2019

New Health Care Laws

From the 86th Texas Legislature

Texas Hospital Association

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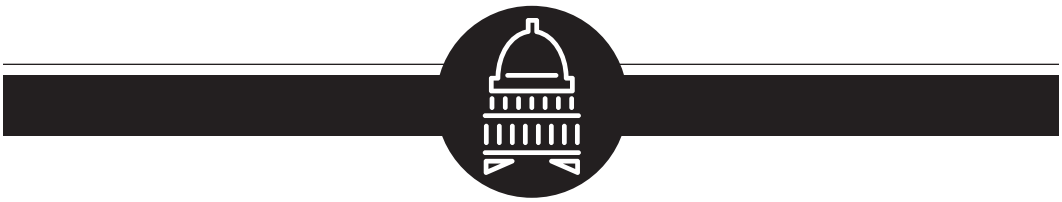
During its 140-day legislative session in 2019, the 86th Texas Legislature passed more than 1,500 bills. Many of those impact hospitals and health systems.

Written by THA's legal and government relations staff, this reference manual contains an overview of health care and hospital-related legislation passed during the 2019 legislative session. The brief analysis provided for each bill is not a detailed synopsis. 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 a valuable resource. Additional copies of *2019 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/hlm2019.



BEHAVIORAL HEALTH

SENATE BILL 11
Sponsors:
Sen. Larry Taylor
Rep. Greg Bonnen
Effective Date: 6/6/19

Texas Child Mental Health Care Consortium/School Safety

ANALYSIS

SB 11 addresses a variety of school safety policies and establishes the Texas Child Mental Health Care Consortium to address urgent mental health challenges and improve the mental health care system for children and adolescents through collaboration with health-related institutions of higher education in Texas. The consortium is composed of the following:

- Baylor College of Medicine.
- Texas A&M University System Health Science Center.
- Texas Tech University Health Sciences Center.
- Texas Tech University Health Sciences Center at El Paso.
- University of North Texas Health Science Center at Fort Worth.
- The Dell Medical School at The University of Texas at Austin.
- The University of Texas M.D. Anderson Cancer Center.
- The University of Texas Medical Branch at Galveston.
- The University of Texas Health Science Center at Houston.
- The University of Texas Health Science Center at San Antonio.
- The University of Texas Rio Grande Valley School of Medicine.
- The University of Texas Health Science Center at Tyler.
- The University of Texas Southwestern Medical Center.
- Texas Health and Human Services Commission.
- Texas Higher Education Coordinating Board.
- Three nonprofit organizations that focus on mental health care; designated by a majority of the members.
- Any other entity that the THHSC executive commissioner deems necessary.

The consortium is administratively attached to THECB for the purpose of receiving and administering appropriations; however, no additional resources (i.e., staff, human resources, contact monitoring or support services) will be provided to the consortium by the State Board of Education.

The consortium is governed by an executive committee composed of behavioral health experts from institutions of higher education; THHSC; THECB; three nonprofits; and a hospital system.

SB 11 also requires the consortium to designate a member of the executive committee to serve as a representative on the Statewide Behavioral Health

Coordinating Council, legislatively created in 2015 to develop and implement the Statewide Behavioral Health Strategic Plan and Coordinated Statewide Expenditure Proposal.

The consortium is tasked with establishing a network of comprehensive child psychiatry access centers to provide consultation services and training opportunities for pediatricians and primary care providers operating in the center's geographic region to better care for children with behavioral health needs. The centers are to be located at the consortium member institutions of higher education. In addition, the consortium must establish and/or expand telemedicine or telehealth programs for identifying and assessing behavioral health needs and providing access to mental health services. The higher education institutions are authorized to enter into a memorandum of understanding with entities that provide these services at the local level, including local mental health authorities, in order to establish a center or establish or expand a program. The consortium must leverage the resources of a hospital system if the system provides services identical to those to be provided at the child psychiatry access centers and that have existing telemedicine and telehealth programs used to provide mental health services.

SB 11 clarifies that a person providing mental health care services to a child younger than 18 years of age through the child psychiatry access centers or through the use of telemedicine or telehealth must obtain the written consent of the parent or legal guardian of the child. A form for the provision of consent must be developed and posted on the consortium website. The new law also prohibits child psychiatry access centers from submitting an insurance claim or charging a pediatrician or primary care provider a fee for providing consultation services or training.

SB 11 also addresses the child mental health workforce by authorizing the executive committee to provide funding for two full-time psychiatrists who treat children and adolescents to serve as the academic medical director at a facility operated by a community mental health provider and two new resident rotation positions in order to expand the amount and availability of mental health care resources. The executive committee also is authorized to fund a physician fellowship position that will lead to a medical specialty diagnosing and treating psychiatric and behavioral health issues affecting children and adolescents.

The bill provides that although the consortium is required to implement the programs mandated, if the legislature does not appropriate funding for those mandates, the consortium is not required to carry out the mandates. Note however, that the legislature appropriated $100 million for the implementation of SB 11 in the 2020-2021 biennium.

IMPLICATIONS

SB 11 demonstrates the state's continued commitment to improving access to mental health care.

SENATE BILL 362
Sponsors:
Sen. Joan Huffman
Rep. Four Price
Effective Date: 9/1/19

Court-Ordered Mental Health Treatment

ANALYSIS

SB 362 makes changes to the law related to court-ordered mental health treatment.

The bill amends the Code of Criminal Procedure to include an option during the pendency of a criminal case to refer certain defendants for court-ordered outpatient mental health services and to dismiss charges upon the successful completion of that course of treatment. The Court of Criminal Appeals is required to institute training for judges on court-ordered outpatient mental health services.

The bill also amends chapter 574 of the Health and Safety Code, related to court-ordered mental health services. At a hearing for temporary inpatient or outpatient mental health services, the proposed patient may waive the right to cross-examine witnesses and the court may admit, as evidence, the certificates of medical examination for mental illness in lieu of testimony. However, in a hearing for extended inpatient or outpatient mental health services, the court may not make its findings solely from the certificates of medical examination for mental illness but rather must hear testimony.

The bill also adds new sections to create separate processes for court-ordered temporary and extended outpatient mental health services. New section 574.0345 of the Health and Safety Code governs orders for temporary outpatient mental health treatment. A judge may order a proposed patient to receive court-ordered temporary outpatient mental health services only if the judge finds that appropriate mental health services are available to the proposed patient, and the judge or jury finds, from clear and convincing evidence, that:

- The proposed patient is a person with severe and persistent mental illness.
- As a result of the mental illness, the proposed patient will, if not treated, experience deterioration of the ability to function independently to the extent that the proposed patient will be unable to live safely in the community without court-ordered outpatient mental health services.

- Outpatient mental health services are needed to prevent a relapse that would likely result in serious harm to the proposed patient or others.
- The proposed patient is unable to participate in outpatient treatment services effectively and voluntarily, demonstrated by any of the proposed patient's actions occurring within the two-year period that immediately precedes the hearing or specific characteristics of the proposed patient's clinical condition that significantly impair the proposed patient's ability to make a rational and informed decision whether to submit to voluntary outpatient treatment.

An order for temporary outpatient mental health may not last longer than 45 days, except that the order may specify a period not to exceed 90 days if the judge finds that the longer period is necessary. A person charged with a criminal offense that involves an act, attempt or threat of serious bodily injury to another person is ineligible for court-ordered outpatient mental services.

New section 574.0355 of the Health and Safety Code governs court-ordered extended outpatient mental health treatment. A judge may order a proposed patient to receive court-ordered extended outpatient mental health services only if the judge finds that appropriate mental health services are available to the proposed patient, and the judge or jury finds, from clear and convincing evidence, that:

- The proposed patient is a person with severe and persistent mental illness.
- As a result of the mental illness, the proposed patient will, if not treated, experience deterioration of the ability to function independently to the extent that the proposed patient will be unable to live safely in the community without court-ordered outpatient mental health services.
- Outpatient mental health services are needed to prevent a relapse that would likely result in serious harm to the proposed patient or others.
- The proposed patient is unable to participate in outpatient treatment services effectively and voluntarily, demonstrated by any of the proposed patient's actions occurring within the two-year period that immediately precedes the hearing; or specific characteristics of the proposed patient's clinical condition that significantly impair the proposed patient's ability to make a rational and informed decision whether to submit to voluntary outpatient treatment.
- The proposed patient's condition is expected to continue for more than 90 days.
- The proposed patient has received court-ordered inpatient mental health services for a total of at least 60 days during the preceding 12 months or court-ordered outpatient mental health services during the preceding 60 days.

An order for extended outpatient mental health services may not exceed 12 months. A person charged with a criminal offense that involves an act, attempt or threat of serious bodily injury to another person is ineligible for court-ordered outpatient mental services.

The bill also imposes a requirement on the administrator of a facility to which a patient is committed for inpatient mental health services, not later than the 30th day after the date the patient is committed to the facility, to assess the appropriateness of transferring the patient to outpatient mental health services. The facility administrator may recommend to the court to modify the order to require the patient to participate in outpatient mental health services. The administrator's recommendation must explain in detail the reason for the recommendation. The recommendation must be accompanied by a supporting certificate of medical examination for mental illness signed by a physician who examined the patient during the seven days preceding the recommendation.

Discharge Planning

New provisions are included related to discharge planning and post-discharge medications for patients under a court order for inpatient mental health treatment. These provisions apply to state hospitals and patients being furloughed or discharged from any psychiatric inpatient bed funded under a contract with the Texas Health and Human Services Commission or operated by or funded under a contract with a local mental health authority or a behavioral mental health authority. Subject to available funding provided to THHSC and paid to a private mental health facility for this purpose, a private mental health facility is responsible for providing or paying for psychoactive medication and any other medication prescribed to the patient to counteract adverse side effects of psychoactive medication on furlough or discharge sufficient to last until the patient can see a physician. The rules adopted by THHSC related to the quantity and manner of providing psychoactive medication may not require a mental health facility to provide or pay for psychoactive medication for more than seven days after furlough or discharge.

Finally, the bill requires the Texas Supreme Court to adopt rules to streamline and promote the efficiency of court processes under chapter 573 of the Health and Safety Code (related to emergency detentions) and to adopt rules or implement other measures to create consistency and increase access to the judicial branch for mental health issues.

IMPLICATIONS

SB 362 makes significant revisions to chapter 574 of the Health and Safety Code. The focus on court-ordered outpatient treatment is intended to highlight the outpatient treatment option for judges and to alleviate pressure on inpatient

facilities. The bill is intended to streamline a patient's transition from inpatient to outpatient treatment and impose requirements for publicly funded facilities to coordinate patients' admission, treatment plan and discharge plan with local mental health authorities. It clarifies the standards for court-ordered mental health services, separates the standards for inpatient and outpatient commitment and makes distinct sections for extended and temporary court-ordered treatment.

Because of hospitals' EMTALA obligations, court-ordered outpatient treatment is not an option for hospitals with patients waiting in emergency rooms for court-ordered services. However, the bill may result in utilization of court-ordered outpatient services more frequently and free up inpatient capacity. The Supreme Court rulemaking process also may be an avenue to create consistency across jurisdictions and promote access to courts to address critically time-sensitive mental health issues.

SENATE BILL 562
Sponsors:
Sen. Judith Zaffirini
Rep. Four Price
Effective Date: 6/14/19

Criminal Justice Procedures for Persons With Mental Illness or Intellectual Disability; Mental Health Court Program Operation

ANALYSIS

SB 562 requires a county transferring a defendant to the Texas Department of Criminal Justice to provide a copy of the defendant's mental health records to an officer designated by TDCJ. The bill also requires the Texas Health and Human Services Commission to transfer a defendant from a maximum security unit to a non-maximum security unit if a review board determines the defendant is not manifestly dangerous. SB 562 also requires a court, upon receiving notice from the head of a facility or outpatient treatment provider of intent to release the defendant, to hold a hearing to determine whether release from the facility or program is appropriate. The bill also amends the definition of forensic patient to include persons with intellectual disabilities.

SB 562 also allows a person to have all records and files related to an arrest for a criminal offense expunged under certain conditions and allows certain fees to be waived if the person successfully completes a veterans' treatment court program or mental health court program. The bill also requires the creation of a mental health court program in counties with a population of more than 200,000 and requires those counties to apply for federal and state funds to pay for the program.

IMPLICATIONS

Because SB 562 requires that a county transferring a defendant to TDCJ provide a copy of the defendant's mental health records to a designated officer at TDCJ, hospitals may be asked to provide a copy of the mental health records for that specific purpose. Hospital medical record staff should be notified of this new requirement.

SENATE BILL 632
Sponsors:
Sen. Lois Kolkhorst
Rep. Four Price
Effective Date: 9/1/19

Composition of Local Mental Health Authority Governing Bodies and the Boards of Trustees of Community Centers

ANALYSIS

SB 632 establishes requirements for the composition of local mental health authority governing bodies and the boards of trustees of community centers operated by local agencies. If an LMHA has a governing body and serves only one county, it must include the county sheriff as an *ex officio* nonvoting member. An LMHA that serves two or more counties must include in its governing body, two sheriffs as *ex officio* nonvoting members. The bill contains specific provisions for certain scenarios that may occur, such as a sheriff designating a representative to serve in his/her place, or an LMHA that does not have a governing body, serving one, two or more counties. Similar provisions are required for boards of trustees of community centers.

SB 632 also adds local law enforcement agencies to the list of entities from which an LMHA may solicit information regarding community needs in developing a local service area plan.

IMPLICATIONS

Hospital districts can establish and operate community centers individually or in coordination with other entities, including a county, municipality or school district. Therefore, hospital district staff should familiarize themselves with the provisions required for the composition of boards of trustees of community centers.

SENATE BILL 633
Sponsors:
Sen. Lois Kolkhorst
Rep. Stan Lambert
Effective Date: 6/14/19

Local Mental Health Authorities Increased Capacity to Provide Access to Mental Health Services

ANALYSIS

SB 633 requires the Texas Health and Human Services Commission to identify, no later than Jan. 1, 2020, local mental health authorities that are located in a county with a population of 250,000 or less or that THHSC determines provides services predominately in a county with a population of 250,000 or less and assign the authorities to regional groups of at least two authorities. THHSC must notify the authorities of this information.

Once the authorities are grouped, THHSC, using existing resources, must develop a mental health services development plan for each LMHA group to increase the group's capacity to provide access to needed services. THHSC is required to focus on reducing:

- The cost to local governments of providing services to persons experiencing mental health crisis.
- The transportation of individuals served by an authority in an LMHA group to mental health facilities.
- The incarceration of persons with mental illness in county jails that are served by an authority in a LMHA group.
- The number of hospital emergency room visits by persons with mental illness at hospitals located in an area served by an authority in the LMHA group.

THHSC and the LMHA group also must evaluate whether and to what degree increasing the capacity of the authorities to provide access to needed services would offset the cost to state or local governmental entities of the focused areas, including admissions to and inpatient hospitalizations at state hospitals and other treatment facilities. In addition, both would have to determine whether available state funds or grant funding could be used to fund the plan and what measures would be necessary to ensure alignment with the statewide behavioral health strategic plan and the comprehensive inpatient mental health plan.

SB 633 also requires THHSC to produce and publish on its website, no later than Dec. 1, 2020, an evaluation of each plan and a comprehensive statewide analysis of mental health services in counties with a population of 250,000 or less and recommendations for implementing the plans.

IMPLICATIONS

Grouping LMHAs into regions hopefully will result in better coordination of care, access to services and transparency into how resources are being utilized.

SENATE BILL 1177
Sponsors:
Sen. José Menéndez
Rep. Toni Rose
Effective Date: 9/1/19

MCOs Offering Certain Evidence-Based Services in Lieu of Mental Health or Substance Use Disorder Services

ANALYSIS

SB 1177 requires that contracts between a Medicaid managed care organization and the Texas Health and Human Services Commission contain language permitting the MCO to offer medically appropriate, cost-effective, evidence-based services from a list approved by the state Medicaid managed care advisory committee and in lieu of mental health or substance use disorder services specified in the state Medicaid plan.

THHSC also is required to submit an annual report to the legislature on the number of times a service from the list included in the contract is used and take into consideration the actual cost and use of any services from the list included in the contract that are offered by the MCO when setting the capitation rates for that organization.

IMPLICATIONS

Hospitals delivering mental health or substance use disorder services should review their Medicaid managed care contracts after the effective date of the bill to determine if there are services they could offer in lieu of the specific state Medicaid plan services.

SENATE BILL 1238
Sponsors:
Sen. Nathan Johnson
Rep. Toni Rose
Effective Date: 9/1/19

Voluntary Inpatient Mental Health Services

ANALYSIS

SB 1238 makes changes to statute regarding voluntary inpatient mental health services.

Temporary Authorization for Inpatient Mental Health Services for Minor Child

The bill adds a new chapter 35A to the Family Code to allow persons eligible to consent to treatment under section 32.001(a)(1)(2) or (3) of the Family Code (grandparents, adult brother or sister, or adult aunt or uncle) and who have had actual care, custody and control of the child for six months to seek a court order for temporary authorization to consent to voluntary inpatient mental health services for a child by filing a petition in the district court in the county in which the person resides.

The petition to consent to voluntary inpatient mental health services for a child must:

- Be styled *"ex parte"* and be in the name of the child.
- Be verified by the petitioner.
- State the name, date of birth, current physical address of the petitioner, and the name, and if known, the current physical and mailing address of the child's parents, conservators or guardians.
- Describe the status and location of any court proceeding in this state with respect to the child.
- Provide the dates during the preceding six months that the child has resided with the petitioner.
- Contain a certificate of medical examination for mental illness prepared by a physician who has examined the child not earlier than the third day before the date the petition is filed and be accompanied by a sworn statement containing the physician's opinion that the child is a person with mental illness or who demonstrates symptoms of serious emotional disorder and who presents a risk of serious harm to self or others if not immediately restrained or hospitalized.
- State any reason that the petitioner is unable to obtain signed, written documentation from a parent, conservator or guardian of the child.

On receipt of the petition, the court must set a hearing and a notice of the hearing must be delivered to the parent, conservator or guardian of the child. At the hearing, the court may hear evidence relating to the child's need for inpatient mental health services by the petitioner and any objection or other testimony of the child's parent, conservator or guardian. The court must dismiss the petition for temporary authorization if an objection is made by the child's parent, conservator or guardian. The court must grant the petition for temporary authorization only if the court finds by a preponderance of the evidence that the child does not have available a parent, conservator, guardian or other legal representative to give consent under section 572.001, Health and Safety Code, for voluntary inpatient mental health services, and by clear and convincing evidence that the child is a person with mental illness or who demonstrates symptoms of serious emotional disorder, and who presents a risk of serious harm to self or others if not immediately restrained or hospitalized.

The order granting temporary authorization under this chapter expires on the earliest of:

- The date the petitioner requests that the child be discharged from the inpatient mental health facility.
- The date the physician determines that the child no longer meets criteria.
- The 10th day after the date the order for temporary authorization is issued

A copy of the order granting temporary authorization must be filed in any court that has rendered a conservatorship or guardian order regarding the child and be sent to the last known address of the child's parent, conservator or guardian.

Physician Exam for Voluntary Inpatient Mental Health Treatment

For a patient to be admitted for voluntary inpatient mental health treatment, an exam must be conducted by a physician. The exam requirements may be satisfied in one of two ways:

- An admitting physician may conduct a physical and psychiatric examination (either in person or through the use of audiovisual or other telecommunications technology) within 72 hours before admission or within 24 hours after admission.
- An admitting physician may consult with a physician who has conducted a physical and psychiatric examination (either in person or through the use of audiovisual or other telecommunications technology) within 72 hours before admission or 24 hours after admission.

A person admitted to a facility before the performance of the physical and psychiatric examination must be discharged by the physician immediately if the physician finds that the person does not meet the clinical standards to receive inpatient mental health services. If a person is discharged under these circumstances, the facility may not bill the patient or his or her third-party payor for the temporary admission to the inpatient mental health facility.

The bill also clarifies that a peace officer may take a person into custody, regardless of the age of the person, if the officer believes that the person has mental illness and because of the mental illness is a risk to themselves or others.

IMPLICATIONS

Hospitals that provide inpatient mental health treatment for adults or children are impacted by the changes in the bill. Prior to SB 1238, the admission exam for voluntary inpatient services was required to be performed before admission. SB 1238 allows the required physician exam to be performed after the patient is admitted, eliminating duplicate pre- and post-admission exams that occurred prior to the effective date of the bill if the facility chooses to conduct the exam post-admission.

The addition of new chapter 35A of the Family Code, related to consent to treatment of a minor by a non-parent, should be carefully reviewed to ensure that consent for a minor is effective if given by a non-parent. Facility policies may need to be revised to incorporate these new provisions.

SENATE BILL 2111
Sponsors:
Sen. Kirk Watson
Rep. Four Price
Effective Date: 9/1/19

THHSC to Contract With a Local Public Institution of Higher Education to Transfer Operations of Austin State Hospital

ANALYSIS

SB 2111 relates to the operation of the Austin State Hospital. It requires the Texas Health and Human Services Commission to establish a plan under which THHSC may contract with a local public institution of higher education to transfer the operations of Austin State Hospital from THHSC to a local public institution of higher education. In developing the plan, THHSC must:

- Consult with local public institutions of higher education.
- Establish procedures and policies to ensure that a local public institution of higher education that contracts with THHSC to operate the Austin State Hospital operates the hospital at a quality level at least equal to the quality level achieved by THHSC.
- Establish procedures and policies to monitor the care of affected state hospital patients.

Additionally, the procedures and policies required to be established must ensure that THHSC is able to obtain and maintain information on activities carried out under the contract without violating privacy or confidentiality rules. The procedures and policies must account for THHSC's obtaining and maintaining information on:

- Client outcomes.
- Individual and average lengths of stay.
- Number of incidents in which patients were restrained or secluded.
- Number of incidents of serious assaults in the hospital setting.
- Number of occurrences in the hospital setting involving contacts with law enforcement personnel.

Not later than Sept. 1, 2020, THHSC must prepare and deliver to the governor, the lieutenant governor, the speaker of the Texas House of Representatives, and the legislature a written report containing the plan and any recommendations for legislation or other actions necessary.

IMPLICATIONS

SB 2111 may be viewed as a precursor to the Dell Medical School at The University of Texas at Austin assuming the operations of the Austin State Hospital. In 2017, THHSC contracted with the Dell Medical School at The University of Texas at Austin to lead a collaborative process related to the redesign of the ASH. Dell Med convened a steering committee that views the

ASH Redesign as a unique opportunity to reimagine the entire continuum of care for brain health. A key recommendation regarding the operations of ASH was to move the management of ASH to an academic partner and create an oversight board.

HOUSE BILL 1501
Sponsors:
Sen. Robert Nichols
Rep. Poncho Nevárez
Effective Date: 9/1/19

Creation of the Texas Behavioral Health Executive Council

ANALYSIS

HB 1501 adds chapter 507 to the Occupations Code and represents a comprehensive restructuring of the licensing of psychologists, social workers, professional counselors and marriage and family therapists. It creates the Texas Behavioral Health Executive Council that will be the licensing agency for those four types of practitioners. The current boards for each respective profession remain intact and will continue to perform certain functions after the establishment of the TBHEC.

ARTICLE 1 of HB 1501 establishes the TBHEC and its operations. The TBHEC will consist of nine members:

- One marriage and family therapist member and one public member of the marriage and family therapy board, each appointed by that board.
- One licensed professional counselor member and one public member of the professional counseling board, each appointed by that board.
- One psychologist member and one public member of the psychology board, each appointed by that board.
- One social worker member and one public member of the social work board, each appointed by that board.
- One public member appointed by the governor.

There are restrictions on who can serve as the governor-appointed public member and additional restrictions that apply to any member or managerial employee of the TBHEC. Additionally, a person may not be a member of the TBHEC or act as the general counsel to the TBHEC if the person is required to register as a lobbyist because of the person's activities for compensation on behalf of a profession related to the operation of the TBHEC, the marriage and family therapy board, the professional counseling board, the psychology board or the social work board.

The TBHEC is empowered to administer the new chapter and chapters 501, 502, 503 and 505 of the Occupations Code (the existing licensing chapters for the

four professions). In carrying out its duties, the TBHEC may request input or assistance from the board for the applicable profession.

The TBHEC is given general rulemaking authority; however, unless the rule has been proposed by the applicable board for the profession, the TBHEC may not adopt:

- A rule regarding the qualifications necessary to obtain a license, including limiting an applicant's eligibility for a license based on the applicant's criminal history; the scope of practice of and standards of care and ethical practice for the profession; or continuing education.
- Requirements for license holders.
- A schedule of sanctions for violations of the laws and rules applicable to the profession.

For each rule proposed by a board, the TBHEC must either adopt the rule as proposed or return the rule to the applicable board for revision. On the return of a rule under this subsection, the executive council must include an explanation of the TBHEC's reasons for not adopting the rule as proposed. The TBHEC retains authority for final adoption of all rules and is responsible for ensuring compliance with all laws regarding the rulemaking process.

Additionally, the TBHEC may not adopt rules restricting advertising or competitive bidding by a person regulated by the TBHEC except to prohibit false, misleading or deceptive practices. The TBHEC also may not include in rules to prohibit false, misleading or deceptive practices by a person regulated by TBHEC a rule that restricts the person's use of any advertising medium, restricts the person's personal appearance or use of the person's voice in an advertisement, relates to the size or duration of an advertisement by the person, or restricts the use of a trade name in advertising by the person. The TBHEC must adopt rules and guidelines as necessary to comply with chapter 53, related to the consequences of a criminal conviction on a license or application for a license.

The TBHEC must maintain a system to receive complaints and adopt rules concerning the investigation of a complaint filed with the TBHEC. The TBHEC must assign priorities and investigate complaints based on the severity of the conduct alleged and the degree of harm to public health and safety. The TBHEC has the authority to issue subpoenas in connection with investigations.

The TBHEC must establish rules for licensing exams and reexaminations, and renewals. It has a comprehensive range of disciplinary options for licensees found to have committed a violation, and disciplinary procedures are provided for in the new chapter.

ARTICLE 2 of HB 1501 accomplishes the transfer of the four licensing programs to the TBHEC. Each chapter is amended to identify the TBHEC as the licensing agency for each type of practitioner. The current licensing boards, e.g., the Texas State Board of Examiners of Psychologists, remain in existence to continue to serve certain non-licensing functions as specified in HB 1501, primarily to propose rules related to their respective specialties.

In addition to transferring licensing for the four types of practitioners to the TBHEC, ARTICLE 2 makes a few substantive revisions to the chapter 501, related to psychologists, by:

- Removing the requirement that applicants take and pass an oral exam.
- Updating the postdoctoral supervision requirements for new applicants for a license.
- Adopting the Psychology Interjurisdictional Compact.

Finally, the Texas Behavioral Health Incubation Task Force is established to assist in the establishment of and transfer of regulatory programs to the TBHEC under HB 1501. The TBHEC must adopt procedural rules necessary to implement chapter 507 no later than July 31, 2020, and as soon as practicable after the appointment of its members, the TBHEC and the transferring entities must adopt a transition plan to provide for the orderly transfer of powers, duties, functions, programs and activities contemplated by HB 1501 that must provide for the transfer of each regulatory program to be completed on or before Aug. 31, 2020.

IMPLICATIONS

HB 1501 resulted from the Sunset Advisory Commission's determination that the administrative attachment of the marriage and family therapy, professional counseling and social work boards to the Texas Health and Human Services Commission was not effective and failed to efficiently regulate those professions, putting vulnerable Texans at risk. It recommended consolidating those boards with the psychology board to form the TBHEC. Major provisions of the bill include:

- Consolidating the licensing and regulation of mental and behavioral health occupations into a new umbrella licensing agency to improve regulation and increase operational efficiencies.
- Retaining each governor-appointed board and its responsibility to establish all standards relating to licensing and regulating its profession, including originating all rules related to standards of care and practice.
- Requiring each board to appoint one of its professional members and one

of its public members to serve with a public member appointed by the governor on the agency's nine-member executive council.

- Updating licensing and enforcement processes that have not kept up with best practices.
- Removing unnecessary and burdensome licensure requirements that create barriers to entry.
- Eliminating a subjective oral examination and increasing flexibility in post-doctoral supervision requirements for psychologists, as well as other overly bureaucratic paperwork requirements.
- Adopting the psychology interjurisdictional compact.
- The appointment of the members of the TBHEC, the rule-making process and the transfer of the licensing functions are placed on an aggressive timeline to be accomplished in 2020.

HOUSE BILL 1901
Sponsors:
Sen. Larry Taylor
Rep. Greg Bonnen
Effective Date: 9/1/19

Disclosure of Certain Mental Health Records of Deceased State Hospital Patients

ANALYSIS

HB 1901 creates a new section in chapter 611 of the Health and Safety Code that requires a professional to disclose confidential information to a descendant of a deceased patient of a state hospital if:

- The patient has been deceased for at least 50 years.
- The professional does not have information indicating that releasing the medical record is inconsistent with any prior expressed preference of the deceased patient or personal representatives of the deceased patient's estate.

The disclosure is required only to the extent permitted by federal law. Further, a person who receives information from confidential communications or records may not disclose the information except to the extent that disclosure is consistent with the authorized purposes for which the person first obtained the information.

IMPLICATIONS

According to the bill analysis, concerns have been raised regarding the time-consuming process of accessing certain mental health records of long-deceased state hospital patients. This bill is intended to streamline that process.

HOUSE BILL 3980
Sponsors:
Sen. José Menéndez
Rep. Todd Hunter
Effective Date: 6/14/19

Report on Rate of Suicide in Texas and State Policies and Programs to Prevent Suicide

ANALYSIS

HB 3980 requires the Texas Health and Human Services Commission, in conjunction with the Texas Department of State Health Services, to prepare a report on:

- The prevalence of suicide in the state.
- State policies and programs adopted across the state systems to prevent suicides.

The report must:

- Include available statewide and regional data on the prevalence rates of suicide-related events, including suicidal thoughts, suicide attempts and deaths caused by suicide. The information should be disaggregated by county and recognized categories of risk and longitudinal to identify changes in suicide prevalence rates since 2000.
- Identify the highest categories of risk with correlation data.
- List state statutes, agency rules and policies related to suicide and suicide prevention, intervention and postvention (activities that promote healing necessary to reduce the risk of suicide by a person affected by the suicide of another).
- Describe state agency initiatives since 2000 to address suicide and include the following information relating to each initiative:
  - The administering state agency.
  - The funding sources.
  - The years of operation.
  - Whether the initiative is an example of a community-based effort to address suicide.

To the extent practicable, the report must include statewide and regional data information that indicates the prevalence of suicide-related events, including the following characteristics:

- Age of the individual.
- Gender of the individual.
- Whether at the time of the event the individual was active duty in a branch of the armed forces of the United States or was a military veteran.

In preparing the report, THHSC and TDSHS must consult and may seek assistance from a nonprofit group that coordinates a multisector network of state and community-based suicide prevention groups and has experience in the

development, implementation and monitoring of a statewide community-based suicide prevention plan. THHSC must complete and submit the summary report no later than May 1, 2020.

The Statewide Behavioral Health Coordinating Council must use the report to prepare a legislative report on suicide in the state that identifies opportunities and makes recommendations, including those that require legislative action, for state agencies to:

- Improve statewide and regional data collection on suicide-related events.
- Use data to guide and inform decisions and policy development relating to suicide prevention.
- Decrease suicide in this state while targeting the highest categories of risk.
- The Council is required to establish a stakeholder workgroup to assist member agencies in preparing the report. The stakeholder group must include:
- A representative of a nonprofit group that coordinates a multisector network of state and community-based suicide prevention groups and assists with the development, implementation and monitoring of a statewide community-based suicide prevention plan.
- A representative of a local mental health authority with experience in suicide prevention and postvention activities.
- Representatives of groups with experience in suicide prevention and postvention activities:
    - In rural, suburban and urban communities.
    - With military and veteran service members and their families.
    - In adult and juvenile justice settings.
- Persons involved in suicide prevention and postvention activities who have lived through the experience of surviving a suicide attempt or have lost a family member to suicide.
- A representative of any other group identified by the Council.

The Council must submit a copy of the legislative report to the governor, lieutenant governor, speaker of the house and each standing committee with jurisdiction over health and mental health by no later than Nov. 1, 2020.

The Act expires Dec. 1, 2020.

IMPLICATIONS

Hospitals may be asked to submit data for the completion of the report. Additionally, hospitals may be able to use the data compiled in the report to inform their delivery of care.

HOUSE BILL 4455
Sponsors:
Sen. Donna Campbell
Rep. Rick Miller
Effective Date: 9/1/19

Mental Health Services Provided Through a Telemedicine Medical Service or Telehealth Service

ANALYSIS

HB 4455 authorizes any health professional to provide mental health services within their license, certification or authorization to any patient located outside of the state through telemedicine or telehealth services. This provision is subject to any laws in the jurisdiction where the patient is located.

IMPLICATIONS

Texas hospitals should be aware that applicable providers are permitted under Texas law to provide mental health services to out-of-state patients through telemedicine or telehealth services. These services are likely subject to the law and regulation of the state where the patient is located, which may require the professional to obtain a license, or other consent, from that state prior to the provision of services.

HOUSE BILL 4559
Sponsors:
Sen. José Rodríguez
Rep. Art Fierro
Effective Date: 9/1/19

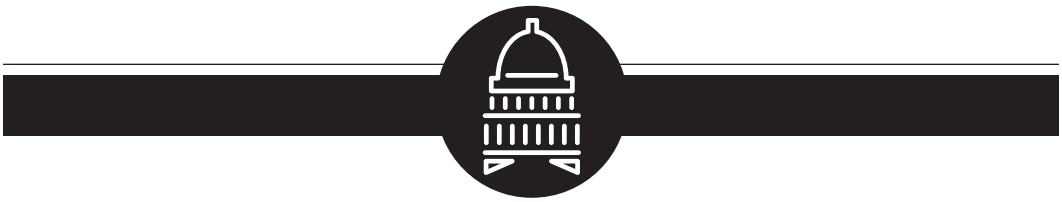
Information on Health Insurance Coverage for County Jail Prisoners who Receive Mental Health Services

ANALYSIS

HB 4559 provides a mechanism for obtaining health insurance coverage information from prisoners in county jails. It requires the Texas Health and Human Services Commission to adopt procedures by which a local mental health authority or other mental health services provider providing services to a prisoner in a county jail under a contract with the county may collect health insurance information, including the policyholder or group contract holder; the number of the policy or evidence of coverage; a copy of the health coverage membership card, if available; and any other information necessary for the prisoner to obtain benefits under the coverage. A local mental health authority or other mental health services provider who provides mental health services to a prisoner under a contract with a county may arrange for the issuer of the health insurance policy or other health benefits coverage to pay for those services.

IMPLICATIONS

Prisoners in county jails with health insurance coverage may be required to use that coverage to cover the cost of any mental health services provided.



CHILDREN'S HEALTH CARE

SENATE BILL 747
Sponsors:
Sen. Lois Kolkhorst
Rep. Eddie Lucio, III
Effective Date: 9/1/19

Administration of the Texas Newborn Screening Program

ANALYSIS

SB 747 relates to the cost of and payment for state-required newborn screening tests. It requires the Texas Department of State Health Services to post the cost of each test on the internet and requires at least 90 days' notice before a change in cost can occur.

It also establishes the Newborn Screening Preservation Account, an account dedicated to ensuring that TDSHS' costs in operating the newborn screening program are covered. The department may use any money remaining in the account after paying the costs of operating the newborn screening program only to pay the costs of offering additional newborn screening tests not offered before Sept. 1, 2019, including the operational costs incurred during the first year of implementing the additional tests, and pay for capital assets, equipment and renovations for the laboratory to ensure the continuous operation of the newborn screening program. TDSHS is prohibited from using money from the account for the department's general operating expenses. Note these provisions are duplicated in SB 748.

The bill also amends the Insurance Code to provide that a health benefit plan that provides maternity benefits or accident and health coverage for additional newborn children may not exclude or limit initial coverage of:

- A newborn child for a period of time.
- Coverage for congenital defects of a newborn child.
- Coverage for administration of required newborn screening tests, including for the cost of a newborn screening test kit in the amount provided on the TDSHS website.

IMPLICATIONS

SB 747 ensures the financial viability of the Texas newborn screening program and limits health insurance companies from excluding coverage for mandated newborn screenings.

SENATE BILL 748
Sponsors:
Sen. Lois Kolkhorst
Rep. Sarah Davis
Effective Date: 9/1/19

Maternal and Newborn Health Care and the Newborn Screening Preservation Account

ANALYSIS

SB 748 contains duplicative provisions to SB 747 to create a newborn screening preservation account for the purpose of carrying out a newborn screening program. The Texas Health and Human Services Commission must ensure that amounts charged are enough to cover the costs of the screening, and pay the costs of the newborn screening program, costs in offering additional newborn screening tests, including operational costs, or pay for capital assets, equipment and renovations for the laboratory established by THHSC for the operation of the screening program.

Additionally, if THHSC determines that an additional newborn screening test is required, THHSC must submit a report to the governor, lieutenant governor and others, summarizing an implementation plan, and attempts to fund the test. THHSC also must provide regular reports to the governor, lieutenant governor and others, summarizing THHSC actions in addressing maternal morbidity and reducing maternal mortality rates – including information from programs created to address maternal morbidity and reduce maternal mortality rates, such as Medicaid, CHIP, Healthy Texas Women and others.

THHSC must work with a task force and interested parties to explore, expand and evaluate certain programs, benefits, payments, funding and services related to pregnancy and maternal health services. The task force will collect statistics and information, annually, related to birthrates and screenings, claims and treatment for postpartum depression. The task force and THHSC also must develop a program to deliver prenatal and postpartum care through telehealth and telemedicine services and must implement the program in at least two counties with populations of at least 2 million, at least one county with a population between 100,000 and 500,000, and at least one rural county with high rates of maternal mortality and morbidity. If THHSC determines it cost-effective, feasible, and likely to reduce unnecessary emergency room visits or hospitalizations, it may provide telemonitoring services and durable medical equipment to women participating in the program and may reimburse providers under Medicaid for the provision of telemonitoring services and durable medical equipment. A report must be submitted to the legislature by Jan. 1, 2021, evaluating the program's success.

The bill also amends the Health and Safety Code to require a sample of blood (or other specimen) taken from the mother on admission for delivery to be tested for syphilis.

THHSC will develop and implement a high-risk maternal care coordination services pilot program and will:

- Conduct a statewide assessment of training courses provided by promotoras or community health workers that target women of childbearing age.
- Study existing models of high-risk maternal care coordination services.
- Identify, adapt or create a risk assessment tool to identify pregnant women who are at a higher risk for poor pregnancy, birth or postpartum outcomes.
- Create educational materials for promotoras and community health workers that include information on assessment tools and best practices for high-risk maternal care.

THHSC will provide support, resources, technical assistance, training and guidance to assess some or all of the pregnant patients in the selected area(s) and integrate community health workers to assist women with high-risk pregnancies in providing education and facilitating care coordination. THHSC will develop training courses to prepare promotoras and community health workers and submit a regular report to the legislature.

SB 748 also requires THHSC to develop a pilot program to establish pregnancy medical homes that provide coordinated evidence-based maternity care management to women who are Medicaid enrollees through a Medicaid managed care model and reside in pilot areas. The program will be implemented in at least two counties with populations of more than 2 million, at least one county with a population of between 100,000 and 500,000, and at least one rural county with high rates of maternal mortality and morbidity as determined by THHSC in consultation with the Maternal Mortality and Morbidity Task Force. In implementing the program, THHSC must ensure that each pregnancy medical home provides a maternal management team that contains appropriate providers, conducts a risk assessment of every program participant, establishes an individual pregnancy care plan for each participant, and follows each participant throughout her pregnancy to reduce poor birth outcomes. THHSC may provide financial incentive for providers who participate in a maternity management team and may waive requirements for a pregnancy medical home located in a rural county. If THHSC determines it will reduce unnecessary emergency room visits or hospitalizations, it may provide telemonitoring services and durable medical equipment to women participating in the program, and at risk of developing pregnancy-related complications, and may reimburse providers under Medicaid for the provision of telemonitoring services and durable medical equipment. THHSC will provide the legislature a report on the pilot program.

IMPLICATIONS

SB 748 creates major changes to maternal and newborn health care in Texas, including updates to the newborn screening program. Texas hospitals offering maternal and newborn services should be aware of these changes, including the potential for new or pilot programs, and possible funding or additional reimbursement. Those interested in participating in the expanded programs or pilots should contact THHSC for additional information.

SENATE BILL 1404
Sponsors:
Sen. Beverly Powell
Rep. Stephanie Klick
Effective Date: 9/1/19

Consent to the Disclosure of Certain Information and to Other Matters Relating to Newborn and Infant Screening Tests

ANALYSIS

SB 1404 amends chapters 33 and 47 of the Health and Safety Code and requires the Texas Department of State Health Services to create an electronic process for the provision of consent for the Texas Newborn Hearing, Screening, Tracking, and Intervention Program. This includes electronic capture and storage of such consent and mandates access to that consent for the child's attending physician. A birthing facility or person required to obtain this consent is not required to use the process created by TDSHS.

This legislation also allows TDSHS to provide required disclosures in various formats and languages, to ensure clear communication of information on the required screening test.

IMPLICATIONS

Facilities subject to TDSHS' Texas Newborn Hearing, Screening, Tracking, and Intervention Program should be aware of the potential to obtain parental consent electronically and of the potential for TDSHS to provide necessary disclosure in various formats and languages.

HOUSE BILL 2255
Sponsors:
Sen. Nathan Johnson
Rep. Drew Darby
Effective Date: 9/1/19

Newborn and Infant Hearing Screening Results and the Provision of Information

ANALYSIS

HB 2255 addresses the handling of the results of newborn hearing screening tests. Under the bill, a birthing facility that operates a newborn or infant hearing screening program must simultaneously distribute to the parents of each newborn or infant who is screened the screening results and educational informational materials that are standardized by the Texas Department of State Health Services on:

- Follow-up care.
- Available public resources, including:
  - Early childhood intervention services.
  - The primary statewide resource center, the Texas School for the Deaf.
  - Contact information for Texas Early Hearing Detection and Intervention.

TDSHS is required to make the educational and information materials available to the public on request.

A birthing facility that operates a newborn or infant hearing screening program now also must report screening results to the Texas School for the Deaf in addition to newborn or infant's parents, the newborn or infant's attending physician, primary care physician or other applicable health care provider and the TDSHS.

The legislation applies to newborn hearing screening, tracking and intervention programs certified by the Texas Department of State Health Services under chapter 47 of the Health and Safety Code.

If a newborn or infant does not pass a hearing screening during a follow-up screening, the newborn hearing screening, tracking and intervention program that performed the follow-up hearing screening must now, in addition to providing the screening results to the newborn's or infant's parents, with the prior written consent of the newborn's or infant's parents, provide the screening results to the primary statewide resource center, the Texas School for the Deaf.

Additionally, newborn hearing screening, tracking and intervention programs must now in addition to referring the newborn or infant to early childhood intervention services refer the newborn or infant to the Texas School for the Deaf.

Finally, the executive commissioner of the Texas Health and Human Services Commission must by rule develop guidelines to protect the confidentiality of

patients in accordance with chapter 159 of the Occupations Code, Physician-Patient Communication, before any individually identifying information is provided to the Texas School for the Deaf. The Texas School for the Deaf must permit a parent or guardian at any time to withdraw information provided to them.

IMPLICATIONS

Birthing facilities and hospitals that operate newborn hearing screening, tracking and intervention programs should adjust their procedures to ensure they are simultaneously distributing the TDSHS-developed educational and information materials and screening results to parents of newborns or infants who are screened. They also should adjust their procedures to ensure they refer newborn or infant screening results to the Texas School for the Deaf. The rulemaking process authorized by HB 2255 may provide additional detail regarding implementation of the new requirements and should be monitored.

