violence occurring at the facility. The policy must require that the facility give "significant consideration" to the plan developed by the workplace violence prevention committee and evaluate any existing plan(s). It must also encourage health care providers and employees to provide confidential information on workplace violence to the committee, include a process to protect providers and employees from retaliation and mandate facility compliance with any licensing agency rules that are established or in existence as related to workplace violence.

***Prevention Plan Required***

The established/designated workplace violence prevention committee must develop a workplace violence prevention plan that must, at a minimum:

- Be based on the practice setting.
- Adopt a definition of “workplace violence” that includes an act or threat of physical force against a health care provider or employee that results in, or is likely to result in, physical injury or psychological trauma; and an incident involving the use of a firearm or other dangerous weapon, regardless of whether a health care provider or employee is injured by the weapon.
- Require the facility to provide, at least annually, workplace violence prevention training or education that may be included in other required training or education provided to the facility’s health care providers and employees who provide direct patient care.
- Prescribe a system for responding to and investigating violent incidents or potentially violent incidents at the facility.
- Address physical security and safety.
- Require the facility to solicit information from health care providers and employees when developing and implementing a workplace violence prevention plan.
- Allow health care providers and employees to report incidents of workplace violence through the facility’s existing occurrence reporting systems.
- Require the facility to adjust patient care assignments, to the extent practicable, to prevent a health care provider or employee of the facility from treating or providing services to a patient who has intentionally physically abused or threatened the provider or employee.

The law does allow a facility’s plan to reference other internal facility policies or documents already in place that address these requirements. Once adopted, the committee must review and evaluate the plan each year and report those findings to the facility’s governing body.

Facilities must make the plan available (electronic or printed) if requested by a provider or employee, however the committee is allowed to redact information in the plan that if released, would pose a security threat to providers or employees.

***Workplace Violence Response***

SB 240 requires facilities to offer, at a minimum, immediate post-incident services including necessary acute medical treatment for each facility health care provider or employee directly involved in the incident. Additionally:

Facilities are prohibited by the law from discouraging providers and employees from reporting workplace violence incidents to law enforcement, including filing charges.

Facilities are also prohibited from engaging in any adverse employment actions (discipline, suspension, termination, discrimination or retaliation) against any employee who makes a good faith report of an incident or advises another employee or provider about their rights to report incidents.

OPERATIONAL IMPACT

- Hospitals should move quickly to develop or designate a current committee as their workplace violence prevention committee and should establish this committee by Sept. 1, 2023. Health systems that are intending to use a single committee for multiple facilities should make this determination in advance of Sept. 1, 2023.
- Hospitals should begin reviewing any internal policies and documents to determine whether any conforming changes need to be made and/or can be referenced in the workplace violence prevention plan.
- Hospitals need to implement their workplace violence prevention plan by Sept. 1, 2024 to ensure compliance. Hospitals should be conscious of the time needed to ensure effective implementation is occurring by this date.
- While the law does require at least one security personnel to be part of the committee, this is not a mandate of facilities to hire security personnel as full-time employees. This portion of the law only applies to facilities who employ a security officer and if having those employees on the committee is practicable. However, the law does not limit a hospital's ability to allow a contracted security officer or local law enforcement to be part of the committee. If hospitals go this route, hospitals should consider compliance with HIPAA and internal confidentiality procedures before inviting non-employed security individuals to join the committee.
- If a hospital governing body adopts a prevention plan that is different in any way from the plan recommended or developed by the committee, the



governing body should document in any meeting minutes or non-confidential internal memorandums the reasons for the deviations and how such deviations will not result in non-compliance and will still ensure safety and security.

Hospitals must adopt and implement the policy and plan no later than Sept. 1, 2024.

SENATE BILL 2406

Author:

Sen. Brandon Creighton

Effective Date: 9/1/23

Allowing Certain Hospitals to Drill Water Wells

ANALYSIS

SB 2406 allows a hospital located in a county that has a population of more than 250,000 and borders the Neches River to drill a water well on property owned by the hospital for the purpose of producing water to supplement the hospital's water supply if an emergency or natural disaster prevents the hospital from receiving water from the hospital's usual source.

A groundwater conservation district may continue to regulate groundwater production under Chapter 36, Water Code, or other law governing a groundwater conservation district.



SENATE BILL 760

Author:
Sen. Morgan LaMantia

Effective Date: 9/1/23

Authorizing the Taking of Blood Specimens from the Body of a Deceased Individual During an Inquest

ANALYSIS

SB 760 amends Article 49.10(j), Code of Criminal Procedure, to allow a justice of the peace to order a blood specimen from the body of a deceased person to aid in the confirmation or determination of the cause and manner of death while conducting an inquest.

OPERATIONAL IMPACT

Hospitals should update policies and procedures to account for additional requests for blood specimens, as ordered by a justice of the peace.

SENATE BILL 768

Author:
Sen. Tan Parker

Effective Date: 9/1/23

Changes to the Process for Notifying the Attorney General of a Breach of Security of Computerized Data

ANALYSIS

Pursuant to Chapter 521, Business and Commerce Code, SB 768 requires that when an entity is required to disclose or provide notice of a breach of system security, such notification must be made as soon as practicable and not later than the 30th day after which it is determined the breach occurred, if the breach involves at least 250 Texas residents.

This is a change from the prior requirement to provide notice no later than 60 days after the breach is determined.

The notification may be submitted electronically, through a form accessed on the Office of the Attorney General's (OAG's) website, which must be posted by the OAG.

OPERATIONAL IMPACT

Hospitals should update policies and procedures related to cybersecurity breaches and notification to account for this shortened reporting period.

**SENATE BILL 780**

Author:

Sen. Bryan Hughes

Effective Date: 9/1/23

Changes to Emergency Possession of Abandoned Children by Designated Providers**ANALYSIS**

SB 780 amends Chapter 262, Family Code, to include fire departments as designated emergency infant care providers, for purposes of taking possession of a child (who appears 60 days old, or younger) when voluntarily delivered to the provider.

A child is voluntarily delivered when left with an employee of the provider or placed in a newborn safety device located inside the provider's facilities.

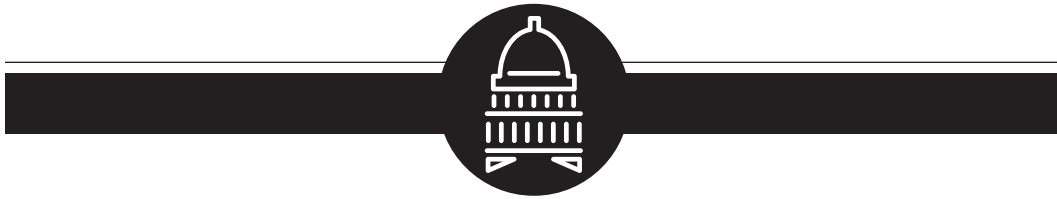
A provider may install a newborn safety device, and the device must:

- Be physically located:
 - Inside a facility that is staffed 24 hours a day by employees of the provider; and,
 - In an area conspicuous and visible to the employees of the provider; and
- Contain an alarm system connected to the device to audibly notify an employee of the provider that a child has been placed in the device.

A designated emergency infant care provider that places a newborn safety device in the provider's facilities must develop procedures to regularly verify that the device's alarm system is in working order.

OPERATIONAL IMPACT

Hospitals that wish to install a newborn safety device should review these requirements and ensure they are in compliance when installing and maintaining such devices.



LIABILITY

**HOUSE BILL 242**

Author:
Rep. Donna Howard, et al.

Effective Date: 9/1/23

Liability Related to the Donation or Distribution of Feminine Hygiene Products**ANALYSIS**

HB 242 provides a shield from liability related to the distribution of feminine hygiene products. Specifically:

- A person, manufacturer or distributor is not liable for the nature, age, packaging or condition of a feminine hygiene product donated in good faith to a nonprofit organization for the distribution to individuals in need of the products, if the donated product meets all quality and labeling standards imposed by law at the time of donation – even if the product is not readily marketable.
- A nonprofit organization is not liable for the nature, age, packaging or condition of a feminine hygiene product donated to the organization and that the organization distributes to individuals in need of the products, if the donated product meets all quality and labeling standards imposed by law at the time of donation – even if the product is not readily marketable.

This liability protection does not apply where an individual donates or an organization distributes a donated feminine hygiene product and, intentionally or with gross negligence, the product results in injury or death of an individual who uses or received the product.

“Feminine hygiene product” means a tampon, panty liner, menstrual cup, sanitary napkin or other similar item used in connection with the menstrual cycle.

“Nonprofit organization” means an organization exempt from federal income taxation under Section 501(a), Internal Revenue Code of 1986, as an organization described by Section 501(c)(3) of that code.

OPERATIONAL IMPACT

Hospitals that donate feminine hygiene products to nonprofit organizations covered under HB 242 should ensure policies and procedures require that donated products follow all quality and labeling standards imposed by law at the time of donation.

Hospitals that meet HB 242’s definition of “nonprofit organization,” and that distribute feminine hygiene products to individuals in need of the products should



ensure policies and procedures require that donated products all quality and labeling standards imposed by law at the time of donation.

Any applicable policies and procedures for donation or distribution of feminine hygiene products should indicate that individuals should undertake all good faith efforts to comply with applicable law and regulation and should avoid donating or distributing products that could cause harm to an individual receiving the products.

HOUSE BILL 609

Author:
Rep. Cody Vasut, et al.

Effective Date: 9/1/2023

Liability Protection Related to Required Vaccines Against Pandemic Diseases

ANALYSIS

HB 609 provides liability protections for businesses that do not require certain vaccines. Specifically, a business owner or operator that does not require employees or contractors to receive a vaccine against a pandemic disease is protected from liability related to injury or death caused by exposure of a person to the pandemic disease through the business's employee or contractor.

OPERATIONAL IMPACT

Hospitals should review this potential liability protection and determine whether current policies and procedures allow for potential liability protection. Of note, the legislation does not:

- Identify any specific pandemic disease, which implies the protection may be afforded for a broad range of pandemic diseases, as may be applicable.
- Create new liability.
- Supersede federal law and requirements, which may conflict with this state law and should be considered in determining appropriate policies and procedures.



SENATE BILL 2171

Author:

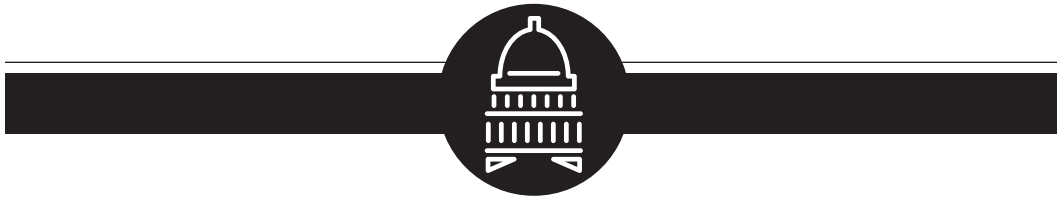
Sen. Carol Alvarado

Effective Date: 9/1/23

Qualifications of Experts in Certain Health Care Liability Claims

ANALYSIS

SB 2171 allows a chiropractor or physician who is otherwise qualified under the Texas Rules of Evidence, with respect to testimony about the causal relationship between the injury, harm or damages claimed and the alleged departure from the applicable standard of care for a chiropractor, to qualify as an expert in a suit involving a health care liability claim against a chiropractor.



LOCAL PROVIDER PARTICIPATION FUNDS



HOUSE BILL 3456

Author:
Rep. Trent Ashby

Effective Date: 6/13/23

HOUSE BILL 4700

Author:
Rep. Travis Clardy

Effective Date: 6/17/23

HOUSE BILL 4835

Author:
Rep. Will Metcalf

Effective Date: 9/1/23

Reauthorization of Local Provider Participation Funds

ANALYSIS

HB 3456 reauthorizes seven local provider participation funds (LPPFs) that were set to expire over the next biennium if not renewed.* Two other bills, HB 4700 (Nacogdoches County) and HB 4835 (Jeffersons County) reauthorized two LPPFs established under temporary authority and similarly set to expire. LPPFs operate in 29 cities and counties in Texas. LPPFs impose a mandatory assessment on all private hospitals in a local jurisdiction to generate the nonfederal share of certain Medicaid supplemental payments. These nine LPPFs will remain authorized to operate through the expiration dates indicated below:

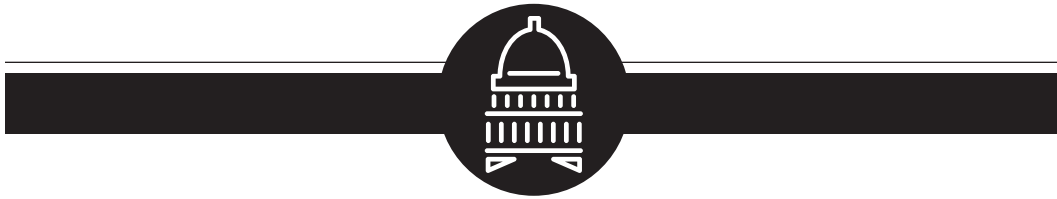
LPPF	New Expiration
Dallas County	Dec. 31, 2027
Tarrant County	Dec. 31, 2027
Wichita County	Dec. 31, 2027
Travis County	Dec. 31, 2027
El Paso County	Dec. 31, 2027
Travis County	Dec. 31, 2027
Harris County	Dec. 31, 2025
Nacogdoches County	Dec. 31, 2027
Jefferson County**	Dec. 31, 2027

**Replaces LPPF formerly operated by City of Beaumont

OPERATIONAL IMPACT

LPPFs will continue to collect mandatory assessments from all private hospitals in these jurisdictions for purposes of funding Medicaid supplemental payments.

*Editor’s note: Each of the seven LPPFs covered by HB 3456 also had stand-alone bills pass containing identical extensions to the extension contained in HB 3456. For reference, those bill numbers are: HB 1925, HB 3191, HB 4888, HB 4928, SB 699, SB 849 and SB 1155.



LONG-TERM CARE



HOUSE BILL 1290

Author:
Rep. Liz Campos

Effective Date: 9/1/23

Administrative Penalty for Confiscating or Misappropriating Federal Funds Distributed to Long-Term Care Residents

ANALYSIS

HB 1290 seeks to address complaints that long-term care facilities have confiscated the federal stimulus checks of their residents. HB 1290 prohibits long-term care facilities licensed under Chapter 242, Health and Safety Code, from confiscating or misappropriating federal payments made to Medicaid recipients without their effective consent or other legal authority. Facilities that violate the bill are subject to an administrative penalty of \$25,000 for each violation. Each day the facility fails to return confiscated or misappropriated money is considered a separate violation.

HOUSE BILL 1673

Author:
Rep. Giovanni Capriglione

Effective Date: 9/1/23

Training Requirement for Assisted Living Facilities on Alzheimer’s Disease and Related Conditions

ANALYSIS

HB 1673 requires assisted living facilities to provide training to their staff members on Alzheimer’s disease and related disorders and pass a competency-based evaluation by Dec. 31, 2024. HB 1673 only applies to assisted living facilities that provide personal care services to residents with Alzheimer’s disease or related disorders that do not hold a license under Section 247.029, Health & Safety Code, to provide those services. A direct service staff member may not provide any direct care to a resident with Alzheimer’s disease or related disorders until the staff member successfully completes four hours of initial training and passes the evaluation. The bill requires the Health and Human Services Commission to enact rules to implement the legislation.