HOUSE BILL 2783
Sponsors:
Sen. Dawn Buckingham
Rep. Terry Wilson
Effective Date: 9/1/19

Pediatric Acute-Onset Neuropsychiatric Syndrome Advisory Council

ANALYSIS

HB 2783 establishes the Pediatric Acute-Onset Neuropsychiatric Syndrome Advisory Council to advise the Texas Health and Human Services Commission and the Texas Legislature on research, diagnosis, treatment and education related to pediatric acute-onset neuropsychiatric syndrome.

Pediatric acute-onset neuropsychiatric syndrome is a clinical diagnosis for children experiencing an acute onset of obsessive-compulsive disorder.

The advisory council is composed of 19 members:

- One member designated by the THHSC executive commissioner.
- Two members of the Texas Senate appointed by the lieutenant governor.
- Two members of the Texas House of Representatives appointed by the Speaker of the House of Representatives.
- 14 members appointed by the governor with the following qualifications:
    - One member who is a licensed health care provider with expertise in treating persons with pediatric acute-onset neuropsychiatric syndrome, including pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and autism.
    - One member who is an osteopathic physician with experience treating

persons with pediatric acute-onset neuropsychiatric syndrome, including pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections.

- One member who is a pediatrician with experience treating persons with pediatric acute-onset neuropsychiatric syndrome, including pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections.
- One member who is a child psychiatrist with experience treating person with pediatric acute-onset neuropsychiatric syndrome, including pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections.
- One member who is an immunologist with experience treating persons with pediatric acute-onset neuropsychiatric syndrome, including pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections, and the use of intravenous immunoglobulin.
- One member who is a dietician or nutritionist who provides services to children with autism spectrum disorders, attention-deficit/hyperactivity disorders and other neuro-developmental conditions.
- One member with experience in conducting research on pediatric acute-care neuropsychiatric syndrome, including pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections, obsessive-compulsive disorder, tic disorders and other neurological disorders.
- One member who is licensed in Texas to practice as a social worker.
- One member who is a representative of the Texas Education Agency with expertise in special education services.
- One member who is a psychologist licensed under chapter 501 of the Occupations code;
- One member who is a representative of a professional organization in Texas for school nurses.
- One member who is a representative of an advocacy and support group in Texas for individuals affected by pediatric acute-onset neuropsychiatric syndrome, including pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections.
- One member who is a representative of an advocacy and support group in Texas for individuals affected by autism.
- One member who is a parent of a child who has been diagnosed with pediatric acute-onset neuropsychiatric syndrome or autism.

The advisory council must prepare and submit to the governor, legislature and THHSC a written report that includes recommendations on:

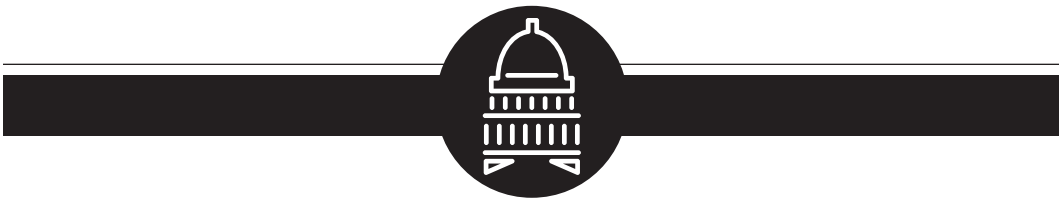
- Practice guidelines for the diagnosis and treatment of pediatric acute-onset neuropsychiatric syndrome, including pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections.
- Mechanisms to increase clinical awareness and education regarding pediatric acute-onset neuropsychiatric syndrome, including pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections, among physicians, including pediatricians, school-based health centers, and mental health care providers.
- Strategies for outreach to educators and parents to increase awareness of pediatric acute-onset neuropsychiatric syndrome, including pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections.
- Developing a network of volunteer experts on the diagnosis and treatment of pediatric acute-onset neuropsychiatric syndrome, including pediatric acute-onset neuropsychiatric disorders associated with streptococcal infections, to assist in the delivery of education and outreach.

Any action to develop or disseminate information or materials pertaining to the advisory council's required report does not create a civil or administrative cause of action or civil or criminal liability and does note create a standard of care, obligations or duty that provides the basis for a cause of action.

The advisory council is subject to review by the Texas Sunset Commission and is abolished on Sept. 1, 2023 unless continued by the commission. Chapter 1110 of the Government Code, State Agency Advisory Committees does not apply to the advisory council.

IMPLICATIONS

Personnel in hospital pediatric or psychiatric departments or affiliated clinics focused on pediatric, psychiatric or family medicine may be interested in the development of this advisory council and its recommendations. Key issue area experts may be interested in applying to serve on the advisory council.



EMERGENCY CARE/TRAUMA

SENATE BILL 285
Sponsors:
Sen. Borris Miles
Rep. Ed Thompson
Effective Date: 9/1/19

Governor's Hurricane Preparedness Proclamation and Report

ANALYSIS

SB 285 requires the governor to issue a proclamation each year before hurricane season instructing:

- Individuals to prepare their property and communities.
- State agencies to review and update their hurricane preparedness plans.
- The Texas Department of Insurance, the Texas Department of State Health Services, municipalities and counties, the Texas Division of Emergency Management of the Texas Department of Public Safety, the Texas Education Agency and the Office of the Comptroller to conduct community outreach and education activities on hurricane preparedness between May 25 and May 31 of each year.

Within 30 days of the proclamation, the governor must publish on the website of the Office of the Governor a report on the preparedness of state agencies for hurricane response. The report must include:

- A list of each state agency involved in the state's response to a hurricane.
- Contact information for each state agency in the event of a hurricane, including the name, e-mail address and telephone number of the officer or employee who manages the state agency's response to a hurricane.
- Information indicating whether the officer or employee managing the agency's response to a hurricane has completed an approved emergency management training course.

The bill authorizes the governor, by executive order, to take any action necessary to ensure each state agency involved in hurricane response is able to respond to a hurricane.

SB 285 also requires the General Land Office to conduct an annual public information campaign before and during hurricane season to provide local officials and the public with information regarding housing assistance that may be available in the event of a major hurricane or flooding event.

IMPLICATIONS

Hospitals should look for the governor's annual proclamation on hurricane preparedness as a reminder to prepare for hurricane season. Hospitals should alert employees working on emergency preparedness to access the governor's annual report for up-to-date information on state agency contacts responding to hurricanes.

SENATE BILL 752
Sponsors:
Sen. Joan Huffman
Rep. Tom Oliverson
Effective Date: 9/1/19

Liability Protection for Volunteer Health Care Professionals

ANALYSIS

SB 752 provides liability protection for volunteer health care professionals, except in cases of reckless conduct or intentional, willful or wanton misconduct, when giving care, assistance or advice during a manmade or natural disaster, regardless of where the care takes place.

Health care facilities also are immune from civil liability for an act or omission by the protected volunteer health care provider providing care, assistance or advice at the facility or under its direction, when there is no expectation of compensation from or on behalf of the recipient, in excess of reimbursement for expenses incurred by the facility in connection with the provision of care, assistance or advice.

IMPLICATIONS

Hospital employees and their affiliated facilities are immune from civil liability when providing care, assistance or advice during a manmade or natural disaster. Volunteer efforts will ensure timely access to essential health care services during disasters, such as a hurricane or terrorist attack. See also House Bill 3365, related to immunity for providing assistance at the request of a charitable organization.

SENATE BILL 982
Sponsors:
Sen. Lois Kolkhorst
Rep. John Zerwas
Effective Date: 9/1/19

Access to Health Care Services During a Disaster

ANALYSIS

SB 982 addresses access to health care services during a disaster. The bill requires the Texas Division of Emergency Management of the Texas Department of Public Safety, in consultation with the Texas Department of State Health Services and local governments, to develop a plan to increase the capabilities of local emergency shelters with respect to specialty care populations during a disaster. Under the bill, TDEM, in consultation with TDSHS, must encourage local government emergency response teams to utilize services provided by local volunteer networks, including the Medical Reserve Corps. SB 982 requires TDEM to develop a plan to create and manage state-controlled volunteer mobile medical units in each public health region to assist counties that lack access to a local volunteer network.

TDSHS must coordinate with local medical organizations that represent physicians to:

- Ensure physicians are informed about local government emergency response teams and that those teams are aware of physician resources in the area.
- Develop a list of physicians in each county or region and their contact information.
- Provide information and education to physicians about disaster planning.
- Promote the Texas Disaster Volunteer Registry and the Emergency System for Advance Registration of Volunteer Health Professionals.
- Consider incentives to assist with recruiting physician volunteers.
- Encourage physicians and health care professionals to advocate for disaster planning measures in health care facilities.

SB 982 creates a task force on disaster issues affecting persons who are elderly and persons with disabilities. By Dec. 1, 2020, the task force must conduct a study and provide a written report with recommendations to the governor and the legislature.

IMPLICATIONS

TDEM and TDSHS consistently provide valuable information regarding coordinated disaster planning and response. The medical community should look to these agencies for resources. Hospitals should look for forthcoming information from TDEM on shelters with increased capabilities for specialty populations and consider those capabilities in disaster planning. Hospitals also should encourage their affiliated physicians to familiarize themselves with local government emergency response teams and to seek out volunteer opportunities through TDSHS in advance of a disaster.

HOUSE BILL 7
Sponsors:
Sen. Joan Huffman
Rep. Jeanie Morrison
Effective Date: 9/1/19

List of Disaster Service Contractors and Statutes That may Require Suspension During Disaster Declaration

ANALYSIS

HB 7 requires the Office of the Governor to develop a comprehensive list of regulatory statutes and rules that may require suspension during a disaster.

In addition, under HB 7, the Texas Division of Emergency Management of the Texas Department of Public Safety must develop a plan to assist political subdivisions with contracting for services that political subdivisions are likely to need following a disaster, including:

- Training on the benefits of executing disaster preparation contracts in advance of a disaster.
- Recommendations on the services political subdivisions are likely to need following a disaster, including:
  - Debris management and infrastructure repair.
  - Assistance with identifying vendors who can provide these services.

HB 7 also requires TDEM to consult with the state comptroller on including contracts likely needed by political subdivisions on the schedule of multiple award contracts or another cooperative purchasing program.

IMPLICATIONS

HB 7 will simplify the identification of which statutes may need to be suspended during a disaster period by requiring the governor to maintain a proactive list. In addition, HB 7 seeks to assist political subdivisions with contracting for both disaster preparation and mitigation by requiring TDEM to enact a disaster contracting plan, which will include best practices, a list of vendors and the possibility of group purchasing through the state. All Texas hospitals should take note of the comprehensive list of statutes subject to suspension during disasters. Hospital districts and public hospitals should monitor the TDEM website for disaster contracting resources and vendors.

HOUSE BILL 1256
Sponsors:
Sen. Lois Kolkhorst
Rep. Dade Phelan
Effective Date: 9/1/19

Access to State Immunization Registry for First Responders and Their Employers

ANALYSIS

HB 1256 requires the Texas Department of State Health Services by Jan. 1, 2020 to implement rules establishing a process to provide an employer of a first

responder with direct access to the first responder's immunization information in the immunization registry to verify immunization history. The process must require a first responder to provide electronic or written consent before the employer is granted direct access. In addition, TDSHS may establish a process to provide a first responder with access to the immunization registry, which will allow first responders to verify their own immunizations during a disaster.

IMPLICATIONS

Hospitals should notify their affiliated first responders and their employers of the ability to access the state immunization registry to verify which immunizations first responders have received. TDSHS must complete rulemaking regarding the process by Jan. 1, 2020.

HOUSE BILL 1418
Sponsors:
Sen. Joan Huffman
Rep. Dade Phelan
Effective Date: 5/27/19

Immunization Information for Emergency Medical Services Personnel on Certification or Re-Certification

ANALYSIS

HB 1418 requires the Texas Health and Human Services Commission to adopt a system to provide immunization information to individuals who file an application for certification or recertification as emergency medical services personnel. The system must require THHSC to provide written notice of the applicant's immunization history using information from the immunization registry if the applicant's history is included in the registry. If the applicant's history is not included in the registry, THHSC must provide details about the immunization registry and the benefits of inclusion. This information must detail specific risks to emergency medical services personnel when responding rapidly to an emergency of exposure to and infection by a potentially serious or deadly communicable disease that an immunization may prevent.

IMPLICATIONS

Emergency services personnel employed by or on contract with a hospital will be able to electronically access their immunization information to ensure they are current on required and recommended immunizations. This information will be particularly helpful during a natural or manmade disaster where emergency services personnel may need to quickly determine their vaccination status so they can ensure they are fully vaccinated before participating in response and recovery efforts.

HOUSE BILL 2048
Sponsors:
Sen. Joan Huffman
Rep. John Zerwas
Effective Date: 9/1/19

Repeal of the Driver Responsibility Program and the Establishment of Alternative Methods to Fund Designated Trauma Hospitals

ANALYSIS

HB 2048 repeals the Driver Responsibility Program and waives all related, outstanding surcharges. New dedicated payments to the state's Trauma Facilities and Emergency Medical Services Account 5111 for designated trauma hospitals will come from the following alternative revenue streams:

- 60 percent of the revenue from fees paid to the Auto Theft Prevention Fund collected by automobile insurance companies. Revenue is raised via a $4 fee multiplied by the total number of motor vehicle years of insurance for insurance policies delivered, issued for delivery or renewed by the insurer.
- 20 percent of the revenue from fines received from individuals convicted of operating a motor vehicle while intoxicated in the amount of:
  - $3,000 for the first conviction within a 36-month period.
  - $4,500 for a second or subsequent conviction within a 36-month period.
  - $6,000 for a first or subsequent conviction if it is shown on the trial of the offense that an analysis of a specimen of the person's blood, breath or urine showed an alcohol concentration level of 0.15 or more at the time of the analysis.
- 30 percent of revenue from the state traffic fine, which increases to $50 from $30. A municipality or county may retain four percent of the money collected as a service fee for the collection if the municipality or the county remits the funds to the comptroller no later than the last day of the month following each calendar quarter.

Seventy percent of funds generated by the state traffic fine and eighty percent from fines for conviction of certain intoxicated driver offenses will be credited to the undedicated portion of the state's general revenue fund.

Revenue allocated to the Trauma Facilities and Emergency Medical Services Account 5111, will be split annually as follows:

- 94 percent will fund a portion of the uncompensated trauma care provided at state designated trauma facilities or an undesignated facility in active pursuit of designation.
- 3 percent of the revenue will fund local emergency medical services to provide coordination with the appropriate trauma service area, the cost of supplies, operational expenses, education and training, equipment vehicles and communications systems.
- 2 percent will fund operation of the 22 regional areas advisory councils for

equipment, communications, education and training. A regional advisory council's share of money must be based on the relative geographic size and population of each trauma service area and on the relative amount of trauma care provided.

Note, House Bill 1631 (Author: Rep. Jonathan Stickland; Sponsor: Sen. Bob Hall) also passed prohibiting the use of photographic traffic signal enforcement systems. The Trauma Facilities and Emergency Medical Services Account 5111 previously received approximately 14 percent of its revenue from these red-light cameras. HB 2048 accommodates for the loss of those dollars by shifting the percentages of revenue flowing to Trauma Facilities and Emergency Medical Services Account 5111 and the undedicated portion of the general revenue fund.

IMPLICATIONS

Designated trauma hospitals will enjoy the benefits of a new, stable source of dedicated funding. The biennial threat of having the Driver Responsibility Program repealed and dedicated funding for the state's designated trauma hospitals lost is gone as a result of HB 2048 becoming law.

HOUSE BILL 2325
Sponsors:
Sen. Kelly Hancock
Rep. Will Metcalf
Effective Date: 9/1/19

Information and Communication of Governmental and Other Entities Regarding Disasters and Health and Human Services

ANALYSIS

Under HB 2325, the Texas Division of Emergency Management of the Texas Department of Public Safety, in consultation with the Texas A&M AgriLife Extension Service, must coordinate state and local government efforts to make 9-1-1 emergency service capable of receiving text messages from a cellular telephone or other wireless communication device.

TDEM, in consultation with any state agency or private entity the division determines appropriate, also must develop standards for the use of social media as a communication tool by governmental entities during and after a disaster. The standards must:

- Require state agencies, political subdivisions, first responders and volunteers that use social media during and after a disaster to post consistent and clear information.
- Optimize the effectiveness of social media use during and after a disaster.
- Require that certain official social media accounts be used during and after a disaster only for providing credible sources of information.

TDEM must develop a mobile application for wireless communication devices to communicate critical information during a disaster directly to disaster victims and first responders. The mobile application may provide information on:

- Road and weather conditions during a disaster.
- Disaster response and recovery activities.

Additionally, TDEM must develop a comprehensive web portal that:

- Provides disaster information to the public, including information on programs and services available to disaster victims and funding for and expenditures of disaster assistance programs.
- Includes information disaster response and recovery activities.
- Provides information on obtaining assistance from the Federal Emergency Management Agency, state agencies, organized volunteer groups and other entities providing disaster assistance.

To the extent feasible, TDEM is charged with using data analytics software to integrate data from federal, state, local and nongovernmental sources to more effectively manage disaster response and recovery.

To improve the state's response to disasters, TDEM also must conduct a study on the use of a standard communication format by first responders to create a common interoperable operating framework during a disaster. The study must:

- Examine the costs and benefits of promoting the use of a standard communication format to create a comprehensive common operating framework that is interoperable across networks.
- Identify any costs that first responders may incur in acquiring or upgrading equipment or services complying with a standard communication format.
- Identify necessary actions to adopt a standard communication format.

A report on the study's findings is due no later than Sept. 1, 2020.

HB 2325 also requires community outreach, including public awareness campaigns, and education activities on disaster preparedness each year. To the extent practicable, the following entities must coordinate on this effort:

- Municipalities and counties.
- The Texas Department of Public Safety, including TDEM.
- The Texas Education Agency.
- The Office of the Comptroller.
- The Texas Department of Insurance.

- The Texas Department of Transportation.
- The Texas Department of Housing and Community Affairs.
- The Texas Health and Human Services Commission.
- The Texas Department of State Health Services.

County hospitals, public hospitals, hospital districts or public safety entities are permitted to purchase commodity items through the Texas Department of Information Resources if the hospital, hospital district or public safety entity finds that the purchase of the commodity items will be of assistance in providing disaster education or preparing for a disaster. Commodity items (as defined in chapter 2157 of the Government Code, Purchase of Automated Information Services) means:

- Commercial software hardware.
- Technology services, other than telecommunications services, which are generally available to businesses or the public and for which the department determines that a reasonable demand exists in two or more state agencies.

The term includes seat management, through which a state agency transfers its personal computer equipment and service responsibilities to a private vendor to manage the personal computing needs for each desktop in the state agency, including all necessary hardware, software and support services.

Public safety entities, defined as public safety services and emergency response providers (see definitions below), may contract with TDIR for the use of the consolidated telecommunications system, the network of telecommunications services serving the state government, if the public safety entity or governmental entity finds that the use of the consolidated telecommunications system will assist the entity in providing disaster education or preparing for a disaster.

For purposes of the bill:

- Public safety services mean services whose sole or principal purpose is to protect the safety of life, health or property; that are not made commercially available to the public by the provider and that are provided by state or local government entities or nongovernmental organizations that are authorized by a governmental entity whose primary mission is the provision of such services.
- Emergency response providers includes federal, state and local governmental and:
    - Nongovernmental emergency public safety.
    - Fire.

- Law enforcement.
- Emergency response.
- Emergency medical (including hospital emergency facilities).
- Related personnel, agencies and authorities.

A public safety entity, county hospital, public hospital or hospital district are added to the list of entities that may purchase commodity items through TDIR. These entities may be charged a reasonable administrative fee as a component of participation. They also are given permission to contract with TDIR for use of the consolidated telecommunications system.

The Texas Information and Referral Network at THHSC is the program responsible for the development, coordination and implementation of a statewide information and referral network that integrates existing community-based structures with state and local agencies. HB 2325 requires the network to:

- Be capable of assisting with statewide disaster response and emergency management, including through the use of interstate agreements with out-of-state call centers to ensure preparedness and responsiveness.
- Include technology capable of communication with clients of state and local agencies using electronic text messaging.
- Include a publicly accessible Internet-based system to provide real-time, searchable data about the location and number of clients of state and local agencies using the system and the types of requests made by clients.

IMPLICATIONS

Hospital emergency management and response personnel should acquaint themselves with the content of HB 2325 to better understand the work being done to coordinate 9-1-1 text communication, develop standards for the use of social media as a communications tool, develop a mobile application for wireless communication devices, develop a disaster web portal, study standard communication format and develop disaster preparedness community outreach. There will be opportunities to participate in and involve key issue area experts in local and state collaboration efforts.

Hospital emergency management and response personnel in coordination with technology communication and operations personnel will want to acquaint themselves with the contracting, purchasing and partnership components of this new law to identify potential opportunities.

HOUSE BILL 2330
Sponsors:
Sen. Eddie Lucio, Jr.
Rep. Armando Walle
Effective Date: 5/24/19

Study of State Intake System and State Case Management System for Disaster Assistance

ANALYSIS

HB 2330 requires the Texas Division of Emergency Management of the Texas Department of Public Safety and the Texas Health and Human Services Commission to conduct a study to determine the feasibility of developing:

- A single intake form to compile all information needed to obtain disaster assistance from multiple state and federal programs for an individual who needs assistance as a result of a disaster.
- An automated intake system for collecting the information.
- A state case management system for disaster assistance, administered by THHSC, which is similar to the Federal Emergency Management Agency case management system and includes contracting with nonprofit vendors to hire caseworkers and provide case management services.

TDEM and THHSC must coordinate with FEMA and determine:

- Whether FEMA and other appropriate state and federal agencies will accept the single intake form.
- The cost of the form and the automated intake system.
- The cost of developing and maintaining a state case management system and the extent to which federal reimbursement is available.

TDEM and THHSC must submit the study to the legislature by Sept. 1, 2020. TDEM and THHSC may implement the single intake form, automated intake system and case management system if they determine, based on the study, that the state will incur no additional cost.

IMPLICATIONS

HB 2330 addresses concerns identified by stakeholders that survivors of natural disasters were required to fill out multiple forms to apply for services, such as case management and financial assistance. HB 2330 requires a study of improvements to case management services to help survivors of natural disasters more easily receive disaster recovery assistance.

HOUSE BILL 3365
Sponsors:
Sen. Carol Alvarado
Rep. Dennis Paul
Effective Date: 6/2/19

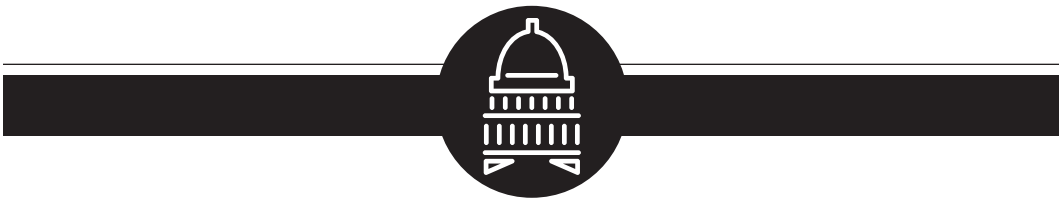
Liability Protections for Charitable Organizations and Their Volunteers Providing Disaster Assistance (Good Samaritan Law)

ANALYSIS

Under HB 3365, a person is immune from civil liability for an act or omission that occurs in giving care, assistance or advice with respect to the management of a manmade or natural disaster at the request of a charitable organization unless the person engages in reckless conduct or intentional, willful or wanton misconduct. Prior to HB 3365, Texas law extended this immunity only to individuals acting at the request of an authorized representative of a local, state or federal agency. HB 3365 also extends full immunity to the governmental entity or charitable organization making the request. These immunities are in addition to any other immunity or limitations of liability provided by law. Finally, the bill clarifies that a disaster includes a major disaster declared by the president of the United States or the governor.

IMPLICATIONS

HB 3365 broadens liability protections for volunteers providing care, assistance or advice during a declared disaster and protects charitable organizations, including nonprofit hospitals, from liability based on an act or omission of a volunteer acting on the organization's request. See also Senate Bill 752, related to the liability of health care professionals providing assistance during a disaster.



END-OF-LIFE CARE

SENATE BILL 916
Sponsors:
Sen. Nathan Johnson
Rep. John Zerwas
Effective Date: 6/10/19

Supportive Palliative Care

ANALYSIS

SB 916 distinguishes supportive palliative care from hospice care and defines "supportive palliative care" as physician-directed interdisciplinary patient- and family-centered care provided to a patient with a serious illness without regard to the patient's age or terminal prognosis that:

- Can be provided concurrently with methods of treatment or therapies that seek to cure or minimize the effects of the illness.
- Seeks to optimize the quality of life for a patient.

Supportive palliative care includes methods seeking to:

- Anticipate, prevent and treat the patient's total suffering related to the patient's physical, emotional, social and spiritual condition.
- Address the physical, intellectual, emotional, cultural, social and spiritual needs of the patient.
- Facilitate for the patient treatment options, education, informed consent and expression of desires.

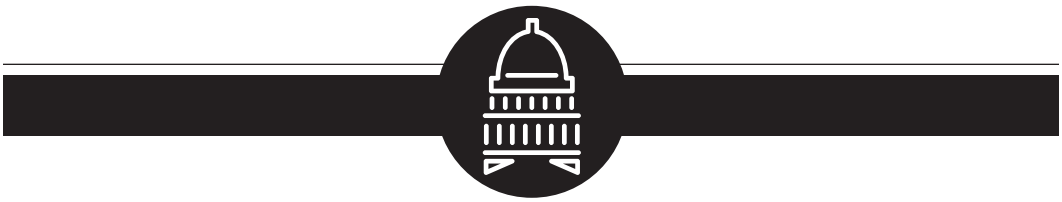
All references to palliative care in the Health and Safety Code and any other law are now tied to the definition of "supportive palliative care" in SB 916.

Under the bill, the Texas Health and Human Services Commission will conduct a study to assess potential improvements to a patient's quality of care and health outcomes through supportive palliative care. The Palliative Care Interdisciplinary Advisory Council will provide recommendations for the structure of the study, and THHSC will report all findings to the PCIAC by Sept. 1, 2022, with the PCIAC including the study in a report submitted to the Texas Legislature by Oct. 1, 2022.

IMPLICATIONS

SB 916 increases the accessibility of supportive palliative care by solidifying the statutory distinction between palliative care and hospice care, requiring THHSC to conduct a study and laying groundwork to facilitate greater access to supportive palliative care.

Facilities with palliative care programs should include the new definitions in policies and procedures and request findings from THHSC and the PCIAC, once available.



FREESTANDING EMERGENCY CENTERS

HOUSE BILL 1112
Sponsors:
Sen. Lois Kolkhorst
Rep. Sarah Davis
Effective Date: 9/1/19

Removing Signs Indicating Freestanding Emergency Medical Care Facilities are Operational

ANALYSIS

HB 1112 requires freestanding emergency medical care facilities licensed under chapter 254 of the Health and Safety Code to immediately remove or cause to be removed any signs within view of the general public indicating that the facility is in operation after a facility closes or for which a license under this chapter expires or is suspended or revoked.

The bill allows the Texas Department of State Health Services to petition a district court for a temporary restraining order and allows the court by injunction to prohibit a person from continuing the violation.

IMPLICATIONS

The bill adds requirements to freestanding emergency centers licensed under chapter 254 that close and brings them more in line with requirements set for hospitals licensed under chapter 241 that have existing requirements regarding signage removal after a closure or license suspension or revocation.

HOUSE BILL 2041
Sponsors:
Sen. Larry Taylor
Rep. Tom Oliverson
Effective Date: 9/1/19

New Disclosure Requirements for Independent and Hospital-Owned Freestanding Emergency Centers

ANALYSIS

Subject to two important exceptions, HB 2041 requires both independent freestanding emergency centers licensed under chapter 254 of the Health and Safety Code and hospital-owned freestanding emergency centers licensed under chapter 241 of the Health and Safety Code to provide to a patient or a patient's legally authorized representative a written disclosure that:

- Lists the facility's observation and facility fees.
- Lists the health benefit plans in which the facility is an in-network provider or states that the facility is an out-of-network provider for all health benefit plans.
- Includes the name and contact information of the facility and a place for the patient or legally authorized individual to sign.
- States, if applicable and without any additional information, "This facility charges a facility fee for medical treatment" and includes the facility's median facility fee, a range of possible facility fees, and the facility fees for each level of care provided at the facility.

- States, if applicable and without any additional information, "This facility charges an observation fee for medical treatment" and includes the facility's median observation fee, a range of possible observation fees, and the observation fees for each level of care provided at the facility.
- Is updated annually.
- May, but is not required, include information on the facility's procedures for seeking reimbursement from the patient's health benefit plan.

The facility must attempt to obtain a signature from the patient or patient's legally authorized representative in accordance with the state version of EMTALA. The disclosure statement must be in English and Spanish in at least 16-point boldface type in a font that is easily readable in a contrasting color. Each facility must provide each patient with a physical copy of the disclosure statement even if the patient refuses or is unable to sign the statement. If the patient refuses or is unable to sign the statement, the facility must indicate in the patient's file that the patient failed to sign. Each facility must retain a copy of a signed disclosure statement for at least one year from the date of signature. A facility's failure to obtain the signed disclosure statement may not be a determining factor in the adjudication of liability for health care services provided to the patient at the facility.

HB 2041 includes two important exceptions to providing the new disclosure statement:

- The statement is not required if the facility determines, before providing emergency care, that the patient will not be billed for the services.
- The full disclosure statement is not required if the facility posts on its website in a manner that is easily accessible and readable: the facility's standard charges, including the fees required by the statement, and updates to the standard charges at least annually or more frequently as appropriate to reflect the facility's current charges. If the facility complies with these online posting requirements, the only portion of the statement the facility must provide is a list of the health benefit plans in which the facility is an in-network provider or a statement that the facility is an out-of-network provider for all health benefit plans. (The signature, font size and language requirements still apply.)

HB 2041 also makes minor changes to the existing notice requirements for independent and hospital-owned freestanding emergency centers most recently required by HB 3276, 85th Texas Legislature, substituting the phrase "out-of-network provider" for the phrase used under current law, which is "may not be a participating provider" and requiring online posting for existing disclosures regarding health benefit plan provider network status.

Under HB 2041, hospital-owned and independent freestanding emergency centers must do one of the following:

- Post a notice stating that the facility is an out-of-network provider for all insurance plans in the facility entrance, each patient treatment room and at each location in the facility where a person pays for services and on the home page of the facility's website or an different page available through a hyperlink that is entitled "Insurance Information" and located prominently on the home page.
- Post a list of the insurance plans in which the facility is an in-network provider in the facility entrance, each patient treatment room and at each location in the facility where a person pays for services and on the home page of the facility's website or a different page available through a hyperlink that is entitled "Insurance Information" and located prominently on the home page.
- If the facility is in-network with one or more insurers, provide a list of those insurance plans on its website and confirm a patient's eligibility in writing.

A facility may not add to or alter the language of a notice required by this section.

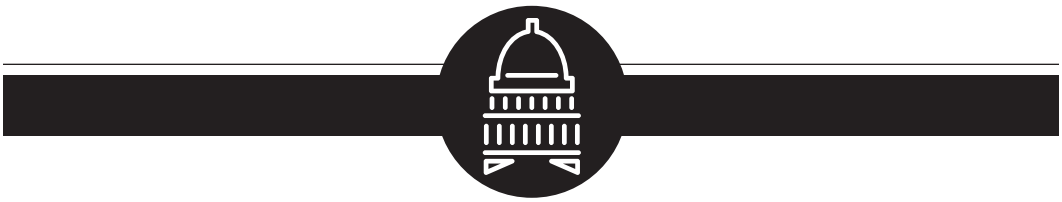
HB 2041 prohibits independent and hospital-owned freestanding emergency centers from advertising or holding themselves out as in-network providers by stating that they "take" or "accept" an HMO, health benefit plan or health benefit plan network if they are out-of-network with all products offered by the health benefit plan issuer. In addition, facilities may not use the name or logo of a health benefit plan issuer in any signage or marketing materials if they are out-of-network with all of the issuer's health benefit plans. A violation of these previsions is actionable by the attorney general under the Deceptive Trade Practices-Consumer Protection Act.

HB 2041 requires an independent freestanding emergency center that closes, is no longer licensed or has its licensed suspended to immediately remove any signs within view of the general public indicating that the facility is in operation. The Texas Department of State Health Services may petition a district court for a temporary restraining order if an independent freestanding emergency center is in continuing violation of the sign removal requirement. Note that HB 1112 includes the same sign removal requirement.

HB 2041 establishes the freestanding emergency medical care facility licensing fund for any penalties assessed against independent freestanding emergency centers licensed under chapter 254 of the Health and Safety Code and removes the $5,000 cap for continuing violations (which are still assessed at $1,000 per violation).

IMPLICATIONS

Hospitals that own freestanding emergency centers operating as hospital outpatient departments under chapter 24 of the Health and Safety Code and hospitals affiliated with independent freestanding emergency centers licensed under chapter 254 of the Health and Safety Code should closely review HB 2041 to ensure they comply with the new posting and disclosure requirements. Hospitals already should be following the majority of the pricing disclosure requirements in HB 2041 due to federal law requiring hospitals to post their chargemasters, but hospitals should closely review the information they post online. Note that facilities that post their charges online do not need to provide the majority of the information in the new disclosure statement; however, independent and hospital-owned freestanding emergency centers still must provide written disclosure to patients and their legally authorized representatives indicating the health benefit plan issuers in which they are in-network. In addition, hospitals should review marketing materials and websites to ensure that the logo of an out-of-network health benefit plan issuer is not featured, and that the words "take" or "accept" are not used in relation to out-of-network health benefit plan issuers. Note that the prohibition on using a logo only applies if the facility is out-of-network with all of an individual health benefit plan issuer's product. Finally, hospitals affiliated with independent freestanding emergency centers should take note of the removal of the $5,000 penalty cap for violations and ensure that they comply with HB 2041's signage removal requirements when not in operation.



HEALTH CARE COVERAGE

SENATE BILL 1739
Sponsors:
Sen. José Menéndez
Rep. Eddie Lucio, III
Effective Date: 9/1/19

Chiropractic Service Reimbursement Protections for HMOs and PPOs

ANALYSIS

SB 1739 prohibits a health maintenance organization or a preferred provider organization offering a health care plan that covers a service within the scope of a chiropractor's license from refusing to provide reimbursement to an in-network chiropractor for the performance of the covered service solely because the service is provided by a chiropractor. An HMO or PPO that violates SB 1739 is subject to an administrative penalty of up to $1000 per claim, per day.

IMPLICATIONS

In Texas, some health insurers reimburse providers for treatment provided by a physician or physical therapist but deny payment if the same treatment is rendered by a chiropractor. SB 1739 requires HMOs and PPOs to reimburse an in-network chiropractor for a covered service within the chiropractor's scope of practice if the payer would reimburse another provider for the same service. Providers of chiropractic services should advise their billing and collections departments of the new reimbursement protections for in-network chiropractors providing covered services.

SENATE BILL 1742
Sponsors:
Sen. José Menéndez
Rep. Julie Johnson
Effective Date: 9/1/19

Physician and Health Care Provider Directories, Preauthorization and Utilization Review for Certain Health Benefit Plans

ANALYSIS

SB 1742 enacts several provisions related to health benefit plans. First, it imposes requirements for provider directories to:

- List under a facility's name separate headings for radiologists, anesthesiologists, pathologists, emergency department physicians, neonatologists and assistant surgeons.
- List under each of these specialties each facility-based physician practicing in the specialty corresponding with that heading that is a preferred provider, exclusive provider or network physician.
- For the facility and each facility-based physician, clearly indicate each health benefit plan issued by the issuer that may provide coverage for the services provided by that facility or physician. The directory must also include the facility in a listing of all facilities included in the directory indicating:
  - The name of the facility.
  - The municipality in which the facility is located or county in which the

facility is located if the facility is in the unincorporated area of the county.

- For each specialty of facility-based physicians practicing at the facility, the name, street address and telephone number of any facility-based physician that is a preferred provider, exclusive provider or network physician or of the physician group in which the facility-based physician practices.
- Each health benefit plan issued by the issuer that may provide coverage for the services provided by the facility.
- Each health benefit plan issued by the issuer that may provide coverage for the services provided by each facility-based physician group.

The directory must list a facility-based physician individually and, if the physician belongs to a physician group, as part of the physician group.

SB 1742 also contains provisions related to preauthorization procedures. Specifically, a health maintenance organization or insurer that uses a preauthorization process for health care services must make the requirements and information about the preauthorization process readily accessible to enrollees, physicians, providers and the general public by posting the requirements and information on the HMO or insurer's website. The preauthorization requirements and information must be posted conspicuously in a location on the website that does not require the use of a log-in or other input of personal information to view the information and in a format that is easily searchable and accessible; be written in plain language that is easily understandable; include a detailed description of the preauthorization process and procedure; and include an accurate and current list of the health care services for which the HMO or insurer requires preauthorization that includes the certain specific information. A summary of the requirements may be posted in lieu of the detailed requirements. If an HMO or insurer wants to change a preauthorization requirement, not later than the 60th day before the date a new or amended preauthorization requirement takes effect, an HMO or insurer must provide notice of the new or amended preauthorization requirement and disclose the new or amended requirement in the health maintenance organization's newsletter or network bulletin, if any, and on the HMO or insurer's website.

SB 1742 also imposes restrictions on utilization review and adverse determinations that give providers more opportunity to provide input into an insurer's decisions. It requires a utilization review agent's UR plan to be reviewed by a physician licensed in Texas and for UR to be conducted under the direction of a Texas-licensed physician. It also provides that before an UR agent may issue an adverse determination based on medical necessity, the ordering provider

must be afforded the opportunity to discuss the determination with a licensed physician.

Finally, SB 1742 appoints a joint interim committee to study, review and report on the use of prior authorization and utilization review processes by private health benefit plan issuers and propose reforms related to the transparency of and improving patient outcomes under the prior authorization and utilization review processes used by private health benefit plan issuers in Texas.

IMPLICATIONS

SB 1742 is designed to increase the transparency and clarity of a health benefit plan's provider directory, particularly related to facility-based providers and their network status, as well as its preauthorization processes, and give providers more opportunity for involvement in utilization review and coverage determinations. Providers should familiarize themselves with the mandates in SB 1742 when navigating issues related to preauthorization and adverse clinical determinations by utilization review agents.

Additionally, hospitals should expect health insurers to seek assistance from them in identifying provider-based physicians in order to comply with the requirements related to provider directories.

SENATE BILL 1940
Sponsors:
Sen. Kelly Hancock
Rep. Tom Oliverson
Effective Date: 9/1/19

Administration of a Temporary Health Insurance Risk Pool

ANALYSIS

SB 1940 relates to the state's high risk health insurance risk pool. It gives the commissioner of the Texas Department of Insurance the authority to increase access to guaranteed health insurance coverage. The bill provides that if necessary to ensure access to quality individual health insurance coverage for individuals with preexisting conditions, the commissioner may take actions necessary to establish a temporary high risk pool substantially similar to the risk pool authorized by former chapter 1506 of the Insurance Code, which was repealed in 2013. Any rule or plan of operation adopted remains in effect only until 30 days following the end of the next regular session of the legislature unless a law is enacted that authorizes coverage to be issued by the temporary risk pool and provides for funding for coverage under the temporary risk pool.

IMPLICATIONS

Following the enactment of the federal Patient Protection and Affordable Care Act that generally prohibited insurers from rejecting applicants due to

preexisting health conditions, the legislature took steps to dissolve the state's high risk pool. SB 1940 is intended to provide a safety net for vulnerable Texans in case federal action requires the establishment of a state risk pool to cover individuals with high-cost medical conditions by postponing the dissolution of the risk pool to August 2021 and providing the commissioner of insurance with broader authority to seek federal waivers with respect to insurance provided under the risk pool.

HOUSE BILL 170
Sponsors:
Sen. Carol Alvarado
Rep. Diego Bernal
Effective Date: 9/1/19

Coverage for Mammography Under Certain Health Benefit Plans

ANALYSIS

HB 170 adds provisions to the Insurance Code that require coverage by a health benefit plan for a diagnostic mammogram that is no less favorable than the coverage for a screening mammogram.

The bill defines a "diagnostic mammogram" as:

- An imaging examination designed to evaluate a subjective or objective abnormality detected by a physician in a breast.
- An abnormality seen by a physician on a screening mammogram.
- An abnormality previously identified by a physician as probably benign in a breast for which follow-up imaging is recommended by a physician.
- An individual with a personal history of breast cancer.

In addition to health benefit plans, the bill applies, to the extent allowed by federal law, to the state Medicaid program under chapter 32 of the Human Resources Code and Medicaid managed care programs operated under chapter 533 of the Government Code.

The bill further repeals current exemptions under the mammography chapters that exclude CHIP plans under chapters 62 and 63 of the Health and Safety Code and Medicaid and Medicaid managed care plans.

IMPLICATIONS

HB 170 ensures coverage for additional diagnostic mammograms and expands the applicability of the current mammography chapter, capturing more patients and different mammogram services.

HOUSE BILL 1584
Sponsors:
Sen. Dawn Buckingham
Rep. Senfronia Thompson
Effective Date: 9/1/19

Health Benefit Plan Coverage of Prescription Drugs for Stage-IV Advanced, Metastatic Cancer

ANALYSIS

HB 1584 prohibits health benefit plans that provide coverage for stage-IV advanced, metastatic cancer and associated conditions from requiring enrollees, prior to providing coverage of a prescription drug approved by the U.S. Food and Drug Administration, from failing to successfully respond to a different drug or prove a history of failure of a different drug.

The bill applies to health benefit plans that provide coverage of medical or surgical expenses or pharmacy benefits issued by all private pay plans and includes the Employee Retirement System, Teacher Retirement System, Medicaid, CHIP and self-funded plans under chapter 91 of the Labor Code.

The bill only applies to a drug the use of which is:

- Consistent with best practices for the treatment of stage-IV advanced, metastatic cancer or associated condition.
- Supported by peer-reviewed, evidence-based literature.
- Approved by the FDA.

The bill applies only to health benefit plans delivered, issued for delivery or renewed on or after Jan. 1, 2020.

IMPLICATIONS

The bill ensures coverage for prescription drugs and other treatment for stage-IV advanced, metastatic cancer and associated conditions.

HOUSE BILL 1757
Sponsors:
Sen. Charles Schwertner
Rep. Eddie Lucio, III
Effective Date: 9/1/19

Authority of an Insured to Select a Pharmacist Under the Insured's Health Insurance Policy

ANALYSIS

HB 1757 adds a new section to chapter 1451 of the Insurance Code to allow a person insured under an accident and health insurance policy to select a pharmacist to provide the services scheduled in the health insurance policy that are within the scope of the pharmacist's license to practice pharmacy.

The new section 1451.128 of the Insurance Code applies only to an insurance policy delivered, issued for delivery or renewed on or after Jan. 1, 2020.

IMPLICATIONS

Chapter 1451 of the Insurance Code currently contains a list of health care practitioners recognized as health care providers under a health insurance policy but did not previously reference pharmacists in that list. This bill adds pharmacists to the list of health care practitioners that an insured individual may select to provide services within the scope of the pharmacist's license.

HOUSE BILL 2486
Sponsors:
Sen. Charles Schwertner
Rep. Craig Goldman
Effective Date: 9/1/19

Disclosures and Prohibited Practices of Certain Employee Benefit Plans and Health Insurance Policies That Provide Dental Benefits

ANALYSIS

HB 2486 affects health insurance policies that provide coverage for dental services. It requires a person or entity that provides or issues an employee benefit plan or health insurance policy or the employer or employee organization, if applicable, to establish a website to provide resources and information to dentists, insureds, participants, employees and members. An employee benefit plan or health insurance policy must provide on the website information about the plan or policy sufficient for patients and dentists to determine the type of dental care services covered by the plan or policy, the percentage of the allowed charges for a covered service that will be paid or reimbursed under the plan or policy, and, for a contracting provider dentist, an estimate of the amount of the payment or reimbursement available for the provider's services under the plan or policy. Access to the website must be at no charge to patients under the plan or policy and dentists providing dental care services to the patients. There are limited exceptions to these requirements depending on the type of policy. The insurer must provide for the method of payment to noncontracted dental providers and may not charge noncontracted providers for accessing that method of payment.

The bill also prohibits an insurer from withholding payment in order to recoup an overpayment from a provider that did not receive the overpayment. It also provides a definition of "predetermination" for purposes of determining eligibility for coverage or amount of benefit available.

Finally, the bill imposes specific requirements for preauthorization of services and limits an insurer's ability to deny payment for services for which preauthorization was previously issued.

IMPLICATIONS

HB 2486 makes changes to the Insurance Code requiring plans that provide dental coverage to provide specific information.

HOUSE BILL 3041
Sponsors:
Sen. Dawn Buckingham
Sen. José Menéndez
Rep. Chris Turner
Rep. Kyle Kascal
Effective Date: 9/1/19

Notice to Physicians and Health Care Providers of Expiration of Prior Authorization

ANALYSIS

HB 3041 requires a health benefit plan issuer regulated by the state that requires prior authorization for a medical or health care service to provide the opportunity for a physician or health care provider to renew an existing prior authorization at least 60 days before the prior authorization expires. If a health benefit plan issuer receives a prior authorization renewal request before the existing preauthorization expires, the health benefit plan issuer must, if practicable, review the request and issue a determination. HB 3041 applies to health benefit plans issued or renewed on or after Jan. 1, 2020.

IMPLICATIONS

HB 3041 seeks to close gaps in the prior authorization process by requiring services subject to prior authorization to be renewed before the expiration date. Hospitals should inform physicians and health care providers of the new obligation of state-regulated health plans to provide physicians and health care providers with notice and the opportunity to renew requests at least 60 days prior to the expiration of a service that requires prior authorization.

HOUSE BILL 3441
Sponsors:
Sen. Charles Schwertner
Rep. Eddie Lucio, III
Effective Date: 9/1/19

Reimbursement Under Certain Health Benefit Plans for Certain Services and Procedures Performed by Pharmacists

ANALYSIS

HB 3441 requires a health insurer to reimburse a pharmacist for any service performed within the scope of a pharmacist's license if the service would be reimbursable if performed by a physician, advanced practice nurse or physician assistant.

IMPLICATIONS

The bill puts pharmacists on equal footing with physicians and other providers for purposes of being paid by a health insurer. It does not require an insurer or other health benefit plan issuer or a third-party administrator or pharmacy benefit manager to reimburse a pharmacist or pharmacy as an in-network or preferred provider.

HOUSE BILL 3911
Sponsors:
Sen. Donna Campbell
Rep. Hubert Vo
Effective Date: 9/1/19

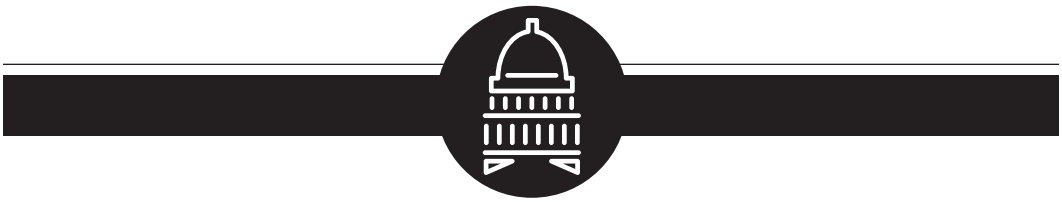
Mandatory TDI Network Adequacy Examinations Every Three Years for PPOs and EPOs

ANALYSIS

HB 3911 requires the commissioner of the Texas Department of Insurance to examine, at least every three years or when the TDI commissioner considers an examination necessary, the quality and network adequacy of preferred provider benefit plans in addition to exclusive provider benefit plans. Prior to HB 3911's passage, examination of network adequacy was discretionary and limited to EPOs. EPOs were subject to quality examinations every five years.

IMPLICATIONS

HB 3911 attempts to strengthen TDI's network adequacy evaluations by making them more frequent and mandatory and including PPOs.



HEALTH CARE PRICING AND DISCLOSURE

SENATE BILL 1264
Sponsors:
Sen. Kelly Hancock
Sen. John Whitmire
Rep. Tom Oliverson
Rep. Trey Martinez Fischer
Effective Date: 9/1/19

Out-of-Network Surprise Billing Ban and Dispute Resolution Process

ANALYSIS

Beginning Jan. 1, 2020, SB 1264 prohibits out-of-network balance bills for patients and creates a dispute resolution process for:

- Out-of-network emergency care (facility's bill or provider's bill).
- Any health care, medical service or supply provided at an in-network facility by an out-of-network physician, health care practitioner or other health care provider (the provider's bill).
- Services provided by diagnostic imaging providers and laboratory service providers provided in connection with a health care service performed by a network physician or provider.

Application

SB 1264 applies to Texas Department of Insurance-regulated: health maintenance organizations, preferred provider organizations and exclusive provider organizations, as well as plans administered by Teacher Retirement System and Employee Retirement System. ERISA plans are not included in the bill. Consumers still are responsible for their applicable copayment, coinsurance and deductible amounts under their health plan.

If an entity subject to the ban on balance billing violates the law, the appropriate regulatory agency may take disciplinary action against the entity, which may include a referral to the attorney general if the entity exhibits a pattern of intentionally violating a law. The attorney general may bring a civil action in the name of the state to enjoin the individual or entity from the violation. If the attorney general prevails, the attorney general may recover its fees, costs and expenses.

The prohibition on balance billing does not apply if a consumer elects to receive in writing in advance of receiving a non-emergent service an explanation that the physician or provider does not have a contract with the enrollee's health benefit plan, the projected amounts for which the enrollee may be responsible, and the circumstances under which the enrollee would be responsible for those amounts.

TDI-regulated health plans and health plan administrators must pay out for covered out-of-network health care services or supplies at the usual and customary rate or at an agreed rate within 30 days for electronic clean claims or within 45 days for nonelectronic clean claims. Usual and customary rate is only defined for ERS and TRS plans, which, applicable to those plans only, means the relevant allowable amount as described by the master benefit plan

document or policy. In addition, health plans must provide a written notice in each explanation of benefits to the enrollee and the physician or provider that of the prohibition on balance billing, the total amount the physician or provider may bill the enrollee under the health benefit plan, an itemization of copayments, coinsurance, deductibles, and other amounts included in that total and information about the availability of arbitration or mediation, as applicable.

SB 1264 sets up two dispute resolution processes:

- A mediation process applicable to out-of-network payment disputes between payers and facilities.
- An arbitration process applicable to out-of-network payment disputes between payers and providers who are not facilities.

Facility Mediation

TDI administers the facility mediation process and maintains a list of qualified mediators. Facilities will request mediation on a TDI internet portal, but the requesting party also must notify TDI and the other party under rules established by TDI. Mediation must be held within 180 days of a request. The $500 threshold under current law to trigger mediation is removed. The parties must agree on a mediator within 30 days, or TDI will select one. There is no payment standard for the mediator to consider, other than the mediation standard under current law, which requires the mediator to determine whether the amount charged by the provider is excessive or the amount paid by the health benefit plan issuer is the usual and customary rate or is unreasonably low. Within 45 days of a mediator's report, if there is no agreement between the parties, either party may file a civil action to determine the amount due to a to an out-of-network provider.

Non-facility Arbitration

Arbitration is a process in which an impartial arbiter issues a binding determination in a dispute between a health benefit plan issuer or administrator and an out-of-network provider or the provider's representative to settle a health benefit claim. Arbitration applies to out-of-network providers who are not facilities. TDI will establish and administer the arbitration program, maintain a list of qualified arbitrators (who do not have conflicts of interest) and enact all necessary rules. Arbitration fees are split between the parties.

Beginning on the date of the initial payment by a payer, a provider has up to 90 days to request arbitration if there is an unpaid charge billed by the provider. The requester must provide written notice to TDI and the other party. TDI must adopt rules on the requirements for submitting multiple claims to arbitration in one proceeding. The rules must provide that the total amount in controversy

for multiple claims in one proceeding may not exceed $5,000 and that multiple claims in one proceeding must be limited to the same out-of-network provider.

In an effort to settle the claim before arbitration, the parties must participate in an informal settlement teleconference within 30 days of a request for arbitration. The parties have 30 days to agree on an independent arbitrator or the TDI commissioner selects one from the preapproved list. Once the arbitrator is selected, the arbitrator has 51 days to issue a decision.

SB 1264 requires the TDI Commissioner to select an organization (that does not have a conflict of interest) to maintain a benchmarking database for each geozip area in the state that contains information necessary to calculate the 80th percentile of billed charges of all physicians or health care providers who are not facilities and the 50th percentile of rates paid to participating providers who are not facilities. "Geozip area" means an area that includes all zip codes with identical first three digits.

The sole issue that an arbitrator may address is the reasonable amount for the health care or medical services or supplies provided to the enrollee by an out-of-network provider. The arbitrator must consider:

1. Whether there is a gross disparity between the fee charged by the out-of-network provider and:
   a. Fees paid to the out-of-network provider for the same services rendered by the provider to other enrollees for which the provider is an out-of-network provider.
   b. Fees paid by the health benefit plan issuer to reimburse similarly qualified out-of-network providers for the same services in the same region.
2. The level of training, education and experience of the out-of-network provider.
3. The out-of-network provider's usual billed charge for comparable services with regard to other enrollees for which the provider is an out-of-network provider.
4. The circumstances and complexity of the enrollee's particular case, including the time and place of the service or supply.
5. Individual enrollee characteristics.
6. The 80th percentile of all billed charges for the service or supply performed by a health care provider in the same or similar specialty and provided in the same geozip area as reported in a benchmarking database.
7. The 50th percentile of rates for the service or supply paid to participating

providers in the same or similar specialty and provided in the same geozip area as reported in a benchmarking database.

8. The history of network contracting between the parties.
9. Historical data for the percentiles described by subdivisions (6) and (7).
10. An offer made during the informal settlement teleconference.

The arbitrator is limited to choosing between either the out of-network provider's billed charge or the amount paid by the payer, as the amounts were last modified in the payer's dispute process (if applicable) or the informal telephone conference. If either party is not satisfied with the decision, within 45 days of the decision, either party may file an action to determine the payment due to an out-of-network provider. The court will review the arbitrator's decision under the substantial evidence standard of review. No payer or provider may file a civil action for an out-of-network claim until arbitration has been utilized and concluded.

Bad Faith Participation

Failing to participate in an arbitration informal settlement conference, failing to provide information the arbitrator or mediator believes is necessary to facilitate a decision and failing to designate a representative participating in the arbitration or mediation with full authority to make a decision constitute bad faith participation, which may result in an administrative penalty.

Study on Effectiveness

SB 1264 requires TDI to conduct a study each biennium on the impact of the bill on consumers and health coverage, which includes:

- Trends in billed amounts.
- A comparison of the total amount spent on services subject to the bill.
- Trends and changes in network participation.
- Trends and changes in amounts paid to participating providers.
- The number of complaints, completed investigations and disciplinary sanctions for balance billing by providers.
- Trends in amounts paid to out-of-network providers.
- Trends in the usual and customary rate for health care or medical services or supplies.
- The effectiveness of arbitration and mediation.

By Dec. 1 of each even-numbered year, TDI must prepare and submit a written report to the legislature.

IMPLICATIONS

Beginning Jan. 1, 2020, hospitals are not permitted to send balance bills to patients for out-of-network emergency care; facility-based providers are not permitted to send balance bills to patients for out-of-network care provided at in-network facilities; and diagnostic imaging providers and laboratory service providers may not balance bill patients for out-of-network services performed in connection with a health care service performed by a network physician or provider. The balance billing prohibition, however, only applies to health plans regulated by the TDI, which does not include federally regulated ERISA plans.

For out-of-network facility bills, SB 1264 modifies the current mediation in statute by no longer requiring the patient to submit a request to trigger mediation. Either a health plan or health plan administrator or the facility may request mediation related to payment of out-of-network claims. For facility-based providers, diagnostic imaging providers and laboratory service providers, SB 1264 establishes a binding "baseball-style" arbitration dispute resolution system where an arbitrator consults a list of 10 factors and selects either the payer's offer or the provider's offer.

Hospitals should modify their billing and collections polices to comply with the sweeping changes made by SB 1264 and should begin assessing anticipated resource needs and defining roles and responsibilities related to the implementation of SB 1264.

HOUSE BILL 1941
Sponsors:
Sen. Kirk Watson
Rep. Dade Phelan
Effective Date: 9/1/19

Unconscionable Prices Charged by Certain Health Care Facilities for Medical Care

ANALYSIS

HB 1941 makes providing emergency care at an "unconscionable" price or demanding or charging an unconscionable price for or in connection with emergency care or other care at an emergency facility a "false, misleading or deceptive act or practice" under section 17.46 of the Business and Commerce Code.

The bill defines an "emergency facility" as a freestanding emergency medical care facility licensed under chapter 254 of Health and Safety Code, or as a hospital that does not meet the conditions of participation for certification under Title XVIII of the Social Security Act. This does not include a hospital that has been operating as a hospital for less than one year, has submitted an application to a federally recognized accreditation program for certification by

the Centers for Medicare & Medicaid Services and has not failed an accreditation for certification.

Under the bill, the consumer protection division of the Office of the Attorney General may not bring an action if the price alleged to be unconscionable is less than 200 percent of the average charge for the same or substantially similar care provided to other individuals by emergency rooms of hospitals located in the same county or nearest county in which the emergency facility is located, as applicable, according to data collected by the Texas Department of State Health Services. If the attorney general determines that the consumer protection division is unable to obtain the charge data, the attorney general may adopt rules designating another source of hospital charge data for use by the division in establishing the average charge for emergency care or other care provided by hospital emergency rooms.

The bill allows the consumer protection division to request, and they may be awarded, attorney's fees, court costs and reasonable expenses incurred by the division to carry out an action brought under this chapter.

The bill does not create a private cause of action for false, misleading or deceptive act or practice.

IMPLICATIONS

The bill applies to all independent freestanding emergency centers licensed under chapter 254 of the Health and Safety Code as well as hospitals licensed under chapter 241 that are not Medicare-participating hospitals.

HOUSE BILL 2536
Sponsors:
Sen. Kelly Hancock
Rep. Tom Oliverson
Effective Date: 9/1/19

Transparency of Drug Costs

ANALYSIS

HB 2536 requires a wholesale drug manufacturer to submit to the executive commissioner of the Texas Health and Human Services Commission by Jan. 15 of each calendar year a report indicating the current wholesale acquisition cost information for prescription drugs sold in Texas. The requirement commences on Jan. 1, 2020. THHSC must post the wholesale acquisition cost information on its website. In addition, for drugs with a wholesale acquisition cost of $100 or more for a 30-day supply, a manufacturer must provide a report to THHSC within 30 days of an increase in wholesale acquisition cost if the manufacture increases the wholesale acquisition cost by:

- 40 percent or more over the preceding three calendar years.

- 15 percent or more in the preceding calendar year.

The manufacturer's report must include the name of the prescription drug, whether it is a generic or name brand, the effective date of the increase and other information regarding the manufacturer's cost and patent exclusivity. Within 60 days of receipt, THHSC must post the report on its website.

Beginning Feb. 1, 2020, a pharmacy benefit manager must by Feb. 1 of each year file a report with the Texas Department of Insurance with detailed information from the previous year regarding rebates, fees and any other payments received from pharmaceutical drug manufacturers and the dollar amounts of those payments either passed on to health benefit plan issuers or enrollees or retained by the PBM. The initial report due in 2020 must include information from the previous three years.

Beginning Feb. 1, 2020, a health benefit plan issuer by Feb. 1 of each year must submit to TDI a report indicating for the preceding calendar year:

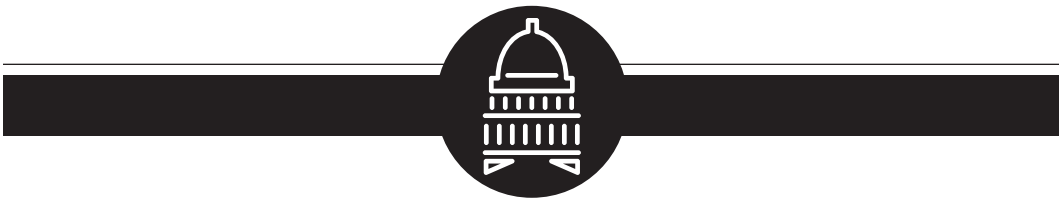
- The names of the 25 most frequently prescribed prescription drugs across all plans.
- The percent increase in annual net spending for prescription drugs across all plans.
- The percent increase in premiums that were attributable to prescription drugs across all plans.
- The percentage of specialty drugs with utilization management requirements across all plans.
- The premium reductions that were attributable to specialty drug utilization management.

The bill defines a "health benefit plan issuer" as an insurance company, a health maintenance organization or a hospital and medical service corporation (a term not defined in Texas law).

By May 1 of each year, TDI must post on its website the reports it received from each PBM and health benefit plan issuer. The bill allows TDI to adopt rules to implement HB 2536's requirements.

IMPLICATIONS

Hospitals should note the state's heightened attention to transparency related to drug costs and the detailed reports that will be available on THHSC's and TDI's websites. Hospitals with affiliated health plans should update their policies and procedures to ensure they comply with the new TDI reporting requirements related to prescription drugs.



HEALTH PROFESSIONS/WORKFORCE

SENATE BILL 37
Sponsors:
Sen. Judith Zaffirini
Rep. Matt Krause
Effective Date: 6/7/19

Prohibition on Using Student Loan or Scholarship Default as Grounds for Disciplinary Action by Licensing Authority

ANALYSIS

SB 37 prohibits a state licensing authority from taking any disciplinary action against a person based on the person's default on a student loan or breach of a student loan repayment contract or scholarship contract. Any pending action by a licensing authority must be terminated.

IMPLICATIONS

Hospitals may consider informing their workforce about SB 37's prohibition on using breach or default of a student loan repayment contract or scholarship contract to refuse to issue or renew a person's license.

SENATE BILL 1200
Sponsors:
Sen. Donna Campbell
Rep. Rick Miller
Effective Date: 9/1/19

Recognition of Out-of-State License of Military Spouse

ANALYSIS

SB 1200 permits a spouse of an active military service member to engage in a business or occupation for which a Texas license is required without obtaining a license if the spouse currently is licensed in good standing by another jurisdiction that has licensing requirements that are substantially equivalent to those in Texas. A military spouse must comply with all other laws and regulations applicable to the profession. The military spouse may engage in the business or occupation for up to three years but only during the time in which the military service member to whom the military spouse is married is stationed in Texas. Prior to engaging in the business or occupation, the military spouse must:

- Notify the applicable state agency of the spouse's intent to practice.
- Submit to the agency proof of Texas residency and a copy of the spouse's military identification card.
- Receive confirmation that the agency has verified the spouse's license in another jurisdiction.
- Obtain permission from the state agency to engage in the business or occupation.

By Dec. 1, 2019, each state agency that issues a license must adopt rules to identify jurisdictions that have licensing requirements that are substantially equivalent to the requirements for a Texas license and to verify that a military

spouse is licensed in good standing. In addition, a state agency may adopt rules to issue license to a military spouse for up to three years. A state agency may not charge a fee for the license.

IMPLICATIONS

SB 1200 requires state agencies to recognize other jurisdictions' substantially similar occupational licenses for spouses of active military service members. The bill applies to physicians, nurses and other licensed health care professionals. Hospitals should notify their credentialing and privileging departments of the change, which should result in expedited licensure of, or permission to practice for, spouses of newly transferred military service members.

SENATE BILL 1217
Sponsors:
Sen. Carol Alvarado
Rep. Christina Morales
Effective Date: 6/14/19

Considering Certain Arrests to Determine an Applicant's Eligibility for an Occupational License

ANALYSIS

SB 1217 amends the Occupations Code to forbid a licensing agency from considering an arrest that did not result in the person's conviction or placement on deferred adjudication community supervision for the purposes of determining an applicant's fitness to perform duties or discharge responsibilities of the licensed occupation.

IMPLICATIONS

An arrest that did not result in conviction or deferred adjudication cannot be considered for determining fitness for occupational licenses under the Occupations Code.

SENATE BILL 1239
Sponsors:
Sen. Nathan Johnson
Rep. Tom Oliverson
Effective Date: 9/1/19

Continuing Education Requirements for Surgical Technologists

ANALYSIS

SB 1239 makes changes to chapter 259 of the Health and Safety Code governing surgical technologists.

A health care facility may not employ an individual as a surgical technologist unless the individual is either certified, was trained in the U.S. military or Public Health Service, currently works for the federal government or was employed to practice surgical technology in a facility before Sept. 1, 2009 (grandfather

provision). However, the health care facility may employ uncertified surgical technicians if the facility was unable to locate a certified individual after a diligent and thorough effort.

SB 1239 requires certified surgical technologists to complete continuing education hours as required by their certifying body. A health care facility may request evidence of the completion of these hours.

The bill also requires continuing education for the other categories of surgical technologists: an individual trained in the Army, Navy, Air Force, Marine Corp, Coast Guard or the U.S. Public Health Service; a surgical technologist practicing under the grandfather clause; or, an uncertified surgical tech hired to work after a search failed to find a certified tech. Every two years, these individuals must complete 30 hours of continuing education related to surgical technology. A facility may request evidence of the completion of these hours.

SB 1239 also provides that a heath care facility may restrict the ability of a person to practice surgical technology if the individual fails to complete the required continuing education.

IMPLICATIONS

A hospital-employed surgical technologist who is not certified or does not fall under the other categories of qualification now are required to complete continuing education every two years. If a hospital is aware of an uncertified individual working in the facility, the employee should be notified of the new continuing education requirement.

The surgical technologist is responsible for the completion of these hours and for maintaining a record of the completion. Hospitals are not statutorily required to verify nor track these hours. However, hospitals that employ uncertified surgical technologists should consider whether they want to request evidence of the completion of the continuing education.

SENATE BILL 1531
Sponsors:
Sen. Kelly Hancock
Rep. James White
Effective Date: 9/1/19

Effect of Criminal Conviction on Licensed Podiatrists and Midwives

ANALYSIS

SB 1531 prohibits the Texas Commission of Licensing and Regulation and the Texas Department of Licensing and Regulation from:

- Refusing to issue a license to a podiatrist due to a felony conviction or a conviction of a crime involving moral turpitude.

- Disciplining a licensed midwife, refusing to renew a midwife's license, or refusing to issue a license to an applicant based on a conviction of a misdemeanor involving moral turpitude or a felony.

IMPLICATIONS

Hospitals should consider informing their privileging and credentialing staff, as well as any affiliated podiatrists and licensed midwives, about SB 1531's prohibition of adverse action by the licensing authority based solely on a criminal conviction.

SENATE BILL 1636
Sponsors:
Sen. Judith Zaffirini
Rep. Four Price
Effective Date: 6/10/19

Health Professions Council Report on Strategies to Expand Health Care Workforce

ANALYSIS

SB 1636 directs the Health Professions Council to add to its annual report strategies to expand the state's health care workforce, including methods to reduce processing time for licensure applications, methods to increase the number of mental and behavioral health care practitioners and recommendations for appropriations to expand the state's health care workforce generally and in medically underserved areas.

The Health Professions Council is a 14-member council comprised of a representative from:

- Texas Board of Chiropractic Examiners.
- Texas State Board of Dental Examiners.
- Texas Optometry Board.
- Texas State Board of Pharmacy.
- Texas State Board of Podiatric Medical Examiners.
- Texas State Board of Veterinary Medical Examiners.
- Texas Medical Board.
- Texas Board of Nursing.
- Texas State Board of Examiners of Psychologists.
- Texas Funeral Service Commission.
- The entity that regulates the practice of physical therapy.
- The entity that regulates the practice of occupational therapy.
- The health licensing division of the Texas Department of State Health Services.

- The Office of the Governor.

SB 1636 requires the Health Professions Council to submit to the Texas Senate and House chairs charged with public health and finance or appropriations in addition to the governor, lieutenant governor and the speaker of the house:

- By June 1, 2020, a report only addressing strategies to expand the health care workforce as added by SB 1636.
- By Feb. 1, 2021, the full annual report that includes strategies to expand the health care workforce in addition to the other elements required by the report prior to SB 1636.

IMPLICATIONS

SB 1636, for the first time, tasks the Health Professions Council with making recommendations to the legislature and the governor on strategies to address the state's increasing health care workforce shortage. Texas hospitals should note the legislature's goal of developing a statewide strategy to address the shortage of nurses, physicians and behavioral health care providers. The Health Professions Council's reports are available on its website at www.hpc.state.tx.us.

HOUSE BILL 29
Sponsors:
Sen. Bryan Hughes
Rep. Ina Minjarez
Effective Date: 9/1/19

Limited Duration Treatment by Physical Therapists Without a Referral From a Physician or Health Care Provider

ANALYSIS

Beginning Nov. 1, 2019, HB 29 permits physical therapists to treat patients within their scope of practice without a referral for a limited duration, provided that the physical therapist: has been licensed for at least one year; possesses the minimum amount of liability insurance required by the Texas Board of Physical Therapy Examiners; and

- Holds a doctorate degree in physical therapy from a program accredited by the Commission on Accreditation in Physical Therapy Education or another institution that is accredited by an agency or association recognized by the United States secretary of education.

Or

- Has completed at least 30 hours of continuing competence activities in the area of differential diagnosis.

A physical therapist who holds a doctorate degree in physical therapy may treat a patient without a referral for up to 15 consecutive business days. A physical

therapist who has completed at least 30 hours of continuing competency in differential diagnosis but does not hold a doctorate degree in physical therapy may treat a patient for up to 10 consecutive business days without a referral. In order to continue treatment beyond the prescribed time period, a physical therapist must obtain a referral from a referring practitioner. A referring practitioner is defined as a qualified licensed health care professional who, within the scope of professional licensure, may refer a person for health care services, which includes a physician, dentist, chiropractor or podiatrist. If a physical therapist provides care outside of the physical therapist's scope of practice, the TBPTE may take disciplinary action against the physical therapist.

Prior to treating a patient without a referral, the physical therapist must obtain the patient's signature on a form created by the TBPTE where the patient acknowledges that:

- Physical therapy is not a substitute for a medical diagnosis by a physician.
- Physical therapy is not based on radiological imaging.
- A physical therapist cannot diagnose an illness or disease.
- The patient's health insurance may not include coverage for the physical therapist's services.

The TBPTE must implement the rules required to implement HB 29 by Nov. 1, 2019.

IMPLICATIONS

Effective Nov. 1, 2019, HB 29 permits licensed physical therapists with doctorates in physical therapy to treat patients for up to 15 consecutive business days without a referral from a referring practitioner and licensed physical therapists to treat patients for up to 10 business days without a referral if they have completed at least 30 hours of education in differential diagnosis. The TBPTE is required to complete rulemaking by Nov. 1, 2019, which will include, among other elements, a prescriptive consent form. Hospitals should monitor the TBPTE for rulemaking and revise their policies and procedures to reflect the change in the law.

HOUSE BILL 278
Sponsors:
Sen. Charles Perry
Rep. Tom Oliverson
Effective Date: 9/1/19

Frequency and Location of Prescriptive Authority Agreement Meetings Between APRNs and Physicians

ANALYSIS

HB 278 aligns the physician/advanced practice registered nurse meeting requirements with those that currently apply to a physician/physician assistant in order to delegate prescriptive authority. Under HB 278, meetings between APRNs and physicians must be documented, occur at least once per month (instead of face-to-face monthly for the first year, and then quarterly), and include the sharing of information related to patient treatment and care, needed changes in patient care plans, issues related to referrals and discussion of patient care improvement.

IMPLICATIONS

HB 278 rectifies an inconsistency between APRNs and PAs regarding the frequency and manner of meetings with physicians for prescriptive authority. Prior to HB 278, prescriptive authority agreements between physicians and advanced practice registered nurses required monthly face-to-face meetings during the first year, and, after the first year, quarterly face-to-face meetings and monthly meetings by any means. HB 278 relaxes prescriptive authority agreement requirements between APRNs and physicians by removing the face-to-face meeting requirement; however, monthly meetings still are required. Hospitals should update their policies and procedures and notify clinical staff and contracted physician groups to update their prescriptive authority agreements.

HOUSE BILL 1342
Sponsors:
Sen. Juan "Chuy" Hinojosa
Rep. Jeff Leach
Effective Date: 9/1/19

Consequences of a Criminal Conviction on a Person's Eligibility for an Occupational License

ANALYSIS

HB 1342 removes barriers to eligibility to receive occupational licenses that relate to past criminal convictions and makes other changes to certain licensing requirements.

For persons licensed by the Texas Commission of Licensing and Regulation or the Texas Department of Licensing and Regulation, the bill allows for relevant education, training or experience gained while imprisoned to be used as evidence of a person's eligibility for a license, as long as the person:

- Previously held a license of the same type.

- Was not convicted of any sexual or first-degree crime.
- Maintained a record of good behavior while imprisoned.
- Participated in an acceptable program determined by the TDLR to prepare for reentry into the workforce and performed work on a regular basis in the occupation for which they seek a license.

Additionally, the bill provides that any person whose occupational license was revoked by order of the TCLR or the executive director of the TDLR for failure to pay an administrative penalty may reapply prior to the one-year anniversary if the person has paid the penalty or established a payment plan with the department to pay the penalty.

More broadly under the Occupations Code, the bill removes a conviction unrelated to the occupational license conviction as grounds for disqualification. (Note these provisions to do not apply to certain licensees, including (1) emergency medical services personnel or (2) a person licensed by the Texas Medical Board, the Texas State Board of Pharmacy, the State Board of Dental Examiners, or the State Board of Veterinary Medical Examiners who has been convicted of a felony under the Texas Controlled Substances Act or the Texas Dangerous Drugs Act.) A conviction that does not directly relate to the responsibilities of the licensed occupation cannot be used as grounds for disqualification. The bill also expands the definition of a related crime, adding that any correlation between the elements of the crime and the duties and responsibilities of the licensed occupation can be seen as a related crime. In addition, the bill repeals requirements that the applicant convicted of a crime furnish proof of maintaining a steady record of employment, supporting dependents, maintaining good conduct and paying all fees, fines and retributions.

The bill requires that licensing authorities that deny a license based on a passed conviction provide a written explanation of the intended denial and give the person at least 30 days to respond with relevant information. This explanation must include statutory factors that serve as the basis for denial, and applies to denial, suspension or revocation of a licenses based on a conviction.

Finally, the bill requires the state auditor to, in collaboration with licensing authorities, develop a guide of best practices for an applicant with a prior conviction to use when applying for a license. The state auditor must publish the guide on the state auditor's website. Additionally, licensing authorities must include a link to the guide on the authority's website.

IMPLICATIONS

The intent of HB 1342 is to enhance opportunities for a person to obtain gainful employment after the person has been convicted of an offense and discharged the sentence for the offense. Licensing boards must provide a more detailed list of reasons for a denial, revocation or suspension of licenses and also allow the person to respond to any complaints within an appropriate amount of time.

HOUSE BILL1899
Sponsors:
Sen. Lois Kolkhorst
Rep. Greg Bonnen
Effective Date: 9/1/19

Revocation or Denial of Certain Health Care Professional Licenses and the Reporting of the Grounds for Revocation or Denial

ANALYSIS

HB 1899 makes several changes intended to ensure that licensing agencies are notified when persons licensed as a health care professional are convicted of certain crimes and requiring the automatic denial or revocation of a health professional license for individuals convicted of those crimes.

The bill makes changes to the Code of Criminal Procedure related to required wording in criminal judgments. The bill requires the judge in a criminal case to make an affirmative finding of fact and include in the criminal judgment if applicable that:

1. At the time the offense was committed the defendant held a license as a health care professional.
2. The offense is an offense for which the defendant is required to register as a sex offender, a felony offense, and the defendant used force or threat of force in the commission of the offense, or a sexual assault, aggravated assault, aggravated sexual assault, or injury to a child, elderly person or disabled individual.
3. The victim of the offense was a patient of the defendant.
4. The offense was committed in the course of providing services within the scope of the defendant's license.

Not later than the 5th day after a conviction for one of those crimes or the granting of deferred adjudication, the court clerk must notify the Texas Department of Public Safety and the appropriate licensing agency of the conviction or deferred adjudication.

The bill further requires parole boards to notify TDPS and licensing agencies when a person is required to register as a sex offender as a condition of release on parole.

Finally, the law requires a licensing board to deny a license to a person, or revoke the license of a health care professional, if factors (1) – (4) apply to the individual. An individual is eligible to reapply or be reinstated only if the conviction is reversed, set aside or vacated on appeal, or in the case of registration as a sex offender, the period of time for required registration has expired.

IMPLICATIONS

This law imposes a mandatory and, in many cases, permanent bar to licensure as a health care professional for a person who commits certain criminal offenses.

HOUSE BILL 2847
Sponsors:
Sen. Kelly Hancock
Rep. Craig Goldman
Effective Date: 9/1/19

Licensing and Regulation of Certain Occupations and Activities

ANALYSIS

HB 2847 makes miscellaneous changes to the licensing and regulation provisions related to several occupations, provider types and regulating agencies.

- It requires the Texas Commission of Licensing and Regulation to establish continuing education requirements to renew certificates for laser hair removal.
- It requires a pharmacy, if it does not dispense any controlled substance prescriptions during a period of seven consecutive days, to send a report to the Texas State Board of Pharmacy indicating that the pharmacy did not dispense any controlled substance prescriptions during that period, unless the pharmacy has obtained a waiver or permission to delay reporting to the board.
- It expands the list of persons whom TSBP can provide prescription information to, including the Texas Department of Licensing and Regulation with respect to the regulation of podiatrists; pharmacist interns and pharmacist technician trainees; and a practitioner who is inquiring about the prescribing activity of an individual to whom the practitioner has delegated prescribing authority.
- It allows a Class E or nonresident pharmacy to fill a prescription drug order for a patient, including a patient in this state, and to perform another pharmaceutical service, as defined by TSBP rule.
- It revises complaint and investigation procedures and adds confidentiality provisions for certain licensed occupations who are under TDLR's authority, including athletic trainers, behavior analysts, dietitians, dyslexia practitioners and therapists, hearing instrument fitters and dispensers, massage therapists,

midwives, orthotists and prosthetists, podiatrists and speech-language pathologists and audiologists.

Podiatrists

HB 2847 also makes several changes to the regulation of podiatry. TCLR cannot refuse admittance into an examination or issuance of a license to a podiatrist for past conviction of a felony or a crime involving moral turpitude (applies only to convictions that occur on or after the effective date). The requirements to develop a system for monitoring compliance of orders by podiatrists transfers from TCLR to TDLR, and the 15-day time frame for notification of a complaint with TDLR is repealed. The bill repeals both the requirement for TCLR to develop a standardized penalty schedule and for TDLR to develop and enforce a written policy for determining the priority of complaints.

Additionally, the bill gives specific authority for a podiatrist to delegate to a qualified and properly trained podiatric medical assistant acting under the podiatrist's supervision any podiatric medical act that a reasonable and prudent podiatrist would find within the scope of sound medical judgment to delegate if in the opinion of the delegating podiatrist, the medical act can be properly and safely performed by the podiatric medical assistant to whom the podiatric medical act is delegated and is performed in a customary manner and not in violation of any other statute; and the podiatric medical assistant to whom the podiatric medical act is delegated does not represent to the public that the medical assistant is authorized to practice podiatry. A delegating podiatrist is responsible for a podiatric medical act performed by the podiatric medical assistant to whom the podiatrist delegates the act. The TDLR may determine whether an act constitutes the practice of podiatric medicine and whether a podiatric medical act may be properly or safely delegated by podiatrists. Finally, it requires persons performing a delegated act involving a radiologic procedure to register with the TDLR.

Audiologists

The bill removes the requirement that audiologists and audiologist interns must register with TDLR or comply with the professional code in addition to state regulation. In addition, the required contact information in a written contract with the state must now include a website address.

Orthotic and Prosthetic Technicians

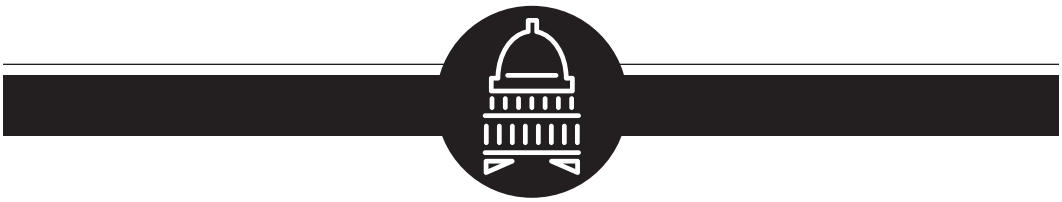
Orthotic or prosthetic technicians no longer need to register with TDLR or TCLR, and rules regulating these occupations are repealed.

Dieticians

TCLR may act as an alternative to TDLR to regulate dieticians.

IMPLICATIONS

Many of the provisions in the bill change licensing for health care professionals. Current licensed professionals should make note of changes affecting their specific fields.



HOSPITAL OPERATIONS

SENATE BILL 370
Sponsors:
Sen. Kirk Watson
Rep. John Smithee
Effective Date: 9/1/19

Employment Protection for Jury Service

ANALYSIS

SB 370 aligns state and federal law by protecting all permanent employees from any adverse employment action taken related to the employee's jury service. These protections cover discharge, threats to discharge, coercion or intimidation, and expand the current law to include public employees.

IMPLICATIONS

All employers must be aware of the expanded protections and take care not to violate an employee's constitutional right and duty to serve on a jury. Policies should be reviewed to ensure that an employee's right to serve on a jury and these protections are not violated.

SENATE BILL 1565
Sponsors:
Sen. Pat Fallon
Rep. Reggie Smith
Effective Date: 9/1/19

Medical Authorization Required to Release Protected Health Information in a Health Care Liability Claim

ANALYSIS

SB 1565 amends a typographical error in the Civil Practice and Remedies Code. Specifically, the Authorization Form for Release of Protected Health Information, found in section 74.052(c), now requires patient date of birth, not "place" of birth as in the prior version of the section.

IMPLICATIONS

This bill corrects an error from the original bill. Texas hospitals should be aware of the updated form.

SENATE BILL 1621
Sponsors:
Sen. Lois Kolkhorst
Rep. Four Price
Effective Date: 9/1/19

Creating a License for Certain Rural Medical Facilities

ANALYSIS

SB 1621 establishes a new type of hospital license for a "limited services rural hospital." The designation applies to a general or special hospital that is or was licensed under chapter 241 of the Health and Safety Code and is either (1) located in a "rural area," as defined by Texas Health and Human Services Commission rule or a specific provision of federal law (42 U.S.C. section 1395ww(d)(2)(D)); or (2) designated by the Centers for Medicare & Medicaid Services as a critical access hospital, rural referral center or sole community

hospital. Further, the facility must otherwise meet the requirements to be designated as a limited services rural hospital or a similarly designated hospital under federal law. A person may not operate a limited services rural hospital unless the U.S. Congress passes a bill creating a payment program specifically for limited services rural hospitals or similarly designated hospitals that becomes law; and THHSC issues a license to the person to establish, conduct or maintain a limited services rural hospital. Upon enactment of a law as described above, THHSC must adopt rules establishing minimum standards for the facilities. THHSC's rules must be at least as stringent as the standards imposed by federal law.

THHSC may waive or modify the requirement of a particular provision or standard if it determines that the waiver or modification will facilitate the creation or operation of the facility and that the waiver or modification is in the best interests of the individuals served or to be served by the facility.

SB 1621 further requires THHSC to develop and implement a rural hospital strategic plan to ensure that residents of rural areas have access to hospital services. The strategic plan must include a proposal for using at least one of the following methods to ensure access to hospital services in the rural areas of Texas:

- An enhanced cost reimbursement methodology for the payment of rural hospitals participating in the Medicaid managed care program in conjunction with a supplemental payment program for rural hospitals to cover costs incurred in providing services to recipients.
- A hospital rate enhancement program that applies only to rural hospitals.
- A reduction of punitive actions under the Medicaid program that require reimbursement for Medicaid payments made to the provider, if the provider is a rural hospital; a reduction of the frequency of payment reductions under the Medicaid program made to rural hospitals; and an enhancement of payments made under merit-based programs or similar programs for rural hospitals.
- A reduction of state regulatory-related costs related to THHSC's review of rural hospitals.
- In accordance with rules adopted by CMS, the establishment of a minimum fee schedule that applies to payments made by managed care organizations to rural hospitals.

The strategic plan must be submitted no later than Jan. 1, 2020 to the Legislative Budget Board for review and comment. Thereafter, not later than Nov. 1 of each even-numbered year, THHSC must submit a report regarding its development

and implementation of the strategic plan to the legislature, the governor and LBB.

Additionally, THHSC must establish the Rural Hospital Advisory Committee, either as another advisory committee or as a subcommittee of the Hospital Payment Advisory Committee, to advise it on issues relating specifically to rural hospitals. The Rural Hospital Advisory Committee is composed of interested persons appointed by the executive commissioner. THHSC also must collaborate with the Office of Rural Affairs to ensure that Texas is pursuing to the fullest extent possible federal grants, funding opportunities and support programs available to rural hospitals as administered by the Health Resources and Services Administration and the Office of Minority Health in the U.S. Department of Health and Human Services.

IMPLICATIONS

Contingent upon passage of federal law, rural hospitals may convert to operating as limited service hospitals. Rural hospitals also will want to monitor THHSC's development of the required rural hospital strategic plan.

SENATE BILL 2270
Sponsors:
Sen. Borris Miles
Rep. J.D. Sheffield
Effective Date: 6/10/19

Discretion for State Medical and Dental Units to Grant Full-Time Benefits to Clinical Employees Working Fewer Than 40 Hours per Week

ANALYSIS

SB 2270 authorizes the president of a state medical or dental unit to provide full-time benefits to a clinical employee working fewer than 40 hours per week. Prior to SB 2270, only nurses were eligible for this determination. The bill makes no other changes to the law.

A state medical or dental unit includes:

- The Texas A&M University System Health Science Center and its component institutions, agencies and programs.
- The Texas Tech University Health Sciences Center.
- The Texas Tech University Health Sciences Center at El Paso.
- The University of Texas Medical Branch at Galveston.
- The University of Texas Southwestern Medical Center.
- The University of Texas Medical School at San Antonio.
- The University of Texas Dental Branch at Houston.
- The University of Texas M. D. Anderson Cancer Center.

- The University of Texas Graduate School of Biomedical Sciences at Houston.
- The University of Texas Dental School at San Antonio.
- The University of Texas Medical School at Houston.
- The University of Texas Health Science Center—South Texas and its component institutions, if established under Subchapter N, Chapter 74, Education Code.
- The nursing institutions of The Texas A&M University System.
- The University of Texas System; and The University of Texas School of Public Health at Houston.
- Other medical or dental schools as may be established by statute or as provided in chapter 61 of the Education Code.

IMPLICATIONS

State academic teaching hospitals should update their policies and procedures to grant to the president the same discretion to authorize full-time benefits for all clinical employees that previously was limited to nurses.

HOUSE BILL 531
Sponsors:
Sen. Dawn Buckingham
Rep. Rick Miller
Effective Date: 9/1/19

Retaining Certain Medical Records of Forensic Medical Exams

ANALYSIS

To address concerns about the extensive backlog of untested rape kits and the increasing use of DNA analysis and matching, HB 531 extends the timeline for a hospital and physician to maintain a medical record of a forensic medical exam.