OPERATIONAL IMPACT

An assisted living facility that cares for patients with Alzheimer’s disease or related disorders that is not licensed under Section 247.029, Health & Safety Code, must provide training to employees and implement a competency-based evaluation by Dec. 31, 2024. The topics of training and evaluation differ based on the type of employee.



An assisted living facility must require each direct service staff member to successfully complete four hours of initial training and pass a competency-based evaluation on:

- Alzheimer's disease and related disorders.
- The provision of person-centered care.
- Assessment and care planning.
- Daily life activities of residents with Alzheimer's disease or related disorders.
- Common behaviors and communications associated with residents with Alzheimer's disease and related disorders.

After the initial training, two hours of annual continuing education on best practices related to the treatment of and provision of care to residents with Alzheimer's disease or related disorders is required.

An assisted living facility must require senior personnel, including administrators and managers, to complete four hours of initial training and pass a competency-based evaluation on:

- The training provided to direct service staff.
- The administrative support services related to information for comorbidities management, care planning, and the provision of medically appropriate education and support services and resources in the community, including person-centered care, to residents with Alzheimer's disease or related disorders and their families.
- Staffing requirements to facilitate collaboration and cooperation among facility staff members.
- The establishment of a supportive and therapeutic environment for residents with Alzheimer's disease or related disorders to enhance the sense of community among residents.
- The transition of care and coordination of services for residents with Alzheimer's disease or related disorders.

After the initial training, two hours of annual continuing education on best practices related to the treatment of and provision of care to residents with Alzheimer's disease or related disorders is required.



Staff members who do not provide direct patient care or serve in leadership positions but come into incidental but recurring contact with residents, including housekeeping staff, front desk staff, maintenance staff, are required to receive training and pass a competency-based evaluation on:

- Alzheimer's disease and related disorders.
- The provision of person-centered care.
- Common behaviors and communications associated with residents with Alzheimer's disease and related disorders.

An assisted living facility must provide a certificate of completion and maintain records of each certificate in accordance with rules implemented by HHSC. Employees must also maintain records of training and certification. Employees who received initial training and passed a competency evaluation at another facility are not required to repeat training. However, an assisted living facility may require a staff member to complete the initial training and competency evaluation if they have a lapse in employment of two years or more.

**HOUSE BILL 54**

Author:
Rep. Senfronia Thompson,
et al.

Effective Date: 9/1/23

Raising the Personal Needs Allowance for Medicaid-Covered Residents of Long-Term Care Facilities**ANALYSIS**

HB 54 raises the personal needs allowance for a resident of a convalescent or nursing facility, or related institution licensed under Chapter 242, Health and Safety Code, assisted living facility, ICF-IID facility or other similar long-term care facility who receives medical assistance from not less than \$60 to not less than \$75 a month. The actual amount of the allowance is set by the executive commissioner of the Health and Human Services Commission.

[Additional background: Residents of long-term care facilities who receive Medicaid are allowed to keep a certain amount of their Social Security income for their own personal needs. This is known as a personal needs allowance. Prior to the passage of HB 54, the allowance amount for these residents had not been raised since 2005.]

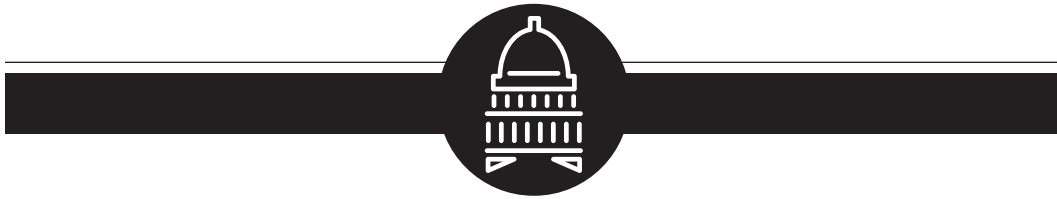
SENATE BILL 681

Author:
Sen. Nathan Johnson

Effective Date: 9/1/23

Consideration of Criminal Convictions for Certain Long-Term Care Workers**ANALYSIS**

SB 681 prohibits the Health and Human Services Commission (HHSC) from considering the criminal convictions in Chapter 53, Occupations Code when revoking, certifying or denying a license to certain long-term care workers. The bill applies to nursing facility administrators of licensed nursing facilities under Chapter 242, Health and Safety Code, certified nurse aides registered under Chapter 250, Health and Safety Code, and the permitting of medication aids through Chapter 242, Health and Safety Code. Under SB 681, HHSC is now limited to considering the enumerated convictions in Chapters 242 and 250, Health and Safety Code. SB 681 only applies to a license, permit, or certificate of registration issued or renewed on or after Sept. 1, 2023.



MANAGED CARE



HOUSE BILL 113

Author:
Rep. Evelina “Lina” Ortega,
et al.

Effective Date: 6/13/23

Allowing MCOs to Categorize Community Health Worker Services as Quality Improvement Costs

ANALYSIS

HB 113 allows Medicaid managed care organizations (MCOs) to categorize costs for services provided by community health workers under the STAR Medicaid program as quality improvement costs, rather than administrative expenses.

Currently, MCOs largely categorize the costs of employing community health workers as administrative expenses, which are capped, thereby disincentivizing the hiring of additional community health workers. The bill clarifies that MCOs are allowed to report the costs associated with community health workers as quality improvement costs, rather than administrative expenses.

OPERATIONAL IMPACT

This bill will impact hospitals who operate MCOs by allowing them to categorize expenses tied to the services of community health workers as quality improvement costs if they choose to do so. It may also change the way hospitals report services provided by community health workers to MCOs, if they work in the hospital setting.



HOUSE BILL 2802

Author:
Rep. Four Price, et al.

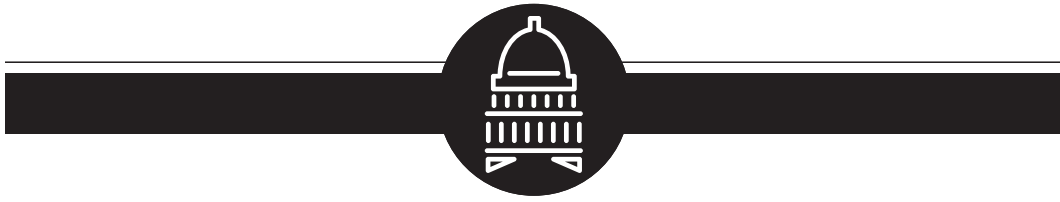
Effective Date: 9/1/23

Expanding the Permissible Modes of Communication Between a Medicaid Managed Care Organization and Its Enrollees

ANALYSIS

HB 2802 makes minor modifications to the provision related to communications between a Medicaid managed care organization and its enrollees. It adds “telephone” to the modes of communication that the Health and Human Services Commission (HHSC) must address in its communications guidelines. In adopting the guidelines for a recipient enrolled in a Medicaid managed care organization’s managed care plan who provides the recipient’s contact information to the organization through any method other than the recipient’s Medicaid application, HHSC must allow the organization to communicate with the recipient through any electronic means, including telephone, text message and email, regarding eligibility, enrollment and other health care matters. Further, HHSC may not require the organization to submit the recipient’s contact preference information to HHSC.

Additionally, HHSC must include in its Medicaid enrollment form a question regarding the applicant’s preferences for being contacted by a managed care organization or health plan provider by telephone, text message or email about eligibility, enrollment and other health care matters, and a notification that the applicant may opt out of being contacted by telephone, text message or email by notifying the applicant’s managed care organization or health plan provider.



MEDICAID

**HOUSE BILL 1009**

Author:
Rep. Chris Turner

Effective Date: 9/1/23

Criminal History Records for Residential Caregivers and Penalties for Medicaid Providers**ANALYSIS**

HB 1009 applies to Medicaid providers that provide community-based residential care services through a group home or other residential facility licensed by the Health and Human Services Commission (HHSC). The bill requires this specific type of Medicaid provider:

- Be entitled to obtain criminal history records from the Department of Public Safety for individuals already employed or contracted as residential caregivers and for applicants seeking employment or a contract as a residential caregiver.
- Review state and federal criminal history record information and obtain electronic updates from the Department of Public Safety of arrests and convictions for each employed or contracted residential caregiver.

A residential caregiver is defined as an individual who provides, through a group home or other residential facility licensed by HHSC, community-based residential care services:

- To not more than four individuals with an intellectual or development disability at any time, and
- At a residence other than the home of the individual providing the services.

Medicaid providers cannot employ or contract individuals that have been convicted of an offense listed in Section 250.006, Health and Safety Code, as residential caregivers or to provide direct care to Medicaid recipients with intellectual or developmental disabilities. A Medicaid provider must discharge any residential caregivers who are convicted of an offense in Section 250.006, Health and Safety Code. HHSC must take disciplinary action as it sees fit against a Medicaid provider that violates this requirement and in determining the appropriate disciplinary action, HHSC must consider:

- The nature and seriousness of the violation,
- The history of previous violations, and
- Any other matter justice may require.



If a residential caregiver receives a notice of a reportable conduct finding, the Medicaid provider employing or contracting them must immediately suspend the individual throughout any appeals processes and pending a final decision by an administrative law judge. A reportable conduct finding includes:

- Abuse or neglect that causes or may cause death or harm to an individual receiving services.
- Sexual abuse of an individual receiving services.
- Financial exploitation of an individual receiving services.
- Emotional, verbal or psychological abuse that causes harm to an individual receiving services.

HHSC must take disciplinary action as it sees fit against a Medicaid provider that violates this requirement and in determining the appropriate disciplinary action, HHSC shall consider:

- The nature and seriousness of the violation,
- The history of previous violations, and
- Any other matter justice may require.

Section 5 requires facilities to also suspend any employees who get notice of a reportable conduct finding throughout any appeals processes and a final decision by an administrative law judge.



HOUSE BILL 1283

Author:
Rep. Tom Oliverson, et al.

Effective Date: 9/1/23

Extending the Statewide Medicaid Drug Formulary until 2033

ANALYSIS

State law establishes content requirements for a managed care contract. Among these requirements are the requirements for managed care organizations operating in the state Medicaid program to adhere to the statewide drug formulary, applicable preferred drug list and prior authorization procedures. These particular requirements were set to lapse on Aug. 31, 2023. HB 1283 extends the requirements an additional 10 years, to Aug. 31, 2033.

HOUSE BILL 1357

Author:
Rep. Justin Holland

Effective Date: Immediately

Extending Medicaid Coverage for Medication-Assisted Treatment Indefinitely

ANALYSIS

The Medicaid program provides reimbursement for medication-assisted opioid or substance abuse treatment. These particular requirements were set to lapse on Aug. 31, 2023 under the statute's sunset provision. HB 1357 repeals that sunset provision, making the coverage requirement permanent.



HOUSE BILL 2727

Author:
Rep. Four Price, et al.

Effective Date: 6/13/23

Increasing Access to Home Telemonitoring Services Under Medicaid

ANALYSIS

HB 2727 expands Medicaid reimbursement for home telemonitoring services in several ways:

- It expands the types of providers that can provide reimbursable qualifying services to include federally qualified health centers and rural health clinics (currently only home health, hospice, personal assistance services and hospitals are eligible).
- It requires the Health and Human Services Commission (HHSC) to adopt rules for the provision and reimbursement of home telemonitoring services under Medicaid.
- It expands the conditions/diagnoses for which home telemonitoring services may be considered for eligibility to include end stage renal disease and any condition that requires renal dialysis treatment.
- It reduces the number of risk factors that must be documented from “two or more” to “at least one.”

HB 2727 also eliminates two risk factors from eligibility considerations: (1) limited or absent informal support systems; and (2) living alone or being home alone for extended periods of time.

The provider of these services must establish a plan of care that includes outcome measures for each recipient who receives home telemonitoring services and share the plan and outcome measures with the recipient’s physician.

Additionally, HHSC must determine whether high-risk pregnancy is a condition for which the provision of home telemonitoring services is cost-effective and clinically effective. If HHSC determines that it is, HHSC must, to the extent permitted by state and federal law, provide recipients experiencing a high-risk pregnancy with clinically appropriate home telemonitoring services equipment for temporary use in the recipient’s home. Additionally, HHSC must:

- Establish criteria to identify recipients experiencing a high-risk pregnancy who would benefit from access to home telemonitoring services equipment.



- Ensure that, if cost-effective, feasible and clinically appropriate, the home telemonitoring services equipment provided includes uterine remote monitoring services equipment and pregnancy-induced hypertension remote monitoring services equipment.
- Require that a provider obtain:
 - Prior authorization from HHSC before providing home telemonitoring services equipment to a recipient during the first month the equipment is provided to the recipient; and
 - An extension of the authorization from HHSC before providing the equipment in a subsequent month based on the ongoing medical need of the recipient.
- Prohibit payment or reimbursement for home telemonitoring services equipment during any period that the equipment was not in use because the recipient was hospitalized or away from the recipient's home, regardless of whether the equipment remained in the recipient's home while that person was hospitalized or away.

HHSC must require that that a request for prior authorization be based on an in-person assessment of the recipient, and documentation of the recipient's ongoing medical need for the equipment is provided before HHSC grants an extension as described above.

Finally, HHSC may discontinue reimbursement for a condition if the agency determines that home telemonitoring services are not cost effective or clinically effective for that condition.

OPERATIONAL IMPACT

Providers who bill the Medicaid program for home telemonitoring services should follow the rulemaking process closely and be prepared to comply with any changes imposed by HHSC for reimbursement for these services.

**HOUSE BILL 3286**

Author:
Rep. Stephanie Klick, et al.

Effective Date: 9/1/2023

Expansion of the Vendor Drug Program**ANALYSIS**

HB 3286 makes several changes to the Medicaid Vendor Drug Program:

- The bill requires the Health and Human Services Commission (HHSC) to ensure that the vendor drug program includes all drugs and national drug codes made available under the federal Medicaid Drug Rebate Program, provided that a form requesting the drug's inclusion in the program has been submitted to, and is approved by, HHSC.
- Further, if HHSC is reviewing the form but has determined that it is included in the federal Medicaid Drug Rebate program and is safe to dispense, HHSC must provisionally make the drug available under the program for no more than 90 days from either the date the form was submitted or the date HHSC has approved the drug.

Section 2 of the bill makes changes to the prescription drug list as follows:

- HHSC is required to adopt rules allowing exceptions to the preferred drug list under the following circumstances:
 - The drug is contraindicated;
 - Will likely cause an adverse reaction or cause physical or mental harm;
 - Is expected to be ineffective based on clinical characteristics of the recipient and the prescription drug regimen;
 - The recipient previously discontinued taking the drug due to ineffectiveness, diminished effect or adverse events;
 - The recipient was prescribed and is taking a nonpreferred drug in the antidepressant or antipsychotic drug class and was prescribed that drug before discharge from an inpatient facility, is stable and at risk of experiencing complications from switching from the nonpreferred drug to another drug; or
 - The preferred drug is not available for reasons outside of the Medicaid managed care organization's (MCO's) control because the drug is in short supply or back-ordered.



The bill also requires the preferred drug list to include all therapeutic equivalents for generic drugs on the list.

HHSC is further required to develop an expedited review process to consider requests from MCOs and providers to add drugs to the preferred drug list. HHSC must also grant temporary non-preferred status to new drugs that are available but have not yet been reviewed by the board.

HB 3286 also eliminates section 531.073(b)(1), Government Code, which under current law prohibits prior authorization requirements for drugs that have not been considered by the Drug Utilization Review Board.

Lastly, HB 3286 adds one more representative from a managed care organization to the board (previously two, now three) and makes them voting members. These members, however, will not be allowed to participate in meetings related to confidential drug pricing.