The bill creates a new statutory section for hospital medical records of forensic medical exams. Hospitals may not destroy a medical record from a forensic medical exam of a sexual assault survivor until the 20th anniversary of the date the record was created.

The same retention requirements are applied to a physician's medical records.

The new retention policy applies to sexual assault victims who report to law enforcement and sexual assault victims who do not report.

The new retention record applies to any medial record created on or after March 1, 2020.

IMPLICATIONS

Hospitals must develop an internal procedure to ensure that a medical record

from a forensic medical exam of a sexual assault survivor is retained for 20 years, for any record created on or after March 1, 2020.

HOUSE BILL 621
Sponsors:
Sen. Judith Zaffirini
Rep. Victoria Neave
Effective Date: 9/1/19

Prohibited Adverse Employment Action Against an Employee who in Good Faith Reports Child Abuse or Neglect

ANALYSIS

HB 621 expands existing protections in section 261.110 of the Family Code, prohibiting employer retaliation against professionals who report child abuse or neglect to a supervisor, regulatory agency or law enforcement agency in good faith. These protections are expanded to prohibit suspension, termination, discrimination or any other "adverse employment actions" that would dissuade a reasonable employee from making or supporting a report of abuse or neglect.

Any employee subject to a violation of this provision may sue for injunctive relief, damages or both.

"Professional" is defined as an individual who is licensed or certified by the state or who is an employee of a facility licensed, certified or operated by the state and who, in the normal course of official duties or duties for which a license or certification is required, has direct contact with children. The term includes nurses, doctors and employees of a clinic or health care facility that provides reproductive services.

IMPLICATIONS

Hospitals should understand the increased scope of section 261.110 of the Family Code and ensure that inappropriate action not be taken against a professional who reports child abuse or neglect, or who initiates or cooperates in an investigation or proceeding relating to an allegation of child abuse or neglect in good faith. Policies and procedures should reflect these protections and clarify that no one should feel dissuaded from making or supporting a report of abuse or neglect.

HOUSE BILL 881
Sponsors:
Sen. Donna Campbell
Rep. Cecil Bell
Effective Date: 9/1/19

Rights of a Deceased Person's Parent to View the Person's Body Before an Autopsy is Performed

ANALYSIS

HB 881 amends chapter 49 of the Code of Criminal Procedure to allow a parent to view the deceased body of a child of any age prior to an autopsy. Current guidelines for viewing a deceased's body, such as certain requirements where a death is subject to certain inquests, are not affected by this legislation.

State law previously allowed parents' viewing of a child's deceased body only where the deceased was a child under the age of 18. HB 881 removes the age requirement.

IMPLICATIONS

Hospitals should revise policies and procedures related to the viewing of a deceased's body to reflect the removal of the age requirement. In the event a parent wishes to view the body of their deceased child, the parent must be allowed to do so, subject to the existing requirements in chapter 49 of the Code of Criminal Procedure.

HOUSE BILL 2059
Sponsors:
Sen. Larry Taylor
Rep. Cesar Blanco
Effective Date: 9/1/19

New Required Human Trafficking Training Course for Practitioners Providing Direct Patient Care

ANALYSIS

HB 2059 requires health care practitioners providing direct patient care to complete a training course approved by the Texas Health and Human Services Commission on identifying and assisting victims of human trafficking by Sept. 1, 2020. THHSC must post a list of approved courses on its website. Completion of an approved course is a condition of licensure or license renewal. For physicians, the human trafficking training will qualify as a medical ethics or professional responsibility course approved by the Texas Medical Board. For nurses, the course will qualify as continuing education approved by the Texas Board of Nursing.

IMPLICATIONS

Hospitals should notify their clinical staff of the obligation to complete a course approved by THHSC on identifying and assisting victims of human trafficking by Sept. 1, 2020, which is a condition of licensure or license renewal. Hospitals that currently offer, or wish to offer, a course on identifying and assisting victims of human trafficking should monitor THHSC's rulemaking process to understand the application process for agency approval.

HOUSE BILL 2454
Sponsors:
Sen. Bryan Hughes
Rep. Four Price
Effective Date: 9/1/19

Continuing Education Requirements for Certain Health Care Professionals Regarding Pain Management and Opioid Prescribing

ANALYSIS

HB 2454 requires physicians and dentists whose practice includes direct patient care, and advanced practice registered nurses and physician assistants with the authority to prescribe opioids, to complete at least two hours of continuing medical education on safe and effective pain management for the prescription of opioids and other controlled substances. For all included providers, the bill requires the CME to include reasonable standards of care, identification of patient drug-seeking behavior, and effectively communicating with patients regarding opioid and other controlled substance prescriptions.

A physician is required to complete the hours in each of the first two renewal periods following the issuance of the physician's initial registration. (Note, "registration" is the term used in the Occupations Code permitting a licensed physician to practice medicine in Texas. While licensure and registration are technically separate processes under the Occupations Code as implemented by the Texas Medical Board, after a license is initially issued a physician then periodically renews their registration to be able to continue to practice under that license.) Two of those hours must be completed by the first anniversary of the date of issuance, except that a physician who holds a license to practice medicine on Jan. 21, 2021 must complete the required two hours of continuing medical education in each of the two registration renewal periods occurring after that date. After the first two renewal periods are completed, the physician is required to complete not less than two hours of continuing medical education every eight years. The hours required under HB 2454 cannot be used to satisfy the requirements for certified pain clinic personnel.

For dentists, advanced practice registered nurses and physician assistants, the two-hour continuing education requirement is annual.

IMPLICATIONS

Physicians and dentists with a direct patient care practice, and other opioid prescribers are required to comply with the requirements of the HB 2454. The requirements apply only to applications for renewal of a registration permit (for physicians) or license (for other practitioners) submitted on or after Jan. 1, 2021.

HOUSE BILL 3163
Sponsors:
Sen. José Menéndez
Rep. Drew Springer, Jr.
Effective Date: 9/1/19

New Standards for Accessible Parking Spaces

ANALYSIS

HB 3163 requires Texas Commission of Licensing and Regulation standards and specifications to provide that:

- A paved accessible parking space includes the international symbol of access painted on the parking space and the words "NO PARKING" are painted on any access aisle adjacent to the parking space.
- A sign identifying an accessible parking space includes a statement regarding the potential consequences of illegally parking a vehicle in the space, including the towing of the vehicle or the assessment of a fine or other penalty against the vehicle owner or operator.

Of particular relevance to hospitals, HB 3163 applies to:

- A building or facility used by the public that is constructed, renovated or modified, in whole or in part, on or after Jan. 1, 1970, using funds from the state or a county, municipality or other political subdivision of the state, which would include a public hospital.
- A privately funded building or facility that is defined as a "public accommodation" under the Americans with Disabilities Act of 1990, which includes a pharmacy, insurance office, professional office of a health care provider, hospital or other service establishment if constructed, renovated or modified on or after Jan. 1, 1992.

Under the bill, the Texas Department of Motor Vehicles must provide a design and stencil at cost to entities required to identify accessible parking spaces.

IMPLICATIONS

HB 3163 is effective Sept. 1, 2019, but rulemaking is required. All hospitals should notify their facilities departments to monitor the TCLR website and alerts for new signage and identification standards for accessible parking spaces. Note that there is some confusing language in the bill modifying section 681.009 of the Transportation Code ("A person who owns or controls private property used for parking may designate a parking space or area without conforming to those standards and specifications, unless required to conform by law."), which makes it appear compliance is discretionary for private entities; however, when read with section 469.003 of the Government Code (requiring hospitals to comply because they are "public accommodations"), it appears compliance is mandatory. Note that the stencils must be provided by the TDMV at cost.

HOUSE BILL 3301
Sponsors:
Sen. Charles Perry
Rep. Drew Darby
Effective Date: 9/1/19

Merger Agreements Between Certain Hospitals

ANALYSIS

HB 3301 sets up a process in a new chapter 314A of the Health and Safety Code for obtaining a certificate of public advantage for a proposed merger between hospitals. It applies only to a merger agreement between hospitals each of which is located within a county that contains two or more hospitals and has a population of (1) fewer than 100,000 and is not adjacent to a county with a population of 250,000 or more; or (2) more than 100,000 and fewer than 150,000 and is not adjacent to a county with a population of 100,000 or more. The process is intended to supplant federal and state antitrust laws and immunize from all federal and state antitrust laws the execution of merger agreements approved under the chapter created by the bill as well as all post-merger activities supervised under the chapter. The governor must designate an appropriate state agency other than the attorney general to administer the COPA process.

One or more parties to a merger agreement may submit a COPA application to the designated agency, with a copy to the attorney general, which must include a written copy of the merger agreement and describe the nature and scope of the merger. The attorney general must review the application, all supporting documents and information provided by the applicants. On completion of the review, the attorney general must advise the designated agency whether the proposed merger agreement would likely benefit the public by maintaining or improving the quality, efficiency and accessibility of health care services offered to the public; and the likely benefits resulting from the proposed merger agreement outweigh any disadvantages attributable to a reduction in competition that may result from the proposed merger.

The designated agency, after reviewing the application and consulting with the attorney general must issue a certificate of public advantage for a merger agreement if the designated agency determines under the totality of the circumstances that the proposed merger would likely benefit the public by maintaining or improving the quality, efficiency, and accessibility of health care services offered to the public; and the likely benefits resulting from the proposed merger agreement outweigh any disadvantages attributable to a reduction in competition that may result from the proposed merger. The application must provide specific evidence showing that the proposed merger would likely benefit the public, explain in detail how the likely benefits resulting from the proposed merger agreement outweigh any disadvantages attributable to a reduction in competition, and address other factor the designated agency may require based on the circumstances specific to the application. In making its determination, the agency must consider the effect of the merger agreement

on the following nonexclusive list of factors:

1. The quality and price of hospital and health care services provided to residents of this state.
2. The preservation of sufficient hospitals within a geographic area to ensure public access to acute care.
3. The cost efficiency of services, resources and equipment provided or used by the hospitals that are a party to the merger agreement.
4. The ability of health care payors to negotiate payment and service arrangements with hospitals proposed to be merged under the agreement.
5. The extent of any reduction in competition among physicians, allied health professionals, other health care providers or other persons providing goods or services to, or in competition with, hospitals.

Post-COPA Issuance

After a COPA is issued, a hospital resulting from a merger agreement approved under this chapter may voluntarily terminate its COPA by giving the designated agency notice at least 30 days before the date of the termination. The designated agency must annually review an approved COPA. The attorney general may also annually review an approved COPA. The designated agency may not complete its annual review until the attorney general informs the designated agency whether the attorney general intends to conduct any review of the COPA. The designated agency must supervise each hospital operating under a COPA to ensure that the immunized conduct of a merged entity furthers the purposes of the chapter.

Additionally, a change in rates for hospital services by a hospital operating under a COPA may not take effect without prior approval of the designated agency. The hospital must submit to the designated agency any proposed change in rates for inpatient and outpatient hospital services; if applicable, any change in reimbursement rates under a reimbursement agreement with a third party payor; and for an agreement with a third party payor, information showing that the hospital and the third party payor have agreed to the proposed rates, and other information about the comparability of the proposed rates to specified benchmarks. The request to approve the change must be submitted at least 90 days before the implementation of any proposed change in rates for inpatient or outpatient hospital services and, if applicable, at least 60 days before the execution of a reimbursement agreement with a third-party payor. After reviewing the proposed change in rates, the designated agency must approve or deny the request based on specified criteria.

Annually, each hospital must submit a report to the designated agency that

includes information about the extent of the benefits attributable to the issuance of the COPA; if applicable, information about the hospital's actions taken in furtherance of any commitments made by the parties to the merger or to comply with terms imposed by the designated agency as a condition for approval of the merger; a description of the activities conducted by the hospital under the merger agreement; information relating to the price, cost, and quality of and access to health care for the population served by the hospital; and any other information required by the designated agency. An annual supervision fee of not less than $75,000 and not more than $200,000 may be imposed and collected by the designated agency.

The designated agency may require a corrective action plan. The designated agency and the attorney general are given specific investigative and enforcement authority, up to and including revocation of the COPA, and judicial review procedures are specified.

IMPLICATIONS

The population brackets limit the availability of the new chapter to eight counties: Angelina, Bowie, Cherokee, Colorado, Taylor, Tom Green, Wichita and Wood. Facilities in those counties considering consolidation through merger should review the bill to determine its potential applicability to the contemplated transaction.

HOUSE BILL 3934
Sponsors:
Sen. Charles Perry
Rep. James Frank
Effective Date: 6/10/19

Authority of Rural Hospitals to Create a Health Care Collaborative

ANALYSIS

HB 3934 allows rural hospitals to create a health care collaborative under chapter 848 of the Insurance Code without the involvement of physicians. The bill removes the requirement that health care collaboratives have physicians as members. The bill defines a rural hospital as a licensed hospital with 75 beds or fewer that:

- Is located in a county with a population of 50,000 or fewer.

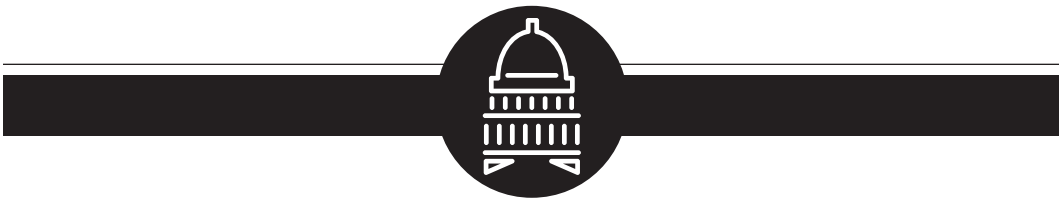
Or

- Has been designated by the Centers for Medicare & Medicaid Services as a critical access hospital, rural referral center or sole community hospital.

If all members of the health care collaborative are rural hospitals, each member of the board of directors must be a representative of a participant.

IMPLICATIONS

Health care collaboratives were established in 2011 after the passage of the federal Patient Protection and Affordable Care Act. A health care collaborative can be formed solely by rural hospitals. A health care collaborative may present rural hospitals with additional flexibility and options for collaboration in dealing with payors without the risk of violating antitrust laws. Rural hospitals as defined by the bill should be aware of the ability to create a collaborative with other rural hospitals and determine whether doing so would be beneficial.



LIABILITY

SENATE BILL 988
Sponsors:
Sen. Kirk Watson
Rep. Giovanni Capriglione
Effective Date: 9/1/19

Assessment of Litigation Costs and Attorney's Fees in Certain Actions Under the Public Information Law

ANALYSIS

SB 988 amends the Texas Public Information Act to clarify that, in relation to an action brought by a governmental unit for a declaratory judgment related to the withholding of information from a requestor, a court may not assess litigation costs or attorney's fees against a party unless the court finds the underlying action or defense to the action groundless in fact or law.

IMPLICATIONS

SB 988 is a response to a court holding requiring the Office of the Attorney General to pay another governmental body's fees and costs and requires a higher standard for the party seeking reimbursement. Practically, these lawsuits will be filed by the OAG, and the claims or defenses must be shown to be totally groundless for the payment provision to take effect. Texas hospitals that may be the subject of legal proceedings by the OAG, under the PIA, should be aware of these changes.

SENATE BILL 1755
Sponsors:
Sen. Brandon Creighton
Rep. Tom Oliverson
Effective Date: 6/10/19

Status of Certain Medical Residents and Fellows as Governmental Employees

ANALYSIS

SB 1755 clarifies that a resident or fellow in a graduate medical training program for physicians that is sponsored by a governmental unit, including a medical or dental unit as listed in section 61.003 of the Education Code, is considered an employee of a governmental unit, regardless of the method or source of payment of the resident or fellow.

Under section 61.003(5), "medical or dental unit" means:

- The Texas A&M University System Health Science Center and its component institutions, agencies, and programs.
- The Texas Tech University Health Sciences Center.
- The Texas Tech University Health Sciences Center at El Paso.
- The University of Texas Medical Branch at Galveston.
- The University of Texas Southwestern Medical Center.
- The University of Texas Medical School at San Antonio.
- The University of Texas Dental Branch at Houston.

- The University of Texas M. D. Anderson Cancer Center.
- The University of Texas Graduate School of Biomedical Sciences at Houston.
- The University of Texas Dental School at San Antonio.
- The University of Texas Medical School at Houston.
- The University of Texas Health Science Center—South Texas and its component institutions, if established under Subchapter N, chapter 74 of the Education Code.
- The nursing institutions of The Texas A&M University System and The University of Texas System.
- The University of Texas School of Public Health at Houston.
- Such other medical or dental schools as may be established by statute or as provided in chapter 61 of the Education Code.

IMPLICATIONS

SB 1755 brings clarity to the question of whether a resident or fellow in a GME program or slot at a governmental unit but funded by a different source such as a nonprofit foundation is treated as an employee of the governmental entity and covered under the Texas Torts Claim Act. The law now clearly states that the resident or fellow would be covered if they are in a GME program listed in section 61.003 of the Education Code.

HOUSE BILL 1592
Sponsors:
Sen. Royce West
Rep. John Smithee
Effective Date: 9/1/19

Health Care Professional Liability Coverage for Certain Public Institutions of Higher Education

ANALYSIS

HB 1592 amends chapter 59 of the Education Code to permit certain institutions to expand liability coverage to additional health care providers. These provisions originally provided coverage for physicians, dentists, veterinarians and podiatrists. The bill allows expanded coverage for physician assistants, nurses, pharmacists and other providers who are appointed to, employed by or volunteer for the:

- University of Texas System.
- Texas A&M University System.
- Texas Tech University System.
- Texas State University System.
- University of Houston System.

- Stephen F. Austin State University.
- University of North Texas System.

The expanded coverage applies to most students participating in patient care programs, and the bill makes several non-substantive changes to update related sections.

HB 1592 applies to a cause of action accruing after Sept. 1, 2019.

IMPLICATIONS

Systems and facilities subject to chapter 59 of the Education Code should update policies and procedures to align with the expanded coverage. Providers and students subject to the expanded coverage should be advised of the expansion and potential for liability coverage.

HOUSE BILL 1693
Sponsors:
Sen. Bryan Hughes
Rep. John Smithee
Effective Date: 9/1/19

Affidavits Concerning Cost and Necessity of Services

ANALYSIS

HB 1693 amends chapter 18 of the Civil Practice and Remedies Code to extend the deadlines for parties to controvert an affidavit concerning the cost and necessity of services. The bill is an effort to decrease the likelihood that a defendant may be disadvantaged in its ability to controvert medical expense damages in personal injury cases. The bill requires the party offering the affidavit to serve a copy by the earlier of:

- 90 days after the defendant files an answer.
- The date the offering party must designate an expert witness under a court order.
- The date the offering party must designate an expert witness pursuant to the Texas Rules of Civil Procedure.

In the event the services identified in the affidavit are provided by a provider for the first time after the date the defendant files their answer, the party offering the affidavit must serve a copy of the affidavit on the other party by the earlier of:

- The date the offering party must designate an expert witness under a court order.
- The date the offering party must designate an expert witness pursuant to the Texas Rules of Civil Procedure.

If continuing services are provided beyond a relevant deadline for an affidavit, a party may supplement an affidavit on or before the 60th day before trial commences or may supplement a counteraffidavit on or before the 30th day before trial commences.

The party offering the affidavit or counteraffidavit also must file notice of service with the clerk of the court. Neither the affidavit or counteraffidavit may be used to establish or controvert the causation element of a cause of action that is the basis for the civil action.

IMPLICATIONS

HB 1693 affords additional time for parties to file, review and respond to affidavits concerning the cost and necessity of services. Parties involved in ligation where such affidavits may be utilized should be familiar with these changes, which are intended to ensure fair treatment for all parties.

HOUSE BILL 1999
Sponsors:
Sen. Brandon Creighton
Rep. Jeff Leach
Effective Date: 9/1/19

Construction Liability Claims for Public Buildings and Public Works

ANALYSIS

HB 1999 impacts how governmental entities can sue for construction defects in public buildings. It imposes pre-suit notification requirements and other procedures related to a suit for a construction defect.

The new requirements apply to governmental entities, which is broadly defined to include:

- The state.
- A municipality, county, public school district or special-purpose district or authority.
- A district, county or justice of the peace court.
- A board, commission, department, office or other agency in the executive branch of state government, including an institution of higher education.
- The legislature or a legislative agency.
- The Supreme Court of Texas, the Texas Court of Criminal Appeals, a court of appeals or the State Bar of Texas or another judicial agency having statewide jurisdiction.

Before bringing a suit for a construction defect, the governmental entity must provide each party with whom the governmental entity has a contract for the design or construction of an affected structure a written report by certified

mail, return receipt requested, that clearly identifies the specific construction defect on which the claim is based, describes the present physical condition of the affected structure, and describes any modification, maintenance or repairs to the affected structure made by the governmental entity or others since the affected structure was initially occupied or used. Not later than the fifth day after the date a contractor receives a report, the contractor must provide a copy of the report to each subcontractor retained on the construction of the affected structure whose work is subject to the claim.

After providing the report, the governmental entity must allow each party with whom the governmental entity has a contract and any known subcontractor or supplier who is subject to the claim a reasonable opportunity to inspect any construction defect or related condition identified in the report for a period of 30 days after sending the report and at least 120 days after the inspection to correct any construction defect or related condition identified in the report; or enter into a separate agreement with the governmental entity to correct any construction defect or related condition identified in the report.

There are exceptions to the requirement to allow correction or repair, including if the party:

- Is a contractor and cannot provide payment and performance bonds to cover the corrective work, cannot provide liability insurance or workers' compensation insurance, or has been previously terminated for cause by the governmental entity.
- Has been convicted of a felony.

Additionally, the "correct or repair" requirements do not apply if the governmental entity previously complied with the process and the defect or condition was not corrected as required or the attempt to correct the construction defect or related condition identified in the report resulted in a new construction defect or related condition.

Compliance with the pre-suit requirements stops the running of the statute of limitations and statute of repose if done in the final year of those limitation periods.

If a governmental entity fails to comply with the requirements, its lawsuit must be dismissed. A second failure to comply with the requirements results in a dismissal with prejudice. The statute does not prevent a governmental entity from making emergency repairs necessary to protect the health, safety and welfare of the public or a building occupant.

IMPLICATIONS

The new statute applies to any cause of action that accrues after the effective date of the law. The definition of "construction defect" is very broad, and includes deficiencies in or arising out of the design, specifications, surveying, planning, or supervision of the construction, that is the result of (1) the use of defective materials, products, or components in the construction, (2) a violation of a building code applicable by law to the construction, (3) a failure of the design of an improvement to real property to meet the professional standards of care applicable at the time of governmental approval of the design or as otherwise applicable if no governmental approval of the design was required or obtained, or (4) a failure to perform the construction in accordance with the accepted trade standards for good and workmanlike construction.

Additionally, failure to comply with the technical requirements of the statute can have harsh results, including dismissal of the case potentially with the inability to refile the suit. Early evaluation of a potential construction defect claim is critical in order to satisfy the requirements of the statute and preserve the ability to pursue litigation for deficient construction projects.

HOUSE BILL 2362
Sponsors:
Sen. Bryan Hughes
Rep. Joe Moody
Effective Date: 9/1/19

Standard of Proof in Health Care Liability Claims Involving Emergency Medical Care

ANALYSIS

HB 2362 amends section 74.153 of the Civil Practice and Remedies Code, in response to a Supreme Court of Texas holding that applied a heightened standard of proof in certain cases involving emergency medical care.

The bill clarifies that the willful and wanton negligence standard of proof is not afforded:

- To providers treating patients who are stabilized and receiving care or treatment as a nonemergency patient.
- To care that is unrelated to a medical emergency.
- When the provider's negligent act or omission proximately causes a stable patient to require emergency medical care.

The changes apply to a cause of action commenced on or after Sept. 1, 2019.

IMPLICATIONS

HB 2362 arose in response to a case involving care provided in an obstetrical

unit. The heightened level of proof afforded by the Texas Supreme Court was reduced through this legislation, although the willful and wanton standard still could apply in many cases involving emergency medical care. Facilities with obstetrical units should be aware of these changes and advise legal counsel and risk management staff accordingly.

HOUSE BILL 2894
Sponsors:
Sen. Dawn Buckingham
Rep. Nicole Collier
Effective Date: 9/1/19

Criminal Offense for Health Care Fraud Involving State or Federal Money

ANALYSIS

HB 2894 expands the crime of Medicaid fraud under the Penal Code to include fraud related to other health care programs in addition to Medicaid. The bill creates a criminal violation for fraud on a medical program, which is defined as a program funded by the state, the federal government or both, and designed to provide health care services to recipients, including a program administered in whole or in part through a managed care delivery model.

IMPLICATIONS

Hospitals should take notice that criminal Medicaid fraud has been redefined as any form of health care fraud involving state or federal money, rather than being isolated to the Medicaid program. This change could have a profound effect on penalty calculations.

HOUSE BILL 2929
Sponsors:
Sen. Kelly Hancock
Rep. Jeff Leach
Effective Date: 6/10/19

Hospital Liens

ANALYSIS

HB 2929 amends chapter 55 of the Property Code (related to Hospital and Emergency Services Liens) to clarify that a hospital may file a lien for services provided to an applicable individual, no matter where in the hospital the treatment, care or service was provided.

The amount of the lien is now limited to the lesser of:

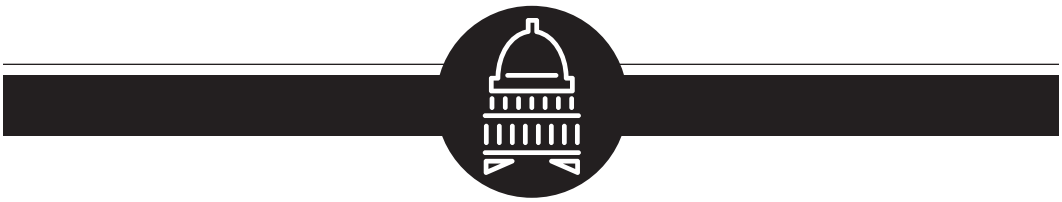
- The amount of the hospital's applicable charges.
- 50 percent of all amounts recovered by the injured individual through their claim for personal injuries.

HB 2929 also adds language providing that a hospital lien does not apply

to charges for which recovery is barred under section 146.003 of the Civil Practice and Remedies Code, which requires a timely billing or request for reimbursement of applicable health insurance.

IMPLICATIONS

Hospitals utilizing liens under chapter 55 of the Property Code should be aware of the clarified definition of "admitted" now in statute, as well as the potential cap on the lien amount. If the billed charges are subject to section 146.003 of the Civil Practice and Remedies Code, attempts to timely recover such amounts from a health benefit plan should be made during the lien process.



LOCAL PROVIDER PARTICIPATION FUNDS

HOUSE BILL 2324
Sponsors:
Sen. Kelly Hancock
Rep. Charlie Geren
Effective Date: 9/1/19

HOUSE BILL 2326
Sponsors:
Sen. Kelly Hancock
Rep. Morgan Meyer
Effective Date: 9/1/19

Extending the Authority for Local Provider Participation Funds in Dallas and Tarrant Counties

ANALYSIS

The Dallas and Tarrant Counties' Hospital Districts' local provider participation funds were established by legislation in 2017. The enabling legislation originally included a sunset date for each of these LPPFs of Dec. 31, 2019.

HB 2324 extends the authority for the Tarrant County Hospital District to administer and operate an LPPF to Dec. 31, 2025.

HB 2326 extends the authority for the Dallas County Hospital District to administer and operate an LPPF to Dec. 31, 2025.

IMPLICATIONS

These bills will allow the Dallas and Tarrant Counties' LPPFs to continue operating through 2025.

HOUSE BILL 4289
Sponsors:
Sen. Lois Kolkhorst
Rep. Garnet Coleman
Effective Date: 6/10/19

Establishing a Model for Local Provider Participation Funds

ANALYSIS

HB 4289 authorizes local jurisdictions throughout the state to create and administer a local provider participation fund and to use revenue generated to fund the non-federal share of Medicaid supplemental payments to private hospitals in the jurisdiction and for other approved purposes. While similar to legislation that was enacted during the last two legislative sessions that created LPPFs in particular counties, cities and hospital districts, this bill has statewide applicability.

The bill would allow the following entities to create and administer an LPPF:

- A hospital district that is not already participating in an LPPF.
- A county or municipality that is not already participating in an LPPF and is not served by a hospital district or a public hospital.

In addition to providing authority for a single hospital district, county or municipality to administer an LPPF, HB 4289 establishes authority for local governments to join to create LPPF districts, authorized by concurrent order approved by the governing body of each creating local government and with the combined boundaries of each creating local government.

The bill allows governing bodies of certain local government units (or groups of local government units) to authorize collection of a mandatory payment from each nonpublic hospital that provides inpatient services in its jurisdiction. The mandatory payment must be updated annually and may not exceed six percent of the aggregate net patient revenue from hospital services provided by all paying hospitals in the jurisdiction.

The bill specifies requirements and uses of LPPFs consistent with those outlined in many other standalone LPPF statutes, including:

- Funding intergovernmental transfers to provide the nonfederal share of Medicaid payments for uncompensated care payments, uniform rate enhancements and other reimbursement for which federal matching funds are available.
- Refunding a portion of a mandatory payment collected in error from a paying hospital.
- Refunding to paying hospitals the proportionate share of money received by the district that is not used to fund the nonfederal share of Medicaid supplemental payment program payments.
- Transferring funds to the Texas Health and Human Services Commission if the corresponding hospital district is legally required to transfer the funds to address a disallowance of federal matching funds.
- Paying administrative expenses, which are capped at $150,000 plus the cost of collateralization of deposits.

Funds cannot be used to expand Medicaid under the federal Patient Protection and Affordable Care Act or fund the nonfederal share of delivery system reform incentive payments or disproportionate share hospital payments.

The authority of a local government to administer and operate an LPPF expires on Sept. 1 following the second anniversary of the governing body's authorization of its participation. The practical effect is that the authority provided by HB 4289 only lasts long enough for the local entity (or entities) to establish separate statutory authority through legislation during the next legislative session.

IMPLICATIONS

HB 4289 allows local entities that do not currently have an LPPF to set one up temporarily until legislative authorization can be obtained during the next legislative session. If any local entities elect to establish an LPPF under this law, the nonpublic hospitals in that jurisdiction are required to make a mandatory payment to support the nonfederal share of Medicaid supplemental payments.

To the extent that hospitals participate in these Medicaid programs or serve indigent patients, they could receive additional payments due to the increased non-federal share generated.

VARIOUS BILLS (SEE TABLE)

New Local Provider Participation Funds in Select Counties

BILL	SPONSORS	AUTHORIZED ENTITY(IES)	EFFECTIVE DATE
HB 1142	Sen. Dawn Buckingham Rep. Stan Lambert	Taylor County, Travis County Hospital District	5/31/19
HB 3459	Sen. Borris Miles Rep. Garnet Coleman	Harris County Hospital District	5/24/19
HB 4548	Sen. Brian Birdwell Rep. John Wray	Ellis County, Wichita County	6/2/19
SB 1350	Sen. Kirk Watson Rep. Gina Hinojosa	Travis County Hospital District	5/31/19
SB 1545	Sen. José Menéndez Rep. Trey Martinez Fisher	Bexar County Hospital District	6/10/19
SB 1751	Sen. José Rodríguez Rep. Joe Moody	El Paso County Hospital District	5/31/19
SB 2286	Sen. Pat Fallon Rep. James Frank	Wichita County	6/10/19
SB 2315	Sen. Juan Hinojosa Rep. Abel Herrero	Nueces County Hospital District	6/10/19
SB 2448	Sen. Charles Perry Rep. Dustin Burrows	Lubbock County Hospital District	6/4/19

ANALYSIS

Nine bills authorize new local provider participation funds in nine Texas counties (see table above). The bills allow the appropriate governing body (county commissioners courts or hospital district boards) to authorize the

county or hospital district to collect a mandatory payment from each nonpublic hospital that provides inpatient hospital services. The amount of the payment is based on the hospitals' net patient revenue and is updated annually.

Typically, the mandatory payment is an amount not to exceed six percent of a hospital's net patient revenue. The Harris County Hospital District has a cap of four percent of net patient revenue. The allowable uses of funds collected vary by LPPF, but most LPPF funds are limited to the following uses:

- Fund intergovernmental transfers for the nonfederal share of Medicaid 1115 waiver payment programs or substantially similar programs. Note that the Travis and Harris County Hospital District LPPFs may not be used to fund IGT for delivery system reform incentive payments, and the Travis, Harris and Bexar County Hospital District LPPFs explicitly prohibit use of LPPF funds to fund the nonfederal share of disproportionate share hospital payments.
- Fund intergovernmental transfers for payments to Medicaid managed care organizations dedicated for payment to hospitals (i.e., uniform hospital rate enhancements or similar programs).
- Subsidize indigent programs.
- Refund a portion of a mandatory payment collected in error from a paying hospital.
- Refund to paying hospitals the proportionate share of money received by the district that is not used to fund the nonfederal share of Medicaid supplemental payment program payments.
- Transfer funds to the Texas Health and Human Services Commission if the corresponding hospital district is legally required to transfer the funds to address a disallowance of federal matching funds.
- Pay administrative expenses, which are capped at various amounts. Many smaller county LPPFs cap administrative expenses at the lesser of four percent of the annual revenue generated from the mandatory payment or $20,000 per year, or just $20,000 per year unless additional revenue is needed. Others are capped at a higher amount plus the cost of collateralization of deposits - $150,000 for the Travis, El Paso and Nueces County Hospital District LPPFs; $600,000 for the Harris County Hospital District LPPF; $184,000 for the Bexar County Hospital District LPPF; and $25,000 for the Lubbock County Hospital District LPPF.

The bills specify that hospitals may not add the mandatory payments as a surcharge to patients and funds collected by LPPFs cannot be used to expand Medicaid under the federal Patient Protection and Affordable Care Act.

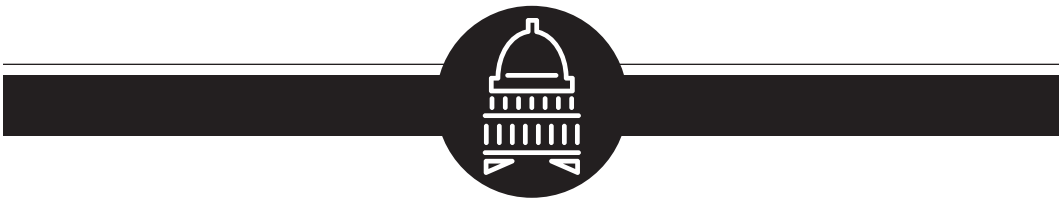
A number of LPPF bills also include sunset dates for the LPPF authority. The

authority to administer and operate a LPPF expires Dec. 31, 2023 for the Travis County Hospital District, Bexar County Hospital District, El Paso County Hospital District and Wichita County LPPFs. The Harris County Hospital District and Nueces County Hospital District's authority to administer and operate an LPPF expires Dec. 31, 2021.

HB 4548 and SB 2286 specify that the Wichita County LPPF funds may not be used to pay for the services of a consultant or a person required to register as a lobbyist.

IMPLICATIONS

If these entities choose to establish LPPFs, the non-public hospitals in those jurisdictions will be required to make mandatory payments to the LPPF. Funds are limited to specific purposes but generally will be used to fund Medicaid supplemental payments to hospitals. To the extent that hospitals participate in these Medicaid programs or serve indigent patients, they could receive additional payments.



MANAGED CARE

SENATE BILL 170
Sponsors:
Sen. Charles Perry
Rep. Four Price
Effective Date: 9/1/19

Cost Reimbursement for Medicaid Payments to Rural Hospitals

ANALYSIS

SB 170 requires the Texas Health and Human Services Commission to develop a cost-based, prospective reimbursement methodology for rural hospitals participating in Medicaid. The methodology must use rural hospitals' most recent cost information and be updated every two years to reflect allowable costs incurred by a rural hospital participating in Medicaid managed care. The methodology may require Medicaid managed care organizations to reimburse rural hospitals using a minimum fee schedule or other method or may require both THHSC and the Medicaid MCOs to share in the total amount of reimbursement paid to rural hospitals.

Beginning in state fiscal year 2022, THHSC is required to adopt and implement a true cost-based reimbursement methodology for inpatient and general outpatient services provided to Medicaid recipients at rural hospitals that provides a prospective payment as well as a cost settlement that provides additional reimbursement to reimburse the hospitals for the true costs incurred during the previous state fiscal year.

IMPLICATIONS

THHSC will be developing rules to implement the provisions of this bill. Rural hospitals should consider working with THHSC on development of the methodologies required to ensure they appropriately reflect costs. Rural hospitals also should ensure that cost reports submitted to the Centers for Medicare & Medicaid Services are comprehensive and accurate, as they will be the basis of THHSC's determination of a hospital's allowable costs.

SENATE BILL 1096
Sponsors:
Sen. Charles Perry
Rep. Tom Oliverson
Effective Date: 9/1/19

Medicaid Managed Care

ANALYSIS

SB 1096 makes a number of changes to the Medicaid managed care program.

It imposes a requirement that the STAR Kids Managed Care Advisory Committee explore the feasibility of adopting a private duty nursing assessment for use in the STAR Kids managed care program and provide recommendations to the Texas Health and Human Services Commission on adopting a private duty nursing assessment tool that would streamline the documentation for prior authorization of private duty nursing. It also requires THHSC to conduct a utilization review on a sample of cases for children enrolled in STAR Kids

to ensure that all imposed clinical prior authorizations are based on publicly available clinical criteria and are not being used to negatively impact a recipient's access to care.

Prior Authorization Procedures for Hospitalized Recipients

With respect to prior authorizations, the bill provides that a contract between a managed care organization and THHSC must require that, notwithstanding any other law, the MCO review and issue determinations on prior authorization requests with respect to a recipient who is hospitalized at the time of the request according to the following time frames:

- Within one business day after receiving the request, except as provided by the two subsections below.
- Within 72 hours after receiving the request if the request is submitted by a provider of acute care inpatient services for services or equipment necessary to discharge the recipient from an inpatient facility.
- Within one hour after receiving the request if the request is related to post-stabilization care or a life-threatening condition.

Managed Care Quality Measures for Provider Networks

Current law requires managed care contracts with THHSC to incorporate the National Committee for Quality Assurance's Healthcare Effectiveness Data and Information Set measures. The bill allows the use of national core indicators adult consumer survey and the national core indicators child family survey for individuals with an intellectual or developmental disorder, as applicable.

Pharmacy Benefits

The bill prohibits the MCO or pharmacy benefit manager from requiring a prior authorization, other than a clinical prior authorization or a prior authorization imposed by THHSC to minimize the opportunity for waste, fraud or abuse, or from imposing any other barriers to a drug that is prescribed that is on the vendor drug program formulary.

MCOs also are required to provide continued access to a drug prescribed to an enrolled child, regardless of whether the drug is on the vendor drug program formulary.

The bill further prohibits MCOs from using protocols that require a sequence of prescription drugs before providing coverage for the recommended drug.

Failure to comply with these provisions will result in the payment of liquidated damages.

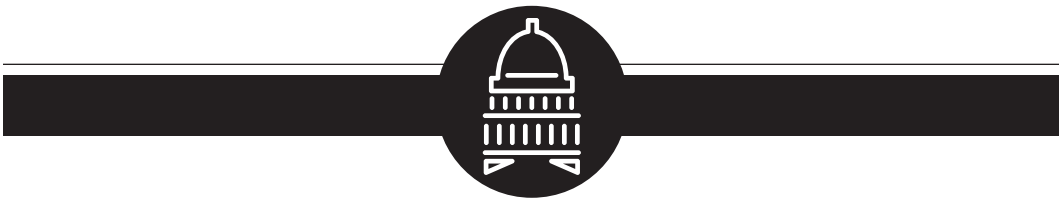
Managed Care Guidance

THHSC is required to provide guidance and additional education to MCOs on requirements under federal law to continue to provide services during an internal appeal, a Medicaid fair hearing or any other review.

The bill only applies to contracts between THHSC and an MCO entered into or renewed after Sept. 1, 2019.

IMPLICATIONS

Hospitals can expect a decision from an MCO on discharges for hospitalized patients within 72 hours on weekends. Other provisions of the bill are designed to improve the functioning of the STAR Kids Managed Care Program.



MEDICAID

SENATE BILL 1207
Sponsors:
Sen. Charles Perry
Rep. Matt Krause
Effective Date: 9/1/19

Medicaid Managed Care Prior Authorization, Medically Dependent Children Waiver Program and Medicaid Wrap-Around Benefits Reform

ANALYSIS

SB 1207 is a Medicaid managed care organization omnibus bill primarily addressing prior authorization reform and care delivery through the medically dependent children and deaf-blind with multiple disabilities waiver programs.

Prior Authorization

After Sept. 1, 2020, SB 1207 moves outpatient prior authorization requirements from the Insurance Code to the MCO contracting requirements in the Government Code. For all Medicaid MCO prior authorization requests (outpatient and inpatient), the bill adds provisions to streamline the prior authorization process, including the opportunity to supplement an initial request with additional documentation. Each Medicaid MCO also must conduct an annual review of its prior authorization requirements.

Under the bill, a Medicaid MCO must provide at least 10 business days' notice by postmarked mail before terminating, suspending or reducing a service to a Medicaid recipient, unless inconsistent with federal law. The Texas Health and Human Services Commission must develop a process to address situations where an individual does not receive adequate notice or where the notice is delivered without a postmark.

SB 1207 also requires Medicaid MCOs to submit separate notices to the provider and the recipient regarding termination, suspension or reduction of a Medicaid service. The notices must include:

- All information required by federal and state law and applicable regulations.
- For the recipient, a clear and easy-to-understand explanation of the decision, a copy of the information sent to the provider and a statement regarding the recipient's rights, including details about the appeals process.
- For the provider, a thorough and detailed clinical explanation of the reason for the decision.

If a Medicaid MCO's determination is based on a coverage or prior authorization request that contains insufficient or inadequate documentation, the Medicaid MCO must submit to the provider and the recipient:

- A clear list of all information and documentation necessary to make a final determination.
- The due date of the information.
- A description of the reconsideration process.

- The contact information for the Medicaid MCO or other entity approving the request.

The Medicaid MCO must send the notice using the provider's and recipient's preferred method of communication and, as applicable, through an internet portal.

Under SB 1207, THHSC must implement rules requiring each Medicaid MCO and other entity responsible for authorizing coverage for Medicaid services to post on its website:

- The timelines for prior authorization.
- A description of the deadlines and notice required for prior authorization requests with insufficient or inadequate documentation.
- The dates and results of any annual reviews of prior authorization requirements.
- An accurate and up-to-date catalogue of coverage criteria and prior authorization requirements, including all required documentation.
- For a prior authorization requirement first imposed on or after Sept. 1, 2019, the effective date of the new prior authorization requirement.

In addition, THHSC must implement rules requiring each Medicaid MCO and other entity responsible for authorizing coverage for Medicaid services to develop a simplified process for a provider or Medicaid recipient to contact the Medicaid MCO or entity to clarify prior authorization requirements or to assist the provider in submitting a prior authorization request.

SB 1207 requires THHSC to contract with an independent external medical reviewer to conduct external medical reviews and to review determinations based on medical necessity or the recipient's medical and functional needs. To obtain an external review, the Medicaid recipient or recipient's representative must make the request, which may not take place until after the Medicaid MCO's internal appeal process, but before a Medicaid fair hearing. THHSC must establish a common procedure for external reviews that addresses medical necessity criteria, time frames, and expedited reviews.

Medically Dependent Children Program and Deaf-Blind With Multiple Disabilities Waiver Programs

SB 1207 makes changes to the MDCP waiver program, requiring THHSC to meet additional notice requirements and permitting a legally authorized representative of a recipient who has aged out of the program or who no longer meets the level of care criteria for medical necessity for nursing facility care to request that THHSC return the child to the program or place the child on the interest list for another waiver program. The bill clarifies that a child who no longer meets the

age requirements may not return to the MDCP program but could be eligible for another waiver program. This section of the bill applies only to a child who becomes ineligible for the MDCP waiver program on or after Dec. 1, 2019 and expires on Dec. 1, 2021.

In addition, effective Dec. 1, 2019, a STAR Kids MCO providing benefits under the MDCP waiver program must provide the beneficiary's parent or legally authorized representative with:

- The results of an initial assessment or reassessment of medical necessity and obtain the parent's or representative's signature.
- An opportunity to request to dispute the results with the Medicaid managed care organization through a peer-to-peer review with the treating physician of choice.

SB 1207 authorizes THHSC to undertake quality improvement activities related to the MDCP waiver program and, beginning Sept. 30, 2020, requires quarterly reporting to the governor and the legislature on data and issues related to access to care in the program. SB 1207 makes changes to eligibility criteria for the MDCP waiver program, the DBMD waiver program and other demonstration projects. The bill requires THHSC to:

- By Mar. 1, 2020, in collaboration with the STAR Kids Managed Care Advisory Committee, make recommendations to improve the initial assessment and reassessment processes and post its plan on the THHSC website.
- Establish a help line for the MDCP or DBMD waiver programs, with plans for expanding the help line to other programs.
- Between Sept. 1, 2020 and Jan. 1, 2021, evaluate the risk-adjustment methods used for recipients under the STAR Kids managed care program in the quality-based payment program to ensure that higher-volume providers are not unfairly penalized.

Other Provisions

Under the bill, the STAR Kids Managed Care Advisory Committee expires Dec. 31, 2023. SB 1207 also requires THHSC to develop a clear policy to address the coordination and timely delivery of Medicaid wrap-around benefits.

IMPLICATIONS

SB 1207 makes several procedural reforms to prior authorization in the Medicaid program designed to streamline the process and provide better information to providers and recipients. Hospitals should inform their clinical staff and update their policies and procedures related to prior authorization in Medicaid managed care. In addition, hospitals treating any children under the MDCP waiver program

should review the additional protections for beneficiaries. SB 1207 also addresses issues meant to simplify coordination of Medicaid wrap-around benefits, which should prove valuable to hospital billing and collections departments. Hospitals should monitor THHSC's website for new rules implementing the bill and look to THA for updates.

SENATE BILL 1283
Sponsors:
Sen. Borris Miles
Rep. Gene Wu
Effective Date: 9/1/19

Medicaid Coverage of HIV Drugs

ANALYSIS

SB 1283 relates to coverage of drugs under Medicaid for the treatment of human immunodeficiency virus. It provides that the Medicaid rules may not require a clinical, nonpreferred or other prior authorization for any antiretroviral drug, or a step therapy or other protocol, that could restrict or delay the dispensing of the drug except to minimize fraud, waste or abuse. "Antiretroviral drug" means a drug that treats HIV infection or prevents acquired immune deficiency syndrome. It applies the same restriction to Medicaid managed care organizations.

IMPLICATIONS

SB 1283 amends current law relating to the availability under Medicaid of certain drugs used to treat HIV infection and prevent acquired immune deficiency syndrome and makes explicit in law that the drugs need to be immediately available to the enrollee.

SENATE BILL 1564
Sponsors:
Sen. Royce West
Rep. Stephanie Klick
Effective Date: 6/10/19

Access to Medication-Assisted Treatment

ANALYSIS

SB 1564 adds sickle cell anemia as a diagnosed illness that exempts providers from having to access the Prescription Monitoring Program to receive information about a patient before prescribing or dispensing opioids, benzodiazepines, barbiturates or carisoprodol.

SB 1564 also requires the Texas Health and Human Services Commission to provide Medicaid reimbursement for medication-assisted opioid or substance use disorder treatment without requiring the recipient or health provider to obtain prior authorization or precertification for the treatment.

The law does not require Medicaid reimbursement for the following:

- A prescription for Methadone.
- A prescription for MAT that is determined to be contraindicated by the recipient's physician.
- A recipient who is subject to an age-related restriction for MAT.

THHSC is required only to provide Medicaid reimbursement for MAT if the treatment is prescribed to a recipient by a licensed health care provider who is authorized to prescribe methadone, buprenorphine, buprenorphine/naloxone or naltrexone. The requirements of SB 1564 expire Aug. 31, 2023.

SB 1564 also requires THHSC, no later than Nov. 1, 2019, to amend its Medicaid Substance Use Disorder Services Medical Policy and any other provider or claims payment policy or manual necessary to authorize Medicaid reimbursement for the prescribing of buprenorphine for the treatment of an opioid use disorder by an advanced practice registered nurse recognized by the Texas Board of Nursing as a clinical nurse specialist, nurse anesthetist or nurse midwife, provided that the APRN is a qualifying practitioner who has obtained a federal waiver from registration requirements for dispensing narcotic drugs.

IMPLICATIONS

SB 1564 provides a new reimbursement stream for MAT, an important component of addressing the opioid crisis.

SENATE BILL 1780
Sponsors:
Sen. Angela Paxton
Rep. Tan Parker
Effective Date: 9/1/19

Value-Based Arrangements for Vendor Drug Program

ANALYSIS

SB 1780 authorizes the Texas Health and Human Services Commission to enter into a value-based arrangement under the Medicaid vendor drug program based on any metrics to which the state and the manufacturer agree in writing. The value-based arrangement may include a rebate, a discount, a price reduction, a contribution, risk sharing, a reimbursement, payment deferral or installment payments, a guarantee, patient care, shared savings payments, withholds, a bonus or any other thing of value.

IMPLICATIONS

SB 1780 provides THHSC with broad discretion to enter into value-based arrangements under the vendor drug program. Hospitals should monitor stakeholder meetings and rulemaking to understand these arrangements and how they may affect payments to hospitals and providers.

HOUSE BILL 25
Sponsors:
Sen. Judith Zaffirini
Rep. Mary González
Effective Date: 9/1/19

Medicaid Transportation Pilot Program for Women and Children

ANALYSIS

HB 25 directs the Texas Health and Human Services Commission to develop a pilot program in one area of the state to allow Medicaid managed transportation organizations to provide transportation to a child who accompanies a woman who is enrolled in the STAR Medicaid managed care program during the woman's pregnancy and for the 60-day eligibility period after she delivers. THHSC must collaborate with the Maternal Mortality and Morbidity Task Force in developing the program and evaluate and report on the results. The transportation must be provided in a manner that results in no additional costs to Medicaid or THHSC.

IMPLICATIONS

The bill may reduce no-show rates in the pilot area for pregnant and postpartum women in the Medicaid program who would have otherwise needed to stay home to care for a child. THHSC will develop rules to specify how far in advance a request for transportation must be made and may make additional rules to implement the pilot program.

HOUSE BILL 72
Sponsors:
Sen. Angela Paxton
Rep. James White
Effective Date: 9/1/19

Continuing Medicaid Coverage for Former Foster Children

ANALYSIS

HB 72 requires the Texas Health and Human Services Commission to ensure continuous care through one of the state's Medicaid programs for children who have been adopted out of the state foster care system. Specifically, the bill requires THHSC and the Texas Department of Family and Protective Services to allow:

1. Certain children who were adopted through TDFPS to remain in STAR Health until they are enrolled in another Medicaid managed care program.
2. The adoptive parent or permanent managing conservator of certain children with disabilities who were adopted through TDFPS to choose between STAR Health and STAR Kids.

The bill also requires TDFPS to provide a $150 monthly subsidy for health care premiums for adopted children under age 18 who were in the conservatorship of TDFPS at the time of adoption and who are not receiving Medicaid benefits.

IMPLICATIONS

Hospitals providing care to adopted children should note certain children may be eligible to continue receiving services through the STAR Health or STAR Kids Medicaid managed care programs.

HOUSE BILL 1063
Sponsors:
Sen. Dawn Buckingham
Rep. Four Price
Effective Date: 9/1/19

Telemedicine Medical, Telehealth and Home Telemonitoring Services Under Medicaid

ANALYSIS

HB 1063 relates to telehealth and telemonitoring services provided under Medicaid. It amends an existing reporting requirement to require the Texas Health and Human Services Commission to include in its biennial report a new reporting element consisting of information on the cost savings associated with the provision of telemedicine medical services, telehealth services and home telemonitoring services to Medicaid enrollees. It also requires the Medicaid telemonitoring program to ensure that home telemonitoring services are available to pediatric patients who are diagnosed with end-stage solid organ disease, have received an organ transplant or require mechanical ventilation.

IMPLICATIONS

HB 1063 requires THHSC to quantify the cost savings associated with telemedicine medical services, telehealth services and home telemonitoring services and expands the Medicaid telemonitoring program to certain pediatric patients. Highlighting the savings generated by telecommunication-based services may result in future expansion of coverage for those services.

HOUSE BILL 1576
Sponsors:
Sen. Dawn Buckingham
Rep. Dade Phelan
Effective Date: 6/14/19

Authorization of Transportation Network Companies' Participation in Medicaid's Medical Transportation Program

ANALYSIS

HB 1576 makes several changes to the way non-emergency transportation services are provided in the Medicaid managed care and fee-for service programs.

For Medicaid managed care, the bill moves administration of the non-emergency medical transportation benefit from managed transportation organizations to the managed care organizations. THHSC must designate

three to four service areas, at least one rural and one urban, by Jan. 1, 2020 to implement this transition in MCO contracts anticipated to be in place by Sept. 1, 2020.

The bill also establishes the "nonmedical transportation" benefit, defined as curb-to-curb transportation to or from a medically necessary, nonemergency covered health care service in a standard passenger vehicle, including transportation services related to discharge from a facility, urgent care services and obtaining prescription drugs. Nonmedical transportation is generally limited to services for reasonably healthy individuals who are ambulatory and lucid.

The bill allows MCOs to use transportation network companies, in addition to more traditional transportation providers, to provide nonmedical transportation services. A TNC is defined as a corporation or entity that enables a passenger to prearrange a ride though the entity's digital network, such as Uber or Lyft. Vehicle operators providing nonmedical transportation services must pass a background check, be at least 18 years of age, maintain a valid driver's license issued by a state and possess proof of registration and financial responsibility for each vehicle used. THHSC may not require a vehicle operator to be enrolled as a Medicaid provider and may not require an MCO to credential vehicle operators. MCOs must continue to use the managed transportation organizations to provide NEMT services outside the scope of nonmedical transportation.

For fee-for-service Medicaid, the bill allows MTOs to also use TNCs to provide nonmedical transportation services.

IMPLICATIONS

The bill changes the way some patients are transported for some non-emergency visits and discharges. THHSC will adopt rules to implement the bill.

HOUSE BILL 2004
Sponsors:
Sen. Pat Fallon
Rep. Jeff Leach
Effective Date: 9/1/19

Dismissal of Causes of Action Related to Medicaid Fraud

ANALYSIS

HB 2004 allows the Attorney General to dismiss *qui tam* petitions brought under the Texas Medicaid Fraud Prevention Act if the court and the attorney general consent, even if the case is no longer under seal. Under current law, consent dismissals are only permitted while the petition is under seal.

IMPLICATIONS

Hospitals should take notice that effective Sept. 1, 2019, the attorney general

may dismiss civil Medicaid fraud petitions with the court's consent after a seal has been lifted, rather than being limited to the period of time a case remains under seal.

HOUSE BILL 4533
Sponsors:
Sen. Lois Kolkhorst
Rep. Stephanie Klick
Effective Date: 9/1/19

System Redesign for Medicaid Acute Care Services and Long-Term Services and Supports for People With Intellectual and Development Disabilities

ANALYSIS

HB 4533 implements a long-delayed pilot program requiring the Texas Health and Human Services Commission to collaborate with the Intellectual and Developmental Disability System Redesign Advisory Committee to establish and collaborate with a pilot program workgroup to develop and implement a Medicaid pilot program to provide long-term services and supports for certain individuals with intellectual or developmental disabilities or certain similar functional needs. It also includes provisions related to Medicaid reforms that were stripped from another bill and that may be of greater interest to providers.

First, the bill requires THHSC to transition from using a state-issued provider identifier number to using only a national provider identifier number. It requires THHSC to use only a national provider identifier number to enroll a provider in Medicaid and to process claims for and authorize Medicaid services.

It also requires THHSC to adopt a definition of "grievance" related to Medicaid and ensure the definition is consistent among divisions within THHSC to ensure all grievances are managed consistently. THHSC is required to:

- Standardize Medicaid grievance data reporting and tracking among divisions within THHSC.
- Implement a "no-wrong-door" system for Medicaid grievances reported to THHSC.
- Establish a procedure for expedited resolution of a grievance related to Medicaid that allows the THHSC to identify a grievance related to a Medicaid access to care issue that is urgent and requires an expedited resolution.
- Resolve the grievance within a specified period.

THHSC also must verify grievance data reported by a Medicaid MCO and aggregate Medicaid recipient and provider grievance data to provide a comprehensive data set of grievances and make the aggregated data available to the legislature and the public in a manner that does not allow for the

identification of a particular recipient or provider.

THHSC is further directed to make available to the public in an easy-to-read format data relating to the quality of health care received by Medicaid recipients and the health outcomes of those recipients.

THHSC must also ensure that notice sent by THHSC or a Medicaid MCO to a Medicaid recipient or provider regarding the denial of coverage or prior authorization for a service includes:

- Information required by federal law.
- A clear and easy-to-understand explanation of the reason for the denial for the recipient.
- A clinical explanation of the reason for the provider.

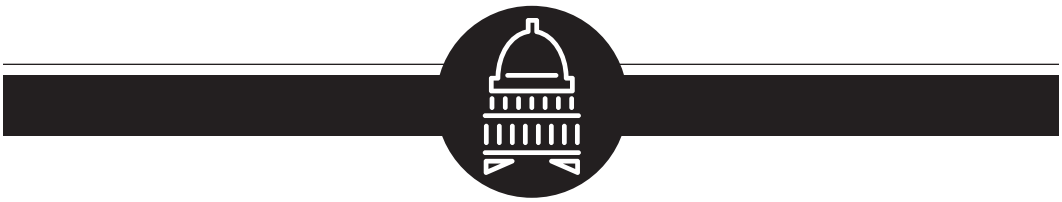
THHSC also is charged with determining the feasibility of providing Medicaid benefits to children enrolled in the STAR Kids managed care program under an accountable care organization model or an alternative model developed by or in collaboration with the Centers for Medicare & Medicaid Services Innovation Center.

Finally, HB 4533 requires a managed care plan offered by a Medicaid MCO to be accredited by a nationally recognized accreditation organization. THHSC may choose whether to require all managed care plans offered by Medicaid MCOs to be accredited by the same organization or to allow for accreditation by different organizations. THHSC may use the data, scoring and other information provided to or received from an accreditation organization in its contract oversight processes.

The pilot will begin Sept. 1, 2023 and operate for at least two years. The bill requires THHSC to collaborate and consult with the IDD System Redesign Advisory Committee and the pilot program workgroup to perform an evaluation and submit a report after the conclusion of the pilot program. The bill also requires THHSC to seek a waiver under Section 1115 of the federal Social Security Act to provide Medicaid benefits to certain medically fragile individuals if THHSC determines it to be cost-effective.

IMPLICATIONS

HB 4533 addresses several issues with the Medicaid program that have been the subject of stakeholder discussions over the months leading up to the 86th Legislature, including use of the national provider identifier number for Medicaid enrollment and billing, a streamlined enrollment process, and a more robust complaint procedure. It also will implement a requirement that MCOs be accredited by a national accrediting body.



NURSE LICENSURE AND PRACTICE

HOUSE BILL 2410
Sponsors:
Sen. Charles Perry
Rep. Stephanie Klick
Effective Date: 9/1/19

Requests for Nursing Peer Review Committee Determinations

ANALYSIS

HB 2410 resulted from concerns with nurses completing the Texas Board of Nursing-developed form to trigger safe harbor protections. "Safe harbor" is the term commonly used in reference to section 303.005 of the Occupations Code, which protects nurses from disciplinary action when the nurse is asked to engage in conduct that the nurse believes violates a nurse's duty to a patient if the nurse follows certain procedures prescribed in that section. Section 303.005 applies to any hospital required to have a nursing peer review committee.

The bill allows a hospital to use the TBON form or to develop its own form that meets the standards developed by the board.

Additionally, if a nurse is unable to complete a form due to immediate patient care needs, the nurse may request a nursing peer review committee determination by orally notifying the nurse's supervisor. After receiving the oral notification, the nurse supervisor must record in writing:

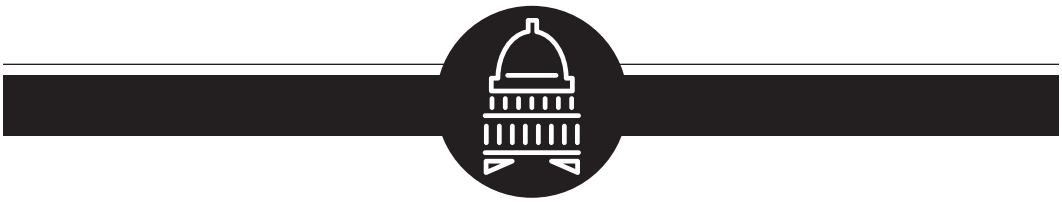
- The name of requesting nurse.
- The date and time of the request.
- The location of the conduct or assignment that is the subject of the request.
- The name of the supervisor recording the request.
- A brief explanation of why the nurse is requesting a nursing peer review determination. a description of the collaboration between the nurse and supervisor.

To be valid, the request must be signed and attested to by the requesting nurse and the nurse's supervisor who prepared the written record.

IMPLICATIONS

After the TBON develops required standards, hospitals will be able to develop their own safe harbor request form.

Additionally, hospitals should educate their supervising nurses that after Sept. 1, 2019, a nurse may be able to request safe patient harbor verbally. The supervising nurse will be able to record the required elements on behalf of the nurse, and the requesting nurse and supervising nurse will both be required to sign and document the request.



OTHER/MISCELLANEOUS

SENATE BILL 943
Sponsors:
Sen. Kirk Watson
Rep. Giovanni Capriglione
Effective Date: 1/1/20

Disclosure of Contracting Information Under the Texas Public Information Act

ANALYSIS

SB 943 makes changes to the Texas Public Information Act related to required disclosures. It states that "contracting information" is public information and must be released in response to a request under the Public Information Act unless excepted from disclosure. The bill defines "contracting information" as the following information maintained by a governmental body or sent between a governmental body and a vendor, contractor, potential vendor or potential contractor:

- Information in a voucher or contract relating to the receipt or expenditure of public funds by a governmental body.
- Solicitation or bid documents relating to a contract with a governmental body.
- Communications sent between a governmental body and a vendor, contractor, potential vendor or potential contractor during the solicitation, evaluation or negotiation of a contract.
- Documents showing the criteria by which a governmental body evaluates responses to a solicitation and, if applicable, an explanation of why the vendor or contractor was selected.
- Communications and other information sent between a governmental body and a vendor or contractor related to the performance of a final contract with the governmental body or work performed on behalf of the governmental body.

Under SB 943, a private entity that contracts with a governmental body must provide contracting information to the governmental body in connection with a TPIA request to the governmental body if the entity has a contract with the governmental body for the purchase of goods or services with a stated or actual value of $1 million or more in public funds. However, the private entity is only required to provide contracting information to the governmental body if the information is in the possession of the private entity and not maintained by the governmental body.

The governmental body has up to three business days after the receipt of a TPIA request to request the information from the private entity and—with grace periods for delayed receipt of information—up to 13 days to notify the requester if it intends to withhold the requested information and ask the attorney general for a decision to withhold information under an exception (the ordinary deadline for exceptions is 10 days, which is extended to allow time to receive the

information from the private entity). Written comments from the governmental body to the attorney general regarding an exception are due within 18 days.

Government contracts valued at $1 million or more with private entities must require the contracting entity to:

- Preserve all contracting information for the duration of the contract.
- Promptly provide to the governmental body any contracting information related to the contract that is in the custody or possession of the entity on request of the governmental body.
- Upon completion of the contract, either provide all contracting information to the governmental body at no cost or preserve the contracting information according to the governmental body's records retention requirements.

Government contracts valued at $1 million or more with private entities must also include the following clause:

> The requirements of Subchapter J, chapter 552 of the Government Code, may apply to this (include "bid" or "contract" as applicable) and the contractor or vendor agrees that the contract can be terminated if the contractor or vendor knowingly or intentionally fails to comply with a requirement of that subchapter.

If a private entity does not produce information in compliance with the bill, the governmental body must provide notice to the entity in writing and indicate to the governmental body that the contract may be terminated if the entity does not cure the violation within 10 business days. However, termination requires a determination by the governmental body that the entity knowingly or intentional violated the terms of the bill and did not take adequate steps to ensure future compliance. A governmental body may not contract with a private entity that has violated SB 943's requirements in the past, unless the governmental body determines and documents that the entity has taken adequate steps to ensure future compliance.

SB 943 also makes changes to some of the exceptions in the TPIA. The bill narrows the TPIA exception for information that would give an advantage to a competitor or vendor, limiting the exception to circumstances where a governmental body demonstrates that releasing the information would harm the governmental body's interests in a particular ongoing competitive situation or in a particular competitive situation in the future.

SB 943 includes new definitions for trade secrets and proprietary information exempt from disclosure under the TPIA. Under the bill, a trade secret—in summation—means all forms of information that the owner has taken

reasonable measures under the circumstances to keep secret and that derive independent economic value from not being generally known to, and not being readily ascertainable by, another person who can obtain economic value from the disclosure or use of the information.

Proprietary information is exempt from disclosure under the TPIA if the information is submitted to a governmental body in response to a request for a bid, proposal, or qualification and the vendor, contractor, potential vendor or potential contractor demonstrates that disclosure of the information:

- Would reveal an individual approach to work, organizational structure, staffing, internal operations, processes or discounts, pricing methodology, cost data or other pricing information that will be used in future solicitation or bid documents.
- Would give advantage to a competitor.

Proprietary information does not include information in a voucher or contract related to a governmental body's expenditure of public funds or communications and other information between a governmental body and a vendor or contractor related to the performance of a final contract. To qualify for the proprietary information exception, the vendor, contractor, potential vendor or potential contractor must assert the exception to the governmental body.

The trade secret and proprietary information exceptions to disclosure do not apply to information indicating whether a vendor, contractor, potential vendor or potential contractor performed its duties under a contract or the following contract terms or their functional equivalents:

- The overall price paid by the governmental body.
- A description of deliverables and deadlines, with the total price for each deliverable, if a total price is identified for the item or service in the contract.
- The remedies for breach of contract.
- The identity of all parties to the contract.
- The identity of all subcontractors in a contract.
- The affiliate overall or total pricing for a vendor, contractor, potential vendor or potential contractor.
- The execution dates and the effective dates.
- The contract duration terms, including any extension options.

Consistent with current law, a governmental body may decline to release information for the purpose of requesting an attorney general decision.

IMPLICATIONS

SB 943 requires private entities to produce a limited, defined set of contracting information under the TPIA related to contracts with governmental bodies valued at $1 million or more. However, private entities will not need to respond directly to TPIA requests; they must only provide responsive information if the governmental body does not have the information. SB 943 is designed not to burden private entities subject to significant reporting and oversight by the governmental bodies with which they contract. Nonpublic hospitals that contract with governmental bodies should update their policies and procedures to ensure timely responses to any requests for information. State and public hospitals should ensure that any contracts with outside entities comply with SB 943. All Texas hospitals should note the new definition of trade secrets and proprietary information under the TPIA.

SENATE BILL 944
Sponsors:
Sen. Kirk Watson
Rep. Giovanni Capriglione
Effective Date: 9/1/19

Texas Public Information Act Exception for Protected Health Information and New Requirements for Governmental Bodies

ANALYSIS

SB 944 clarifies that protected health information defined by section 181.006 of the Health and Safety Code, is not public information and is not subject to disclosure under the Texas Public Information Act.

In addition, SB 944 adds a new exception to the TPIA for information obtained by a governmental body provided by an out-of-state health care provider in connection with a quality management, peer review or best practices program paid for by an out-of-state health care provider.

SB 944 requires a current or former officer or employee of a governmental body who maintains public information on a personal device to forward or transfer all public information to the governmental body or preserve public information in accordance with the governmental body's retention policy. The bill clarifies that laws governing the preservation, destruction or other disposition of records or public information apply to public information held on personal devices. Within 10 days of a request from the governmental body, a current or former officer or employee of a governmental body must provide any requested public information to the governmental body.

SB 944 repeals the current definition of a valid written TPIA request, replacing it with a request in writing through U.S. mail, email, hand delivery or any other appropriate method approved by the governmental body that is posted

on a sign and the governmental body's website. A governmental body may designate one mailing address and one email address for receiving written requests for public information and is not required to respond to requests by other means except by hand delivery or another method approved by the governmental body that is properly communicated to the public.

By Oct. 1, 2019, SB 944 requires the attorney general to create a new public information request form that provides a requestor the option of excluding from a request information that the governmental body determines is confidential or excepted from disclosure. If a governmental body chooses to utilize the new form, the governmental body must post the form on its website.

IMPLICATIONS

SB 944 codifies in the TPIA an existing exception for protected health information. Hospitals should also note the new quality and peer review exceptions to the TPIA. Hospitals that qualify as governmental bodies should review the bill's new requirements for current and former employees and update all necessary policies and procedures. In addition, state and public hospitals should review the bill's requirements for valid TPIA requests and monitor the attorney general's website for the optional new request form.

SENATE BILL 1259
Sponsors:
Sen. Joan Huffman
Rep. Stephanie Klick
Effective Date: 9/1/19

Prosecution of Sexual Assault Offenses

ANALYSIS

SB 1259 makes changes to the Code of Criminal Procedure and the Penal Code to make a sexual assault offense punishable as a state jail felony if a health care provider, in the course of performing an assisted reproduction procedure on the other person, uses human reproductive material from a donor knowing that the other person has not expressly consented to the use of material from that donor. The two-year statute of limitations does not begin running until the offense is discovered.

IMPLICATIONS

SB 1259 closes a gap in the law by making it a criminal offense to use reproductive donor material from anyone other than the donor for whom the person receiving the material has consented.

SENATE BILL 1978
Sponsors:
Sen. Bryan Hughes
Rep. Matt Krause
Effective Date: 9/1/19

Protection of Religious Beliefs and Moral Convictions, Including Beliefs and Convictions Regarding Marriage

ANALYSIS

SB 1978, popularly known as the "Chick-fil-A Bill" because it was filed and pursued in response to the City of San Antonio's refusal to allow the restaurant chain to have a franchise in the San Antonio airport because of its history of donations to certain groups and causes, prohibits a governmental entity from taking any adverse action against any person based wholly or partly on the person's membership in, affiliation with, or contribution, donation or other support provided to a religious organization. A person subjected to adverse action may assert an actual or threatened violation as a claim or defense in a judicial or administrative proceeding and obtain injunctive relief, declaratory relief and court costs and reasonable attorney's fees. Sovereign or governmental immunity, as applicable, is waived and abolished in an action for a violation.

The definition of "adverse action" is broad. It includes any action taken by a governmental entity to:

1. Withhold, reduce, exclude, terminate or otherwise deny any grant, contract, subcontract, cooperative agreement, loan, scholarship, license, registration, accreditation, employment or other similar status from or to a person.
2. Withhold, reduce, exclude, terminate or otherwise deny any benefit provided under a benefit program from or to a person.
3. Alter in any way the tax treatment of, cause any tax, penalty or payment assessment against, or deny, delay or revoke a tax exemption of a person.
4. Disallow a tax deduction for any charitable contribution made to or by a person.
5. Deny admission to, equal treatment in or eligibility for a degree from an educational program or institution to a person.
6. Withhold, reduce, exclude, terminate or otherwise deny access to a property, educational institution, speech forum or charitable fund-raising campaign from or to a person.

Likewise, "governmental entity" is defined broadly to include:

1. The state.
2. A board, commission, council, department or other agency in the executive branch of state government that is created by the state constitution or a statute, including an institution of higher education as defined by section 61.003 of the Education Code.
3. The legislature or a legislative agency.

4. A state judicial agency or the State Bar of Texas.
5. A political subdivision of this state, including a county, municipality or special district or authority.
6. An officer, employee or agent of an entity described in (1)-(5).

IMPLICATIONS

Public entities, including special districts such as hospital districts, risk litigation if they base decisions on conducting business with individuals or entities on improper motives. The bill as filed applied to adverse action based on a person's religious beliefs and moral convictions, including belief's regarding marriage. The version of the bill that passed is somewhat narrower and more objective in applying it to observable acts of membership in, affiliation with, or contribution, donation or other support provided to a religious organization.

HOUSE BILL 541
Sponsors:
Sen. Judith Zaffirini
Rep. Mary González
Effective Date: 9/1/19

Right to Express Breast Milk

ANALYSIS

HB 541 expands section 165.002 of the Health and Safety Code, which allows a mother to breastfeed in any location the mother was authorized to be, to allow the mother the right to express breast milk in any location where the mother's presence is otherwise authorized.

IMPLICATIONS

Facilities may be required to change policies to account for the increased scope of section 165.002 of the Health and Safety Code and increased protection of a mother's right to express breast milk.

HOUSE BILL 1590
Sponsors:
Sen. Kirk Watson
Rep. Donna Howard
Effective Date: 6/4/19

Creation of the Sexual Assault Survivors' Task Force

ANALYSIS

HB 1590 creates the Sexual Assault Survivors' Task Force in the Office of the Governor's Criminal Justice Division and establishes its duties and membership. The task force will be designed to effectively coordinate funding for services to child and adult survivors and better prevent, investigate and prosecute incidents of sexual assault and other sex offenses. Duties of the task force include:

- Facilitating communication and cooperation between state agencies.
- Collecting, analyzing and making publicly available information on the prevention, investigation and prosecution of sex offenses and on services provided to survivors, including a list of designated sexual assault forensic exam-ready facilities.
- Providing resources to the Texas Commission on Law Enforcement and other law enforcement organizations to improve officer training related to investigating and documenting sex offenses, with a focus on interactions between officers and survivors.
- Biennially contracting for a survey of the resources provided to survivors by nonprofits, health care facilities, institutions of higher education, sexual assault response teams and other governmental entities in each region of the state.
- Making recommendations to improve the collecting and reporting of data on the investigation and prosecution of sexual assault and other sex offenses.
- Developing statewide best practices in the funding and provision of services to survivors by various entities.

The presiding body of the task force is a steering committee that will create working groups focusing on survivors, ensures the task force identifies systemic issues, and reviews and approves all products. The committee will consist of the governor, the president of the Texas Association Against Sexual Assault and the president of the Children's Advocacy Centers of Texas.

The task force will be comprised of the governor, an appointed senator and House member, a sexual assault nurse examiner, and specific representatives of certain state agencies, including the Office of the Attorney General, the Texas Health and Human Services Commission, the TCLE, the Texas Forensic Science Commission and the Texas Department of Public Safety—in addition, the presidents of the following organizations:

- Texas Association of Crime Laboratory Directors.
- Texas District and County Attorney's Association.
- Texas Municipal Police Association.
- Texas Society of Pathologists.
- International Association of Forensic Nurses Texas Chapter.
- Children's Advocacy Centers of Texas.
- TAASA.

The task force must submit a report that includes a description of the

differences between the resources provided to both child and adult survivors and the statewide standards, recommendations the state and each region could take to better comply with the standards, and a description of potential funding sources to implement the recommendations. These evidence-based standards must be submitted to the legislature by Nov. 1 of each even-numbered year.

The bill's task force provisions expire on Sept. 1, 2023.

IMPLICATIONS

HB 1590 was part of a renewed focus by the 86th Texas Legislature on issues affecting sexual assault survivors. Providers should monitor the work of the task force for recommendations and policies affecting their interactions and involvement with survivors.

HOUSE BILL 1735
Sponsors:
Sen. Kirk Watson
Rep. Donna Howard
Effective Date: 9/1/19

Sexual Harassment, Sexual Assault, Dating Violence and Stalking at Postsecondary Educational Institutions

ANALYSIS

HB 1735 requires each postsecondary educational institution to adopt policies and procedures on sexual harassment, sexual assault, dating violence and stalking. If the Texas Higher Education Coordinating Board determines that an institution is not in substantial compliance with the requirements, THECB may assess an administrative penalty up to $2 million.

To facilitate effective communication and coordination of services, HB 1735 requires each postsecondary educational institution to enter into a memorandum of understanding with one or more local law enforcement agencies, sexual assault or violence prevention advocacy groups or hospital or medical resource providers.

HB 1735 provides confidentiality protections to alleged victims, persons who report an incident to the institution and to an alleged perpetrator when the report is determined to be unsubstantiated or without merit. The identity of those protected in the statute may be disclosed to a law enforcement officer or a health care provider in an emergency situation.

IMPLICATIONS

Hospitals may be approached by their local postsecondary educational institutions seeking a memorandum of understanding. Hospital staff should be aware that these arrangements are required as part of HB 1735 and intended to facilitate better coordination for issues of sexual assault and dating violence.

If a hospital encounters an allegation of sexual assault or dating violence related to a postsecondary campus, HB 1735 contains a confidentiality provision related to emergency care. This may be able to be more clearly addressed in an MOU.

HOUSE BILL 1960
Sponsors:
Sen. Charles Perry
Rep. Four Price
Effective Date: 5/25/19

Creation of the Governor's Broadband Development Council

ANALYSIS

HB 1960 creates a 17-member council, tasked with helping to develop broadband access in rural areas of Texas for economic development, education and telemedicine and telehealth. The council will study the progress of broadband development in underserved areas, identify barriers to that development, study solutions to overcome those barriers and analyze how statewide access to broadband would benefit economic development, the delivery of educational opportunities, law enforcement, emergency preparedness and the delivery of health care services.

The council will report annually to the legislature.

IMPLICATIONS

Texas hospitals should be aware of these efforts to increase health services in the most rural areas of Texas by identifying and overcoming barriers to broadband access in areas not currently able to access telemedicine or telehealth. The annual findings and report from the council should be reviewed by facilities affected by the council's mission.

HOUSE BILL 3609
Sponsors:
Sen. Kelly Hancock
Rep. Trey Martinez Fisher
Effective Date: 9/1/19

Filing an Assumed Name Certificate by Certain Business Entities

ANALYSIS

HB 3609 deletes the requirement that a business file an assumed name certificate in the county where the business' registered or principle office is located. Current law requires the filing of the assumed name (sometimes referred to as the "doing business as" or "D/B/A") certificate in both the county where the business' principle or registered office is located and with the Texas Secretary of State.

IMPLICATIONS

This bill provides relief from the duplicative assumed name certificate filing

requirements that have existed for many years by requiring the assumed name certificate to be filed only with the Secretary of State.

HOUSE BILL 3716
Sponsors:
Sen. Jane Nelson
Rep. Tan Parker
Effective Date: 9/1/19

Establishment of the Office of Medical Examiner in Certain Counties

ANALYSIS

HB 3716 raises the minimum population requirement for a county to establish an office of medical examiner to 2 million from 1 million. In addition, the bill removes the exemption for counties with a medical school.

IMPLICATIONS

Texas hospitals in counties with a population between 1 and 2 million should be aware that their county medical examiner is no longer required by law. Counties with populations of more than 2 million, and which were exempt from maintaining a medical examiner's office due to a medical school operating in the county will have to establish a separate medical examiner's office, which may affect ties with the local medical school.

HOUSE BILL 3803
Sponsors:
Sen. Judith Zaffirini
Rep. Ryan Guillen
Effective Date: 9/1/19

Maximum Amount of an Administrative Penalty Assessed on Certain Long-Term Care Facilities

ANALYSIS

HB 3803 limits the administrative penalties in section 252.065 of the Health and Safety Code, pertaining to intermediate care facilities for persons with intellectual disabilities. There is no change in the underlying penalties, which the Texas Health and Human Services Commission may assess against a person who:

- Knowingly makes a false statement of material fact.
- Refuses to allow inspection by a representative of THHSC.
- Willfully interferes with the work of a representative of THHSC.
- Fails to pay a penalty assessed by chapter 252 of the Health and Safety Code.
- Fails to submit a plan of correction within 10 days of receiving a violation.
- Fails to notify THHSC of a change in ownership before the effective date.

These penalties apply for each day a violation occurs and are now capped at

$5,000 for a facility with fewer than 60 beds, or $25,000 for a facility with 60 beds or more.

Under applicable statute, "facility" means a home or an establishment that:

- Furnishes food, shelter and treatment or services to four or more individuals unrelated to the owner.
- Is primarily responsible for the diagnosis, treatment or rehabilitation of individuals with an intellectual disability or related conditions.
- Provides in a protected setting continuous evaluation, planning, 24-hour supervision, coordination and integration of health or rehabilitative services to help each resident function at the resident's greatest ability.

IMPLICATIONS

Facilities subject to section 252.065 of the Health and Safety Code should note the new limits on potential penalties.

HOUSE BILL 4390
Sponsors:
Sen. Jane Nelson
Rep. Giovanni Capriglione
Rep. Trey Martinez Fischer
Rep. Eddie Rodriguez
Rep. Nicole Collier
Effective Date: 9/1/19

Privacy of Personal Identifying Information and the Creation of the Texas Privacy Protection Advisory Council

ANALYSIS

HB 4390 amends section 521.053 of the Business and Commerce Code to require disclosure of a breach of sensitive personal information to any affected individual without unreasonable delay and no later than 60 days from a determination that the breach occurred.

The Attorney General also must receive notice of a breach involving at least 250 Texas residents; this notice must be issued within 60 days from a determination that the breach occurred and must include:

- A detailed description of the nature and circumstances of the breach or the use of sensitive personal information acquired as a result of the breach.
- The number of Texas residents affected by the breach at the time of notification.
- The measures taken by the person regarding the breach.
- Any measures the person intends to take regarding the breach after the notification under this subsection.
- Information regarding whether law enforcement is engaged in investigating the breach.

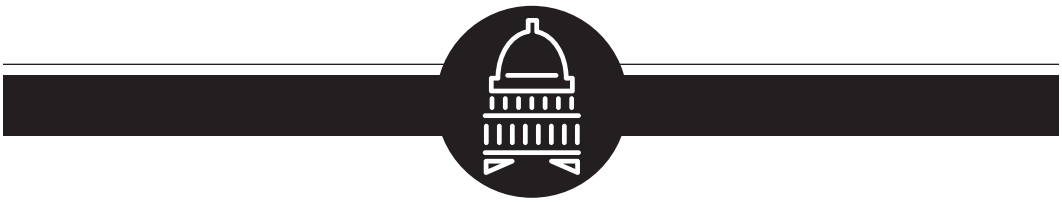
Under chapter 521 of the Business and Commerce Code, "sensitive personal information" is defined as:

- An individual's first name or first initial and last name in combination with any one or more of the following items, if the name and the items are not encrypted:
  - Social security number.
  - Driver's license number or government-issued identification number.
  - Account number or credit or debit card number in combination with any required security code, access code, or password that would permit access to an individual's financial account.
- Information that identifies an individual and relates to:
  - The physical or mental health or condition of the individual.
  - The provision of health care to the individual.
  - Payment for the provision of health care to the individual.

HB 4390 also creates the Texas Privacy Protection Advisory Council, to study data privacy laws in this state, other states and relevant foreign jurisdictions, and make recommendations to the legislature on specific statutory changes regarding the privacy and protection of potentially sensitive information by Sept. 1, 2020.

IMPLICATIONS

Policies and procedures related to sensitive personal information should be updated to include these new requirements in the event of a breach. Individuals responsible for maintaining such sensitive personal information should be educated on the changes in law and the need for additional notification in the event of a breach. Should a breach occur, the provisions in chapter 521 of the Business and Commerce Code, should be followed, in addition to any other state, federal or other applicable requirement.



PHARMACY LICENSURE AND PRACTICE

SENATE BILL 683
Sponsors:
Sen. Dawn Buckingham
Rep. Steve Allison
Effective Date: 9/1/19

Texas State Board of Pharmacy Omnibus Bill

ANALYSIS

SB 683 is an omnibus bill related to the Texas State Board of Pharmacy. The bill requires a pharmacy that has not dispensed any controlled substances during a period of seven consecutive days to send a report to TSBP indicating that no controlled substances were dispensed during the seven-day period, unless the pharmacy has obtained a waiver or permission to delay reporting to TSBP.

SB 683 also updates the Health & Safety Code to allow a pharmacist-intern or pharmacy technician trainee to access a patient's prescription history from TSBP if acting at the direction of a pharmacist and if the patient is a patient of that pharmacist. In addition, the bill permits a practitioner to access prescription history information from TSBP related to a practitioner to whom the practitioner has delegated prescribing authority.

SB 683 requires a wholesale distributer to report to the TSBP the distribution of all Schedules II, III, IV and V controlled substances in the same format and with the same frequency as the information is reported to the Federal Drug Enforcement Administration.

SB 683 changes the frequency of the meeting requirements of the interagency prescription monitoring work group, which is now required to meet only when necessary as determined by TSBP. Prior to SB 683, the work group was required to meet at least quarterly.

SB 683 expands the purposes for which a TSBP may award a Class E pharmacy license or nonresident pharmacy license, which now may be issued to a pharmacy located in another state whose primary business is to process a prescription drug order for a patient or perform another pharmaceutical service, as defined by board rule.

SB 683 includes a provision also located in House Bill 3496 stating if a pharmacy ceases to operate for 30 days or longer, TSBP must notify the pharmacy that its license will be revoked. The notice must inform the pharmacy of its right to a hearing to contest the revocation. A pharmacy has up to 20 days from receipt of the notice to submit a written request for a hearing from a panel of three TSBP board members. If the pharmacy does not submit a written request within the deadline or if the pharmacy does not prevail at the hearing, the pharmacy's license will be revoked.

Finally, SB 683 repeals a provision of the Occupations Code permitting a Texas pharmacy to order a prescription drug from a Canadian pharmacy, as well as all regulatory provisions in the Occupations Code regulating Canadian pharmacies.

The bill also repeals a portion of the Occupations Code prohibiting a pharmacy from renewing its Texas license if the pharmacy's license to operate in another state is suspended, revoked, canceled or subject to an action that prohibits the pharmacy from operating in that state.

IMPLICATIONS

Although likely very rare, hospitals should notify their affiliated pharmacies of SB 683's additional reporting requirements for pharmacies that have not dispensed any controlled substances for a period of seven consecutive days. Hospitals should notify affiliated pharmacists and prescribers, especially practitioners who delegate prescriptive authority, of the updates to access of prescription history from TSBP. Finally, hospital-affiliated pharmacies should closely review the provisions of the bill related to wholesale distributor reporting, disciplinary actions in other states, mail order pharmacies, and periods of inactivity for 30 days or longer.

SENATE BILL 1056
Sponsors:
Sen. Judith Zaffirini
Rep. John Raney
Effective Date: 9/1/19

Additional Conditions for Physicians to Delegate to Pharmacists the Implementation or Modification of a Patient's Drug Therapy Under a Protocol

ANALYSIS

SB 1056 adds two new conditions for a physician to delegate to a pharmacist the implementation or modification of a patient's drug therapy under a protocol:

- The delegation must follow a diagnosis, initial patient assessment and drug therapy order by the physician.
- The pharmacist must maintain a copy of the protocol for inspection until at least the seventh anniversary of the protocol's expiration date.

IMPLICATIONS

Hospitals should notify physicians and affiliated pharmacists of the additional conditions required to delegate the implementation or modification of a patient's drug therapy under a protocol. Note that House Bill 2425 also addresses physician delegation to pharmacists.

HOUSE BILL 1264
Sponsors:
Sen. Dawn Buckingham
Rep. Senfronia Thompson
Effective Date: 5/7/19

Communication by Dispensers of Biological Products to Prescribers of Biological Products

ANALYSIS

HB 1264 repeals the Sept. 1, 2019 expiration date of section 562.0051 of the Occupations Code, which requires a dispensing pharmacist or the pharmacist's designee to communicate within three business days to the prescriber of a biological product the specific product provided to the patient, unless there is no FDA-approved alternative for the biological product or unless a refill prescription is unchanged from the product dispensed on the prior filling of the prescription.