HOUSE BILL 4888

Author:
Rep. Cole Hefner

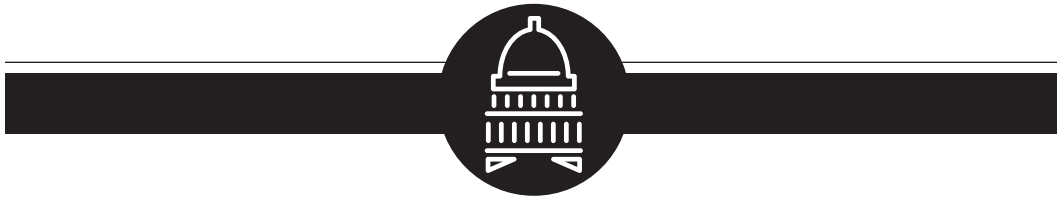
Effective Date: 9/1/23

Medicaid Reimbursement for Non-Opioid Treatments

ANALYSIS

HB 4888 ensures the state Medicaid program reimburses providers who supply non-opioid treatment to Medicaid enrollees, and directs the Health and Human Services Commission to ensure by rule that a hospital outpatient department providing non-opioid treatment is reimbursed separately for that treatment under Medicaid.

HB 4888 defines non-opioid treatment as a drug or biological product indicated to produce analgesia without acting on the body's opioid receptors.



OTHER/MISCELLANEOUS



HOUSE BILL 1957

Author:
Rep. Charlie Geren

Effective Date: 9/1/23

Inspection of Financial Information at Nonprofit Corporations

ANALYSIS

HB 1957 defines and limits the documents that a nonprofit 501(c)(3) corporation is required to make available for public inspection at its principal office. Prior to the legislation, nonprofit corporations were required to make available broadly defined records, books and annual financial reports. HB 1957 now limits the documents to only those required to be available for public inspection by Section 501(a), Internal Revenue Code of 1986.

OPERATIONAL IMPACT

Nonprofit 501(c)(3) hospitals should update their policies and procedures so that the only documents required to be available for public inspection are those required by Section 501(a) of the Internal Revenue Code. HB 1957 aligns Texas law with federal law and removes ambiguity about which records are publicly available for inspection and copying. Hospitals are still permitted to charge a reasonable fee for copying documents.

HOUSE BILL 2127

Author:
Rep. Dustin Burrows

Effective Date: 6/17/23

Providing for State Law Preemption of Certain Local Laws and Regulations

ANALYSIS

HB 2127 is titled the Texas Regulatory Consistency Act. In creating this new statute, the legislature finds that the state has historically been the exclusive regulator of many aspects of commerce and trade and in recent years, several local jurisdictions have sought to establish their own regulations for commerce that differ from state regulations. The statement of finding in HB 2127 indicates that local regulations have led to a patchwork of regulations that applies inconsistently across Texas. The stated purpose of the Act is “to provide statewide consistency by returning sovereign regulatory powers to the state where those powers belong in accordance with Section 5, Article XI, Texas Constitution.”

SECTIONS 5, 6, 8, 9, 10, 11, 13, 14 and 15 contain language indicating that unless expressly authorized by another statute, a municipality or county may not adopt, enforce or maintain an ordinance, order or rule regulating conduct in a field of regulation that is occupied by a provision of the Agricultural Code, Business and Commerce Code, Finance Code, Insurance Code, Labor Code, Local Government Code, Natural Resources Code, Occupations Code or Property Code. An ordinance, order or rule that violates these sections is void, unenforceable and inconsistent



with that particular code. There are narrow carve-outs of the Finance Code preemption section related to regulating any conduct under Finance Code, Chapter 393; to the Local Government Code preemption section, related to an ordinance, rule or police regulation that is for the good government, peace or order of the municipality, for the trade and commerce of the municipality and is necessary or proper for carrying out a power granted by law to the municipality or to one of its offices or departments; to the Occupation Code preemption section related to the regulation of massage establishments; and to the Property Code preemption section, related to evictions.

HB 2127 further provides that it may not be construed to:

- Prohibit a municipality or county from building or maintaining a road, imposing a tax, or carrying out any authority authorized by statute; or prohibit a home-rule municipality from providing the same services and imposing the same regulations that a general-law municipality is authorized to provide or impose.
- Except as expressly provided by the Act, affect the authority of a municipality to adopt, enforce or maintain an ordinance or rule that relates to the control, care, management, welfare or health and safety of animals.
- Affect the authority of a municipality or county to conduct a public awareness campaign.
- Prohibit the authority of a municipality or county to:
 - Enter into or negotiate terms of a collective bargaining agreement with its employees; or
 - Adopt a policy related to its employees.
- Affect the authority of a municipality or county to repeal or amend an existing ordinance, order or rule that violates the provisions of this Act for the limited purpose of bringing that ordinance, order or rule in compliance with this Act.

Additionally, a new chapter is added to the Civil Practice and Remedies Code that addresses municipal and county liability for certain regulations. It allows any person who has sustained an injury in fact, actual or threatened, from a municipal or county ordinance, order, or rule adopted or enforced by a municipality or county in violation of any of the provisions added by HB 2127, to bring an action against the municipality or county. The new chapter indicates that a trade association representing the person may bring an action against the municipality or county. A claimant is entitled to recover declaratory and injunctive relief and costs and reasonable attorney's fees. A municipality or county is entitled to recover costs and reasonable attorney's fees if the court finds the action to be frivolous. The chapter addresses procedural requirements of pre-notice and venue.



OPERATIONAL IMPACT

The operational impact to hospitals and health care systems will be determined by the particular municipal and county ordinances in place in any given area and will be most burdensome for hospitals and health care systems that operate in multiple areas of the state.

It is recommended that compliance officers work closely with their legal counsel office to establish a process for reviewing the relevant municipal and county regulations to determine the edits that must be made to current hospital policies and procedures. Hospital operations personnel are a likely key component of this review process.

HOUSE BILL 3462

Author:
Rep. Candy Noble

Effective Date: 9/1/23

Consolidating the Offices of Ombudsman Residing Under the Health and Human Services Commission

ANALYSIS

HB 3462 consolidates various ombudsman programs that exist under the Health and Human Services Commission (HHSC) under a single statutory subchapter. It is not intended to change the way the various programs operate. The various ombudsman offices were functionally consolidated in the 84th (2015) Texas Legislature following the Sunset Advisory Commission's review and recommendation. However, while the offices were consolidated, the various statutes that governed these offices remained unconsolidated, resulting in conflicting statutory authority and procedures for the ombudsman programs administered by HHSC and leading to confusion among clients needing the assistance of an ombudsman, as well as among ombudsman staff and HHSC program staff. HB 3462 also formally abolishes the ombudsman for the Department of Family and Protective Services, although those functions remain under the consolidated program.

Under HB 3462, the following offices and functions are reenacted and consolidated under Subchapter Y, Chapter 531, Government Code (sections 531.991-531.998):

- The office of the ombudsman for health and human services in accordance with Section 531.9915.
- The ombudsman for children and youth in foster care in accordance with Section 531.9931.
- The ombudsman for managed care assistance in accordance with Section 531.9932.



- The ombudsman for behavioral health access to care in accordance with Section 531.9933.
- The ombudsman for individuals with an intellectual or developmental disability in accordance with Section 531.9934.

The HHSC executive commissioner has the authority to appoint the ombudsman for each program.

HOUSE BILL 3466

Author:

Rep. Liz Campos, et al.

Effective Date: 9/1/2023

DSHS Community Collaboratives Grant Program Expanded and Revised

ANALYSIS

The Department of State Health Services (DSHS) operates a Community Collaborative Grant Program for local governments, nonprofit organizations and faith-based organizations to establish or expand community collaboratives that bring the public and private sectors together to provide services to people experiencing homelessness, substance abuse issues or mental illness.

HB 3466 adds a new criterion for consideration in awarding the grants, to include entities that are providing services to an average of at least 50% of people experiencing homelessness in a geographic area serviced by a Continuum of Care Program funded by the federal Department of Housing and Urban Development. Additionally, the grant parameters will now require any entity awarded a grant to also have a policy to divert people from mental health facilities.

Finally, HB 3466 requires DSHS to prepare a biennial report on the grant program that details the methods of awarding grants, amount of grants, number of people serviced by each community collaborative receiving a grant and the results of the annual review of outcome measures. The report must be submitted by September 1 of each odd-numbered year to the legislative leadership and the Legislative Budget Board.

OPERATIONAL IMPACT

Any entity receiving a grant from the DSHS Grants for the Establishment and Expansion of Community Collaboratives should be aware that a new award requirement was added. Additionally, the grant program added new considering criterion so that specific entities focused on addressing homelessness may now be eligible.

**HOUSE BILL 55**

Author: Rep. Julie Johnson,
et al.

Effective Date: 9/1/23

Indecent Assault Committed by a Health Care or Mental Health Services Provider Now a Felony**ANALYSIS**

HB 55 amends Section 22.012(b) of the Penal Code, Indecent Assault, to add that if the indecent assault offense is committed by a health care or mental health services provider, the punishment is a state jail felony, rather than a Class A misdemeanor. In order to charge the provider with a state jail felony, the act must have been committed during the course of providing the health care or mental health treatment or service and must be beyond the scope of generally accepted practices for the treatment or service.

Under new subsection (d), if a health care services or mental health care services provider has been previously convicted for the offense as described above, the punishment for any future acts is a third-degree felony.

“Health care services provider” has the same meaning as defined in Penal Code Section 22.011(c)(3), which is limited to the following licensed individuals:

- Physician.
- Chiropractor.
- Physical therapist.
- Physician assistant.
- Registered nurse, vocational nurse or advanced practice nurse.

“Mental health services provider” is defined in Penal Code Section 22.011(c)(4) and is limited to the following licensed or unlicensed individuals who perform mental health services:

- Licensed social worker.
- Chemical dependency counselor.
- Licensed professional counselor.
- Licensed marriage and family therapist.
- Clergy.
- Psychologist offering psychological services.
- Certified special officers for mental health assignments.

The new punishments apply to offenses committed on or after Sept. 1, 2023.



HOUSE BILL 9

Author:
Rep. Trent Ashby

Effective Date: 1/1/24
(pending voter approval)

Funding and Development of Broadband and Telecommunication Services

ANALYSIS

Editor’s Note: These provisions only take effect if HJR 125 is approved by Texas voters in November 2023.

HB 9 creates the broadband infrastructure fund for the purposes of, among other things, outreach regarding expansion, adoption, affordability and use of broadband services, funding for 911 and next-generation 911 services, supporting the deployment of next-generation 911 services and expanding access to broadband services in economically distressed areas.

The fund exists to, in part, provide matching funds for federal dollars provided to meet its mission of expanding and ensuring access to reliable, high-speed broadband and telecommunications connectivity.

The comptroller must develop rules to effect these changes and must create an annual report on the status of the fund.

OPERATIONAL IMPACT

Hospitals should be aware of HB 9 if they are located in an area designated as an underserved broadband access area, and how this fund might provide resources to improve such access to broadband infrastructure.



**HOUSE JOINT
RESOLUTION 125**

Author:
Rep. Trent Ashby

Effective Date: 5/30/23

**Proposed Constitutional Amendment to Expand High-Speed Broadband
Access**

ANALYSIS

In November 2023, voters will decide whether to adopt a constitutional amendment that creates a broadband infrastructure fund. This fund would exist only to expand access to and adoption of broadband and telecommunications services, including:

- The development, construction, reconstruction and expansion of broadband and telecommunications infrastructure or services;
- The operation of broadband and telecommunications infrastructure;
- The provision of broadband and telecommunications services; and
- The reasonable expenses of administering and managing the investments of the fund.

Other available funds, such as federal funding, may be used in conjunction with this fund. If approved by voters, the fund may be formed on Jan. 1, 2024.

**SENATE BILL 2040**

Author:
Sen. Drew Springer, et al.

Effective Date: 9/1/23

Regulation of Willed Body Programs, Non-Transplant Anatomical Donation Organizations, Anatomical Facilities, and the Creation of the State Anatomical Advisory Committee**ANALYSIS**

SB 2040 makes a number of changes related to anatomical donations.

The Anatomical Board of the State of Texas is abolished but continues in existence until Sept. 1, 2024, for the sole purpose of transferring obligations, property, rights, powers and duties to the Texas Funeral Service Commission.

The State Anatomical Advisory Committee is created to advise and provide expertise to the commission on the regulation and operation of willed body programs, non-transplant anatomical donation organizations, and anatomical facilities. The commission may set and collect fees to receive and distribute bodies and anatomical specimens; conduct inspection and verification activities; and register willed body programs and non-transplant anatomical donation organizations.

The commission must adopt rules, establish procedures and prescribe forms, including rules establishing registration and inspection requirements and procedures. The commission may issue a reprimand, assess an administrative penalty, impose other penalties or revoke, suspend or probate a registration or other authorization for violations of statute or a commission rule, including a violation related to an inspection conducted under Section 691.034, in the manner provided by Chapter 651, Occupations Code.

Additional requirements are added to the donation process, including:

- The donor's acknowledgment that the donor was informed about:
 - The consequences of the donation before providing consent;
 - The use the donee plans for the donated body parts; and,
 - If applicable, any body part and the condition in which the body part will be returned to the person designated by the donor.
- The donor must be informed in writing about the information described in a clear manner on a single piece of paper that is 8.5-by-11 inches with 14-point type. By rule, the commission must design and adopt a form that complies with this requirement, which willed body programs and non-transplant anatomical donation organizations must use.



A willed body program or non-transplant anatomical donation organization may not operate in this state unless the program or organization registers with the commission in the form and manner prescribed by the commission. To be eligible for registration under this section, a non-transplant anatomical donation organization must be accredited by the American Association of Tissue Banks under the association's Standards for Non-Transplant Anatomical Donation. The commission may issue conditional registration to a non-transplant anatomical donation organization that is not yet accredited. The commission must establish a process to periodically verify a non-transplant anatomical donation organization's compliance with the Standards for Non-Transplant Anatomical Donation.

"Anatomical Facility" means a Texas facility inspected and approved by the commission that does not operate as a willed body program or a non-transplant anatomical donation organization.

"Non-Transplant Anatomical Donation Organization" means a person accredited to engage in the recovery, receipt, screening, testing, processing, storage or distribution of tissue or human remains for any purpose other than transplantation into a living person in Texas.

"Willed Body Program" means a program operated at a Texas institution of higher education that allows a living person to donate the person's body or anatomical specimen for educational or research purposes.

OPERATIONAL IMPACT

Hospitals with operations meeting the definition of "Anatomical Facility," "Non-Transplant Anatomical Donation Organization," or "Willed Body Program" should understand the broad changes made through this legislation, including all new requirements and commission rights, powers and responsibilities. Any facility wishing to serve on the Advisory Committee should contact the commission for additional information.

Applicable policies and procedures should be reviewed to ensure compliance with these changes.



SENATE BILL 2123

Author:
Sen. Bryan Hughes

Effective Date: 9/1/23

Adding the University of Texas Health Sciences Center at Tyler as a Participating Medical School in the Joint Admission Medical Program

ANALYSIS

SB 2123 adds the medical school at The University of Texas Health Sciences Center at Tyler as a participating medical school in the Joint Admission Medical Program. The program is established under Section 51.822, Education Code, as a program administered by the Joint Admission Medical Program Council to:

- Provide services to support and encourage highly qualified, economically disadvantaged students pursuing a medical education;
- Award undergraduate and graduate scholarships and summer stipends to those students; and
- Guarantee the admission of those students to at least one participating medical school, subject to certain conditions set forth in the subchapter.

SB 2123 further directs the medical school at The University of Texas Health Science Center at Tyler, as soon as practicable after the effective date, to:

- Enter into the agreement with the Joint Admission Medical Program Council required by Section 51.829, Education Code; and
- Select an appropriate faculty member to represent the medical school on the council.

Finally, the medical school must provide internships and mentoring under the Joint Admission Medical Program as appropriate beginning not later than the 2025-2026 academic year, but is not required before the 2026-2027 academic year to admit participating students to the school under the program.



SENATE BILL 2186

Author:

Sen. Judith Zaffarini

Effective Date: 9/1/23

Adding an Online Registry for Execution of Documents Related to Anatomical Gifts

ANALYSIS

SB 2186 allows a donor or other person authorized to make an anatomical gift under Section 692A.004, Health and Safety Code, to make a gift through an online registry. The online registration:

- Does not require the consent of another person or require a witness to sign at the donor's request or a notary public to acknowledge the gift.
- Constitutes a legal document that remains binding after the donor's death.

In addition, the process for executing a donor card may now include the acknowledgment by a notary public or two witnesses.



SENATE BILL 739

Author:

Sen. Nathan Johnson

Effective Date: 9/1/23

Designating October 10 as Supportive Palliative Care Awareness Day

ANALYSIS

Supportive palliative care is defined by the Department of State Health Services as patient and family-centered health care that optimizes quality of life for seriously ill patients (high risk of mortality or life-limiting illness) and their families by:

- Anticipating, preventing and treating a patient’s “total pain” or total suffering.
- Addressing the physical, intellectual, emotional, cultural, social and spiritual needs of the patients.
- Facilitating patient autonomy.
- Ensuring the patient receives relevant information to support the informed consent decision-making process.

Supportive palliative care is provided without regard to patient age or terminal prognosis and does not require the patient to decline attempts at cure or other disease-modifying therapy.

SB 739 designates October 10 as Supportive Palliative Care Awareness Day to raise awareness about supportive palliative care optimizing the quality of life for seriously ill patients and their families.

Supportive Palliative Care Awareness Day may be regularly observed by appropriate ceremonies and activities.

OPERATIONAL IMPACT

Hospitals or health systems with robust supportive palliative care programs might consider collaborating with partners in their immediate community and in their service area to promote supportive palliative care through education and resources.



SENATE BILL 745

Author:

Sen. Lois Kolkhorst, et al.

Effective Date: 9/1/23

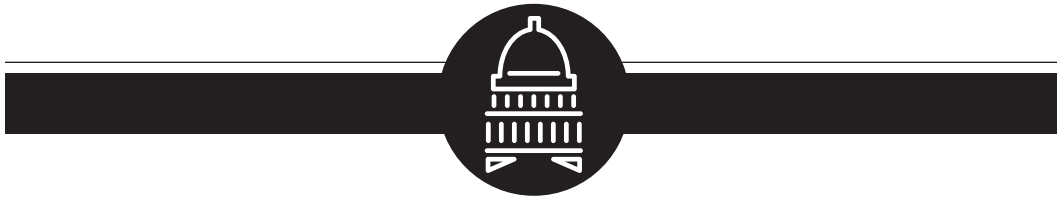
Expanding the State’s Medicaid Fraud Prevention Program to Include the Child Health Plan and Healthy Texas Women Programs

ANALYSIS

SB 745 amends Chapter 36 of the Human Resources Code, covering Medicaid fraud prevention, to expand it to cover fraud prevention in the child health plan and the Healthy Texas Women programs. Currently Chapter 36 specifies various acts that constitute fraud within the Medicaid program and the remedies available against people who commit Medicaid fraud, including civil monetary penalties, injunctive relief, and exclusion from the program. SB 745 revises the chapter to cover “health care program” fraud prevention.

“Health care program” is defined as the Medicaid program, the child health plan program and the Healthy Texas Women program.

Thus, Chapter 36 now contains the authority to pursue the specified remedies contained therein against people who commit fraudulent acts in the child health plan program and the Healthy Texas Women program.



PHARMACY LICENSURE AND PRACTICE

**HOUSE BILL 25**

Author:
Rep. James Talarico, et al.

Effective Date: 9/1/23

**Creating the Wholesale Prescription Drug Importation Program
Allowing Importation of Drugs from Canada****ANALYSIS**

HB 25 requires the Health and Human Services Commission (HHSC) to establish the wholesale prescription drug importation program to provide lower-cost prescription drugs available outside the United States to consumers in the state at the lower cost. It requires HHSC to implement the program by:

- Contracting with one or more prescription drug wholesalers and Canadian suppliers to import prescription drugs and provide prescription drug cost savings to consumers in Texas.
- Developing a registration process for health benefit plan issuers, health care providers and pharmacies to obtain and dispense prescription drugs imported under the program.
- Developing a list of prescription drugs, including the prices of those drugs, that meet the requirements for eligible drugs (set forth below) and publishing the list on HHSC's website.
- Establishing an outreach and marketing plan to generate program awareness.
- Establishing and administering a telephone call center or electronic portal to provide information about the program.
- Ensuring the program and the prescription drug wholesalers that contract with this state comply with the tracking, tracing, verification and identification requirements of 21 U.S.C. Section 360eee-1.
- Prohibiting the distribution, dispensing or sale of prescription drugs imported under the program outside Texas.
- Performing any other duties HHSC determines necessary to implement the program.

HHSC must ensure that the program meets the requirements of 21 U.S.C. Section 384 (the federal law related to importation of drugs). In developing the program, HHSC must consult with interested parties.

Under the program, a prescription drug may be imported into the state only if the drug meets the U.S. Food and Drug Administration's standards related to prescription drug safety, effectiveness, misbranding and adulteration; does not violate any federal patent laws through its importation; is expected to generate cost



savings for consumers; and is not listed as a controlled substance under state or federal law, a biological product, an infused drug, an intravenously injected drug, a drug that is inhaled during surgery or a parenteral drug.

In operating the program, HHSC, in consultation with the attorney general, must identify and monitor any potential anticompetitive activities in industries affected by the program. HHSC may impose a fee on each prescription drug sold under the program or establish another funding method to administer the program.

HHSC by rule must develop procedures to effectively audit a prescription drug wholesaler participating in the program.

Finally, not later than December 1 of each year, HHSC must submit a report to the governor and the legislature regarding the operation of the program during the preceding state fiscal year, including:

- Which prescription drugs and Canadian suppliers are included in the program.
- The number of health benefit plan issuers, health care providers and pharmacies participating in the program.
- The number of prescriptions dispensed through the program.
- The estimated cost savings to consumers, health plans, employers and this state since the establishment of the program and during the preceding state fiscal year.
- Information regarding the implementation of the audit procedures described above.
- Any other information the governor or the legislature requests, or that HHSC considers necessary.



HOUSE BILL 4166

Author:
Rep. Stephanie Klick

Effective Date: 9/1/23

Allowing Donated Prescription Drugs to Be in Original Bottle or Container

ANALYSIS

HB 4166 amends Chapter 442, Health and Safety Code, to allow donated drugs to be in their original, opened, sealed and tamper-evident bottle, container or unit-dose packaging. Prior to this change, donated drugs could only be accepted or dispensed if they were in unit-dose packaging.

OPERATIONAL IMPACT

Chapter 442, Health and Safety code allows hospitals and pharmacies to accept and dispense certain donated drugs, provided the drugs meet certain safety requirements and standards. With HB 4166, facilities are now able to accept and dispense drugs that are in their original, opened, sealed and tamper-evident bottles or containers, not just unit-dose packaging.

HOUSE BILL 4332

Author:
Rep. Stephanie Klick

Effective Date: 9/1/23

Allowing Donated Prescription Drugs to Be Repackaged

ANALYSIS

HB 4332 amends Chapter 442, Health and Safety Code, to allow donated drugs to be repackaged and relabeled from a commercial container to one intended for dispensing to a consumer. Specifically, the bill provides the criteria under which donated prescription drugs can be repackaged and relabeled. It allows hospitals and pharmacies to dispense prescription drugs that have been repackaged and relabeled, in accordance with statute and Board of Pharmacy rules. The repackaged drug must be labeled with the following:

- The drug's brand or, for generics, the drug's generic name and the manufacturer or distributor of the drug.
- The amount of drug in a dose.
- The drug's lot number.
- The earliest expiration date for that drug lot number.
- The quantity of drug the provider dispenses in more than one dose.



Hospitals and pharmacies must also maintain the following information in their records:

- The drug's name, the amount of drug in a dose, and the dosage size or frequency.
- The provider's lot number for that drug.
- The drug's manufacturer or distributor.
- The expiration dates of the drug from that drug's lot number.
- The quantity of the drug in each repackaged unit.
- The number of repackaged units that include the drug.
- The date the drug was repackaged.
- The name, initials, or written or electronic signature of the individual who repackaged the drug.
- The written or electronic signature of the pharmacist responsible for the drug's repackaging.

OPERATIONAL IMPACT

A hospital that intends to repackage and relabel prescription medications should follow the rulemaking process and be prepared to comply with the applicable requirements of HB 4332.



SENATE BILL 241

Author:
Sen. Charles Perry

Effective Date: 9/1/24

New Written Verification Required From Manufacturers of Brand Name Insulin Drugs Included in the Medicaid Drug Formulary

ANALYSIS

SB 241 requires manufacturers of brand name insulin drugs included in the Medicaid vendor drug program formulary, for which a generic or biosimilar drug is not available, to submit a new written verification to the Health and Human Services Commission (HHSC). The manufacturers must verify to HHSC whether or not the unavailability of a generic or biosimilar drug is a result wholly or partly of:

- A scheme by the manufacturer to pay a generic or biosimilar prescription drug manufacturer to delay manufacturing or marketing the generic or biosimilar drug;
- A legal or business strategy to extend the life of a patent on the brand name prescription drug;
- The manufacturer directly manipulating a patent on the brand name prescription drug; or
- The manufacturer facilitating an action described above on behalf of another entity.

HHSC is required to adopt rules that will create a form written verification document.

**SENATE BILL 2173**

Author:

Sen. Carol Alvarado

Effective Date: 9/1/23

Development and Implementation of a Prescription Drug Safe Disposal Pilot Program**ANALYSIS**

SB 2173 requires the Texas State Board of Pharmacy (TSBP) to develop and implement a prescription drug safe disposal pilot program. The purpose of this program is to increase the number of locations in the state where unused, unwanted or expired prescription drugs can be collected from the public for subsequent safe disposal. To be eligible for the program, pharmacies must be registered as an authorized drug collection agent by the U.S. Drug Enforcement Administration, not the subject of state or federal opioid litigation and meet the eligibility requirements established under 21 C.F.R. Section 1437.40.

TSBP must adopt rules covering the application process and evaluation of applications, and preference will be given to pharmacy applicants not collecting unused ultimate user prescription drugs under 21 C.F.R. Part 1317 and pharmacies located in areas designated by TSBP as underserved or rural.

Pharmacies participating in the program must provide a collection receptacle that:

- Meets the requirements of 21 C.F.R. Section 1317.75;
- Is accessible during the pharmacy's regular hours of operation;
- Allows the anonymous deposit of unused controlled substance prescription drugs listed in Schedules II-V; and
- Provides disposal of unused drugs at no cost to the user.

Participating pharmacies with collection receptacles may also, as determined necessary by the pharmacy, provide ultimate users a vendor mail-back envelope. This envelope must come at no cost to the user, be pre-addressed and postage paid, and meet the requirements of 21 C.F.R. Section 1317.70. Pharmacies may not provide more than 250 mail-back envelopes during the pilot program.

TSBP will designate participating pharmacies as Texas premier pharmacy providers, and pharmacies may use this designation in their marketing materials.

TSBP will reimburse participating pharmacies for costs incurred in maintaining one collection receptacle and the incineration of drugs and inner liner thereof, ordering and distributing vendor mail-back envelopes, and other operational needs the board determines appropriate.



TSBP must also:

- Develop and distribute materials to the public about the safe prescription drug disposal in the state; and
- Report results of the program to the governor and Legislature, including recommending the program’s continuation or discontinuation.

OPERATIONAL IMPACT

The Legislature did not appropriate funds to this program for the 2024-2025 state biennium, resulting in potential delay in implementation by TSBP.

Once the program is implemented, pharmacies choosing to participate must meet the program’s statutory and administrative requirements, the latter to be memorialized in future rulemaking.

SENATE BILL 773

Author:

Sen. Tan Parker

Effective Date: 6/18/23

Access to Life-Altering Investigational Drugs, Biological Products and Devices for Certain Conditions

ANALYSIS

SB 773 adds Chapter 490, Health and Safety Code, to allow patients with severe chronic disease to use potentially life-altering investigational drugs, biological products and devices, not including low-THC cannabis or products containing marijuana. Such drugs, products and devices must have successfully completed Phase One of a clinical trial but not have received U.S. Food and Drug Administration approval for general use.

The bill requires the executive commissioner of the Health and Human Services Commission to designate medical conditions considered to be severe chronic diseases, and defines these diseases as a condition, injury or illness that:

- May be treated;
- May not be cured or eliminated; and
- Entails significant functional impairment of pain.



A patient with a severe chronic disease, as confirmed in writing by the patient's physician, is eligible to access and use a drug, product or device if the patient's physician:

- In consultation with the patient, considers all currently approved treatment options unavailable or unlikely to provide relief from impairment or pain associated with the patient's severe chronic disease; and
- Recommends or prescribes in writing the patient's use of a specific class of investigational drug, biological product or device.

If the patient provides the manufacturer the informed consent required by this chapter, the manufacturer may, but is not required to, make available the investigational drug, biological product or device. The drug, product or device must be provided without the manufacturer receiving compensation.

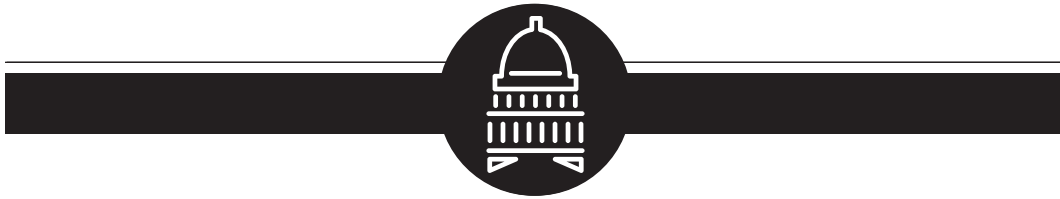
SB 773 does not create a private or state cause of action against a manufacturer or any other person or entity involved in the care of an eligible patient using a drug, product or device under this chapter for any harm caused by such use.

SB 773 does not affect the coverage of enrollees in clinical trials under Chapter 1370, Insurance Code.

The Texas Medical Board may not take any action against a physician's license based solely on the physician's recommendations to an eligible patient regarding access to drugs, products or devices under this chapter, provided the recommendations meet statutory and administrative requirements.

OPERATIONAL IMPACT

Hospitals should consider reviewing policies and procedures in anticipation of a request by a patient to receive a drug, product or device under the new chapter 490, as well as implications for continuity of care if a patient is admitted to the hospital while being treated with a covered product, drug or device.