IMPLICATIONS

Hospitals and hospitals with Class C pharmacies located in their facilities should communicate to prescribers and dispensers that the existing duty to notify prescribers of the specific biologic product dispensed will not expire as it was scheduled to prior to the passage of HB 1264, but rather will continue to apply after Sept. 1, 2019.

HOUSE BILL 1455
Sponsors:
Sen. Dawn Buckingham
Rep. Todd Hunter
Effective Date: 9/1/19

Audit of Pharmacy Wholesale Invoices

ANALYSIS

HB 1455 prohibits a health benefit plan issuer or pharmacy benefit manager that audits wholesale invoices from auditing the pharmacy claims of another health benefit plan or pharmacy benefit manager.

HB 1455 requires a health benefit plan issuer or PBM to reverse a finding of a discrepancy based on a technical error, specifically if the National Drug Code is in a quantity that is a subunit or multiple of the drug purchased as supported by the wholesale invoice, the pharmacist or pharmacy dispensed the correct quantity of the drug according to the prescription and the drug dispensed by the pharmacist or pharmacy shares all but the last two digits of the NDC code of the drug reflected on the supplier invoice.

HB 1455 requires a health benefit plan or PBM to accept as evidence of pharmacy claim: supplier invoices, certain supporting documentation and reports required by a board or agency.

IMPLICATIONS

Hospitals with Class C Pharmacies located in their facilities should take note of

HB 1455's protections against claim denials for technical errors, so that these pharmacies may update their policies and procedures.

HOUSE BILL 2088
Sponsors:
Sen. Bryan Hughes
Rep. Jay Dean
Effective Date: 9/1/19

Providing Information Related to Safe Disposal of Controlled Substance Prescription Drugs

ANALYSIS

HB 2088 requires dispensers of Schedule II controlled substances to provide written notice, defined by Texas State Board of Pharmacy rule, on the safe disposal of controlled substances unless the pharmacy dispensing the drug is authorized and regularly accepts those drugs for safe disposal, or the dispenser provides the person to whom the drug is being dispensed a mail-in pouch for surrendering unused controlled substances or chemicals to render any unused drugs unusable or non-retrievable.

TSBP is required to adopt rules to prescribe the form of written notice on the safe disposal of the drugs. The notice must include information on locations at which Schedule II controlled substances are accepted for safe disposal. The notice may also provide the address of a website that provides a searchable database of locations for disposal in lieu of listing the locations on the form. TSBP also is allowed to take disciplinary action against a person who fails to comply with this section.

The bill applies to controlled substance prescription drugs dispensed on or after Jan. 1, 2020.

IMPLICATIONS

The bill applies to hospital pharmacies that dispense Schedule II controlled substance prescriptions.

HOUSE BILL 2174
Sponsors:
Sen. Lois Kolkhorst
Rep. John Zerwas
Effective Date: 9/1/19

Electronic Prescribing of Controlled Substances and Reimbursement for Treatment of Substance Use Disorders

ANALYSIS

HB 2174 establishes limits on prescribing opioids by prohibiting a practitioner from prescribing more than a 10-day supply of an opioid prescription or from providing a refill of an opioid, when treating a patient with acute pain. Under

the bill, "acute pain" means the normal, predicted, physiological response to a stimulus such as trauma, disease and operative procedures. Acute pain is time limited. The term does not include chronic pain; pain being treated as part of cancer care; pain being treated as part of hospice or other end-of-life care; or pain being treated as part of palliative care.

Opioids used to treat substance use disorder are exempt from the prescribing limits. Also, under the Medicaid program, there are no limits on prescription drugs used to treat acute pain.

The Texas Health and Human Services Commission is required to reimburse certain medication-assisted opioid or substance use disorder treatments without requiring prior authorization or precertification, and HB 2174 amends certain policies to authorize Medicaid reimbursement for the prescribing of buprenorphine for SUD treatment by an advanced practice nurse meeting certain Texas Board of Nursing and federal requirements.

E-Prescribing

A person administering a controlled substance is required to use an electronic prescription, with the exception of several provisions allowing a prescription be issued in writing. In the case of an emergency, a practitioner or designated agent is allowed to submit an oral or telephonically communicated prescription. Within seven days of authorizing the emergency prescription, the practitioner must provide an electronic prescription to the pharmacist where the prescription was dispensed.

The bill authorizes certain regulatory agencies to grant waivers from the electronic prescribing requirement. The Texas State Board of Pharmacy is tasked with convening an interagency workgroup that includes representatives from each regulatory agency that issues a license, certification or registration to prescribers. This workgroup will establish recommendations and standards in which a waiver is appropriate and also will develop a process under which a prescriber must request and receive the waiver. The waiver can be issued to prescribers for one year but prescribers must reapply for a subsequent waiver 30 days before the date the waiver expires.

Continuing Education

HB 2174 also amends continuing education requiring practitioners and pharmacists, within a year of the issuance of their license, to complete two hours of professional education on approved procedures of prescribing and monitoring controlled substances.

IMPLICATIONS

Prescribers must be aware of new prescribing limitations for acute pain and should be advised which patients being treated for acute pain are covered under Medicaid since prescribing limits are not applicable to this group. Hospitals not currently using e-prescribing will need to establish a system requiring electronic prescriptions.

HOUSE BILL 2425
Sponsors:
Sen. Charles Schwertner
Rep. Kyle Kacal
Effective Date: 9/1/19

Physician Delegation of Implementation and Modification of Drug Therapies Under a Protocol to Pharmacists Practicing at Federally Qualified Health Centers

ANALYSIS

HB 2425 allows a physician to delegate the implementation or modification of a patient's drug therapy under a protocol, including the authority to sign a prescription drug order for dangerous drugs, to a pharmacist practicing at a federally qualified health center, as long as the other existing conditions of delegation are satisfied. Prior to HB 2425, a pharmacist was required to practice at either a hospital, a hospital-based clinic or an academic health care institution.

IMPLICATIONS

Hospitals should notify their affiliated physicians and pharmacists of the ability to delegate implementation and modification of drug therapies to pharmacists practicing at federally qualified health centers and update applicable policies and procedures accordingly. Note that Senate Bill 1056 also addresses physician delegation to pharmacists.

HOUSE BILL 2594
Sponsors:
Sen. Angela Paxton
Rep. Justin Holland
Effective Date: 9/1/19

Disposal of Controlled Substance Prescription Drugs by Hospice Service Providers

ANALYSIS

HB 2594 authorizes home and community support services agencies licensed to provide hospice services to adopt policies and procedures related to the disposal of a patient's unused controlled substances prescriptions upon a patient's death or in other circumstances in which disposal is appropriate. A license holder that chooses to adopt policies and procedures must:

- Provide a copy of the policies and procedures to the patient and the patient's family.
- Discuss the policies and procedures with the patient and the patient's family in a manner in which the patient and patient's family understand.
- Document in the patient's clinical record that the policies and procedures were provided and discussed.

A license holder may provide training to its employees regarding secure and responsible disposal of controlled substance prescription drugs in order to discourage abuse, misuse or diversion.

HB 2594 authorizes an employee of a license holder who has received training from the licensed entity to confiscate and dispose of the patient's controlled substance prescription drug if:

- The patient has died.
- The drug has expired.
- The patient's physician has given written instructions that the patient should no longer use the drug.

An employee confiscating the prescription drug is required to dispose of the drug in a manner consistent with recommendations of the U.S. Food and Drug Administration and Texas law. The disposal of the prescription drug must occur at the location at which the drug was confiscated and must be witnessed by another person, 18 years of age or older. Once the employee has disposed of the prescription drug, he or she must document in the patient's record:

- The name of the drug.
- The dosage of the drug the patient was receiving.
- The path by which the prescription drug is administered (i.e., oral or intravenous).
- The quantity of the prescription drug originally dispensed and the quantity of the drug remaining.
- The time, date and manner of disposal.

The employee also is required to document in the patient's file if a family member of the patient prevented the confiscation and disposal of the prescription drug.

IMPLICATIONS

Hospitals that own or operate a hospice should determine whether the organization will develop policies and procedures concerning the disposal

of controlled substance prescription drugs. If the organization does develop policies and procedures, it should adhere to the provisions of HB 2594 and provide training to the organization's employees on secure and responsible disposal of controlled substance prescription drugs.

HOUSE BILL 3284
Sponsors:
Sen. Jane Nelson
Rep. J.D. Sheffield
Effective Date: 9/1/19

Prescribing and Dispensing under the Texas Controlled Substances Act

ANALYSIS

HB 3284 delays until March 1, 2020 the requirement for pharmacists and prescribers to check the Prescription Monitoring Program before dispensing or prescribing opioids, benzodiazepines, barbiturates or carisoprodol. Access to information in the PMP is granted to health care facilities certified by the Centers for Medicare & Medicaid Services. In addition, a patient or patient's legal guardian is authorized to request and receive a copy of the patient's prescription record and list of persons who have accessed the patient's prescription record. The Texas State Board of Pharmacy is authorized to charge a fee for providing a copy of a patient's prescription record.

The bill also establishes an advisory committee of five physicians, an oral surgeon, a physician assistant or nurse practitioner, three pharmacists, and two health information technology representatives to serve three-year terms and meet at least twice yearly. The advisory committee is required to make recommendations to TSBP on:

- Operational improvements to the PMP.
- Resolutions to identified data concerns.
- Methods to improve data accuracy, integrity and security, and to reduce technical difficulties.
- The addition of any new data set or service.

Other provisions of HB 3284 prohibit TSBP from granting the Texas Department of Public Safety and other law enforcement or prosecutorial staff access to information in the PMP database unless a warrant, subpoena or other court order compelling disclosure is provided.

In addition, HB 3284 creates a criminal offense (Class A or C misdemeanors, respectively) for a person authorized to access patient prescription information if the person discloses or uses the information in an unauthorized way of if in the request, the person makes a material misrepresentation or fails to disclose a material fact. Administrative penalties are assessed to individuals authorized to

receive information who disclose that information in a manner not authorized by law. Regulatory agencies that issue a license, certification or registration to a prescriber or dispenser are required to periodically update administrative penalties or disciplinary guidelines assessed by the agency for a violation of unauthorized disclosure of information.

IMPLICATIONS

Hospitals have additional time to develop and implement policies and procedures before requiring prescribers to access the PMP prior to prescribing controlled substances. Hospitals also should develop processes to prevent the unauthorized access to or disclosure of prescription information.

HOUSE BILL 3285
Sponsors:
Sen. Joan Huffman
Rep. J.D. Sheffield
Effective Date: 9/1/19

Prevention and Response to Opioid Misuse and Treatment of Co-Occurring Conditions

ANALYSIS

HB 3285 imposes a number of requirements on certain entities to address the opioid crisis in Texas by requiring:

- The Texas Higher Education Coordinating Board to encourage health-related institutions of higher education and their faculty to conduct public health research on substance use disorders and addiction involving prescription drugs.
- The Texas Health and Human Services Commission to establish by rule, a program to increase opportunities for and expand access to telehealth treatment for SUD.
- THHSC to operate a statewide public awareness campaign to deliver public service announcements explaining risks related to opioid misuse.
- THHSC to operate a program to provide opioid antagonists to emergency medical services personnel, first responders and other persons likely to be in a position to respond to an opioid overdose.

THHSC is required to reimburse medication-assisted opioid or SUD treatment without requiring preauthorization or precertification for the treatment; however, the duty to provide reimbursement does not apply to:

- A prescription for methadone.
- A recipient for whom medication-assisted opioid or SUD treatment is contraindicated by the recipient's physician.

- A recipient who is subject to age-related restrictions applicable to medication-assisted opioid or SUD treatment.

HB 3285 also requires prescribers or dispensers of opioids to annually attend at least one-hour of continuing education covering best practices, alternative treatment options and multi-modal approaches to pain management which may include physical therapy, psychotherapy and other treatments.

Other provisions of HB 3285 include requiring:

- The criminal justice division of the Office of the Governor to establish and administer a grant program to provide financial assistance for opioid antagonists to law enforcement and related personnel who are likely to come in contact with opioids or encounter people suffering from an overdose.
- The Statewide Behavioral Health Coordinating Council to incorporate into the statewide behavioral health strategic plan strategies related to SUD and treatment developed in cooperation with the Texas Medical Board and Texas State Board of Pharmacy.

Additional efforts to address the crisis include requiring:

- The Texas Department of State Health Services to collect and analyze data related to opioid overdose deaths and the co-occurrence of SUD and mental illness.
- TSBP to encourage pharmacists to participate in a program that provides a comprehensive approach to delivering early intervention and treatment services for person with or at risk for SUD.
- Public or private institutions of higher education that impose mandatory training requirements on certain staff and students to also include overdose awareness and response methods in that training.

IMPLICATIONS

Hospitals will be able to seek reimbursement for providing medication-assisted opioid or substance use disorder treatment without first seeking preauthorization or precertification for treatment; thereby, allowing hospitals the opportunity to treat more individuals suffering from opioid misuse. In addition, hospitals can expand access to treatment for SUD through the use of telehealth. Finally, hospitals should ensure that prescribers and dispensers of opioids within their facilities annually attend the required one-hour training covering various treatment options for pain management.

HOUSE BILL 3496
Sponsors:
Sen. Brandon Creighton
Rep. J.D. Sheffield
Effective Date: 1/1/20

New Texas State Board of Pharmacy Enforcement Mechanisms

ANALYSIS

HB 3496 updates several enforcement mechanisms by the Texas State Board of Pharmacy relevant to Class C pharmacies located in hospitals and ambulatory surgical centers.

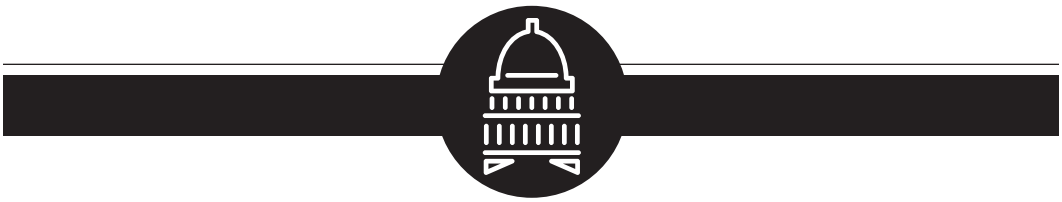
Under the bill, TSBP may discipline an applicant or license holder for dispensing drugs for nontherapeutic purposes.

In addition, HB 3496 permits TSBP to require, through rulemaking, a license holder to submit a surety bond to the board not to exceed $25,000 to secure the payment of a fine, fee or penalty imposed on the pharmacy for failing to or ceasing to engage in the business described in its application or engaging in fraud, deceit or misrepresentation, if the pharmacy fails to pay the fine, fee, penalty or cost.

Finally, under HB 3496, if a pharmacy ceases to operate for 30 days or longer, TSBP must notify the pharmacy that its license will be revoked. The notice must inform the pharmacy of its right to a hearing to contest the revocation. A pharmacy has up to 20 days from receipt of the notice to submit a written request for a hearing from a panel of three TSBP members. If the pharmacy does not submit a written request within the deadline or if the pharmacy does not prevail at the hearing, the pharmacy's license will be revoked. Note that Senate Bill 683 includes an identical provision.

IMPLICATIONS

Hospitals should notify their affiliated pharmacies of the expansion of TSBP's enforcement mechanisms, which include discipline for dispensing drugs for nontherapeutic purposes and a new potential requirement to submit a surety bond. Pharmacies that suspend operations for 30 days or longer or cease to operate will be subject to license revocation. Hospitals with affiliated pharmacies should monitor the TSBP website for rulemaking. Note that HB 3496 contains additional financial disclosure requirements for pharmacies not described in this summary because Class C pharmacies, which are pharmacies located in hospitals and ambulatory surgery centers, are exempt.



PHYSICIAN LICENSURE AND PRACTICE

SENATE BILL 1378
Sponsors:
Sen. Dawn Buckingham
Rep. Chris Turner
Effective Date: 5/20/19

Meeting the Graduate Medical Education Needs of Medical Degree Programs Offered or Proposed by Public Institutions of Higher Education

ANALYSIS

In 2017, the legislature passed a requirement that new medical degree programs (M.D. and D.O.) submit to the Texas Higher Education Coordinating Board a specific plan regarding the addition of first-year residency positions. The current required plan is based on the school's inaugural class size.

If the medical school's plan shows a long-term increase in enrollment class size that differs from its proposed initial maximum class size, SB 1378 requires the plan to include a proposed increase in the number of first-year residency position over time that will be sufficient to accommodate the maximum class size.

Schools that anticipate a substantial increase in enrollment class size after the approval of their plans must submit an updated plan to THECB. THECB will define "substantial increase" by rule.

IMPLICATIONS

Hospitals that provide medical residency slots in partnership with a medical school should be aware of the new requirement for schools to better anticipate and plan for future enrollment growth.

HOUSE BILL 3463 – LUBBOCK COUNTY
Sponsors:
Sen. Charles Perry
Rep. John Frullo
Effective Date: 6/10/19

HOUSE BILL 4663 – PARKER COUNTY
Sponsors:
Sen. Pat Fallon
Rep. Phil King
Effective Date: 9/1/19
(Continued next page)

Allowing Certain Hospital Districts to Directly Employ Physicians

ANALYSIS

Four bills passed in the 86th Texas Legislature to allow specific hospital districts to directly employ physicians. Each bill was negotiated between the hospital district and the Texas Medical Association. Although the four bills vary in terms of the specific requirements of the employment contracts, they each contain detailed provisions to protect the independent judgment of the physician.

All four bills allow the specific hospital district to directly employ physicians. HB 3463, for Lubbock County, limits the employment option to hospital-based physicians in emergency medicine, general medicine hospitalists and radiologists.

Each bill requires the adoption of policies by the board or medical committee related to:

- Credentialing and privileging.

SENATE BILL 1142 – TRAVIS COUNTY
Sponsors:
Sen. Kirk Watson
Rep. Donna Howard
Effective Date: 5/7/19

SENATE BILL 1236 – HUNT COUNTY
Sponsors:
Sen. Bob Hall
Rep. Dan Flynn
Effective Date: 9/1/19

- Quality assurance.
- Utilization review.
- Peer review.
- Medical decision making.
- Due process.

All four bills state that allowance of employment may not be construed to authorize the hospital board of directors to supervise or control the practice of medicine.

The bills require the appointment of a chief medical officer or a physician on the medical executive committee to ensure the exercise of independent medical judgment. That physician must report immediately to the Texas Medical Board any action or event that the physician reasonably believes constitutes a compromise of the independent medical judgment of a physician in caring for a patient.

The Travis County and Lubbock County bills limit the terms of an employment contract to four and five years respectively.

The Travis and Lubbock County bills require the adoption of policies related to disclosure of financial conflicts of interest of the medical executive committee. The Hunt County bill requires the adoption of a conflict of interest policy to resolve conflicts between the medical staff and district policy.

The Hunt County bill gives an employed physician the right to participate in the selection of the district's professional liability coverage, the right to an independent defense at the physician's own cost and the right to consent to the settlement of any action brought against the physician.

IMPLICATIONS

Hospital districts continue to seek the statutory ability to directly employ physicians. The bills granting the option to employ vary by hospital district.

The hospital districts contained in this summary must meet the specific requirements of their statutory changes, including the adoption of policies and the appointment of physician leaders to oversee the procedural changes.

Hospital districts considering the pursuit of legislation granting the option to employ should review the four bills for the potential elements of future legislation.

HOUSE BILL 826
Sponsors:
Sen. Joan Huffman
Rep. John Zerwas
Effective Date: 5/1/19

University of Houston College of Medicine

ANALYSIS

HB 826 authorizes the University of Houston to establish the University of Houston College of Medicine.

IMPLICATIONS

A new medical school in the state at the University of Houston, if approved by the Board of Regents, should result in much-needed additional medical residents and help address the statewide physician shortage.

HOUSE BILL 1065
Sponsors:
Sen. Lois Kolkhorst
Rep. Trent Ashby
Effective Date: 6/10/19

Rural Physician Grant Program

ANALYSIS

HB 1065 establishes the Rural Physician Grant Program and requires the Texas Higher Education Coordinating Board to enact rules and administer the program. The goal of HB 1065 is to encourage new graduate medical education positions in rural and nonmetropolitan areas. THECB must establish criteria for the grant program in consultation with one or more physicians, including a physician who practices in a rural area, teaching hospitals, medical schools, independent physician residency programs and with other persons considered appropriate by THECB. THECB may provide grants only to support a residency program that provides the level of care most needed in a rural or nonmetropolitan area and until the program becomes eligible for federal grant funding. Grant funds may be used only to pay direct costs associated with creating or maintaining a residency position.

Each grant application must specify the number of residency positions created or maintained with the grant money, specify the grant amount requested per year, include documentation of the infrastructure and staffing to support the residency program's accreditation requirements, include documentation that the primary goal is to produce physicians prepared to practice in a rural area, and include evidence of community support for residency training by sponsoring institutions and the community.

THECB must adopt rules as soon as practicable, establish the grant program by Oct. 1, 2019 and begin to award grants by Jan. 1, 2020. However, the requirements to implement the program apply only if money is allocated specifically for the purpose of the bill. Because there was no specific allocation of funding to implement HB 1065, THECB may, but is not required, to implement the program.

IMPLICATIONS

HB 1065 creates the Rural Physician Grant Program, which was not funded by the legislature, but may be implemented by THECB. Hospitals in rural and nonmetropolitan areas that seek to offer additional residency slots should monitor rulemaking at THECB for developments on the grant program, as well as eligibility requirements and details on the application process.

HOUSE BILL 1532
Sponsors:
Sen. Bryan Hughes
Rep. Morgan Meyer
Effective Date: 9/1/19

Regulation of Certain Health Organizations Certified by the Texas Medical Board

ANALYSIS

HB 1532 affects organizations certified by the Texas Medical Board under section 162.001(b) of the Occupations Code (often referred to as 5.01a organizations, a reference to the former and no-longer-in-use section number under which these organizations were certified). The bill establishes specific procedures by which TMB must receive, process and dispose of complaints against an organization.

The bill further requires an organization to "develop, implement, and comply with" an anti-retaliation policy that prohibits an organization from terminating, demoting, retaliating against, disciplining, discriminating against or otherwise penalizing a physician for:

- Filing in good faith a complaint against the organization with the TMB.
- Cooperating in good faith with an investigation or proceeding of the TMB relating to a complaint.
- "Communicating to a patient in good faith what the physician reasonably believes to be the physician's best, independent medical judgment."

On a determination that an organization has failed to develop, implement or comply with an anti-retaliation policy, the TMB may take any action allowed under the Occupations Code or TMB rule applicable to the organization.

Additionally, the bill codifies into the Occupations Code the biennial reporting requirements for a 162.001(b) organization. These requirements already exist in TMB rules and, organizations already are providing all of the information required in the new statutory section. The required information includes:

- A statement signed and verified by the president or chief executive officer of the organization that:

- Provides the name and mailing address of the organization; each member of the organization, except that if the organization has no members, a statement indicating that fact; each member of the board of directors of the organization; and each officer of the organization.
- Discloses any change in the composition of the board of directors since the most recent biennial report.

- A statement signed and verified by the president or chief executive officer of the organization that indicates whether the organization's certificate of formation or bylaws were amended since the date of the most recent biennial report; if applicable, provides a concise explanation of the amendments and states whether the amendments were recommended or approved by the board of directors; and has attached to the statement a copy of the organization 's current certificate of formation and bylaws if a copy is not already on file with the board.
- A statement from each current director of the organization, signed and verified by the director:
  - Stating that the director is licensed by the board to practice medicine, is actively engaged in the practice of medicine, and has no restrictions on the director 's license.
  - Stating that the director will exercise independent judgment in all matters, specifically including matters relating to credentialing, quality assurance, utilization review, peer review and the practice of medicine; exercise best efforts to cause the organization to comply with all relevant provisions of the law and board rules; and immediately report to the board any action or event the director reasonably and in good faith believes constitutes a violation or attempted violation of this subtitle or board rules.
  - Identifying and concisely explaining the nature of each financial relationship the director has, if any, with a member, another director, or a supplier of the organization or an affiliate of those persons.
  - Stating that the director has disclosed all financial relationships described above.
- A statement signed and verified by the president or chief executive officer of the organization indicating that the organization is in compliance with the requirements for continued certification provided by the statute and board rules.

IMPLICATIONS

Certified 162.001(b) organizations always have been subject to TMB jurisdiction and potential disciplinary action for violation of the Occupations Code or

TMB rule. Historically, TMB has received very few complaints against these organizations. Proponents of the bill believe the new complaint procedures may raise awareness of the availability of the complaint process as applicable to these organizations.

Additionally, there are new statutory requirements for the adoption, implementation and enforcement of an anti-retaliation policy, and TMB has authority to discipline an organization that fails to adopt, implement or enforce such a policy. In the case of an allegation of failure to implement and enforce a policy, the law the bill could put TMB in the difficult position of adjudicating complex, quasi-employment law charges of retaliation by an employed physician. Additionally, the retaliation prohibition for "communicating to a patient in good faith what the physician reasonably believes to be the physician's best, independent medical judgment" is nebulous but must be considered by an organization when faced with a physician that is perceived to be engaging in conduct that may undermine organizational goals as it may constitute protected activity.

Organizations should be vigilant about keeping the channels of communication open so that an aggrieved physician does not believe his or her only recourse is to make a complaint to TMB.

HOUSE BILL 2261
Sponsors:
Sen. Juan "Chuy" Hinojosa
Rep. Armando Walle
Effective Date: 9/1/19

$20,000 Increase for New Applicants to Physician Education Loan Repayment Program

ANALYSIS

HB 2261 increases the amount of assistance available to new applicants under the physician education loan repayment program by $5,000 per year of eligibility for the assistance (up to four years), resulting in a total of up to $180,000 in assistance per physician. After the passage of HB 2261, the repayment amounts per year of eligibility are:

- For the first year, $30,000.
- For the second year, $40,000.
- For the third year, $50,000.
- For the fourth year, $60,000.

To be eligible for the loan repayment program, a physician must complete at least one year of practice in a health professional shortage area or provide health care services to a designated number of patients who are enrollees in

Medicaid or the Texas Women's Health Program. The Texas Higher Education Coordinating Board administers the program and gives preference to physicians working in health professional shortage areas.

IMPLICATIONS

Hospitals, particularly hospitals in areas with a shortage of health care professionals, should inform their affiliated physicians of the additional $20,000 available under the physician education loan program to new applicants applying after Sept. 1, 2019.

HOUSE BILL 2867
Sponsors:
Sen. Brandon Creighton
Sen. Borris Miles
Sen. Charles Schwertner
Rep. Will Metcalf
Rep. Tom Oliverson
Rep. Cecil Bell
Rep. Ernest Bailes
Rep. Trent Ashby
Effective Date: 5/29/19

New Sam Houston State College of Osteopathic Medicine

ANALYSIS

HB 2867 establishes the Sam Houston State University College of Osteopathic Medicine as a college of Sam Houston State University.

IMPLICATIONS

Texas hospitals should note the existence of new school of osteopathic medicine at Sam Houston State University, which will result in additional medical residents and help address the statewide physician shortage.

HOUSE BILL 3148
Sponsors:
Sen. Paul Bettencourt
Sen. Eddie Lucio, Jr.
Sen. Judith Zaffirini
Rep. Tan Parker
Rep. Drew Springer
Rep. John Zerwas
Rep. Eddie Lucio, III
Effective Date: 9/1/19

Updates to Investigational Stem Cell Treatment Protocol

ANALYSIS

HB 3148 updates investigational stem cell treatment authorized by House Bill 810, 85th Texas Legislature. The bill requires the Texas Department of State Health Services to establish and maintain an investigational stem cell registry that lists each physician who administers investigational stem cell treatment in the state. TDSHS may not establish the registry until Sept. 1, 2027, at the earliest.

In addition, HB 3148 requires the Texas Health and Human Services Commission to develop an informed consent form for investigational stem cell treatment, which previously was discretionary.

HB 3148 also updates the requirements for an institutional review board that oversees investigational stem cell treatments, requiring an IRB to meet one of the following conditions:

- Affiliation with a medical school in Texas or a hospital licensed under chapter 241 of the Health and Safety Code and with at least 150 beds.
- Accreditation by the Association for the Accreditation of Human Research Protection Programs.
- Registration by the U.S. Department of Health and Human Services, Office for Human Research Protections in accordance with 21 C.F.R. Part 56.
- Accreditation by a national accreditation organization acceptable to the Texas Medical Board.

Finally, HB 3148 prohibits governmental entities or employees from interfering with an eligible patient's access to an authorized investigational stem cell treatment, except in cases where the adult stem cell product is considered adulterated or misbranded under chapter 431 of the Health and Safety Code. A governmental entity may not consider an adult stem cell product to be an adulterated or misbranded drug solely because it is not approved by the U.S. Food and Drug Administration.

IMPLICATIONS

Hospitals currently offering or seeking to offer investigational stem cell therapy should review HB 3148, which expands the availability of investigational stem cell therapy in the state. HB 3148 authorizes three additional affiliations allowing administration of investigational stem cell therapy in addition to affiliation with a medical school or hospital with at least 150 beds. The bill also requires THHSC to develop, by rule, a mandatory informed consent form for treatment, which hospitals must provide to patients. Beginning in 2027 (at the earliest), TDSHS will maintain a registry of physicians administering investigational stem cell therapy.

HOUSE BILL 3703
Sponsors:
Sen. Donna Campbell
Rep. Stephanie Klick
Effective Date: 6/14/19

Prescription of Low-THC Cannabis for Additional Medical Conditions

ANALYSIS

Prior to HB 3703, a physician could prescribe low-THC cannabis to a patient but only for intractable epilepsy and only if two or more antiepileptic drugs failed to control the seizures. Provided the additional requirements of the bill are met, HB 3703 permits a physician to prescribe low-THC cannabis to a patient to treat any of the following conditions:

- Epilepsy.
- Multiple sclerosis.
- Spasticity.

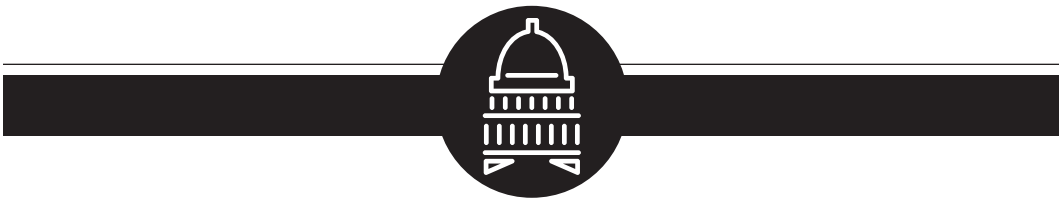
- Amyotrophic lateral sclerosis.
- Autism.
- Terminal cancer.
- An incurable neurodegenerative disease (to be defined in rule by the Texas Health and Human Services Commission by Dec. 1, 2019).

By definition, low-THC cannabis must contain 0.5 percent or less, by weight, of tetrahydrocannabinols. The bill removes the requirement that low-THC cannabis contain not less than 10 percent by weight of cannabidiol.

HB 3703 replaces the previous narrow physician board certification requirements with a requirement that the physician is board certified in a medical specialty relevant to the treatment of the patient's particular medical condition by a specialty board approved by the American Board of Medical Specialties or the Bureau of Osteopathic Specialists. To prescribe low-THC cannabis, the physician also must dedicate a significant portion of clinical practice to the evaluation and treatment of the patient's particular medical condition. HB 3703 still requires the physician to determine the risk of the medical use of low-THC cannabis by the patient is reasonable in light of the potential benefit to the patient. However, the bill no longer requires a second physician to concur with the physician's determination. The physician must record a prescription for low-THC cannabis in the compassionate-use registry. The Texas Department of State Health Services may not publish the name of a physician in the compassionate use registry unless the physician expressly grants permission.

IMPLICATIONS

HB 3703 is a significant expansion of low-THC cannabis use in Texas. Hospitals should notify their affiliated physicians of the additional permitted conditions for which physicians may prescribe low-THC cannabis and if physicians meet the bill's other requirements related to experience and board certification.



PUBLIC HEALTH

SENATE BILL 384
Sponsors:
Sen. Jane Nelson
Rep. J.D. Sheffield
Effective Date: 9/1/19

Reporting of Health Care-Associated Infections and Preventable Adverse Events at Health Care Facilities

ANALYSIS

SB 384 changes the reporting requirements related to health-care associated infections to align state and federal reporting requirements. Specifically, the law requires a health care facility to report to the Texas Department of State Health Services each health care-associated infection, including the causative pathogen if the infection is laboratory-confirmed, that occurs in the facility and that the federal Centers for Medicare & Medicaid Services requires a facility participating in the Medicare program to report through the federal Centers for Disease Control and Prevention's National Healthcare Safety Network, or its successor. A health care facility must report each health care-associated infection to TDSHS regardless of the facility's participation in Medicare.

A health care facility is defined as a general hospital or an ambulatory surgical center.

The change in reporting requirements applies to reports for health care-associated infections occurring on or after Jan. 1, 2020.

Provisions of chapter 98 (Reporting of Health Care-Associated Infections and Potentially Adverse Events) of the Health and Safety Code, detailing specific reporting of the incidence of surgical site infections occurring in connection with certain procedures are repealed. Those procedures were:

- Colon surgeries.
- Hip arthroplasties.
- Knee arthroplasties.
- Abdominal hysterectomies.
- Vaginal hysterectomies.
- Coronary artery bypass grafts.
- Vascular procedures.

Also repealed are specific provisions requiring:

- Pediatric and adolescent hospitals to report to TDSHS the incidence of surgical site infections, including the causative pathogen if the infection is laboratory-confirmed, occurring in cardiac procedures, excluding thoracic cardiac procedures; ventricular shunt procedures; and spinal surgery with instrumentation.
- A general hospital to report to TDSHS the incidence of laboratory-confirmed

central line-associated primary bloodstream infections, including the causative pathogen, occurring in any special care setting in the hospital and the incidence of respiratory syncytial virus occurring in any pediatric inpatient unit in the hospital.

Statutory authority allowing the executive commissioner of the Texas Health and Human Services Commission to modify the list of procedures that are reportable by rule based on changing reporting guidelines and definitions established by CDC also is repealed. The THHSC executive commissioner must adopt rules to implement SB 384 by Jan. 1, 2020.

IMPLICATIONS

Hospital infection control, quality, patient safety, chief medical and nursing officers should be informed of this revision repealing current duplicative and outdated health care-associated infection reporting requirements previously housed in state statute. Individuals in charge of TDSHS and CMS reporting should be informed of the change and asked to review current CDC NHSN reporting requirements to familiarize themselves with required elements for future reporting.

Hospitals with relationships with ambulatory surgical centers should note that ASCs no longer are required to report health care-associated infection data because they are not required to report to CMS.

SENATE BILL 999
Sponsors:
Sen. Donna Campbell
Rep. John Zerwas
Effective Date: 9/1/19

Alzheimer's Disease and Related Disorders State Plan

ANALYSIS

SB 999 directs the Texas Department of State Health Services to develop and implement a state plan on education and treatment of Alzheimer's disease and related disorders. The state plan must include best practices and strategies for:

- Improving early detection, reducing disease onset risks and improving treatment for specific demographic groups.
- Educating health care professionals, caregivers and the public to increase awareness.
- Providing caregiver support.
- Advancing basic science and applied research.
- Collecting and evaluating information on efforts to prevent and treat Alzheimer's disease and related disorders.

In identifying best practices and strategies, TDSHS is required to consult with physicians and other health care providers who have clinical training and experience in caring for persons with Alzheimer's disease and related disorders.

TDSHS also is directed to seek comments from other interested parties including:

- Members of the public with, or who care for persons with, Alzheimer's disease or related disorders.
- Each state agency that provides services to persons with Alzheimer's disease or related disorders.
- Any advisory body that addresses issues related to Alzheimer's disease or related disorders.
- Public advocates concerned with issues related to Alzheimer's disease or related disorders.
- Physicians and health care providers licensed in the state who have clinical experience caring for persons with Alzheimer's disease or related disorders.
- Researchers of issues affecting persons with Alzheimer's disease or related disorders.

TDSHS must meet with these parties at least twice annually to discuss the progress of developing and implementing the state plan. TDSHS also is required to review and modify the plan as necessary every five years and is authorized to accept gifts and grants to fund the provisions of this law.

SB 999 does not create a civil, criminal or administrative cause of action or liability, or create a standard of care, obligation or duty that provides a basis for a cause of action, including the use of or failure to use any information or materials developed or disseminated under this law.

IMPLICATIONS

Health care providers who have clinical training and experience in caring for persons with Alzheimer's disease and related disorders should consider consulting with TDSHS to assist the agency in developing strategies and best practices for the state plan to further the efforts to prevent and treat Alzheimer's disease and related disorders.

SENATE BILL 1312
Sponsors:
Sen. Eddie Lucio, Jr.
Rep. Bobby Guerra
Effective Date: 6/2/19

Programs to Prevent Vector-Borne and Zoonotic Disease in Border Counties

ANALYSIS

SB 1312 requires the Texas Department of Agriculture by rule to provide for the issuance of a noncommercial applicator license that authorizes a person to purchase and use restricted-use and state-limited-use pesticides for the limited purpose of mosquito control in counties located along the Mexico border. The bill also requires, to the extent practicable, that TDA minimize fees and other requirements to obtain a license. In order to implement the law and identify and solicit funding, TDA is authorized to coordinate with the following entities:

- Federal agencies.
- State agencies.
- Nonprofit organizations.
- Public and private hospitals.
- Institutions of higher education.
- Private entities.

SB 1312 also requires the Texas Department of State Health Services to address vector-borne and zoonotic diseases and standardize practices in counties located along the Mexico border by consulting with TDA and other appropriate state agencies to study:

- The ongoing and potential needs of border counties.
- The availability of and capacity for vector mitigation and control, including increased staffing, equipment, education and training.
- Strategies to improve or develop continuing education and public outreach initiatives for vector-borne and zoonotic disease prevention.

TDSHS also is authorized to coordinate with the entities listed above to solicit and accept gifts, grants and donations to implement and administer the requirements of this bill.

IMPLICATIONS

Hospitals located in counties along the border should coordinate with both TDA and TDSH and other identified entities to aid with efforts to prevent vector-borne and zoonotic disease in these areas. Hospitals can expect to receive additional information concerning coordination once TDA promulgates rules.

HOUSE BILL 121
Sponsors:
Sen. Brandon Creighton
Rep. Valoree Swanson
Effective Date: 9/1/19

Defense to Prosecute Trespassing by Certain Persons Carrying Handguns

ANALYSIS

HB 121 amends the Penal Code provisions related to unlawfully carrying a handgun by a holder of a license to carry. Sections 30.06 and 30.07 relate to criminal trespass by a license holder (section 30.06 covers carrying a concealed handgun and section 30.07 covers open carry) and make it a criminal offense for a license holder to carry a handgun if the person has been given notice, by oral or written communication, that handguns are prohibited on the premises. Under current law, possession of a handgun on such premises is a Class C misdemeanor, except that the offense becomes a Class A misdemeanor if it is shown at trial that the license holder was personally given the required notice by oral communication subsequently failed to depart.

HB 121 makes it a defense to prosecution that the license holder was personally given notice by oral that handguns were prohibited and promptly departed from the property.

IMPLICATIONS

A holder of a license to carry a handgun may avoid prosecution for carrying a handgun onto premises displaying signage prohibiting the carrying of a handgun if the person is orally notified that the carrying of a handgun is prohibited and the person promptly departs from the property.

NOTE: HB 121 does not amend or affect sections 43.03 and 43.035 of the Penal Code related to prohibiting carrying of a handgun or prohibited weapon on ***hospital*** premises. It remains a criminal offense for a person to carry a prohibited weapon under those sections onto the premises of a hospital that has given oral or written notice of the prohibition regardless of whether the person "promptly departed from the property" as described in HB 121.

HOUSE BILL 1177
Sponsors:
Sen. Brandon Creighton
Rep. Dade Phelan
Effective Date: 9/1/19

Carrying a Handgun During a Declared Disaster

ANALYSIS

HB 1177 relates to carrying a handgun during a declared disaster. It allows any person to carry a firearm when evacuating from an area following the declaration of a state of disaster or a local state of disaster with respect to that area or when reentering that area following the person's evacuation. The allowance applies for 168 hours after the state of disaster or local state of

disaster is declared, which can be extended by the governor.

HB 1177 also allows a person to carry a handgun onto the premises of a place where handguns would otherwise be prohibited if the premises are functioning as an emergency shelter during a state of disaster, if the owner, controller or operator of the premises or a person acting with the apparent authority of the owner, controller or operator, authorized the carrying of the handgun and the person carrying the handgun complies with any rules and regulations of the owner, controller or operator of the premises that govern the carrying of a handgun on the premises.

However, the provisions related to carrying a handgun into an emergency shelter do not apply to a hospital functioning as an emergency shelter.

Neither provision would allow a person who is otherwise prohibited from carrying a firearm by state or federal law to carry a firearm.

IMPLICATIONS

While certain places where firearms would otherwise be prohibited may permit firearms to be carried onto the premises during a declared disaster if it is functioning as an emergency shelter, a hospital may not grant permission to carry a firearm onto its premises under those circumstances.

HOUSE BILL 1225
Sponsors:
Sen. Jose Menedez
Rep. Ryan Guillen
Effective Date: 9/1/19

Re-creation of Chronic Kidney Disease Task Force

ANALYSIS

Under HB 1225, the Chronic Kidney Disease Task Force is recreated to:

- Coordinate implementation of the state's cost-effective plan for prevention, early screening, diagnosis and management of chronic kidney disease for the state's population through national, state and local partners.
- Educate health care professionals on the use of clinical practice guidelines for screening, detecting, diagnosing, treating and managing chronic kidney disease, its comorbidities and its complications based on the Kidney Disease Outcomes Quality Initiative Clinical Practice Guidelines for Chronic Kidney Disease.

The task force is composed of two members of the Texas Senate appointed by the lieutenant governor, two members of the Texas House of Representatives appointed by the Speaker of the House and 20 members appointed by the governor including:

- One family practice physician.
- One pathologist.
- One nephrologist from a nephrology department of a state medical school.
- One nephrologist in private practice.
- One representative from the National Kidney Foundation.
- One representative from the Texas Kidney Foundation.
- One representative from the South Plains Kidney Foundation of West Texas.
- One representative from the Texas Renal Coalition.
- One representative of the Texas Health and Human Service Commission's Kidney Health Care Program.
- One representative of an insurer that issues a preferred provider benefit plan or of a health maintenance organization.
- One representative of clinical laboratories.
- One representative of private renal care providers.
- One pediatrician in private practice.
- One kidney transplant surgeon.
- One primary care physician.
- One licensed and certified renal dietician.
- One certified nephrology nurse.
- One representative from a health care system.
- One representative of THHSC whose duties involve the state Medicaid program.
- One end stage renal disease expert.

The task force must submit its findings and recommendations to the governor, lieutenant governor and speaker and the presiding officers of the appropriate standing committees of the legislature with jurisdiction over health issues no later than Jan. 1 of each odd-numbered year.

The continued need for the task force will be reviewed at least once every five years.

IMPLICATIONS

Hospitals with kidney disease programs may want to nominate a member of their team to serve on the task force. Additionally, hospitals with kidney disease programs will want to stay apprised of the task force's activity and recommendations that may impact patient care including those related to prevention and treatment.