PHYSICIAN LICENSURE AND PRACTICE



SENATE BILL 415

Author:
Sen. Angela Paxton

Effective Date: 9/1/23

Amended Continuing Medical Education Requirements on Trafficked Persons

ANALYSIS

SB 415 amends Section 156.060, Occupations Code, which mandates continuing medical education for physicians on the identification and assistance of trafficked persons.

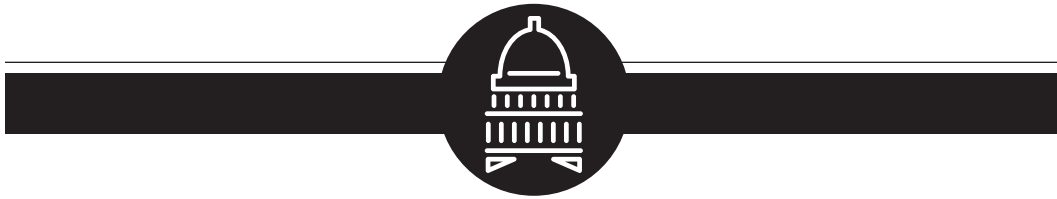
The amended mandate specifically applies to physicians who designate a direct patient care practice on an application for renewal of a registration permit.

Before applying for their first renewal of this permit, these physicians must complete one hour of CME that provides education on identifying and assisting trafficked persons. Following this first renewal, these physicians must complete this CME every third renewal period, but only if the Texas Medical Board (TMB) approves more than one CME course.

The law mandates that the CME hours earned count towards medical ethics and professional responsibility requirements and be TMB-approved. SB 415 mandates the TMB adopt rules to establish the content of and approval requirements for this specific CME course(s).

Until Jan. 1, 2025, physicians subject to this law can comply with this first renewal period CME requirement by completing the one-hour training course approved by the Health and Human Services Commission.

Finally, between Sept. 1, 2023 and Jan. 1, 2024, all physicians who hold a license to practice medicine must complete at least one hour of CME on identifying and assisting trafficked persons. This requirement expires on Jan. 1, 2024.



PUBLIC HEALTH

**HOUSE BILL 1488**

Author:

Rep. Toni Rose

Effective Date: 9/1/23

Expansion of Sickle Cell Disease Awareness and Efforts to Improve the Health Care Delivered to Texans with Sickle Cell Disease; Changes to the Sickle Cell Disease Task Force**ANALYSIS**

HB 1488 charges the Health and Human Services Commission (HHSC), in collaboration with the state's Sickle Cell Task Force, to:

- Support initiatives to assist managed care plans in promoting timely, evidence-informed health care services to enrollees diagnosed with sickle cell disease to ensure the services reflect national clinical practice guidelines and protocols for sickle cell disease treatment and meet medical necessity criteria.
- Address sickle cell disease education for Medicaid providers, including emergency department providers, by collaborating with medical specialty organizations in Texas, state agencies and health-related institutions to promote existing or new continuing education courses or facilitate the development of new courses necessary to improve the diagnosis, treatment and management of sickle cell disease and the personal treatment of patients with sickle cell disease.
- Use existing HHSC data to identify opportunities for improving health outcomes of recipients diagnosed with sickle cell disease by reducing hospital admissions and readmissions and connecting those recipients to a sickle cell disease health home or sickle cell disease expert.

Additionally, the task force is expanded to include:

- One representative of the Texas Education Agency.
- One representative of HHSC.
- One physician with experience addressing the needs of people with sickle cell disease or sickle cell trait.
- One researcher from a public health-related or academic institution with experience addressing sickle cell disease and sickle cell trait.
- One health care professional with experience addressing the needs of people with sickle cell disease or sickle cell trait.



The task force is also expanded to have three, rather than two, members of the public. One member of the public must have sickle cell disease or sickle cell trait and two members of the public must either have sickle cell disease or be a parent of a person with sickle cell disease or sickle cell trait.

HB 1488 directs the task force, in collaboration with HHSC, to include in their annual written report recommendations for improving sickle cell disease education for health care providers.

An expiration date for the task force is set as Aug. 31, 2035.

New education requirements target medical schools or graduate medical education programs in Texas that offer emergency medicine, family medicine, internal medicine, obstetrics or a pediatrics residency program. This statute requires these programs to examine and, to the extent possible, incorporate into their curriculum education focused on sickle cell disease and sickle cell trait. This new requirement applies to people entering their residency in Texas on or after Jan. 1, 2024. Medical schools or graduate medical education programs are allowed to enter into agreements as necessary to fulfill this education requirement.

Additionally, the Texas Education Agency, in collaboration with sickle cell disease community-based organizations, is required to provide information on sickle cell disease and sickle cell trait to public school districts and district staff, including school nurses, teachers and coaches. HHSC, in collaboration with the task force, must explore methods for improving sickle cell disease education and awareness within the public school system and provide recommendations to the TEA on the improvement methods.

OPERATIONAL IMPACT

Hospitals affiliated with, or who own and operate managed care plans, should make note that HHSC, in collaboration with the task force, is now required to support initiatives to assist managed care plans in promoting timely, evidence-informed health care services to enrollees diagnosed with sickle cell disease. Hospitals with such an affiliation or ownership should take this opportunity to ensure the services provided to enrollees with sickle cell disease reflect clinical practice guidelines and protocols for sickle cell disease treatment and meet medical necessity criteria.

Hospitals affiliated with a health-related institution should note that HHSC and the task force must collaborate with health-related institutions to promote existing or new continuing education courses or facilitate the development of new courses



necessary to improve the diagnosis, treatment and management of sickle cell disease and the personal sickle cell disease. Any interest in collaboration should be made clear to HHSC and the task force. This training is specific to sickle cell disease education for Medicaid providers, including emergency department providers.

For hospitals serving Medicaid recipients, chief medical officers, chief nursing officers and people charged with quality improvement should be made aware that HHSC, in collaboration with the task force, will be identifying opportunities to improve health outcomes of Medicaid recipients diagnosed with sickle cell disease by keying in on efforts to reduce hospital admissions and readmissions, as well as connecting Medicaid recipients to sickle cell disease health homes or disease experts. Any effort already being made in this space may be of interest to HHSC and the task force. Likewise, those involved in programs that are being built should be aware of this changing landscape.

Hospitals or health systems affiliated with medical schools or graduate medical education programs should be aware that their residency program curriculum must, by Jan. 1, 2024, include education on sickle cell disease and sickle cell trait.

HOUSE BILL 2166

Author:
Rep. Bobby Guerra

Effective Date: 9/1/23

Designating March 4 as COVID-19 Heroes and Memorial Day

ANALYSIS

Designates March 4 as COVID-19 Heroes and Memorial Day to honor those who lost their lives to COVID-19 and to honor health care workers, first responders and other essential workers who continued to work during the COVID-19 pandemic.

HB 2166 stipulates that this day of remembrance shall be observed by appropriate ceremonies and activities.

OPERATIONAL IMPACT

Hospitals and hospital systems should mark their calendars for March 4 and consider developing activities and/or ceremonies honoring those that worked tirelessly through the pandemic to ensure the state's public health was protected to the highest degree possible. Hospital leadership should be encouraged to participate in, if not lead, these activities.

**HOUSE BILL 44**

Author:
Rep. Valoree Swanson

Effective Date: 9/1/23

Prohibition on Provider Discrimination of a Medicaid or CHIP Recipient Based on the Enrollee's Vaccination Status**ANALYSIS**

HB 44 stipulates that a Medicaid or CHIP provider may not refuse to provide health care services to a Medicaid recipient or CHIP enrollee based solely on the individual's refusal to obtain a vaccine or immunization for a particular infectious or communicable disease.

This prohibition extends to a provider participating in the provider network of a managed care organization that contracts with the Health and Human Services Commission to provide services under Medicaid or CHIP.

Providers are not in violation if they:

- Adopt a policy requiring some, or all, of their patients, including Medicaid recipients or CHIP enrollees, to be vaccinated or immunized against a particular infection or communicable disease to receive health care services; and
- Provide an exemption to that policy based on a reason of conscience, including a sincerely held religious belief, observance or practice, that is incompatible with the administration of the vaccine or immunization; or a recognized medical condition for which the vaccination or immunization is contraindicated.

The Health and Human Services Commission (HHSC) is restricted from providing Medicaid or CHIP reimbursement to a provider that violates this prohibition unless HHSC finds that the provider is in compliance. This restriction only applies to an individual physician. HHSC may not refuse to provide reimbursement to a provider based on their membership in a provider group or medical organization with another individual physician who is in violation.

HB 44 does not apply to a provider who is a specialist in oncology or organ transplant services.

HHSC must adopt rules establishing the right of a provider who is alleged to have violated this new section of law to seek administrative and judicial review.



OPERATIONAL IMPACT

HB 44 states that health care services may not be refused “solely” related to a patient’s vaccine or immunization status, which preserves the ability for hospitals to operationalize policies and procedures that protect immunocompromised patients.

Further, a specific exemption is allowed for oncology and organ transplant services within a hospital. These patients are likely to be the most vulnerable to exposure to a communicable or infectious disease. Additionally, oncology and organ transplant medical care must be in compliance with federal rules, regulations and well-established best practices that may stipulate patients must have received certain vaccines or immunizations to be viable candidates for treatment.

Individual or group physician practices will need to carefully review and/or draft office policies and procedures to make sure such discrimination does not occur.

There are no details as to how HHSC should determine whether a provider is in compliance. Clarity will likely come via the rulemaking process.

**SENATE BILL 1249**

Author:

Sen. Kelly Hancock

Effective Date: 9/1/23

Living Organ Donor Education Program and Promotion**ANALYSIS**

Under SB 1249, the Department of State Health Services (DSHS) is required to establish a living organ donor education program to educate Texas residents about:

- The need for living organ donors, including the particular need for donors from minority populations.
- The partnership between the Glenda Dawson Donate Life Texas Registry for deceased organ donation, maintained by Donate Life Texas, and other organ donor registries for living organ donation.
- The requirements for registering as a potential living organ donor.
- The medical screening and procedures necessary for an individual to be a living organ donor.
- The availability of information about living organ donation in health care facilities, transplant centers, organ procurement organizations, tissue banks, eye banks and driver's license offices.

DSHS in coordination with the Department of Public Safety (DPS) must develop written and electronic informational materials, including links to the websites and machine-readable codes regarding living organ donations and the process of registering with a living donor registry.

Donate Life Texas has the option to develop and provide the informational materials to DSHS. DSHS and DPS are required to post the information on each of the agency's websites. Appropriate health care facilities, transplant centers, organ procurement organizations, tissue banks, eye banks and driver's license offices may access the informational materials on the DSHS and DPS websites and print those materials to place in their facilities or offices to provide to residents of Texas.

OPERATIONAL IMPACT

All hospitals or health systems should be made aware of this education program and be prepared to promote the information materials, when available, throughout their campuses and within any affiliated medical buildings but particularly those hospitals and health systems with responsibility over organ procurement, donation and transplant. This education role is optional, but to the degree the materials are found to be useful, promotion to patients and community members could serve to grow future living organ donations and perhaps stave off any future legislative efforts to require education.



SENATE BILL 1319

Author:
Sen. César Blanco

Effective Date: 9/1/23

Reporting of Overdose Information by Emergency Medical Service Providers for the Purpose of Overdose Mapping

ANALYSIS

SB 1319 requires EMS personnel who respond to an overdose incident to report information about the incident as soon as possible to the local health authority or law enforcement agency, as applicable, that has entered into a participation agreement under Section 370.007, Local Government Code (described below). A person satisfies the reporting requirements by reporting information to either the appropriate local health authority or law enforcement agency.

The requirement to report applies only to emergency medical services personnel operating within the geographical jurisdiction of a local health authority or law enforcement agency, as applicable, that has entered into a participation agreement for overdose mapping under Section 370.007, Local Government Code.

The report described above must include, if possible:

- The date and time of the overdose incident.
- The approximate location of the overdose incident, using an address, the latitude and longitude of the location, or the location data from a cellular device.
- Whether an opioid antagonist was administered, and if so, the number of doses and the type of delivery.
- Whether the overdose was fatal or nonfatal.

A person who reports information about an overdose incident in good faith is not subject to civil or criminal liability for making the report. A law enforcement agency may use information received from a report under this section only for mapping overdose locations for public safety purposes. Information in such a report is confidential and not subject to disclosure under the Texas Public Information Act.

Section 370.007, Local Government Code (referenced above), indicates that a local health authority or law enforcement agency must enter into a participation agreement with an entity that maintains a computerized system for mapping overdoses of one or more controlled substances for public safety purposes. The local health authority or law enforcement agency must provide information received from EMS personnel to the entity with which the authority or agency



has a participation agreement for purposes of entering the information into the computerized system. The local health authority or law enforcement agency is not required to provide information regarding a controlled substance if the entity with which the authority or agency has a participation agreement does not maintain an overdose map that includes the controlled substance.

A local health authority or law enforcement agency, or its employees, are not subject to civil or criminal liability for providing the required information. Information provided to an entity is confidential and not subject to disclosure under the Texas Public Information Act.

SENATE BILL 2193

Author:
Sen. Morgan LaMantia

Effective Date: 5/19/23

Establishing Programs Operated by Federally Qualified Health Centers to Provide Primary Care Access to Certain Employees

ANALYSIS

SB 2193 establishes a Federally Qualified Health Center (FQHC) Primary Care Access Program (PCAP) to:

- Increase access to primary care services at federally qualified health centers for low-income or at-risk people.
- Improve the health of the employees of participating employers and their families by improving access to health care.
- Contribute to economic development by assisting small businesses in remaining competitive through employment of a health workforce and provision of health care benefits that attract employees.
- Encourage innovative solutions for providing and funding health care services and benefits for participating employees.

An FQHC may establish and operate a PCAP for the provision of primary care services and benefits directly to employees of participating employers and their dependents within the service area of the FQHC. An employee is defined as a person who is employed by an employer for compensation. The term includes a partner of a partnership and a proprietor of a sole proprietorship.



A PCAP within the service area of a FQHC, to the extent practicable, must:

- Reduce the number of individuals who lack access to primary care services.
- Reduce the cost of primary care services for small business employers and their employees.
- Promote preventive care and reduce the incidence of preventable health conditions, such as heart disease, cancer, diabetes and low birth weight in infants.
- Promote efficient and collaborative delivery of primary care services.
- Serve as a model for the innovative use of health information technology.
- Provide fair payment rates for participating health care providers.

An FQHC may require participating employees and dependents to obtain primary health care services under a program only from health care providers at the FQHC.

An FQHC that operates a program is not subject to regulation by the Texas Department of Insurance (TDI) as an insurer or health maintenance organization.

SB 2193 allows an FQHC to establish program participation criteria for employers, employees of the employer and the employees' dependents. In doing so they may:

- Require participating employers and their employees to pay a share of the premium or other cost of the primary care services.
- Contract with a health foundation or other nonprofit organization to support payment of the employer's or employee's share of the premium or other costs.
- Screen employees and their dependents for eligibility to enroll in other state programs and for federal subsidies in the health insurance marketplace.

FQHCs may accept gifts, grants or donations from any source to administer and finance the program. An FQHC shall actively solicit gifts, grants and donations to:

- Fund primary care services and benefits provided under the program.
- Reduce the cost of participation in the program for employers and their employees.



TDI, in collaboration with the Health and Human Services Commission (HHSC), is charged with establishing and administering a grant program to award grants to FQHCs operating a PCAP.

In awarding a grant, TDI must consider whether a PCAP will accomplish the purposes and meet the objectives outlined in SB 2193 as practicable.

TDI is charged with establishing performance objectives for a grant recipient and monitoring whether the recipient meets those objectives.

In addition to money appropriated by the legislature, TDI may accept gifts, grants or donations from any source to administer and finance the grant program.

No later than December 1 of each even-numbered year, TDI and HHSC must jointly submit to the governor, lieutenant governor and the speaker of the House of Representatives a report evaluating the success of the program in accomplishing the purposes of the chapter, and recommending any legislative or other action necessary to facilitate or improve the program.



SENATE BILL 29

Author:
Sen. Brian Birdwell

Effective Date: 9/1/23

Prohibiting Certain Government Actions to Prevent the Spread of COVID-19

ANALYSIS

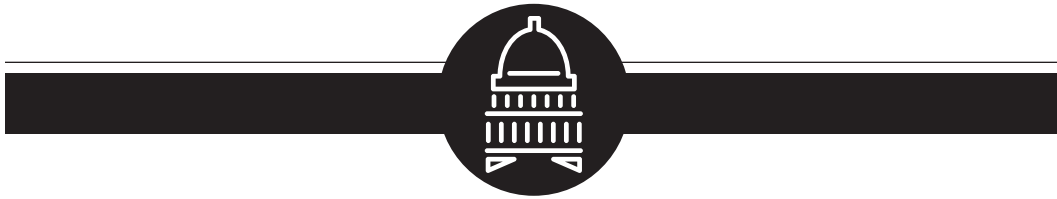
SB 29 prohibits governmental entities, as defined in Section 418.004, Government Code, including an open-enrollment charter school, or Texas agency or local government agency, from ordering or otherwise implementing a mandate to require:

- The wearing of a face mask or other face covering to prevent the spread of COVID-19.
- Vaccination against COVID-19.
- The closure of a private business, public school, open-enrollment charter school or private school to prevent the spread of COVID-19.

A hospital or other health care facility owned by a governmental entity, including a hospital or other health care clinic operated by or associated with an institution of higher education, as defined by Section 61.003, Education Code, is not subject to the prohibition against masking requirements – subject to any other conflicting order, ordinance or guidance issued by a governmental entity.

OPERATIONAL IMPACT

Hospitals operating as governmental entities should understand these limitations and exceptions with regard to COVID-19 mitigation protocols. Policies and procedures should be updated accordingly, to ensure compliance.



**PUBLIC HEALTH EMERGENCIES
AND DISASTERS**

HOUSE BILL 3223

Author:
Rep. Ryan Guillen

Effective Date: 9/1/23

Management of a Declared State of Disaster

ANALYSIS

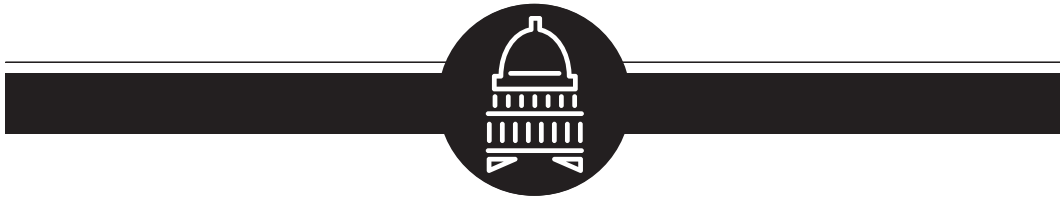
Texas is divided into disaster districts to engage in Homeland Security preparedness and response activities. The boundaries of these districts coincide with the geographic boundaries of the state planning regions established by the governor in the Local Government Code.

HB 3223 makes changes to the management of disaster districts. The chair of the state’s emergency management council must now appoint a chair of each disaster district committee based on the declared disaster and phase of disaster response in accordance with the National Incident Management System guidelines. Previously that duty fell to the public safety director of the Texas Department of Public Safety (DPS). The DPS public safety director was required to appoint a commanding officer from the Texas Highway Patrol to serve as chair of each disaster district committee.

The role of each disaster district committee is to inform the chair of the emergency management council on all matters relating to disasters and emergencies as requested. This updates Section 418.113(d) of the Government Code to correspond with the language outlined in HB 3223. Previously, the chair was charged with informing the state director of Homeland Security on all such matters as requested by the director.

OPERATIONAL IMPACT

The impact on hospitals and health systems will depend on their level of involvement in disaster districts. Any key hospital staff that interacts with disaster district committees should be informed of these changes, so the change in hierarchy is an understood component of any work they conduct on behalf of the hospital or health system.



PUBLIC HOSPITALS



HOUSE BILL 1911

Author:
Rep. Dustin Burrows

Effective Date: 6/9/23

TDCJ and TJJD Correctional Health Care Worker Home Address Confidentiality

ANALYSIS

State law provides confidentiality protection of home address information in property tax appraisal records for a specified list of individuals. Employees of the Texas Department of Criminal Justice (TDCJ) or the Texas Juvenile Justice Department (TJJD) are among those currently covered by these confidentiality protections. However, contract employees providing health care services at corrections facilities are not covered because they are not employees of TDCJ or TJJD.

HB 1911 extends home address confidentiality protections to a current or former employee or contract staff member of a university health care provider at a corrections facility operated by TDCJ or TJJD, as well as to a current or former attorney for the Department of Family and Protective Services.

The person must choose to restrict public access to their home address information on the form prescribed for that purpose by the comptroller. Under existing law, the choice to be confidential remains until rescinded in writing by the individual.

OPERATIONAL IMPACT

A university health care provider that maintains employees or contract staff at a TDCJ or TJJD corrections facility should alert those employees and staff that their home address information may be confidential if requested, and that a comptroller form submission is necessary to trigger this new protection.

**HOUSE BILL 3033**

Author:
Sen. Angela Paxton

Effective Date: 9/1/23

Modifications to the Texas Public Information Act Related to Administrative Matters, Certain Exceptions; Establishing a Searchable Database**ANALYSIS**

HB 3033 is significant legislation that makes many important and notable changes to the Texas Public Information Act, or PIA(Chapter 552, Government Code). HB 3033 makes the following administrative changes:

- Establishes a definition of “business day” that includes weekends, national holidays and state holidays identified in statute, optional holidays observed by a governmental body’s public information officer, public institutions of higher education holidays, Fridays or Mondays before or after a weekend holiday, and days designated by governmental entities for minimum staffing or closure of administrative offices (subject to certain requirements). The law clearly states that employees working from an alternative work site does not affect whether a day is a business day under the PIA. In other words, working from an alternative work site will not allow a governmental body to skip that day in their business-day calculation.
- Allows the attorney general’s (AG’s) office to require training of public officials it determines have failed to comply with the PIA.
- Amends Sections 552.271 and 551.272, related to the right of requestors to inspect a paper or electronic record, by: (a) limiting the right of a requestor who has exceeded any pre-established monthly or yearly limits of the governmental entity to inspect on behalf of another requestor, unless they have paid the statement issued by the governmental entity, and (b) allowing a governmental entity to include the time spent preparing a written statement for open records requests that require large amounts of employee or personnel time, if the requestor has exceeded any pre-established limits.
- Allows governmental entities to request photo identification of requestors, but only for the sole purpose of tracking whether a requestor has exceeded any pre-established limits and to confirm the requestor has not concealed their identity. A requestor is allowed to decline providing a photo ID and can still obtain the information if they pay the statement issued by the governmental body.
- Allows governmental bodies to withhold producing public information for inspection or duplication for requestors who have exceeded pre-established



limits, unless the requestor has paid the statement issued to them by the governmental body, or produces a photo ID or pays the statement in lieu of providing one.

- Establishes a process that requires most governmental bodies to submit a request for an attorney general decision on an open records request through the AG's designated electronic filing system. Governmental bodies that have fewer than 16 full-time employees or are located in a county with a population of less than 150,000 are not required to submit electronic requests. Additionally, if use of the electronic system would be impractical, impossible or is hand-delivered, then governmental bodies are not required to submit electronic requests.

HB 3033 also amends certain exceptions to disclosure and creates a new exception to disclosure under the PIA, as follows:

- Amends the litigation exception to disclosure found in Section 552.103 to not apply to information related to general, primary or special elections, and to information in the possession of election administrators of certain governmental bodies: a board, commission, department, committee, institution, agency, or office within or created by the executive or legislative branch and directed by one or more elected officials.
- Amends the law enforcement exception to disclosure found in Section 551.108 by requiring prompt release of basic information about an arrested person, arrest or crime unless the governmental body is seeking to withhold that information under another exception set forth in the PIA. This requirement applies regardless of the governmental body requesting to withhold other information that is related to the basic information.
- Creates a new exception for Attorney General Settlement Negotiations related to investigations or litigation conducted under the Texas Deceptive Trade Practices Act (Subchapter E, Chapter 17, Business & Commerce Code).

HB 3033 also amends Section 552.306 on rendition/issuance of an AG's opinion by adding new requirements that governmental bodies must follow after the opinion has been issued, specifically by requiring certain notices be provided to the requestor, the AG or both when the governmental body is going to take certain actions.



Finally, HB 3033 requires the AG’s office to create a searchable electronic database accessible through the AG’s website that will allow the public to search for requests for attorney general decisions and the corresponding AG opinions. It must provide the current status of a request and an estimated timeline on the review of a request. This database must be in place and accessible no later than Jan. 1, 2024.

OPERATIONAL IMPACT

Hospital districts and other applicable governmental entities should familiarize themselves with this legislation and conduct a review of their open records and public information policies and procedures to update and reflect these new requirements.

HOUSE BILL 3191

Author:
Rep. David Spiller, et al.

Effective Date: 9/1/23

Permitting Changes to Election Cycles, and Making Other Changes Related to Hospital District Election, Governance and Operational Processes

ANALYSIS

HB 3191 makes several notable changes to the governance and operating procedures of certain hospital districts.

Section 1 allows the governing board of a hospital district created under general or special law to, on its own motion, order that the members of the governing board are to be elected to serve staggered three-year terms. The new provision applies if the members of the governing board serve staggered four-year terms on the date the governing board enters the order and subsection (b), (c), or (d) (described immediately below) applies to the governing board.

- Subsection (b) describes a governing board of a hospital district with five members. The election of board members in the even-numbered year following the date an order is entered as described above in which three board members are to be elected must be held as previously scheduled. Two of the members elected at that time serve three-year terms, and one of the members elected serves a four-year term, to be determined by random draw. Board members elected in subsequent elections serve three-year terms.



- Subsection (c) describes a governing board of a hospital district with seven members. The election of board members in the even-numbered year following the date an order is entered as described above in which four members are to be elected must be held as previously scheduled. Two of the elected members will serve three-year terms and two will serve four-year terms, to be determined by random draw. Board members elected in subsequent elections serve three-year terms.
- Subsection (d) describes a governing board of a hospital district with nine members. The election of board members in the even-numbered year following the date an order is entered as described above in which five members are to be elected must be held as previously scheduled. Two of the members elected at that election serve three-year terms and three of the members serve four-year terms, to be determined by random draw. The election of board members in the next even-numbered year following the date an order is entered as described above in which four members are to be elected must be held as previously scheduled. Three of the elected members will serve three-year terms and one of the members will serve a four-year term, to be determined by random draw. Board members elected in subsequent elections serve three-year terms.

HB 3191 also adds a new section 285.083, Health and Safety Code, that specifies that a member of the governing board of a hospital district is considered to have resigned from the board if the member is absent from five or more regularly scheduled board meetings that the member is eligible to attend in any 12-month period without an excuse approved by a majority vote of the board. Such a resignation is effective on the date of the fifth regularly scheduled board meeting at which the member is absent without a board-approved excuse. The validity of an action of the board is not affected by the fact that the action is taken during a period in which a board member is considered to have resigned. Note that this provision does not apply to a hospital district created under Chapter 281, Health and Safety Code.

SECTION 3 of HB 3191 amends Section 286.022(c), Health and Safety Code, to specify that a petition calling for an election for the creation of a hospital district may specify that directors are to be elected by a combination of at large and by place, and must specify whether directors will be elected to serve two-year or four-year terms.

HB 3191 also aligns the election publication requirements for a creation election with the procedures in the Election Code, and clarifies the terms of initial



directors depending on whether directors serve two- or four-year terms, as well as subsequent election dates, publication requirements and ballot application procedures.

Section 10 of HB 3191 updates language related to the appointment to the staff of “health care practitioners” (replacing “doctors”) as well as language related to clinical privileges.

Section 11 allows a hospital district to enter into “a public work contract as authorized under Chapter 2269, Government Code,” striking “construction contracts that involve spending more than \$10,000 only after competitive bidding as provided by Subchapter B, Chapter 271, Local Government Code.”

Section 14 updates language in Section 286.129, Health and Safety Code, removing language related to authorized investments and instead allowing investments authorized under Chapter 2256, Government Code.

Section 15 amends Section 1023.054(a), Special District Local Laws Code (governing the Eastland Memorial Hospital District), to clarify that if a vacancy occurs in the office of director, the remaining directors shall appoint a director for the unexpired term.

Section 16 repeals certain provisions superseded by the changes in HB 3191.

OPERATIONAL IMPACT

Hospital districts, particularly those with elected directors, should review HB 3191 and determine what changes to procedures and processes will be required. Additionally, the optional processes related to director elections may provide needed flexibility.

**HOUSE BILL 4082**

Author:
Rep. Craig Goldman, et al.

Effective Date: 9/1/23

Defining “Public Works” that Can be Funded by Anticipation Notes or Certificates of Obligations Issued by Cities or Counties**ANALYSIS**

HB 4082 defines “public works” in Chapter 271, Local Government Code, applicable to the permitted purposes for which a municipality or county may issue anticipation notes or certificates of obligations. The new definition of public works does not apply to hospital district issuers. Under the definition, a public work is defined as:

- A street, road, highway, bridge, sidewalk or parking structure.
- A landfill.
- An airport.
- A utility system, water supply project, water treatment plant, wastewater treatment plant, or water or wastewater conveyance facility.
- A wharf or dock.
- A flood control and drainage project.
- A public safety facility, including a police station, fire station, emergency shelter, jail or juvenile detention facility.
- A judicial facility.
- An administrative office building housing the governmental functions of the municipality or county.
- An animal shelter.
- A library.
- A park or recreation facility that is generally accessible to the public and is part of the municipal or county park system.
- The rehabilitation, expansion, reconstruction or maintenance of an existing stadium, arena, civic center, convention center, or coliseum that is owned and operated by the municipality or county or by an entity created to act on behalf of the municipality or county.

It does not include:

- A facility for which more than 50% of the average annual usage is or is intended to be for professional or semi-professional sports.
- A new stadium, arena, civic center, convention center or coliseum that is or is intended to be leased by a single for-profit tenant for more than 180 days in a single calendar year.
- A hotel.



HOUSE BILL 471

Author:
Rep. Jared Patterson, et al.

Effective Date: 6/12/23

Imposing a Requirement to Grant Leave Due to Injury or Illness to Certain Employees of Political Subdivisions

ANALYSIS

Under HB 471, a political subdivision must provide a leave of absence for illness or injury related to the line of duty for a firefighter, police officer or emergency medical services personnel. This leave is with full pay for a period commensurate with the nature of the illness or injury.

If necessary, the leave must continue for at least one year and the political subdivision may extend the leave at full or reduced pay.

If the firefighter, police officer or emergency medical services personnel is temporarily disabled by a line-of-duty injury or illness and the leave of absence and any extension have expired, the worker may use accumulated sick leave, vacation time and other benefits accrued before the person is placed on temporary leave. A person who requires additional leave after the expiration of the leave of absence and any extension must be placed on temporary leave.