HOUSE BILL 1791
Sponsors:
Sen. Pat Fallon
Rep. Matt Krause
Effective Date: 9/1/19

Carrying of Handguns by License Holders on Property Owned or Leased by a Governmental Entity

ANALYSIS

HB 1791 is an attempt to clarify some perceived ambiguities in the existing statute (section 411.209 of the Government Code) that prohibits a governmental body from excluding a handgun license holder carrying a handgun from government property. It was filed in response to concerns over lawsuits being filed under the existing statute and suggestions that that some local governments have enacted regulations that circumvent the legislature's original intent.

HB 1791 amends existing statute to clarify that a state agency or a political subdivision of the state may not take any action, including providing notice, that states or implies that a license holder who is carrying a handgun is prohibited from entering or remaining on a premises or other place owned or leased by the governmental entity unless license holders are prohibited from carrying a handgun on the premises or other place by law. The bill requires the general facts of an alleged violation of that prohibition to be included in the written notice provided by a Texas resident or a license holder as part of a complaint filed with the attorney general. The bill removes the requirement that the specific location of a sign found to be in violation of the prohibition be contained in the complaint notice.

IMPLICATIONS

Public hospitals are treated like all other hospitals and are not required to permit handguns on hospital property. However, the provisions of section 411.209 of the Government Code, as revised by HB 1791, apply to non-hospital property owned by a governmental body.

HOUSE BILL 1848
Sponsors:
Sen. Dawn Buckingham
Rep. Stephanie Klick
Rep. J.D. Sheffield
Rep. Bobby Guerra
Effective Date: 9/1/19

Prevention of Communicable Diseases in Certain Long-Term Care Facilities

ANALYSIS

HB 1848 requires long-term care facilities to maintain an infection prevention and control program, which must include:

- Monitoring of key infections agents, including multidrug-resistant organisms.
- Procedures for making rapid influenza diagnostic tests available to facility residents.

Long-term care facilities include nursing facilities licensed under chapter 242 of the Health and Safety Code, assisted living facilities licensed under chapter 247 of the Health and Safety Code and intermediate care facilities licensed under chapter 252 of the Health and Safety Code.

HB 1848 also creates regional advisory committees in each public health region to address antimicrobial stewardship in long-term care facilities. The committees must include physicians, directors of nursing or equivalent consultants with long-term care facilities, public health officials knowledgeable about antimicrobial stewardship, and other interested parties.

IMPLICATIONS

Texas hospitals with facilities covered by this requirement must update policies and procedures to include the statutory requirements for the infection prevention and control program.

Any facilities desiring to take part in a regional committee to address antimicrobial stewardship in these facilities should contact the Texas Hospital Association or the Texas Department of State Health Services for additional information.

HOUSE BILL 3147
Sponsors:
Sen. Brandon Creighton
Rep. Tan Parker
Effective Date: 9/1/19

New Cancer Clinical Trial Participation Program

ANALYSIS

HB 3147 permits an independent, third-party organization to develop and implement a new cancer clinical trial participation program, which will be funded by the Cancer Prevention and Research Institute of Texas. The program will reimburse participants for costs associated with participation in a cancer clinical trial, including costs for travel, lodging, parking and tolls and other costs approved by the organization. The program will involve collaboration with physicians and health care providers to notify prospective subjects about the program, and reimburse patients based on financial need. Patients with incomes at or below 700 percent of the federal poverty level will qualify.

IMPLICATIONS

The financial burdens of cancer trials can be a barrier to accessibility and participation. According to the legislature's findings, the resulting disparity in subject participation threatens the basic ethical underpinning of clinical research, which requires the benefits of the research to be made available equitably among all eligible individuals. HB 3147 is an attempt to promote broader participation in cancer clinical trials by providing a mechanism for reimbursement of expenses

that does not violate the U.S. Food and Drug Administration's prohibition on impermissible inducements to study subjects. Hospitals should be aware of this increased access to clinical trials and should consider evaluating their processes to ensure that qualifying patients have access to the new program.

HOUSE BILL 3405
Sponsors:
Sen. Borris Miles
Rep. Jarvis Johnson
Effective Date: 9/1/19

Establishment of a Sickle Cell Task Force

ANALYSIS

Under HB 3405, the executive commissioner of the Texas Health and Human Services Commission, in collaboration with the members of the Newborn Screening Advisory Committee appointed to represent the sickle cell community, must establish and maintain a task force to raise awareness of sickle cell disease and sickle cell trait.

The task force is charged with advising the Texas Department of State Health Services on implementing the recommendations made in the 2018 Sickle Cell Advisory Committee Report published by the Sickle Cell Advisory Committee or other report the executive commissioner determines is appropriate. The executive commissioner may assign tasks to the task force.

The task force is composed of the following members appointed by the executive commissioner:

- Two members from community-based organizations with expertise addressing the needs of individuals with sickle cell disease.
- Two physicians specializing in hematology.
- Two members of the public, each of whom either has sickle cell disease or is a parent of a person with sickle cell disease or trait.
- One representative of a health-related institution.

No later than Dec. 1 of each year, the task force is required to prepare and submit to the governor and the legislature an annual written report that summarizes the task force's work and includes any recommended actions or policy changes endorsed by the task force.

IMPLICATIONS

Hospitals and health-related institutions with sickle cell programs or affiliated with experts in sickle cell disease or trait should be aware of the development of the task force and any ensuing recommended actions or policy changes. Issue area experts are encouraged to apply to serve on the task force.

HOUSE BILL 4260
Sponsors:
Sen. Eddie Lucio
Rep. Phillip Cortez
Effective Date: 9/1/19

Possession and Administration of an Epinephrine Auto-Injector by Certain Entities

ANALYSIS

HB 4260 creates a new section under chapter 773 (Emergency Medical Services) of the Health and Safety Code, allowing the ability to adopt a policy regarding the maintenance, administration and disposal of epinephrine auto-injectors. This language applies to:

- An amusement park.
- A child-care facility.
- A day camp or youth camp.
- A private or independent institution of higher education.
- A restaurant.
- A sports venue.
- A youth center.
- Any other entity that the executive commissioner of the Texas Health and Human Services Commission by rule designates as an entity that would benefit from the possession and administration of epinephrine auto-injectors.

An adopted policy must provide that only an entity employee or volunteer who is authorized and trained may administer an epinephrine auto-injector to a person who is reasonably believed to be experiencing anaphylaxis on the premises of the entity. Each entity that adopts a policy must have at least one employee or volunteer authorized and trained to administer an epinephrine auto-injector present during all hours the entity is open to the public or to the population that the entity serves, as applicable.

The executive commissioner is required to adopt rules regarding the maintenance, administration and disposal of an epinephrine auto-injector by these entities. The rules must establish:

- The number of epinephrine auto-injectors and the dosages of the auto-injectors available at each entity.
- The process for each entity to verify the inventory of epinephrine auto-injectors at regular intervals for expiration and replacement.
- The amount of training required for an entity employee or volunteer to administer an epinephrine auto-injector.

The supply of epinephrine auto-injectors at each entity must be stored in

accordance with the manufacturer's instructions in a secure location and be easily accessible to an employee or volunteer authorized and trained to administer an epinephrine auto-injector.

Employee and volunteer training must include information on:

- The signs and symptoms of anaphylaxis.
- The recommended dosage for an adult and a child.
- The administration of an epinephrine auto-injector.
- The implementation of emergency procedures, if necessary, after administering an epinephrine auto-injector.
- The proper disposal of used or expired epinephrine auto-injectors.
- Be completed annually in a formal training session or through online education.

These entities are required to maintain records on the training completed by each employee and volunteer.

A physician or employee who has been delegated prescriptive authority may prescribe epinephrine auto-injectors in the name of an entity. A physician or other person who prescribes epinephrine auto-injectors must provide the entity with a standing order for the administration of an epinephrine auto-injector to a person reasonably believed to be experiencing anaphylaxis. The standing order is not required to be patient-specific, and the epinephrine auto-injector may be administered to a person without a previously established physician-patient relationship.

Supervision or delegation by a physician is considered adequate if the physician:

- Periodically reviews the order.
- Is available through direct telecommunication as needed for consultation, assistance and direction.

A person who has been delegated prescriptive authority is not engaged in the unauthorized practice of telemedicine or acting outside the person's scope of practice by consulting a physician when prescribing an epinephrine auto-injector for this purpose.

An order must contain:

- The name and signature of the prescriber.
- The name of the entity to which the order is issued.

- The quantity of epinephrine auto-injectors to be obtained and maintained under the order.
- The date of the issue.

A pharmacist may dispense an epinephrine auto-injector to an entity without requiring the name or any other identifying information related to the user.

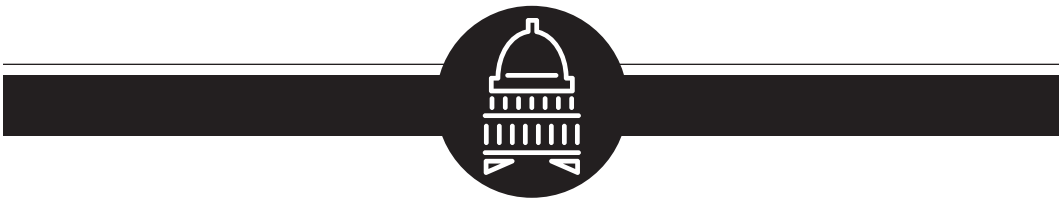
A person who in good faith takes, or fails to take, any action under this section is immune from civil or criminal liability or disciplinary action resulting from that action or failure to act including:

- Issuing an order for epinephrine auto-injectors.
- Supervising or delegating the administration of an epinephrine auto-injector.
- Possessing, maintaining, storing or disposing of an epinephrine auto-injector.
- Prescribing an epinephrine auto-injector.
- Dispensing an epinephrine auto-injector.
- Administering, or assisting in administering, an epinephrine auto-injector.
- Providing or assisting in providing, training, consultation or advice in the development, adoption or implementation of policies, guidelines, rules or plans.
- Undertaking any other act permitted or required under this section.

The immunities and protections provided by this section are in addition to other immunities or limitations of liability provided by the law. A civil, criminal or administrative cause of action or liability to create a standard of care, obligation or duty that provides a basis for a cause of action for an act or omission is not created.

IMPLICATIONS

Physicians and nurses affiliated with system-linked primary care clinics should be made aware of this new law so they can consider, in an informed manner, any potential requests for epinephrine auto-injector prescriptions or be asked to enter a relationship to provide oversight, review and consultation related to a delegated prescriptive authority. Emergency room personnel might be interested in this permissive attempt to expand the availability of epinephrine auto-injectors in locations where people gather. Hospital personnel involved in community partnerships might also find this update of interest.



PUBLIC HOSPITALS

SENATE BILL 65
Sponsors:
Sen. Jane Nelson
Rep. Charlie Geren
Effective Date: 9/1/19

Disclosure of State Agency and Political Subdivision Contracts Related to Lobbying

ANALYSIS

SB 65 primarily revises the oversight process of state agency contracting and procurement. Notably, however, in section 21, the bill incorporates required disclosures and itemization of certain expenditures by political subdivisions relating to lobbying activities.

First, a governmental entity that enters into a contract for services that would require a person to register as a lobbyist must obtain a form from the contractor (Disclosure of Interested Persons) and submit that form to the Texas Ethics Commission within 30 days.

Second, a political subdivision "that enters or has entered into a contract for consulting services with a state agency, regardless of whether the term of the contract has expired," must prominently display on the political subdivision's website specific information regarding contracts for services involving lobbyists. The political subdivision must display either the contract itself or the execution date, duration, terms, effective dates, amount of money transferred and a list of all legislation advocated for, on or against by all parties to the contract. This would include the position taken by each party on each piece of legislation in the prior fiscal year. This information will be classified as public information, and the political subdivision's proposed budget must include line items detailing the funds spent to influence or attempt to influence the outcome of legislation or an administrative action.

IMPLICATIONS

The disclosure provisions of section 21 are intended to increase transparency, allowing any lobbying contract, or the information in the contract, to be viewed by the general public. The political subdivision also must publicly disclose its planned expenditures, so the public may see which bills state agency lobbyists support or oppose.

The wording of section 21 related to consulting services, however, is ambiguous and the scope unclear. The public disclosure requirements apply to a political subdivision that "enters or has entered into a contract for consulting services with a state agency…" Legislative intent suggests the bill applies to a political subdivision's consulting arrangement with a registered lobbyist to represent the political subdivision in matters before a state agency, though that is not the language used in the bill. Section 21 was added as a late-stage floor amendment on the third reading of the bill, which may explain the awkward wording. A political subdivision that plans to enter into a contractual arrangement with a

lobbyist should be aware of the language in section 21 of SB 65 and consult with legal counsel regarding its obligations related to the arrangement.

SENATE BILL 494
Sponsors:
Sen. Joan Huffman
Rep. Armando Walle
Effective Date: 9/1/19

Relaxation of Open Meetings Act Requirements During Emergencies

ANALYSIS

SB 494 reduces the notice period required for open meetings during emergencies from two hours to one hour, if the governmental body is discussing items related to an emergency or a matter of urgent public necessity. Governmental bodies also are required to notify the news media at least one hour prior to convening an emergency meeting. A governmental body may not deliberate or take action on a matter pursuant to the exception, other than a matter directly related to the emergency or urgent public necessity identified in the notice or supplemental notice of the meeting or an agenda item listed on a notice of the meeting before the supplemental notice was posted.

An emergency or an urgent public necessity exists only if there is:

- An imminent threat to public safety.
- A reasonably unforeseen situation, including but not limited to, fire, flood, earthquake, hurricane, tornado or wind, rain or snowstorm; power failure, transportation failure or interruption of communication facilities; an epidemic; or a riot, civil disturbance, enemy attack or other actual or threatened act of lawlessness or violence.

The attorney general may file suit in Travis County to enjoin the governmental body from convening an emergency meeting that violates the bill's provisions.

SB 494 also permits a governmental body to suspend the requirements of the Open Meetings Act for an initial period of up to seven days during a catastrophe, defined as condition or occurrence that interferes with the ability of a governmental body to comply with the requirements of the Open Meetings Act, including fire, flood, earthquake, hurricane, tornado or wind, rain or snowstorm; power failure, transportation failure or interruption of communication facilities; an epidemic; or a riot, civil disturbance, enemy attack or other actual or threatened act of lawlessness or violence. To suspend provisions of the Open Meetings Act, the governmental body must provide notice to the public in accordance with relevant provisions of the Act and to the office of the attorney general in the form it prescribes. The governmental body may extend the suspension for up to an additional seven days if still impacted by the emergency situation. The office of the attorney general must post each notice of suspension on its website for one year.

IMPLICATIONS

Public hospitals and hospital districts should update their policies and procedures related to open meetings to reflect the decreased notice requirement for open meetings during an emergency or matter of urgent public necessity, as well as the ability to suspend the Open Meetings Act for up to a total of 14 days during a catastrophe. SB 494 requires the Office of the Attorney General to develop a form for meeting suspension notices as soon as practicable, which public hospitals and hospital districts should obtain in case of a catastrophic event.

SENATE BILL 1640
Sponsors:
Sen. Kirk Watson
Sen. Paul Bettencourt
Effective Date: 6/10/19

New Definition of Prohibited Walking Quorum Under the Texas Open Meetings Act

ANALYSIS

SB 1640 updates the Texas Open Meetings Act's prohibition on holding a series of small meetings in order to avoid a quorum, commonly known as a "walking quorum." The bill amends the definition of "deliberation" to mean: a verbal or written exchange between a quorum of a governmental body, or between a quorum of a governmental body and another person, concerning an issue within the jurisdiction of the governmental body. Prior to SB 1640, the definition of deliberation applied only to a verbal exchange during a meeting and included any issue related to public business.

Under SB 1640, a prohibited walking quorum occurs when a member of a governmental body engages in at least one communication among a series of communications outside of an open meeting without a quorum if the member knew that the series of communications involved a quorum and would constitute a deliberation once a quorum of members engaged in the series of communications.

IMPLICATIONS

SB 1640 addresses a ruling by the Texas Court of Criminal Appeals that the Texas Open Meetings Act's prohibition on a walking quorum was unconstitutionally vague. The bill addresses the constitutional issues by making the walking quorum prohibition more specific, precise, and clear. Public hospitals should take note of the new definition of a walking quorum and ensure that their policies and procedures continue to reflect that participating in a walking quorum is an offense under the Texas Open Meetings Act.

HOUSE BILL 305
Sponsors:
Sen. Jane Nelson
Rep. Dennis Paul
Effective Date: 9/1/19

Requiring State Agencies and Political Subdivisions With Taxing Authority to Post Certain Information Online

ANALYSIS

HB 305 amends chapter 2051 of the Government Code to increase the transparency and accessibility of information about certain political subdivision by requiring those bodies to provide certain information on their website. The new provisions apply to any political subdivision that (1) has the authority to impose a tax and (2) at any time after Jan. 1, 2019, maintained a publicly accessible website.

Except as noted below, a political subdivision to which the law applies must post on its website all of the following information:

1. The political subdivision's contact information, including a mailing address, telephone number and e-mail address.
2. Each elected officer of the political subdivision.
3. The date and location of the next election for officers of the political subdivision.
4. The requirements and deadline for filing for candidacy of each elected office of the political subdivision (this information must be continuously posted for at least one year before the election day for the office).
5. Each notice of a meeting of the political subdivision's governing body under the Texas Open Meetings Act (chapter 551 of the Government Code).
6. The minutes or recording of each meeting of the political subdivision's governing body kept in accordance with the Texas Open Meetings Act.

The requirements in (5) and (6) do not apply to:

- A county with a population of fewer than 10,000 residents.
- A municipality with a population of fewer than 5,000 residents located in a county with a population of fewer than 25,000 people.
- A school district with a population of fewer than 5,000 residents in the district's boundaries and located in a county with a population of fewer than 25,000 individuals.

Additionally, the requirements in (5) and (6) apply only to a meeting held on or after Sept. 1, 2019.

IMPLICATIONS

A political subdivision with taxing authority that has maintained a public website any time after Jan. 1, 2019 will need to comply with the law's

requirements starting Sept. 1, 2019. Some of the requirements overlap with existing requirements of the Open Meetings Act related to meeting notices and the Election Code related to election notices.

HOUSE BILL 440
Sponsors:
Sen. Eddie Lucio, Jr.
Rep. Jim Murphy
Effective Date: 9/1/19

General Obligation Bonds Issued by Political Subdivisions

ANALYSIS

HB 440 affects procedures and requirements related to the issuance and use of general obligation bonds by political subdivisions. It amends the Elections Code to require a sample ballot to be included on the political subdivision's website at least 21 days prior to the bond election.

More importantly, it places limits on the issuance of general obligation bonds for real or personal property by specifying that a political subdivision may not issue general obligation bonds to purchase, improve or construct one or more improvements to real property, to purchase one or more items of personal property or to do both, if the weighted average maturity of the issue of bonds exceeds 120 percent of the reasonably expected weighted average economic life of the improvements and personal property financed with the issue of bonds.

It also allows the use of unspent proceeds of issued general obligation bonds only for the specific purposes for which the bonds were authorized, to retire the bonds or for a purpose other than the specific purposes for which the bonds were authorized if:

- The specific purposes are accomplished or abandoned.
- A majority of the votes cast in an election held in the political subdivision approve the use of the proceeds for the proposed purpose.

The election order and the notice of election for an election for an alternative use must state the proposed purpose for which the bond proceeds are to be used and must be held in the same manner as an election to issue bonds in the political subdivision.

IMPLICATIONS

HB 440 primarily is intended to accomplish two things: ensure that the proceeds of a general obligation bond issuance are used only for a purpose specifically approved by the voters that approve the bonds and make sure that general obligation bond indebtedness does not significantly outlive the useful life (the "reasonably expected weighted average economic life") of the property the proceeds are intended to fund. A political subdivision will need to be able to

demonstrate compliance with the new provisions if is contemplating a general obligation bond issue.

HOUSE BILL 477
Sponsors:
Sen. Paul Bettencourt
Rep. Jim Murphy
Effective Date: 9/1/19

Notice Required for Debt Obligations by Political Subdivisions

ANALYSIS

HB 477 repeals the current bond notice requirements and replaces them with a more detailed set of voter notification elements. Under HB 477, a political subdivision, including a municipality, county and a special taxing district, which submits a bond approval initiative to voters must include on the ballot:

- A general description of the purposes for the bond.
- The total principal amount.
- A notice stating that taxes sufficient to pay the principal and interest of the bond will be imposed.

In addition, a political subdivision with at least 250 registered voters must, for each bond, prepare a voter information document and publicly post the document along with the bond notice. If the political subdivision maintains a website, at least 21 days before an election the political subdivision must post the voter information on its website. The voter information document must include:

- The language that will appear on the ballot.
- A table with: the principal of the debt obligation; the estimated interest; the estimated combined principal and interest if paid on time; and the principal of all debt obligations of the political subdivision; the estimated remaining interest; and the estimated combined principal and interest required to pay on time all outstanding debt obligations of the political subdivision;
- The estimated maximum annual increase in the amount of taxes that would be imposed on a residence homestead in the political subdivision with an appraised value of $100,000 to repay the debt obligations.
- Any other information that the political subdivision considers relevant or necessary to explain the information above.

The voter information document must identify any major assumptions on the annual tax increase of a residence homestead in with an appraised value of $100,000, which includes the amortization of the political subdivision's debt obligations, changes in estimated future appraised values and the assumed

interest rate on the proposed bond.

HB 477 updates the Public Property Finance Act to require political subdivisions to provide notice of certificates of obligation at least 45 days prior to the estimated date of enactment, rather than the 30 days required under current law. In addition, if the issuer has a website, the political subdivision must post a notice continuously on the issuer's website for at least 45 days before the date tentatively set for the passage of the order or ordinance authorizing the issuance of the certificate. The notice must include:

- The then-current principal of all outstanding debt obligations of the issuer.
- The then-current combined principal and interest required to pay all outstanding debt obligations of the issuer on time and in full, which may be based on the issuer's expectations relative to the interest due on any variable rate debt obligations.
- The maximum principal amount of the certificates to be authorized.
- The estimated combined principal and interest required to pay the certificates.
- The estimated interest rate for the certificates to be authorized or that the maximum interest rate for the certificates may not exceed the maximum legal interest rate.
- The maximum maturity date of those certificates.

IMPLICATIONS

Hospital districts and public hospitals that submit bonds payable by taxes for voter approval should take note of the more detailed voter notification requirements set out in HB 477. In addition, public hospitals with the authority to issue certificates of obligation should ensure that they comply with the additional posting requirements, which include earlier notification to the public (45 days before adoption, rather than 30 days) and internet posting (only if the entity has a website).

HOUSE BILL 2477
Sponsors:
Sen. Borris Miles
Rep. Garnet Coleman
Effective Date: 6/14/19

Automatic Employee Participation in and Administration of a Deferred Compensation Plan Provided by Certain Hospital Districts

ANALYSIS

HB 2477 adds new provisions to chapter 609 of the Government Code permitting a hospital district to elect to require automatic employee participation in an applicable deferred compensation plan offered by the hospital district. The standard employee contribution under these provisions is 3 percent to the default investment product selected by the plan administrator in compliance with applicable regulation. These deductions must be made by automatic payroll deduction.

An employee may affirmatively elect not to participate in the plan, or may elect to discontinue participation in the plan, to contribute to a different investment product, to contribute a different amount to the plan, or designate all or a portion of the contribution to a Roth contribution program, where available and subject to the rules adopted by the hospital district.

The hospital district must inform employees, at the time of employment, of the elections the employee may make, and the employee's responsibilities, under these provisions. Information regarding new employee's automatic enrollment and right to opt out must be included in the new employee orientation process and the hospital district must maintain a record of a new employee's acknowledgement of receipt of this information.

The board of the hospital district, or its designee, must ensure that the applicable plan conforms to federal rules.

The hospital district may transfer an employee's deferred amounts and investment income from a qualified investment product to the trust fund of the deferred compensation plan in which the employee participates, if the hospital district determines that the transfer is in the best interest of the plan and employee. The hospital district is not required to provide notice of such transfer before it occurs, but must provide notice to the employee promptly after the transfer with information stating the reason for the transfer and a request for the employee promptly designate another qualified investment product to receive the transferred amount. Alternatively, the hospital district may elect to deposit deferred amounts and investment income in a qualified investment product, designated by the hospital district, rather than the plan's trust fund.

HB 2477 permits a hospital district to contract for necessary goods, consolidated billing, accounting and other services provided in connection with the deferred compensation plan. The hospital district may provide for periodic audits of the person with whom the contract is made, and such audit may cover the proper

handling and accounting of public or trust funds and other matter related to the proper performance of the contract. A private entity may be contracted with to conduct this audit.

These provisions apply only to an applicable employee who initially begins employment on or after Jan. 1, 2020. However, acts related to discretionary transfers of funds and consolidation of billing and accounting for deferred compensation plans that occurred prior to the bill's effective date will be validated as if they were authorized by law, as long as the act was not a misdemeanor or felony.

IMPLICATIONS

Hospital districts with applicable deferred compensation plans should understand the full scope of these provisions and adjust policies and procedures accordingly. If the hospital district elects to require automatic participation by employees, the required notice should be provided to applicable employees and a record of the employee's acknowledgement of receipt of such notice should be maintained.

HOUSE BILL 2826
Sponsors:
Sen. Joan Huffman
Rep. Greg Bonnen
Effective Date: 9/1/19

Procurement of a Contingent Fee Contract for Legal Services by a State Agency or Political Subdivision

ANALYSIS

HB 2826 affects the ability of political subdivisions to enter into contingent fee contracts for legal services. The bill was a priority of Texans for Lawsuit Reform.

The bill imposes selection criteria and indicates that the political subdivision must select "a well-qualified attorney or law firm on the basis of demonstrated competence, qualifications, and experience in the requested services" and attempt to negotiate a contract with that attorney or law firm for a fair and reasonable price.

The political subdivision may require an attorney or law firm to indemnify or hold harmless the political subdivision from claims and liabilities resulting from negligent acts or omissions of the attorney or law firm or persons employed by the attorney or law firm. However, a political subdivision may not require an attorney or law firm to indemnify, hold harmless or defend the political subdivision for claims or liabilities resulting from negligent acts or omissions of the political subdivision or its employees.

HB 2826 further imposes procedural requirements prior to entering into the

contract. The political subdivision must provide notice to the public, before or with the meeting notice where the contract will be considered, indicating:

- The reasons for pursuing the matter that is the subject of the legal services for which the attorney or law firm would be retained and the desired outcome of pursuing the matter.
- The competence, qualifications and experience demonstrated by the attorney or law firm selected.
- The nature of any relationship, including the beginning of the relationship, between the political subdivision or governing body and the attorney or law firm selected.
- The reasons the legal services cannot adequately be performed by the attorneys and supporting personnel of the political subdivision.
- The reasons the legal services cannot be reasonably obtained from attorneys in private practice under a contract providing for the payment of hourly fees without contingency.
- The reasons entering into a contingent fee contract for legal services is in the best interest of the residents.

The political subdivision must then approve the contract in an open meeting. On approval of a contingent fee contract, the governing body must state in writing that:

- The political subdivision finds that there is a substantial need for the legal services.
- The legal services cannot adequately be performed by the attorneys and supporting personnel of the political subdivision.
- The legal services reasonably cannot be obtained from attorneys in private practice under a contract providing only for the payment of hourly fees, without regard to the outcome of the matter, because of the nature of the matter for which the services will be obtained or because the political subdivision does not have funds to pay the estimated amounts required under a contract providing only for the payment of hourly fees.
- The contract is public information under Texas Public Information Act and may not be withheld from a requestor.

In addition to these requirements, before a contingent fee contract is effective and enforceable, the political subdivision must receive attorney general approval of the contract. The political subdivision must file the contract with the attorney general along with a description of the legal matter, a copy of the notice required meeting notice and a statement of the method and date of the

provision of the notice, and a copy of the statement described above. Within 90 days after receiving a contract from a political subdivision, the attorney general may approve the contract, refuse to approve the contract because the requirements were not fulfilled or refuse to approve the contract because the legal matter that is the subject of the contract presents one or more questions of law or fact that are in common with a matter the state has already addressed or is pursuing and pursuit of the matter by the political subdivision will not promote the just and efficient resolution of the matter.

A contract submitted to the attorney general is considered approved unless, not later than the 90th day after the date the attorney general receives the request to approve the contract, the attorney general notifies the political subdivision that the attorney general is refusing to approve the contract. If the attorney general refuses to approve a contract, the attorney general must specifically identify the provisions of this law with which the contract fails to comply or the political subdivision failed to comply. A political subdivision may contest the attorney general's refusal to approve the contract by appealing to the State Office of Administrative Hearings.

A contract entered into or an arrangement made in violation of the law is void as against public policy, and no fees may be paid to any person under the contract or under any theory of recovery for work performed in connection with a void contract. However, a contract that is submitted to and approved by the attorney general cannot later be declared void.

IMPLICATIONS

A political subdivision considering entering into a contingent fee contract for legal services should carefully review the requirements of HB 2826 to ensure full compliance with its provisions and should allow ample lead time in advance of the expiration of the statute of limitations of a contemplated legal claim in order to fulfill the requirements of the bill. Failure to comply could result in the voiding of the contract with the attorney and could potentially jeopardize the legal position of the governmental entity if it finds itself without adequate legal representation because its attorney's contract has been voided.

HOUSE BILL 2840
Sponsors:
Sen. Bryan Hughes
Rep. Terry Canales
Effective Date: 9/1/19

Rights of the Public to Address the Governing Body of a Political Subdivision at an Open Meeting

ANALYSIS

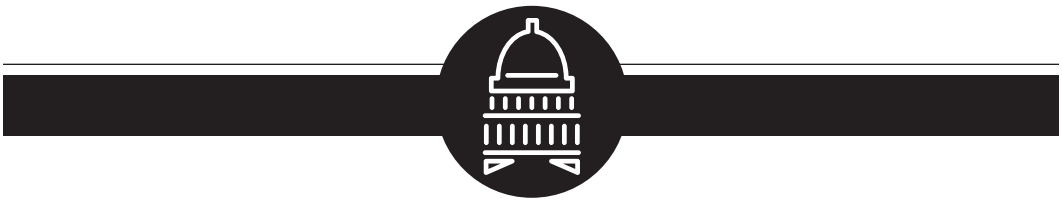
HB 2840 imposes requirements for a governmental body to allow members of the public to address the governing body at a meeting required to be open to the public. Specifically, the governmental body must allow each member of the public who desires to address the body regarding an item on an agenda to address the body regarding the item at the meeting before or during the body's consideration of the item.

The governmental body may adopt reasonable rules regarding the public's right to address the body, including rules that limit the total amount of time that a member of the public may address the body on a given item. However, if a governmental body does not use simultaneous translation equipment in a manner that allows the body to hear the translated public testimony simultaneously, a rule that limits the amount of time that a member of the public may address the governmental body must provide that a member of the public who addresses the body through a translator must be given at least twice the amount of time as a member of the public who does not require the assistance of a translator.

Further, a governmental body may not prohibit public criticism of the governmental body, including criticism of any act, omission, policy, procedure, program or service, unless the public criticism is otherwise prohibited by law.

IMPLICATIONS

The public input requirements apply to almost all public bodies with the notable exception of a board, commission, department, committee or agency within the executive or legislative branch of state government that is directed by one or more elected or appointed members. Many governing bodies of public entities already allow the opportunity for public input during an open meeting, and those entities will need to ensure that their public input process complies with the statute.



STATE AGENCY OPERATIONS

SENATE BILL 68
Sponsors:
Sen. Jane Nelson
Rep. Matt Schaefer
Effective Date: 6/7/19

Strategic Fiscal Reviews of State Agencies and Programs

ANALYSIS

SB 68 requires the Legislative Budget Board to perform a strategic fiscal review for each state agency that is the subject of Sunset Advisory Commission review. Agencies that are not subject to the legislative appropriations process are excepted. A report of the findings must be submitted by Sept. 1 of the even-numbered year of the biennium during which the review is conducted to the governor, lieutenant governor and speaker of the House of Representatives and to the members of the Senate Finance and House Appropriations Committees. The review report must contain a description of:

- The discrete activities the state agency is charged with conducting or performing together with a justification for each activity by reference to a statute or other legal authority.
- An evaluation of the effectiveness and efficiency of the state agency's policies, management, fiscal affairs and operations in relation to each activity.

The report also must contain:

- A quantitative estimate of any adverse effects that reasonably may be expected to result if an activity of the agency were discontinued.
- An itemized account of expenditures required to maintain the activity at the minimum level of service or performance required and the current level of service or performance.
- A ranking of the activities of the agency that illustrates "the relative importance of each activity to the overall goals and purposes of the state agency at current service or performance levels.
- Recommendations to the legislature regarding whether the legislature should continue funding each activity of the agency.

The legislature may consider the strategic fiscal review reports in connection with the legislative appropriations process.

IMPLICATIONS

SB 68 embodies a comprehensive fiscal justification process for agencies under sunset review. The preparation of the report will require a great deal of input from the affected agency under review.

SENATE BILL 2138
Sponsors:
Sen. Juan Hinojosa
Rep. Sarah Davis
Effective Date: 6/10/19

Authorization for THHSC to Retain a Portion of Hospital Supplemental Payments

ANALYSIS

SB 2138 allows the Texas Health and Human Services Commission to retain a portion of hospital payments under the Medicaid 1115 Transformation Waiver or a directed payment program. These funds must be used to support estimated costs necessary to administer the programs, except funds cannot be used to support costs that were funded with state general revenue before June 1, 2019. The bill authorizes THHSC to retain an amount limited to estimates of what is necessary, but not to exceed $8 million annually. If additional funds are needed, THHSC may seek approval of the governor and Legislative Budget Board to retain an additional amount not to exceed a total retained amount of 0.25 percent of the program total.

The bill also requires THHSC to submit an annual report to the governor and LBB detailing the amount of money retained, amount spent, how it was used, any increase in the amount retained above $8 million and an assessment of the extent to which the money retained covered the estimated costs to administer the program and a description of any adjustments in the amount retained.

The bill also requires THHSC's medical and utilization review appeals unit to comply with federal coding guidelines, including those adopted by the U.S. Department of Health and Human Services in accordance with the Health Insurance Portability and Accountability Act of 1996.

In addition, SB 2138 requires Medicaid managed care organizations to be accredited by a nationally recognized accreditation organization and allows THHSC to use this information in contract oversight processes. This requirement duplicates the requirement found in House Bill 4533.

IMPLICATIONS

THHSC is required to adopt rules to implement the provisions related to retaining funds for administration of the supplemental payment programs.

Hospitals participating in Medicaid supplemental payment programs should be aware of THHSC's retention of these funds and monitor implementation to ensure that programs are adequately supported by the retained funds.

HOUSE BILL 1504
Sponsors:
Sen. Robert Nichols
Rep. Chris Paddie
Effective Date: 9/1/19

Continuation and Functions of the Texas Medical Board

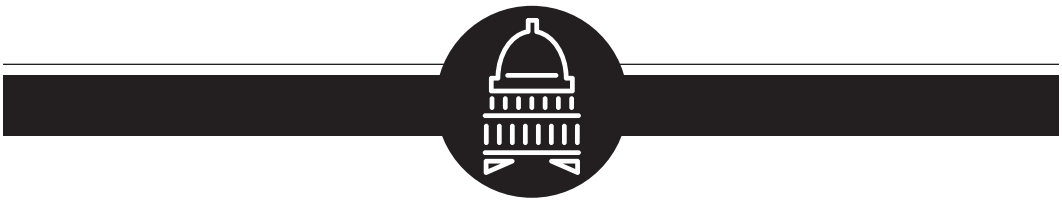
ANALYSIS

HB 1504 extends the Texas Medical Board's sunset date to Sept. 1, 2031 and makes a number of changes to the Occupations Code to update and streamline statutes related to TMB's authority, public information, disclosures and licensing, investigative and disciplinary activity. Additionally, the legislation contains a process aimed at waiving certain exam limit requirements for certain out-of-state applicants

The bill also amends the Occupations Code to make it a prohibited act, subject to discipline, if a physician in complying with the procedures outlined in sections 166.045 and 166.046 of the Health and Safety Code (part of the Texas Advance Directives Act related to procedures if not effectuating a directive or treatment decision), willfully fails to make a reasonable effort to transfer a patient to a physician who is willing to comply with a directive.

IMPLICATIONS

The primary focus of HB 1504 is on the ongoing functions of the TMB and streamlining related statutes. However, HB 1504 may impact Texas hospitals indirectly through the addition of the language that references compliance with the TADA in the disciplinary section of the Occupations Code. Hospitals should anticipate that physicians involved in the processes set forth in the TADA may have concerns that their involvement could lead to disciplinary action by the TMB, and should ensure that their policies and procedures related to the implementation of the TADA are up to date and compliant with the act in order to allay those concerns.



STATE BUDGET/APPROPRIATIONS

SENATE BILL 500
Sponsors:
Sen. Jane Nelson
Rep. John Zerwas
Effective Date: 6/6/19

HOUSE BILL 1
Sponsors:
Sen. Jane Nelson
Rep. John Zerwas
Effective Date: 9/1/19

State Budget for the 2020-2021 Biennium & Supplemental Appropriations for Fiscal Year 2019

ANALYSIS

HB 1 is the primary budget document that appropriates state and federal funds to all state agencies and programs for fiscal years 2020 and 2021. HB 1 appropriates $250.6 billion across all areas of state government, including more than $125 billion in state general revenue-related funds and $86.4 billion in federal funds.

SB 500 is the supplemental appropriations bill that provides funding for fiscal year 2019 and disaster-related appropriations. Supplemental appropriations for fiscal year 2019 total $8.7 billion, including $4.15 billion to cover the Medicaid budget shortfall from the last legislative session.

HB 1 and SB 500 provide funding for multiple hospital priorities.

Rate Enhancements

- $360 million all funds to maintain Medicaid rate enhancements for designated trauma hospitals (HB 1).
- $60 million all funds to maintain Medicaid rate enhancements for rural hospitals' outpatient services (HB 1).
- $300 million all funds to maintain Medicaid rate enhancements for safety net hospitals (HB 1).
- $90.5 million all funds for a new Medicaid rate enhancement for inpatient services at rural hospitals (HB 1).
- $16 million all funds for a new $500 Medicaid rate enhancement for labor and delivery services at each rural hospital that provides them (HB 1).
- $50 million in state general revenue for a new Medicaid rate increase for children's hospitals (SB 500).
- $15 million from the state's savings account, the Economic Stabilization Fund or the "Rainy Day Fund," to provide $15 million in grant funding to increase trauma capacity and improve trauma response infrastructure (SB 500).

Behavioral Health

- $6.1 million in state general revenue to integrate the state's Prescription Monitoring Program with hospitals' electronic medical records (SB 500).
- $1.7 million in state general revenue for private mental health facilities to provide or pay for psychoactive medication upon discharge until a patient can see a physician (HB 1).
- $445.6 million from the Economic Stabilization Fund for phase II of the

state psychiatric hospital redesign plan, including $90 million for a 100-bed maximum security unit at Rusk State Hospital; $165 million to begin construction of a 240-bed replacement of Austin State Hospital; and $190.3 million to begin construction of a 300-bed replacement of San Antonio State Hospital (SB 500).

- $26 million in state general revenue for the Texas Health and Human Services Commission to purchase 50 new inpatient beds at non-state psychiatric hospitals (HB 1).
- $5 million in state general revenue to increase availability of substance use disorder treatment (HB 1).
- $100 million for implementation of the Texas Child Mental Health Care Consortium and related programs under SB 11 (HB 1).

Maternal Health

- $7 million in state general revenue for maternal safety initiatives, including $1.33 million in general revenue annually to implement maternal safety initiatives statewide; $1.17 million in general revenue to develop and establish a high-risk maternal care coordination services pilot for women of childbearing age; and $1 million in general revenue to increase public awareness and prevention activities related to maternal mortality and morbidity (HB 1).
- $14.7 million in state general revenue to implement a limited postpartum care package in the Healthy Texas Women program (HB 1).
- Rider requiring THHSC to work with the federal Centers for Medicare & Medicaid Services to add bulk purchasing for long acting reversible contraception to the Healthy Texas Women 1115 Waiver (HB 1).

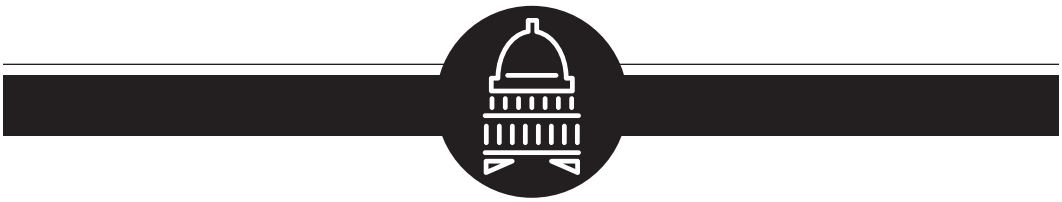
Workforce

- $19.9 million in state general revenue to maintain Professional Nursing Shortage Reduction Program funding (HB 1).
- $60 million in state general revenue to expand the graduate medical education program for physician training (HB 1).

Miscellaneous

- $1.5 million annually to establish a pediatric tele-connectivity resource program for rural Texas (HB 1).
- $6 million in state general revenue ($3 million annually) for Grants to Sexual Assault Forensic Exam (SAFE)-ready facilities, awarded equally between existing SAFE-ready designated facilities and facilities not yet SAFE ready designated (HB 1).

- $755,000 in state general revenue for an independent review organization contractor for Medicaid managed care external medical reviews (HB 1).
- Rider directing THHSC to report the following DSRIP information for demonstration years 7 and 8: measure bundles selected, core activities and performance associated with selected measure bundles, core activities associated with successful performance and with positive returns on investments, summary of final costs and savings reports, and the amount of DSRIP funds earned by each type of performing provider (HB 1).
- Rider requiring THHSC to achieve savings of at least $350 million in state general revenue. The rider states the legislature's intent for THHSC to achieve savings "without adjusting amount, scope, or duration of services or otherwise negatively impacting access to care" and that "prior to making any changes, THHSC must consider stakeholder input, including complying with any statutory requirements related to rulemaking and public hearings." (HB 1).



STATE TAXES

SENATE BILL 2
Sponsors:
Sen. Paul Bettencourt
Sen. Brandon Creighton
Sen. Kelly Hancock
Sen. Angela Paxton
Sen. Larry Taylor
Rep. Dustin Burrows
Effective Date: 1/1/20

Property Tax Reform

ANALYSIS

SB 2 requires cities, counties and most other state taxing units to obtain voter approval for property tax increases of more than 3.5 percent; however, the 3.5 percent cap does not apply to a "special taxing unit," which includes a hospital district. The voter approval tax rate for hospital districts will remain consistent with current law, which is an 8 percent cap of the maintenance and operations rate plus the current debt rate. SB 2 also excludes county hospitals from the 3.5 percent cap. Under the bill, county hospitals are subject to an 8 percent increase in expenditures, unless their proposed expenditures for the new tax year result in less than an 8 percent increase.

Hospital Districts

If a hospital district adopts a tax rate that exceeds the 8 percent cap, the hospital district's voters must approve the adopted tax rate in an election. The ballot measure must appear as a proposition in an election held in November. The order calling the election must be issued at least 71 days prior to the election. The ballot proposition must include the adopted tax rate, the difference between the adopted tax rate and the tax rate to be approved by the voters and the hospital district's tax rate for the preceding tax year. SB 2 requires the ballot proposition to state:

> Approving the ad valorem tax rate of $_____ per $100 valuation in (name of taxing unit) for the current year, a rate that is $_____ higher per $100 valuation than the voter-approval tax rate of (name of taxing unit), for the purpose of (description of purpose of increase). Last year, the ad valorem tax rate in (name of taxing unit) was $_____ per $100 valuation.

If the voters do not approve the new tax rate, the hospital district's current tax rate is adopted for the next taxing year. Note that if a hospital district exceeds the 8 percent cap to respond to a disaster, including a tornado, hurricane, flood, wildfire or other calamity, but not including a drought, which has impacted the district, and the governor has declared any part of the district as a disaster area, an election is not required to approve the adopted tax rate for the year following the year of the disaster.

County Hospitals

Under SB 2, county hospitals are subject to the lesser of:

- An 8 percent increase in eligible county hospital expenditures, divided by the difference between the current and new year's property value.

- The difference in eligible county hospital expenditures between the current tax year and the preceding tax year, divided by the difference between the current and new year's property value.

SB 2 defines "eligible county hospital expenditures" as the amount paid by a county or municipality in the period beginning on July 1 of the tax year preceding the tax year and ending on June 30 of the tax year for which the tax is adopted to maintain and operate a county hospital. The county or municipality must include a description and the amount of eligible county hospital expenditures in the information required to be mailed to each property owner in the taxing unit or published in a newspaper, as well as at the taxing unit's public hearing and public meeting to vote on the tax rate.

IMPLICATIONS

Hospital districts and county hospitals should closely review SB 2 to ensure their adopted tax rates do not exceed the bill's rate caps. For hospital districts, consistent with current law, SB 2 imposes an 8 percent cap of the maintenance and operations rate plus the current debt rate. If a hospital district exceeds the cap, voter approval is required. For county hospitals, the cap is slightly different—an 8 percent increase in expenditures, unless their proposed expenditures for the new tax year are lower than an 8 percent increase

HOUSE BILL 492
Sponsors:
Sen. Larry Taylor
Rep. Hugh Shine
Effective Date: 1/1/20 (if a constitutional amendment to adopt the temporary exemption is approved by the voters on 11/5/19)

Temporary Exemption From Taxation for Appraised Value of Property Damaged by a Disaster

ANALYSIS

HB 492 repeals the current reappraisal process for property damaged in a disaster area and creates a new temporary exemption for property damaged by a disaster if the property is in an area subject to a disaster declaration by the governor and is at least 15 percent damaged due to the disaster. If the taxing unit adopted a tax rate for the year in which the disaster declaration was issued, the exemption does not apply, unless the taxing unit chooses to adopt it for that year (otherwise, it would apply for the following year). If the taxing unit did not adopt a tax rate prior to the disaster declaration, a person seeking to claim a partial exemption must apply within 105 days of a disaster declaration. If the taxing unit elects to adopt the exemption for a year in which the taxing unit already adopted a tax rate, the application deadline is 45 days from the date of adoption.

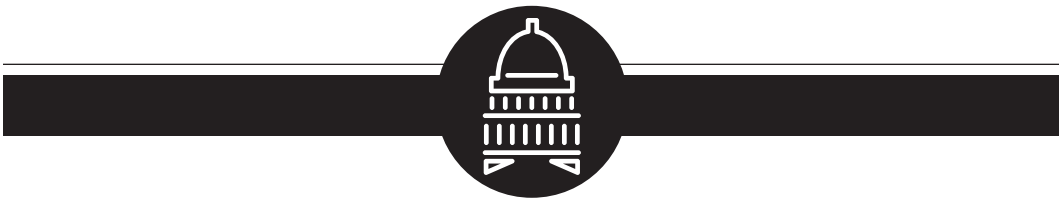
The partial exemption will apply only for one year for each disaster declaration.

The chief appraiser will determine the level of damage to the property, which will dictate the amount of the exemption. Within 30 days of the chief appraiser's decision, HB 492 allows a person to protest the modification or denial of an exemption or the determination of the amount of damages.

To be effective, HB 492 requires a constitutional amendment, which is set out in House Joint Resolution 34. The amendment will be submitted to the voters at an election on Nov. 5, 2019. The ballot will read: "The constitutional amendment authorizing the legislature to provide for a temporary exemption from ad valorem taxation of a portion of the appraised value of certain property damaged by a disaster."

IMPLICATIONS

Both investor-owned hospitals that are subject to ad valorem taxation and public hospitals that receive taxpayer revenue should take note of HB 492. Investor-owned hospitals located in counties with disaster declarations may be able to claim a partial temporary exemption for damage sustained during a disaster. Public hospitals that either tax or receive taxpayer revenue should closely monitor the effect of temporary disaster exemptions on revenue. All hospitals should note that HB 492 is not effective unless Texas voters approve a constitutional amendment, which will appear on the ballot in the Nov. 5, 2019 election. The bill's earliest possible effective date is for a tax year that begins on or after Jan. 1, 2020.



TELEMEDICINE AND TELEHEALTH

SENATE BILL 670
Sponsors:
Sen. Dawn Buckingham
Rep. Four Price
Rep. Ryan Guillen
Rep. J.D. Sheffield
Rep. Trent Ashby
Rep. Mary González
Effective Date: 9/1/19

Telemedicine and Telehealth Services

ANALYSIS

SB 670 amends and repeals several sections of the Government Code and Occupations Code, and adds language to section 531.0216 of the Government Code, directing the Texas Health and Human Services Commission to ensure that a Medicaid managed care organization:

- Does not deny reimbursement for covered services or procedures solely because the service or procedure is delivered via a telehealth service and not through in-person consultation.
- Does not limit, deny or reduce reimbursement for covered services or procedures based on the provider's choice of platform for providing the service or procedure.
- Promotes patient-centered medical homes in allowing a recipient to receive telemedicine and telehealth services, with some exceptions, if:
  - The telemedicine or telehealth service provider complies with legal and contractual requirements applicable to the same service as provided in an in-person setting.
  - The telemedicine or telehealth service provider gives notice to the Medicaid recipient's primary care physician or provider (if the recipient has one), and includes a summary of the service, findings, a list of prescribed or administered medications, and patient instructions, and if the recipient, or their appropriate parent or legal guardian, consents to such notice.

THHSC is charged with developing a process to ensure that Medicaid MCOs promote and support patient-centered medical homes and care coordination through telemedicine and telehealth services. THHSC must also ensure that federally qualified health centers may be reimbursed for telemedicine and telehealth services, in the event the Texas Legislature approves funding for such purposes, and amends rules for telepharmacy systems located in FQHCs.

Appropriate reimbursement for Medicaid MCOs must consider factors such as the cost-effectiveness of the service and whether the service is clinically effective. THHSC cannot limit a physician's choice of platform for providing a telemedicine medical service or telehealth service by requiring that the physician use a certain platform to receive reimbursement for the service.

SB 670 also eliminates various regulatory requirements, including statutory provisions related to:

- The required rulemaking process imposed on THHSC when issuing rules related to Medicaid reimbursement of telemedicine and telehealth services.

- A requirement that THHSC establish and adopt minimum standards for an operating system used in the provision of telemedicine medical services, telehealth services, or home telemonitoring services by a health care facility participating in Medicaid, including standards for electronic transmission, software and hardware.
- A limitation on Medicaid reimbursement if the medical condition, illness, or injury for which the patient is receiving the service is likely, within a reasonable degree of medical certainty, to undergo material deterioration within the 30-day period following the date of the visit.
- The requirement that THHSC develop rules to allocate reimbursement between a physician consulting from a distant site and a health professional present with the patient, or establish a facility fee that a physician consulting from a distant site must pay a health professional present with the patient.
- A limitation on THHSC's ability to require a telemedicine medical service if an in-person consultation with a physician is reasonably available where the patient resides or works.
- A requirement to compare and align Texas Medicaid payment policies for telemedicine services with those of Medicare.
- Requirements for patient site presenters in school-based clinics.
- A bar on reimbursement for home telemonitoring services beyond Sept. 1, 2019.

IMPLICATIONS

SB 670 expands on SB 1107, 85th Texas Legislature, and further streamlines regulation of teleservices by THHSC and through Texas Medicaid. Texas hospitals participating in Medicaid and offering telemedicine or telehealth services should understand the changes made by this legislation and modify policies and procedures accordingly. This legislation provides additional freedom to engage in telemedicine and telehealth and receive reimbursement for those services.

HOUSE BILL 871
Sponsors:
Sen. Charles Perry
Rep. Four Price
Effective Date: 9/1/19

Use of Telemedicine by Level IV Trauma Designated Hospitals

ANALYSIS

HB 871 allows a hospital located in a county with a population of fewer than 30,000 residents to use a telemedicine medical service to qualify for Level IV trauma facility designation in lieu of an on-site physician.

A telemedicine medical service is one in which an on-call physician with a special competence in the care of critically injured patients provides patient assessment, diagnosis, consultation or treatment or transfers medical data to a physician, advanced practice registered nurse or physician assistant located at the facility.

In establishing the requirements for designating a hospital as a Level IV trauma facility, the executive commissioner of the Texas Health and Human Services Commission may not adopt rules that:

- Require the physical presence or physical availability of a physician who has special competence in the care of critically injured patients.
- Prohibit the use of telemedicine medical service for a hospital located in a county with a population of fewer than 30,000.

IMPLICATIONS

Hospitals in counties with populations of fewer than 30,000 will be able to use telemedicine to quality for Level IV trauma facility designation. This will allow qualifying hospitals that have difficulty recruiting a physician to continue to be designated as a Level IV trauma designated facility. It also will allow qualifying hospitals that otherwise have not applied for designation because of their inability to meet the physician on-site requirement to apply to become a Level IV trauma designated hospital.

HOUSE BILL 3345
Sponsors:
Sen. Bryan Hughes
Rep. Four Price
Rep. Eddie Lucio, III
Rep. Dennis Paul
Rep. Ryan Guillen
Rep. Stan Lambert
Effective Date: 9/1/19

Health Benefit Coverage Provided by Certain Health Benefit Plans for Telemedicine Medical Services and Telehealth Services

ANALYSIS

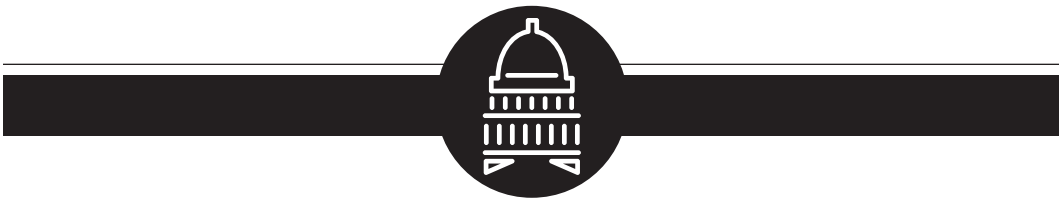
HB 3345 requires health benefit plans to provide the same coverage for telemedicine or telehealth services as they would for an in-person service. The health plan may not limit, deny or reduce coverage, nor may they impose annual or lifetime maximum coverage rates on telemedicine or telehealth, other than those applied to all items covered by the plan. In addition, the bill clarifies that the Insurance Code does not authorize a health plan to charge a separate deductible that applies only to telemedicine or telehealth services.

This applies to health benefit plans issued on or after Jan. 1, 2020.

IMPLICATIONS

Texas hospitals utilizing telemedicine or telehealth services should be aware

that telemedicine and telehealth services will receive the same coverage as in-person services by health plans subject to this regulation.



WOMEN'S HEALTH

SENATE BILL 22
Sponsors:
Sen. Donna Campbell
Rep. Candy Noble
Effective Date: 9/1/19

Relating to Prohibiting Certain Transactions Between a Governmental Entity and an Abortion Provider or Affiliate of the Provider

ANALYSIS

SB 22 prohibits the state, a state agency or a political subdivision from entering into a taxpayer resource transaction with an abortion provider or affiliate of an abortion provider, if the transaction is not subject to federal law in conflict with the bill. A "taxpayer resource transaction" is defined as a sale, purchase, lease, donation of money, goods, services or real property, or any other transaction between a governmental entity and a private entity that provided to the private entity something of value derived from state or local tax revenue. This excludes basic public services such as fire or police protection.

Under the bill, an "abortion provider" is a licensed abortion facility or an ambulatory surgical center that performed more than 50 abortions in any 12-month period. "Affiliate" means a person or entity who entered into with another person or entity a legal relationship that was created by at least one written instrument, including a certificate of formation, a franchise agreement, standards of affiliation, bylaws or licenses that demonstrate:

- Common ownership, management or control.
- A franchise granted by the person or entity to the affiliate.
- The granting or extension of a license or other agreement authorizing the affiliate to use the other person's or entity's brand name, trademark, service mark or other registered identification mark.

SB 22 grants exceptions to:

- A licensed general or special hospital.
- A licensed physician's office that performed 50 or fewer abortions in any 12-month period.
- A state hospital providing inpatient care and treatment for persons with mental illness.
- A public or private higher education teaching hospital.
- An accredited residency program providing training to resident physicians.

Additionally, the bill exempts a facility that performs an abortion in a medical emergency, meaning a life-threatening physical condition aggravated by, caused by or arising from a pregnancy that, as certified by a physician, places the woman in danger of death or a serious risk of substantial impairment of a major bodily function unless an abortion is performed.

The bill allows the attorney general to bring action to enjoin those in violation.

IMPLICATIONS

SB 22 is intended to close loopholes to ensure that taxpayers do not inadvertently subsidize abortions. It applies to both abortion providers and affiliates of abortion providers. Non-exempted entities should examine their relationships with abortion providers to evaluate whether those relationships could jeopardize the receipt of public funds.

SENATE BILL 24
Sponsors:
Sen. Eddie Lucio, Jr.
Rep. Chris Paddie
Effective Date: 9/1/19

Providing Informational Materials and Certain Other Information to a Pregnant Woman Before an Abortion

ANALYSIS

SB 24 revises the "Voluntary and Informed Consent" section of existing law related to abortions. Existing law requires informational materials to be provided to a woman prior to an abortion as part of the informed consent process. SB 24 specifies that the physician who is to perform the abortion, or the physician's designee, must "hand to the pregnant woman a copy of the informational materials" on the day of the sonogram consultation required by existing law for a pregnant woman who lives less than 100 miles from the nearest abortion facility or before any sedative or anesthesia is administered to the pregnant woman on the day of the abortion and at least two hours before the abortion if the woman lives 100 miles or more from the nearest abortion facility.

IMPLICATIONS

SB 24 was filed in response to a disparity between the number of information material forms shipped to providers and the number of abortions performed, leading legislators to conclude that the required consent process was being neglected. Given the concerns expressed about whether providers were following the law, this technical requirement could be an area of enforcement focus, and the process followed by providers should be documented carefully.

SENATE BILL 71
Sponsors:
Sen. Jane Nelson
Rep. Senfronia Thompson
Effective Date: 9/1/19

Establishing a Statewide Telehealth Center for Sexual Assault Forensic Medical Examination

ANALYSIS

SB 71 addresses the difficulty of accessing a sexual assault nurse examiner throughout the state. The bill requires the Office of Attorney General to

establish the Statewide Telehealth Center for Sexual Assault Forensic Medical Examination to expand access to SANEs for underserved populations.

The center will allow a SANE to facilitate, in person or through telecommunications or information technology, training or technical assistance to a sexual assault examiner conducting a forensic medical exam or the provision of consultation services, guidance or technical assistance during an exam. The center may facilitate telehealth services during a forensic medical exam if authorized by the facility and to the extent authorized by law.

The center and the OAG will develop operation protocols to address compliance with applicable laws and rules governing telehealth services, standards of professional conduct for licensure and practice, standards of care, maintenance of records, technology requirements, data privacy and security of patient information and the operation of a telehealth center. The center must strive to ensure the telehealth system meets national standards for interoperability.

During implementation of the center, the OAG must consult with medical, forensic and legal experts. The OAG will adopt rules to implement this new statute.

IMPLICATIONS

To implement the law, the OAG will establish the center, adopt operational protocols and undergo rulemaking. There will be opportunity for interested hospitals to engage in the process. It is likely that the center will be established with Texas A&M University. Once established, hospitals will be able to engage their sexual assault examiners with a SANE for in-person training or for remote consultations.

SENATE BILL 436
Sponsors:
Sen. Jane Nelson
Rep. Four Price
Effective Date: 6/7/19

Statewide Initiatives to Improve Maternal and Newborn Health for Women With Opioid Use Disorder

ANALYSIS

Under SB 436, the Texas Department of State Health Services, in collaboration with the Maternal Mortality and Morbidity Task Force, must develop and implement initiatives to:

- Improve screening procedures to better identify and care for women with opioid use disorder.
- Improve continuity of care for women with opioid use disorder by ensuring that health care providers refer the women to appropriate treatment and

verify the women received the treatment.

- Optimize health care provide to pregnant women with opioid use disorder.
- Optimize health care provided to newborns with neonatal abstinence syndrome by encouraging maternal engagement.
- Increase access to medication-assisted treatment for women with opioid use disorder during pregnancy and the postpartum period.
- Prevent opioid use disorder by reducing the number of opioid drugs prescribed before, during, and following a delivery.

Before implementing these initiatives statewide, TDSHS may conduct a limited pilot program in one or more geographic areas of the state to implement the initiatives at hospitals with expertise in caring for newborns with neonatal abstinence syndrome or related conditions. The pilot program must conclude no later than March 1, 2020.

Using existing resources, TDSHS, in collaboration with the Maternal Mortality and Morbidity Task Force, must promote and facilitate the use among health care providers of maternal health informational materials, including tools and procedures related to best practices in maternal health to improve obstetrical care for women with opioid use disorder.

TDSHS must produce a written report evaluating the success of the initiatives and the pilot program and submit it to the presiding officers of the standing committees of each house of the legislature with primary jurisdiction over public health.

IMPLICATIONS

SB 436 codifies work already underway to pilot opioid use disorder-specific initiatives in hospitals with expertise for caring for newborns with neonatal abstinence syndrome or related conditions and creates a firm mandate that the work being done in the opioid use disorder pilot program be expanded to birthing hospitals throughout Texas. Key labor and delivery as well as postpartum staff including chief nursing, physician and quality officers, should be made aware of this requirement and expect to receive information pertaining to an opioid-specific bundle of care recommendations sometime in 2020.

SENATE BILL 749
Sponsors:
Sen. Lois Kolkhorst
Rep. Four Price
Effective Date: 6/10/19

Level of Care Designations for Hospitals That Provide Neonatal and Maternal Care

ANALYSIS

Section 241.282 of the Health and Safety Code requires the state to assign a level of care designation to hospitals based on the neonatal and maternal services provided. The Texas Department of State Health Services, in coordination with the state's Perinatal Advisory Commission, has adopted rules establishing the designation and the requirements for the levels of care. SB 749 was passed to address concerns raised by hospitals and physicians that the process was inflexible and administratively could be improved.

The current maternal levels of care designation rule became effective on March 1, 2018. Prior to this legislation, designation for maternal levels of care is an eligibility requirement for Medicaid reimbursement beginning Sept. 1, 2020. SB 749 moves that date to Sept. 1, 2021. The Texas Health and Human Services Commission must complete the designations by Aug. 31, 2021. A hospital that has submitted a maternal levels of care designation application before the effective date of the bill (June 10, 2019) may amend the application to reflect the changes in law made by SB 749.

SB 749 requires THHSC, in consultation with TDSHS, to adopt rules to:

- Establish a process for a limited follow-up survey by an independent third party.
- Permit a hospital to satisfy any requirement for a Level I or II designation that relates to an obstetrics or gynecological physician by granting maternal care privileges to a family physician with OB training and developing and implementing a plan for response to OB emergencies.
- Clarify that, regardless of a hospital's designation level, a health care provider at the hospital may provide the full range of health care services within the provider's scope of practice and for which he/she has privileges.
- Require TDSHS to provide to each hospital a written explanation of the basis for the designation, including specific reasons that prevented a hospital from receiving a higher level of are designation.

THHSC must allow for the use of telemedicine by a physician providing on-call services to satisfy certain requirements (as identified in rule) for a Level I, II and III designation. These telemedicine services must meet the same standard of care as in-person service or care. In identifying what requirements may be satisfied using telemedicine, THHSC and TDSHS must consult with hospitals, physicians, nurses and other appropriate interested persons.

The rules must establish a process to allow a hospital to appeal a level of care designation to a three-person panel that includes TDSHS, THHSC and an independent person with expertise in the specialty area for which the hospital is seeking the designation. The independent person may not be an employee or affiliated with TDSHS, THHSC or the hospital. The independent person must rotate from a list of five to seven similarly qualified persons. TDSHS will solicit persons for this role, who must be approved to be placed on the list.

TDSHS must develop a conditional designation process, to allow a hospital to receive or maintain a level of care designation conditioned on complying with all elements of the designation by a certain timeframe. The conditional designation process will require the hospital to develop a plan and an agreement, to be approved by TDSHS. The conditional designation may not exceed one year. A hospital may apply for this conditional designation at any time.

TDSHS must develop a process to allow a hospital to waive one specific requirement for a level of care designation. TDSHS may enter into an agreement with a hospital to waive this requirement only if the agency determines a waiver is justified after considering:

- The expected impact on the accessibility of care in the geographical areas served by the hospital if the waiver is not granted and the quality of care and patient safety.
- Whether the health care services related to the requirement can be provided through telemedicine.

The waiver must expire by the end of the designation cycle, but it may be renewed by TDSHS on the same or different terms. TDSHS also may require ongoing reporting or monitoring. A hospital with a waiver from one requirement must satisfy all other requirements of the designation. Before submitting the request, the hospital must provide notice, and document the notice, of the intent to seek the waiver to the hospital's medical staff who practice in a specialty service area affected by the waiver.

TDSHS must post on its website the list of hospitals that have a conditional designation or a waiver, including an aggregated list of the conditional requirements or the waived element. A hospital with a conditional designation or a waiver must post on its own website the nature and general terms of the agreement with TDSHS.

TDSHS, along with the Perinatal Advisory Council, must conduct a strategic review of the practical implementation of the designation rules and identify:

- Any barriers to a hospital obtaining its request level of care.
- Whether the barriers identified are appropriate to ensure and improve neonatal and maternal care.
- Requirements for a level of care designation that relate to gestational age.
- Whether, in making a designation determination, TDSHS should consider:
  - The geographic area of the hospital.
  - The hospital's capabilities in providing care, regardless of the number of patients of a particular gestational age treated by the hospital.

If TDSHS determines that modification of the rules is warranted after the strategic review, it will make that recommendation and submit a report to the legislature by Dec. 31, 2020 summarizing the review and the actions taken as a result.

TDSHS will be adopting rules to implement SB 749.

IMPLICATIONS

Hospitals undertaking an application for maternal levels of care designation immediately should evaluate whether they need to make any changes to their application in relation to the elements of SB 749.

TDSHS will have to undertake some significant rulemaking. Hospitals interested in this process will want to pay attention to the rulemaking related to telemedicine, the new appeal process, the waiver process and the conditional designation process.

Hospitals may want to recommend a qualified physician or nurse for the appeals panel.

Hospitals should note any issues with meeting the requirements of a specific designation level and determine if they want to seek flexibility under the new processes when rulemaking is finalized.

SENATE BILL 750
Sponsors:
Sen. Lois Kolkhorst
Rep. Angie Chen Button
Effective Date: 6/10/19

Maternal and Newborn Health Care/Quality of Services Provided to Women

ANALYSIS

SB 750 amends current law relating to maternal and newborn health care and the quality of services provided to women in Texas under certain health care programs. The bill requires the Texas Health and Human Services Commission to:

- Apply for federal funds from the Centers for Medicare & Medicaid Services to implement a model of care to improve quality and accessibility of care for pregnant women with opioid use disorder and their children.
- Establish rules to ensure that women receiving services under the Healthy Texas Women program are referred to and provided with information on the primary health care services program.
- Collaborate with Medicaid managed care organizations to develop and implement cost-effective, evidence-based and enhanced prenatal care services to high-risk pregnant women enrolled in Medicaid.
- Evaluate postpartum care services provided to women enrolled in the HTW program after the first 60 days of the postpartum period and based on that evaluation, develop an enhanced, cost-effective and limited care services package for women enrolled in HTW to be provided after the first 60 days of the postpartum period for not more than 12 months after enrollment in HTW.
- Assess the feasibility and cost-effectiveness of contracting with an MCO to provide HTW services through managed care in one or more health care services regions if the HTW 1115 Waiver is approved. This provision expires Sept. 1, 2021.
- Develop and implement strategies to ensure the continuity of care for women who transition from Medicaid to HTW.
- Use money from an available source designated by THHSC and in collaboration with Medicaid MCOs and HTW providers, to develop and implement a postpartum depression treatment network; and
- Develop or enhance statewide initiatives to improve the quality of maternal health care services. MCOs that contract with THHSC are required to incorporate initiatives into their plans. The initiatives may address:
    - Prenatal and postpartum care rates.
    - Maternal health disparities for minority women and other high-risk populations of women.
    - Environmental conditions in which individuals live that affect the individuals' health and quality of life.
    - Other THHSC specified priorities.

SB 750 requires hospitals, birthing centers and other custodians of record to submit records to the Texas Department of State Health Services no later than the 30th business day after receiving a request from the department regarding a pregnancy-related death for a specific patient. The request from the department is limited to a patient's medical records. The bill creates an exception under which certain confidential information acquired by TDSHS regarding a

pregnancy-related death or severe maternal morbidity could be disclosed to an appropriate federal agency for the limited purpose of complying with applicable federal requirements.

SB 750 renames the Maternal Mortality Task Force as the Texas Maternal Mortality and Morbidity Review Committee. The Sunset Advisory Commission is required to review the committee during the two-year period preceding the date TDSHS is scheduled to be abolished (Sept. 1, 2023) with the requirement expiring Sept. 1, 2025; however, the review committee would continue until Sept. 1, 2027.

IMPLICATIONS

SB 750 continues to prioritize maternal and newborn health care in Texas through the mandates on THHSC. THHSC will adopt rules to implement provisions of this bill. Hospitals should ensure that employees who provide medical records to TDSHS in response to requests regarding a pregnancy-related death submit the records no later than the 30th business day after the request is received. Employees also should be advised that the request from TDSHS is limited to a patient's medical records.

SENATE BILL 2132
Sponsors:
Sen. Beverly Powell
Rep. Angie Chen Button
Effective Date: 5/20/19

Healthy Texas Women Program – Access to Care

ANALYSIS

SB 2132 automatically enrolls women in the Healthy Texas Women program after their Medicaid coverage for pregnant women expires. The Texas Health and Human Services Commission is required to provide information about the HTW program to women upon enrollment, including services provided and participating health care providers located in the same geographic region where the woman resides.

SB 2132 also directs THHSC to consult with the Maternal Morbidity Task Force (now known as the Maternal Mortality and Morbidity Review Committee, as a result of SB 750) to improve the process for providing information by determining the best time and the best manner to provide the information.

IMPLICATIONS

Providing additional care for women after pregnancy through the Healthy Texas Women program will ensure that women continue to receive the care they need and likely will prevent the need for emergency care, resulting in a decrease in hospital emergency room visits.

HOUSE BILL 8
Sponsors:
Sen. Jane Nelson
Rep. Victoria Neave
Effective Date: 9/1/19

Statute of Limitations for Certain Sexual Offenses and the Collection, Analysis and Preservation of Evidence of Sexual Assault and Other Sex Offenses

ANALYSIS

Increasing attention to the backlog of rape kits waiting to be tested led to the filing of HB 8. The bill extends the statute of limitation for sexual offenses, revises the timelines for possession and analysis of sexual assault exam kits and improves the analysis and preservation of collected evidence.

The bill expands the definition of material subject to chain of custody to include evidence of a sexual assault or other sexual offenses.

Related to evidence collection, the bill puts in statute a timeline for release of the evidence. If a health care facility receives signed, written consent to release the evidence, the facility must promptly notify any law enforcement agency investigating the alleged offense. The law enforcement agency must take possession of the evidence not later than seven days after being notified, unless the law enforcement agency is located more than 100 miles from the facility, in which case the evidence must be collected within 14 days. Failure to comply with this requirement will not affect admissibility of the evidence in a trial.

The Texas Department of State Health Services must update its standard information form for sexual assault survivors to include a statement that a state agency will pay for the forensic portion of the exam for both sexual assault survivors who report to law enforcement and survivors who do not report. Hospitals continue to be required to provide this form to the survivor.

In addition to providing TDSHS with the standard information form, a health care facility must ensure that a sexual assault survivor orally is notified that the state agency will pay for the forensic portion of the exam.

For a sexual assault survivor who did not report the assault to law enforcement, the Texas Department of Public Safety or the entity receiving the evidence must develop procedures to notify a victim before the destruction of evidence. The required preservation period is extended to five years from two years.

To ensure the non-report is notified of the new preservation timelines, TDSHS must develop a new information form for sexual assault survivors who have not reported the assault. The health care facility must provide this form to the non-reporting survivor. The TDSHS form will detail TDPS' storage policy, notification and destruction procedures, the process to file a report and contact information for law enforcement and rape crisis centers.

Law enforcement must ensure that a sexual assault exam collected for a felony

offense is preserved for 40 years or until the statute of limitations has expired, whichever is longer.

The bill also creates new standards and deadlines for crime labs to analyze evidence. Law enforcement and crime labs must report to TDPS the number of unanalyzed kits, which will be incorporated into a report for the governor and legislature by Sept. 1, 2020.

The legislation is effective on Sept. 1, 2019, but the changes in law related to evidence collection apply only to sexual assault collected on or after Sept. 1, 2019.

Also note that in addition to the evidence collection portion of the bill, Senate Bill 71, which established a Statewide Telehealth Center for Sexual Assault Forensic Medical Exams was added as an amendment to HB 8. Senate Bill 71 also passed as a standalone bill.

IMPLICATIONS

Hospitals must make several updates to their procedures related to communications with sexual assault survivors. All survivors will have to be **informed orally** that the forensic medical exam will be paid by the state. Each survivor must receive the updated standard sexual assault information form. Survivors who choose not to report to law enforcement must receive the new TDSHS form outlining TDPS' evidence storage and destruction procedures.

Hospitals must ensure they promptly notify law enforcement of any evidence collected. Law enforcement should collect evidence within 7 or 14 days, depending on their location from the facility.

Hospitals should review their procedures to ensure they have on hand the required and updated TDSHS forms.

HOUSE BILL 16
Sponsors:
Sen. Lois Kolkhorst
Rep. Jeff Leach
Effective Date: 9/1/19

Enforcement of the Rights of a Living Child Born After an Abortion

ANALYSIS

HB 16 establishes a physician-patient relationship between a child born alive after an abortion and the physician who performed or attempted the abortion. The physician must exercise the same degree of professional skill, care and diligence to preserve the life and health of the child as a reasonably diligent and conscientious physician would render to any other child born alive at the same gestational age. The physician must ensure that the child born alive

immediately be transferred to a hospital.

The bill establishes a third-degree felony against a physician or health care provider who failed to provide the appropriate medical treatment. A physician also would be liable to the state for a civil penalty of at least $100,000. The Office of Attorney General is authorized to sue to collect the civil penalty and reasonable attorney fees.

A person who has knowledge of a failure to provide the care must report to the OAG. The identity and any personally identifiable information of the person reporting the failure to comply is confidential under chapter 552 of the Government Code.

A woman on whom the abortion is performed cannot be held liable under HB 16.

IMPLICATIONS

Hospitals should be aware of the requirement and new penalties for the failure to provide care to a child born alive after an attempted abortion. Hospitals also should take note of the requirement of any person with knowledge of failure to comply to report to the OAG because this requirement could fall upon emergency room personnel.

HOUSE BILL 253
Sponsors:
Sen. Lois Kolkhorst
Rep. Jessica Farrar
Effective Date: 9/1/19

Strategic Plan to Improve Access to Postpartum Depression Screening Referral, Treatment and Support Services

ANALYSIS

HB 253 requires the Texas Health and Human Services Commission to develop and implement a five-year strategic plan to improve access to postpartum depression screening, referral, treatment and support services. The plan must provide strategies to:

- Increase awareness among state-administered program providers who may serve women at risk of or experiencing postpartum depression about the prevalence and effects of postpartum depression on outcomes for women and children.
- Establish a referral network of community-based mental health providers and support services addressing postpartum depression.
- Increase women's access to formal and informal peer support services, including access to certified peer specialists who have received additional

training related to postpartum depression.

- Raise public awareness of and reduce the stigma related to postpartum depression.
- Leverage sources of funding to support existing community-based postpartum depression screening, referral, treatment and support services.

THHSC must consult with the Texas Department of State Health Services, the Statewide Health Coordinating Council, the Office of Mental Health Coordination and the Statewide Behavioral Health Coordinating Council to review and update annually, as necessary, the strategic plan.

No later than Sept. 1 of the last fiscal year in the five-year period, THHSC is required to develop a new strategic plan for the next five fiscal years beginning with the following fiscal year.

Postpartum depression is defined as a disorder in which a woman experiences moderate to severe depression following a pregnancy, regardless of whether the pregnancy resulted in birth.

IMPLICATIONS

Hospitals providing labor and delivery services as well as pediatric or family practice clinics affiliated with hospital systems should be aware of the development of the strategic plan and prepared to implement components of the plan when complete.

HOUSE BILL 616
Sponsors:
Sen. Jane Nelson
Rep. Victoria Neave
Effective Date: 9/1/19

Reimbursement by the Office of the Attorney General for Sexual Assault Forensic Exams

ANALYSIS

In response to concerns from Dallas-area hospitals and law enforcement that reimbursement for rape kits is fragmented and difficult to obtain, HB 616 was filed to allow hospitals to be directly reimbursed by the Office of the Attorney General. HB 616 also requires law enforcement to document the decision to request a forensic medical exam. The bill also extends the timeline in which a forensic medical exam may be performed.

The bill extends the time to 120 hours post assault from 96 hours post assault for when a sexual assault survivor has the right to a forensic medical exam at a health care facility.

For any sexual assault reported to law enforcement, the law enforcement

agency must document and retain, in the form and manner required by the Attorney General, whether the agency requested a forensic medical exam be performed. Law enforcement must provide documentation about the decision to the health care facility and/or the sexual assault examiner or sexual assault nurse examiner who provides the services. The documentation must also be provided by law enforcement to the victim or the person who consented on behalf of the victim.

Hospitals and sexual assault examiners and sexual assault nurse examiners, when appropriate, are eligible for direct reimbursement from the OAG's crime victim's compensation fund as described below.

A health care facility, sexual assault examiner or sexual assault nurse examiner may apply directly to the OAG for reimbursement for the provision of a forensic medical exam. Reimbursement amounts, as established by OAG rulemaking, will be for the reasonable costs of the forensic portion of an exam and for the evidence collection kit.

For sexual assault survivors who reported to law enforcement, the reimbursement application by the health care facility or examiner must be in the form and manner as required by the OAG and must include documentation that a law enforcement agency requested the exam, and a complete and itemized bill of the reasonable costs of the forensic portion of the exam.

For sexual assault survivors who did not report, the reimbursement application by the health care facility of examiner must include certification that the exam was in accordance with the statutory requirements of consent and was within 120 hours of the assault. A complete and itemized bill of the reasonable costs of the forensic portion of the exam must also be attached.

The facility or examiner that request reimbursement must accept OAG payment unless the facility or examiner requests additional funds in writing and provides documentation to support the request. The OAG will use this documentation to determine if there is reasonable justification for additional reimbursement.

The OAG, upon request, may provide training to a health care facility regarding the new process.

The bill also makes the same changes as found in HB 8 to ensure the Texas Department of State Health Services standard information form for sexual assault survivors includes a statement that a state agency will be responsible for paying the forensic portion of an exam. The TDSHS form will be updated with this information.

The TDSHS standard information form for sexual assault survivors will also be

updated to reflect the new standard of 120 hours from the time of a sexual assault.

IMPLICATIONS

Hospitals will need to educate their forensic exam staff and reimbursement staff that a new process allows for direct reimbursement by the OAG for the forensic portion of an exam and for the kit. Hospitals will have to provide a complete and itemized bill to the OAG. Hospitals also will want to ensure that they receive the law enforcement documentation of the request for an exam to submit with the reimbursement application.

The OAG will begin rulemaking to develop the application and determine the reasonable costs for the forensic portion of the exam. Interested hospitals may engage in the rulemaking process.

Hospitals will want to ensure that they have the updated TDSHS standard information form for sexual assault survivors to distribute as required.

HOUSE BILL 1651
Sponsors:
Sen. Carol Alvarado
Rep. Mary González
Effective Date: 9/1/19

Care of Pregnant Women Confined in County Jail

ANALYSIS

Under HB 1651, the Texas Commission on Jail Standards is required to adopt reasonable rules and procedures establishing minimum requirements for a county jail to ensure that a jail's health services plan addresses obstetrical and gynecological care for prisoners who are known or determined to be pregnant and identify when a pregnant prisoner is in labor and provide appropriate care to the prisoner, including promptly transporting the prisoner to a local hospital.

TCJS also must adopt rules and procedures regarding the use of any type of restraint to control or restrict the movement of a prisoner, including a limb or other part of the prisoner, who is confirmed to be pregnant or who gave birth in the preceding 12 months. The rules and procedures must prohibit the use of restraints on a prisoner for the duration of the pregnancy and for a period of not less than 12 weeks after the prisoner gives birth unless supervisory personnel determines:

- The use of restraints is necessary to prevent an immediate and credible risk that the prisoner will attempt to escape.
- The prisoner poses an immediate and serious threat to the health and safety of the prisoner, staff or any member of the public, or a health care professional responsible for the health and safety of the prisoner determines

that the use of restraints is appropriate for the health and safety of the prisoner.

- A health care professional responsible for the health and safety of the prisoner determines that the use of restraints is appropriate for the health and safety of the prisoner and, if applicable, the unborn child of the prisoner.

The rules and procedures also must require jail staff who use restraints to use the least restrictive restraints necessary to prevent escape or to ensure health and safety and require jail staff, at the request of a health care professional responsible for the health and safety of the prisoner, to refrain from using restraints on the prisoner or to remove the restraints.

No later than Feb. 1 of each year, each county jail is required to submit a report to TCJS regarding the jail's use, during the preceding calendar year, of any type of restraint to control or restrict the movement of a prisoner, including a limb or other part of the prisoner, who is confirmed to be pregnant or who gave birth in the preceding 12 months. The report must include the circumstances of each use of restraints including:

- The specific type of restraints used.
- What activity the prisoner was engaged in immediately before being restrained.
- Whether the prisoner was restrained while being transported to a local hospital.
- The reasons supporting the determination to use the restraints, a description of the process by which the determination was made, and the name and title of the person or persons making the determination.

TCJS is required to prescribe a form for the report to be submitted.

TCJS is required to adopt the related rules and procedures no later than Dec. 1, 2019.

IMPLICATIONS

Once TCJS has finalized rules, hospitals that are in close proximity to or have agreements with local county jails to provide medical care will need to educate their obstetrical and gynecological teams on the required procedures for the use of any type of restraint to control or restrict the movement of a prisoner, including a limb or other part of the prisoner, who is confirmed to be pregnant or who gave birth in the preceding 12 months. Education about the county jail reporting requirement focused on whether a prisoner was restrained while being transported to a local hospital; and the reasons supporting the determination to use the restraints, a description of the process by which the

determination was made, and the name and title of the person or persons making the determination will be helpful in the event key hospital personnel is called upon in the process of completing or validating the county jail's report.

HOUSE BILL 4531
Sponsors:
Sen. Judith Zaffirini
Rep. Victoria Neave
Effective Date: 9/1/19

Elderly Persons and Persons With a Disability who are Survivors of Sexual Assault

ANALYSIS

HB 4531 affects the process for obtaining consent for a sexual assault forensic exam. It adds a statement to the existing consent language in section 323.004 of the Health and Safety Code that states that a facility conducting an exam "shall presume that an adult sexual assault survivor requesting a forensic medical examination and treatment is competent."

It also adds a new section 323.0044.that requires a health care facility to provide a forensic medical examination and treatment to an adult sexual assault survivor for whom a guardian is appointed without the consent of the survivor's guardian, guardian *ad litem* or other legal agent if the health care facility determines the survivor understands the nature of the forensic medical examination and treatment and the survivor agrees to receive the forensic medical examination and treatment.

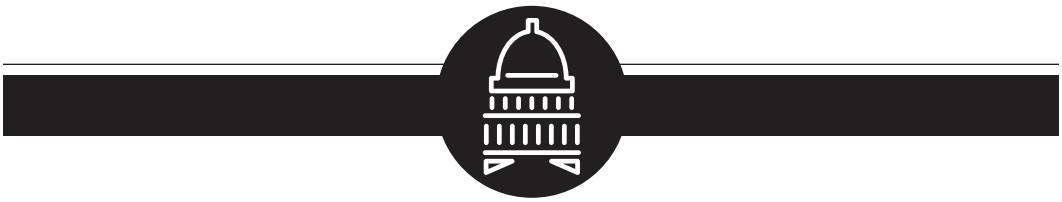
If an adult sexual assault survivor requests a forensic medical examination and treatment and a health care facility determines the survivor potentially is incapable of consenting to the forensic medical examination and treatment, the health care facility may obtain consent from a relative or caretaker of the survivor on the survivor's behalf, obtain consent from the survivor's guardian, guardian *ad litem* or other legal agent, or petition a court with probate jurisdiction in the county in which the facility is located for an emergency order authorizing the forensic medical examination and treatment. However, if the health care facility knows or has reason to believe that the survivor's relative, caretaker, guardian, guardian *ad litem* or other legal agent is a suspect or accomplice in the sexual assault of the survivor, the health care facility may not contact the survivor's relative, caretaker, guardian, guardian *ad litem* or other legal agent. Further, a health care facility may not provide a forensic medical examination to an adult sexual assault survivor for whom a guardian is appointed if the survivor refuses the examination, regardless of whether the survivor's guardian requests or consents to the examination.

The bill also limits the disclosure of information about an exam to a guardian and addresses the circumstances when a guardian or other person may consent

to the release of information about an exam. Information may not be provided to a guardian if the guardian is a suspect or accomplice in the assault. The ability of a guardian to consent to the release of information is restricted and the guardian must obtain a court order permitting the release if the survivor is unable to consent.

IMPLICATIONS

HB 4531 attempts to address vulnerable adults who have guardians appointed and the ambiguities in existing law over whether forensic evidence can be collected from such individuals or whether information relating to a sexual assault can be disclosed without the consent of the adult sexual assault survivor's guardian. It establishes a protocol by which health care facilities may provide a forensic medical examination and treatment to such an individual and by providing for the release of certain information without requiring consent by an applicable guardian. Exams performed on an adult sexual assault survivor who has a guardian or who may not have the capacity to consent to the exam or the release of information are impacted by the bill, and facilities will need to incorporate the consent and release of information provisions into their work flows and processes.



WORKERS' COMPENSATION

HOUSE BILL 387
Sponsors:
Sen. Brandon Creighton
Rep. Philip Cortez
Effective Date: 9/1/19

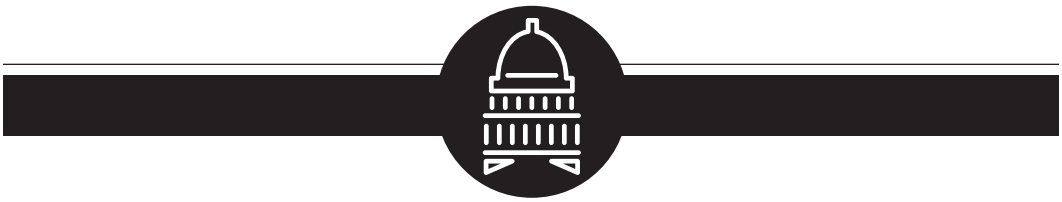
Submission of Reports by an Advanced Practice Registered Nurse Under the Workers' Compensation System

ANALYSIS

HB 387 makes a change to the Texas Workers' Compensation Act. It amends section 408.125(a-1) of the Labor Code to allow the completion of work status reports to be delegated by the treating physician to an advanced practice registered nurse. Current law permits such delegation only to a physician assistant. In either case, the treating physician maintains responsibility for the acts of the PA or APRN.

IMPLICATIONS

Treating physicians responsible for workers' compensation reports under section 408.025(a-1) may delegate the signing and filing of work status reports to both PAs and APRNs. The delegating physician maintains responsibility for the acts of either the PA or the APRN.



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