If able, the employee may return to light duty while recovering from a temporary disability. If medically necessary, a light duty assignment may continue for at least one year. Upon recovery from a temporary disability, the worker must be reinstated with the same rank and seniority held before taking temporary leave. Another firefighter, police officer or emergency medical services personnel may voluntarily undertake the work of the injured person until a return to duty.

“Firefighter” is a firefighter who is a permanent, paid employee of the fire department of a political subdivision, and includes the chief of the department but not a volunteer firefighter.

“Police officer” is a paid, full-time, employee who regularly serves in a professional law enforcement capacity for the police department of a political subdivision, including the chief of the department, and who holds an officer license under Chapter 1701, Occupations Code.

“Emergency medical services personnel” is a person as defined in Section 773.003, Health and Safety Code, and a paid employee of a political subdivision.

OPERATIONAL IMPACT

Hospitals operating as political subdivisions and who operate EMS or employ police officers should review these requirements and update policies related to affected individuals accordingly. Policies concerning leave and workplace injuries for EMS, firefighters and police officers should, at a minimum, meet these new requirements.



SENATE BILL 1097

Author:

Sen. Tan Parker

Effective Date: 5/23/23

Liability Clarification for Certain Municipal Hospital Authority

ANALYSIS

Current law is unclear on whether a municipal hospital authority can indemnify the purchaser of the authority's assets for liabilities that predate the sale and whether a sovereign immunity would block any claim by a purchaser to recover liabilities from the municipal hospital authority that predate the sale.

SB 1097 says that if this municipal hospital authority enters into a contract to sell a hospital owned by the authority, it waives governmental immunity to suit for the purpose of adjudicating a claim for breach of contract. In a breach of contract claim in this instance, a claimant may not be awarded a total amount that exceeds the amount due and owned by the authority, or consequential or exemplary damages.

SB 1097 is bracketed to apply only to a municipal hospital authority wholly located in a county with a population of less than 70,000. The only municipal hospital authority that falls within this bracket is Decatur Hospital Authority.

OPERATIONAL IMPACT

SB 1097 clarified an ambiguity in law to ensure that a clear waiver of immunity is in place for the Decatur Hospital Authority. Any future municipal hospital authority acquisitions impacted by this ambiguity can use SB 1097 as a legislative example of clarification.



SENATE BILL 1893

Author:
Sen. Brian Birdwell

Effective Date: 6/14/23

Banning TikTok and Other Apps from Public Devices

ANALYSIS

SB 1893 adds chapter 620 to the Government Code and requires a governmental entity, including the state and political subdivisions, to adopt a policy prohibiting the installation or use of a “covered application” on any device owned or leased by the governmental entity and requiring the removal of covered applications from those devices. The Department of Information Resources and the Department of Public Safety must jointly develop a model policy for governmental entities to use in developing the required policy.

A “covered application” is defined as:

- The social media service TikTok or any successor application or service developed or provided by ByteDance Limited or an entity owned by ByteDance Limited; or
- A social media application or service specified by proclamation of the governor as described below.

The required policy may provide for the installation and use of a covered application to the extent necessary for providing law enforcement or developing or implementing information security measures. However, certain mitigation measures are required in the event an exception applies.

By proclamation, the governor may identify social media applications or services that pose a risk. The Department of Information Resources and the Department of Public Safety must jointly identify social media applications or services that pose a risk.

SB 1893 became effective immediately. A governmental entity is required, not later than the 60th day after the date the model policy described above is made available, to adopt the policy required by SB 1893.

OPERATIONAL IMPACT

Hospitals owned or operated by a governmental entity should monitor the publication of the model policy and timely adopt the required policy prohibiting the use of banned apps, and ensure that banned apps are not installed or used on devices owned or leased by the governmental entity.



SENATE BILL 232

Author:
Sen. Chuy Hinojosa, et al

Effective Date: 9/1/2023

Automatic Removal from Hospital District Board for Criminal Offenses

ANALYSIS

SB 232 provides for the automatic removal of an elected or appointed official of a political subdivision upon pleading guilty or no contest to, receiving deferred adjudication for, or being convicted of one of several qualifying offenses related to public corruption.

Any person who holds an elected or appointed office of a political subdivision, including a hospital district, is automatically removed from and vacates the office upon entering such a plea to, or receiving deferred adjudication for, the included list of qualifying offenses.

Qualifying offenses listed in SB 232 are bribery, theft of public money, perjury, coercion of public servant or vote, tampering with a governmental record, misuse of official information, abuse of official capacity or conspiracy, or the attempt to commit any of these offenses.

At the first regularly scheduled meeting (for which notice is required) following a removal from office, the governing body of the political subdivision shall either order an election, if an election is required, to fill the vacancy on the first day that allows sufficient time to comply with all requirements; or fill the vacancy in the manner provided for in law if an election is not required.

SB 232 also amends other sections of the Local Government Code to ensure existing appeals processes are not available for a local official removed under these offenses.

OPERATIONAL IMPACT

Hospital districts should ensure that their bylaws and policies reflect the process laid out in SB 232 for immediate removal of office for the listed qualifying offenses, and subsequent election or selection timelines of a new official.



SENATE BILL 271

Author:
Sen. Nathan Johnson

Effective Date: 9/1/23

State Agency Computer Security Incident Notification Procedures Now Applicable to Local Governments

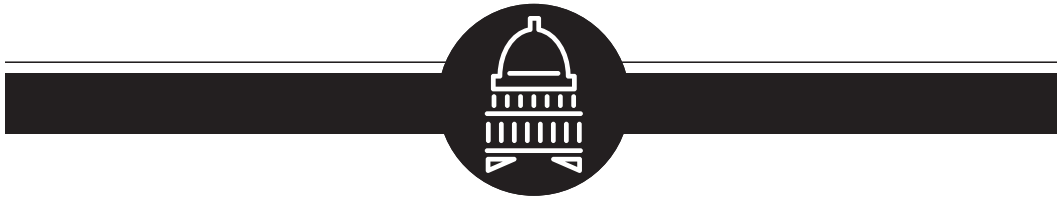
ANALYSIS

SB 271 revises Section 2054.603, Government Code, which was originally only applicable to state agencies, to also include local governments who suffer from a breach or suspected breach of their computer systems, including the introduction of ransomware. Local governments include a county, municipality, special district, school district, junior college district or other political subdivision of the state. The new law modifies the following:

- Deletes the previous “Breach of system security” definition and replaces it with “Security Incident,” which is defined as including a breach or suspected breach of system security (defined in Section 521.054, Business and Commerce Code) that also includes the introduction of ransomware into a state agency or local government computer, computer network or computer system. Conforming amendments to replace the old term with the new term are made throughout Section 2054.603.
- Requires local governments to notify the Texas Department of Information Resources (DIR) regarding any security incidents, and, if such incident involves election data, the Texas Secretary of State. Local governments are also required to comply with all DIR rules related to the reporting of security incidents.
- Makes clear that the section does not apply to security incidents that are required to be reported to an independent organization certified by the Public Utility Commission of Texas.

OPERATIONAL IMPACT

Hospital districts and other local government entities that are considered political subdivisions of the state, and any hospitals that are owned, operated or are considered state agencies, should familiarize themselves with this legislation. They should review their breach notification and reporting policies and procedures to update and reflect the new notification and reporting requirements.



**STATE BUDGET /
APPROPRIATIONS**

**HOUSE BILL 1**

Author:
Rep. Greg Bonnen

Effective Date: 9/1/23

SENATE BILL 30

Author:
Sen. Joan Huffman

Effective Date: 6/9/23

State Budget for the 2024-2025 Biennium and Supplemental Appropriations Act for Fiscal Year 2023**ANALYSIS**

HB 1 is the General Appropriations Act, the primary budget document appropriating state and federal funds to all state agencies and programs for fiscal years 2024 and 2025. HB 1 also includes riders directing state agencies on how appropriations are to be spent. HB 1 appropriates \$321 billion across all areas of government, including over \$150 billion in state general revenue related funds and \$102 billion in federal funds. The Health and Human Services Commission (HHSC) received \$43 billion in general revenue funds, a 10% increase in general revenue spending over the previous biennium.

SB 30 is the supplemental budget that funds the state's remaining obligations through the current fiscal year. SB 30 expends \$13.2 billion in all funds, including \$9.5 billion for health and human services.

HB 1 and SB 30 provide funding for many significant hospital priorities.

Medicaid rates

HB 1 provides \$80.8 billion in all funds across all health and human services agencies for Medicaid. This includes full funding for base Medicaid payments, and level or increased funding for Medicaid rate enhancements as follows (all figures represent all funds):

- \$360 million to maintain Medicaid rate enhancement for designated trauma hospitals. (HB 1)
- \$133 million to maintain Medicaid rate enhancement for rural hospitals' outpatient services, a \$73 million increase over the previous biennium. (HB 1)
- \$300 million to maintain Medicaid rate enhancement for safety net hospitals. (HB 1)
- \$214 million in other rural hospital payments. (HB 1)
- \$63 million to increase the add-on payment for rural hospitals' labor and delivery services from \$500 to \$1,500 per delivery. (HB 1)

Medicaid rates were also enhanced elsewhere across the continuum of care. This includes \$16.2 million all funds for a 25% increase in the Medicaid ground ambulance mileage rate, \$126 million all funds to support a 6% reimbursement rate increase for pediatric services for well-child visits for children, and \$15 million all funds to provide a 3% rate increase for birth and women's health-related surgeries. (HB 1)



SB 30 provides \$2.5 billion in general revenue funds to close the state's Medicaid shortfall for the fiscal 2022-2023 biennium. This amount covers additional costs related to Medicaid and ensures no interruptions in provider payments through the remainder of state fiscal year 2023.

Rural hospital stabilization grants

HB 1 creates a \$50 million grant program providing opportunities for state awards of lump-sum funding for financial stabilization of rural hospitals, maternal care operations in rural hospitals and alternative payment model readiness.

Behavioral health

HHSC received \$306 million in all funds to fund inpatient community psychiatric beds. This amount includes \$100 million to contract for 170 competency restoration beds and \$206 million all funds to maintain existing capacity and add 193 additional state-purchased inpatient psychiatric beds, including 70 rural beds and 123 urban beds. Budget writers also allocated \$228 million to support community mental health grant programs. (HB 1)

The budget appropriated \$7.4 million in general revenue to support telepsychiatry consultations in rural hospitals. HHSC is directed to contract with a statewide organization to implement this effort. (HB 1)

SB 30 continued the state's multi-year effort to invest state hospital construction, renovation, replacement and inpatient capacity projects. A total of \$2.2 billion was appropriated to support several state hospital projects, including construction and bed capacity increases in Dallas, Lubbock, San Antonio, Amarillo, the Rio Grande Valley, Terrell, Wichita Falls and El Paso.

Women's health

An all-funds allocation of \$436 million was appropriated for women's health programs, including Healthy Texas Women, the Family Planning Program and the Breast and Cervical Cancer Screening Program. An additional \$10 million in contingency funds was added for the programs in the event that caseloads exceed projections. This offers better protection against historical program funding shortfalls due to caseloads that have resulted in insufficient payments to enrolled providers. (HB 1)

TexasAIM maternal safety initiatives at the Department of State Health Services received \$7 million in all funds, and \$10 million in general revenue was appropriated to increase women's health mobile units in underserved areas.



Workforce

HB 1 made several substantial investments in the health care workforce pipeline, appropriating to the Texas Higher Education Coordinating Board:

- \$25 million for nursing scholarships;
- \$47 million for the Professional Nursing Shortage Reduction Program;
- \$7 million for the Nurse Faculty Loan Repayment Program; and
- \$28 million for the Mental Health Loan Repayment Program.

The legislature also increased spending on graduate medical education for physician training to \$233 million to maintain the current 1.1-to-1 ratio of residency slots to Texas medical school graduates. (HB 1)

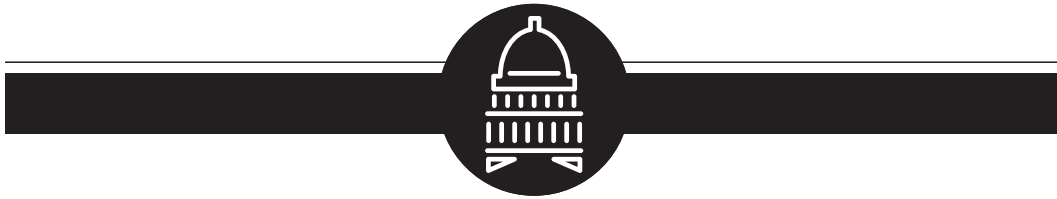
Hospital charity care and transparency study

HB 1 contains budget riders directing HHSC to report to the Legislature on hospital-specific information. Of major note, HHSC will receive \$5 million to contract with a third-party vendor to perform a charity care and hospital transparency study. The study must include recommendations to improve hospital reporting and reduce duplicate reporting, a summary of all revenue streams by hospital and system, the value of charity care, bad debt expense, unreimbursed costs of care, the value of hospitals' tax exemption benefit, compliance with charity care disclosure requirements and an analysis of hospitals' operating costs in relation to household incomes in their service areas. (HB 1).

OPERATIONAL IMPACT

Hospitals will not experience cuts to Medicaid reimbursement rates, and most rural hospitals will enjoy an increase. Most hospital payment programs and other funding items of interest received level or enhanced funding and will continue with similar operational capacity. Enhancements to workforce funding will make available new loan repayment opportunities for hospital staff and set into motion long-term workforce growth.

Hospitals should review state agency-funded programs or services they operate. If budget changes occurred, correspond with program staff at state agencies to ascertain the expected impact and begin planning operational adjustments prior to the budget effective date of Sept. 1, 2023. Monitor electronic communications from implementing agencies to stay abreast of reporting requirements, funding program application deadlines, rate change postings and other applicable administrative activities related to expenditure of these funds.



WOMEN'S HEALTH

**HOUSE BILL 12**

Author:

Rep. Toni Rose

Effective Date: 6/18/23*

Extension of Eligibility for Postpartum Medicaid Coverage to 12 Months**ANALYSIS**

HB 12 provides for the extension of maternal Medicaid coverage after pregnancy from 60 days to twelve months. Specifically, the bill amends Section 32.024(1-1) of the Human Resources Code to say that the Health and Human Services Commission (HHSC) must continue to provide medical assistance to a woman who is eligible for a period of not less than 12 months, beginning on the last day of the woman's pregnancy.

Section 3 of the bill directs HHSC to seek an amendment to the state's Medicaid state plan from the appropriate federal agency in order to implement the coverage extension above. It allows the delay of implementation until the state plan amendment is approved.

***HB 12 is effective immediately, but implementation may be delayed until the state plan amendment is approved by the U.S. Centers for Medicare and Medicaid Services.**

**HOUSE BILL 1575**

Author:
Rep. Lacey Hull

Effective Date: 9/1/23

Non-Medical Drivers of Health Screening for Pregnant Women and Requirements for the Case Management for Children and Pregnant Women Program**ANALYSIS**

HB 1575 directs the Health and Human Services Commission (HHSC) to develop and adopt a set of standardized screening questions geared toward nonmedical drivers of health for pregnant women eligible for Medicaid and the Alternatives to Abortion programs.

- Managed care organizations and providers in the Alternatives to Abortion program must utilize the standardized set of questions, and prior to use must:
 - Inform women about the type of data collected and the purpose;
 - Disclose that their responses will become part of their medical record or service plan; and
 - Obtain informed consent.
- Managed care organizations and Alternatives to Abortion providers must provide the collected data from the standardized screening to HHSC.
- HHSC must submit a report to the Legislature by December 1 of each even-numbered year with the de-identified data collected from the standardized screenings in the previous biennium.

Section 3 clarifies that services received through the Case Management for Children and Pregnant Women program do not preempt or affect a Medicaid managed care organization's obligation to provide coordination benefits to pregnant beneficiaries. This section also adds a list of provider qualifications to perform the program services in the Case Management for Children and Pregnant Women program. A provider must be one of the following:

- An advanced practice nurse with a license other than a provisional or temporary license;
- A registered nurse with a license other than a provisional or temporary license that has either completed a bachelor's degree in nursing or an associate's degree in nursing, coupled with:
 - Two years of cumulative paid full time work experience; or
 - In the past 10 years, two years of cumulative, supervised full-time



educational internship or practicum experience that included assessing psychosocial and health needs and making community referrals of children 21 years of age and younger or pregnant women.

- A social worker with a license (other than a provisional or temporary license);
- A community health worker certified by the Department of State Health Service; or
- A doula certified by a recognized national certification program.

All participating providers must also complete trauma-informed training prescribed by HHSC that includes education on:

- State and local social services programs.
- Community assistance programs.
- Domestic violence and coercive control dynamics.
- How to explain and obtain informed consent for program services screenings and any services offered as a result of that screening.
- Procedures through which an eligible person can decline the program services screening and withdraw consent for services, as well as how to ensure the person is not penalized for declining or discontinuing any benefits.

HB 1575 also directs Medicaid managed care organizations providing Medicaid services to pregnant women to conduct an initial health needs screening, and the newly prescribed nonmedical health-related needs screening, to determine if a woman, regardless of whether her pregnancy is considered high risk:

- Is eligible for service coordination benefits from the managed care organization, or
- Should be referred to the Case Management for Children and Pregnant Women Program.

The managed care organization service coordination benefits must include identifying and coordinating provision of:

- Non-covered services;
- Community supports; and
- Other resources that will improve the person's health outcomes.



The managed care organization must inform every person screened and/or referred for services that they have the right to decline the screening or services and will not be penalized for doing so in the provision of other services.

Section 4 requires HHSC to create a new Medicaid provider enrollment type for:

- Community health workers providing case management services under the Case Management for Children and Pregnant Women Program.
- Doulas certified by a recognized national doula certification program approved by HHSC and providing case management services under the same program.

HHSC is required to submit a status report to the Legislature no later than Dec. 1, 2024, on the implementation of case management services for pregnant women through that program for the previous fiscal year, and include:

- Nonmedical health-related needs of women receiving services.
- The number and types of nonmedical assistance referrals made to women.
- The birth outcomes of women receiving services.

OPERATIONAL IMPACT

A Medicaid managed care organization providing plans to pregnant women under the STAR Medicaid managed care program will have to utilize the standardized set of questions developed by HHSC to assess non-medical drivers of health for this population and submit the necessary collected data to that agency. It will also have to cooperate with the screening requirements for Medicaid managed care service coordination eligibility and the Case Management for Children and Pregnant Women Program.

All providers participating in that program will have to comply with the new requirements outlined in the bill.

**HOUSE BILL 852**

Author:
Rep. Shawn Thierry

Effective Date: 9/1/23

Addition of Specific Member Slots to the Texas Maternal Mortality and Morbidity Review Committee**ANALYSIS**

HB 852 adds an additional six members to the Texas Maternal Mortality and Morbidity Review Committee, bringing the membership count from 17 to 23. It also specifies that one-third or as near as possible to one-third of the member's terms expire February 1 of each odd-numbered year (members will continue to serve staggered six-year terms).

The additional physician members are specified as follows:

- One physician specializing in emergency care;
- One physician specializing in cardiology;
- One physician specializing in anesthesiology; and
- One physician specializing in oncology.

The additional nonphysician members are specified as follows:

- One representative of a managed care organization.
- One additional community member.

Prior to HB 852, there was one community member representative and the specification was that it be a community advocate in a relevant field. HB 852 changes that to now be two community member representatives, and the specification removes the term "advocate," requiring instead that they have experience in a relevant health care field, including health care data analysis, and one must represent an urban area of the state while the other represent a rural area of the state.

**HOUSE BILL 3058**

Author:

Rep. Ann Johnson, et al.

Effective Date: 9/1/23

Creating a Defense to Civil, Licensing and Criminal Actions Related to the Performance of Certain Abortions**ANALYSIS**

HB 3508 adds new Subchapter L to the Texas Medical Liability Act found at Chapter 74 of the Civil Practice and Remedies Code. It is an attempt to allow physicians the ability to exercise reasonable medical judgment in the management of certain specified pregnancy complications without violating the prohibition on abortion found at Chapter 170A, Health and Safety Code.

The new Subchapter L adds Section 74.552, which creates an affirmative defense to liability in a civil action brought against a physician or health care provider for a violation of Section 170A.002, Health and Safety Code, including an action to recover a civil penalty under Section 170A.005, Health and Safety Code, *if the physician or health care provider exercised reasonable medical judgment in providing medical treatment to a pregnant woman in response to an ectopic pregnancy at any location, or a previable premature rupture of membranes*. Further, a pharmacist or pharmacy that receives, processes or dispenses a prescription drug or medication order written by a physician or health care provider to whom the preceding sentence applies is entitled to the same affirmative defense.

Section 170A.002, referenced above, provides that a person may not knowingly perform, induce or attempt an abortion. This prohibition does not apply if:

- The person performing, inducing or attempting the abortion is a licensed physician;
- In the exercise of reasonable medical judgment, the pregnant female on whom the abortion is performed, induced or attempted has a life-threatening physical condition aggravated by, caused by or arising from a pregnancy that places the female at risk of death or poses a serious risk of substantial impairment of a major bodily function unless the abortion is performed or induced; and
- The person performs, induces or attempts the abortion in a manner that, in the exercise of reasonable medical judgment, provides the best opportunity for the unborn child to survive unless, in the reasonable medical judgment, that manner would create:
 - A greater risk of the pregnant female's death; or
 - A serious risk of substantial impairment of a major bodily function of the pregnant female.



The exception described above does not apply if, at the time the abortion was performed, induced or attempted, the person knew the risk of death or a substantial impairment of a major bodily function.

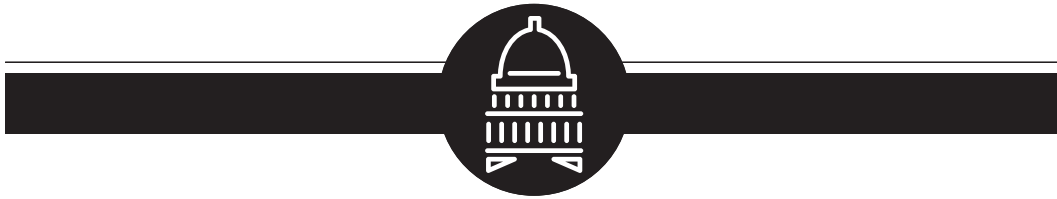
Under Section 170A.002, Medical treatment provided to a pregnant female by a licensed physician that results in the accidental or unintentional injury or death of the unborn child does not constitute a violation.

HB 3058 also adds a provision to the Medical Practice Act at Section 164.055, Occupations Code, that indicates that the Texas Medical Board may not take disciplinary action against a physician who exercised reasonable medical judgment in providing medical treatment to a pregnant woman as described by Section 74.552, Civil Practice and Remedies Code.

Finally, HB 3058 adds a provision to the Texas Penal Code at Section 9.35 that indicates that a physician or health care provider is justified in exercising reasonable medical judgment in providing medical treatment to a pregnant woman as described by section 74.552, Civil Practice and Remedies Code.

OPERATIONAL IMPACT

Hospitals should consider reviewing their policies and processes related to pregnancy care in light of the provisions of HB 3058. Laws enacted in 2021 containing broad prohibitions against abortion have led to uncertainty in how to proceed in pregnancy-related medical emergencies. HB 3058 is intended to clarify that a physician or health care provider may exercise reasonable medical judgment in the treatment of two specified pregnancy-related conditions and not be exposed to civil, criminal or licensing action.



WORKERS' COMPENSATION

**HOUSE BILL 2468**

Author:
Rep. Dustin Burrows, et al.

Effective Date: 9/1/23

Creating an Entitlement of Certain Injured Employees to Lifetime Workers' Compensation Income Benefits**ANALYSIS**

HB 2468 provides that first responders who sustain a serious bodily injury in the course and scope of their employment or volunteer service that renders the first responder permanently unemployable may be entitled to receive lifetime income benefits paid until the person's death.

Any dispute, contested case hearing or appeal requested by the employee, regarding the employee's continuing entitlement to lifetime income benefits under this section must be accelerated. The employee must provide notice to the division that the dispute involves a first responder.

A first responder receiving lifetime income benefits must annually certify, in the form and manner prescribed by Texas Department of Insurance Division of Workers' Compensation (DWC), that the first responder was not employed in any capacity during the preceding year.

An insurance carrier may periodically review a first responder's continuing entitlement to lifetime income benefits not more than once during any five-year period. An insurance carrier may review a first responder's continuing entitlement to lifetime income benefits if:

- The first responder certifies to the insurance carrier that the employee was not employed in any capacity during the preceding year;
- The insurance carrier provides evidence to DWC that the certification provided by the employee is not accurate; and
- The DWC notifies the insurance carrier of its determination that the evidence provided by the insurance carrier is sufficient to show that the certification provided by the first responder may not be accurate.

An insurance carrier reviewing a first responder's continuing entitlement must request the commissioner to order a medical examination conducted by a designated doctor.

A first responder is not entitled to lifetime income benefits, and an insurance carrier is authorized to suspend the payment of lifetime income benefits for a period in which the employee fails to complete the annual certification required by this



change in statute, or the first responder is employed in any capacity, unless the commissioner determines that there is good cause.

By rule, DWC must ensure that a first responder receives reasonable notice of the insurance carrier's basis for the suspension and is provided a reasonable opportunity to complete the annual certification or otherwise respond to the notice.

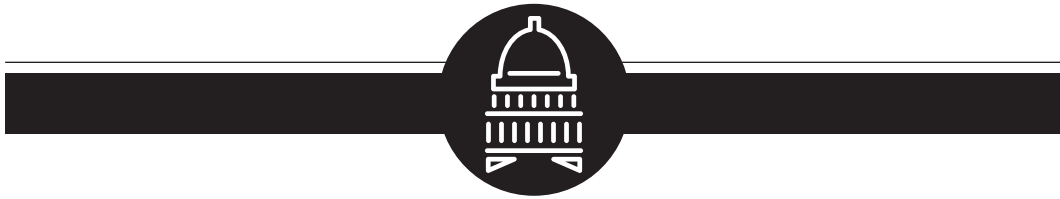
"First Responder" means a person who is:

- A peace officer under Article 2.12, Code of Criminal Procedure;
- Certified under Chapter 773, Health and Safety Code, as an emergency care attendant, advanced emergency medical technician, emergency medical technician-paramedic or a licensed paramedic;
- A firefighter subject to certification by the Texas Commission on Fire Protection under Chapter 419, Government Code, whose principal duties are aircraft crash and rescue or firefighting; or
- A person covered under Section 504.012, Labor Code, who is providing volunteer services as:
 - A volunteer firefighter, regardless of whether the person is certified under Chapter 419, Government Code; or
 - An emergency medical services volunteer, as defined by Section 773.003, Health and Safety Code.

"Serious bodily injury" has the meaning assigned by Section 1.07, Penal Code.

OPERATIONAL IMPACT

Hospitals who employ first responders, as defined through these statutory changes, should be aware of the potential for such employees to qualify for lifetime income benefits. Related policies and procedures should be amended and aligned with applicable insurance carriers.



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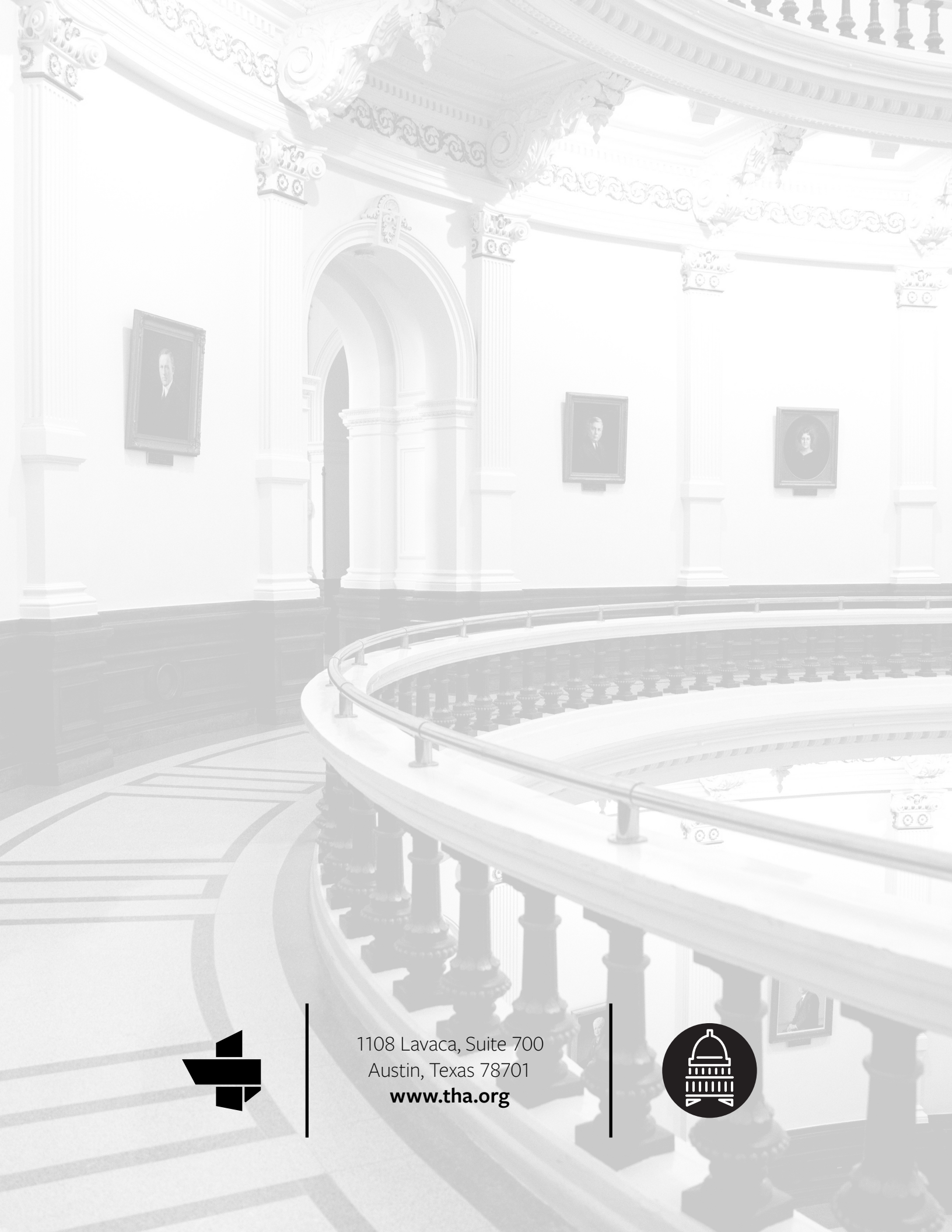
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