HOUSE JOURNAL

EIGHTY-SECOND LEGISLATURE, FIRST CALLED SESSION

PROCEEDINGS

FIFTH DAY — WEDNESDAY, JUNE 8, 2011

The house met at 1 p.m. and was called to order by the speaker.

The roll of the house was called and a quorum was announced present (Record 8).

Present — Mr. Speaker; Aliseda; Allen; Alonzo; Alvarado; Anchia; Anderson, C.; Anderson, R.; Aycock; Beck; Berman; Bohac; Bonnen; Branch; Brown; Burkett; Burnam; Button; Cain; Callegari; Carter; Castro; Chisum; Christian; Coleman; Cook; Craddick; Crownover; Darby; Davis, J.; Davis, S.; Davis, Y.; Deshotel; Driver; Dukes; Dutton; Eiland; Eissler; Elkins; Farias; Farrar; Fletcher; Flynn; Frullo; Garza; Geren; Giddings; Gonzales, L.; Gonzales, V.; Gonzalez; Gooden; Guillen; Gutierrez; Hamilton; Hancock; Hardcastle; Harless; Harper-Brown; Hartnett; Hernandez Luna; Hochberg; Hopson; Howard, C.; Howard, D.; Huberty; Hughes; Hunter; Isaac; Jackson; Johnson; Keffer; King, P.; King, S.; King, T.; Kleinschmidt; Kolkhorst; Kuempel; Landtroop; Larson; Laubenberg; Lavender; Legler; Lewis; Lozano; Lucio; Lyne; Madden; Mallory Caraway; Margo; Marquez; Martinez; Martinez Fischer; McClendon; Menendez; Miles; Miller, D.; Miller, S.; Morrison; Muñoz; Murphy; Naishtat; Nash; Oliveira; Orr; Otto; Parker; Patrick; Peña; Perry; Phillips; Pickett; Pitts; Price; Quintanilla; Raymond; Reynolds; Riddle; Ritter; Rodriguez; Schwertner; Scott; Sheets; Sheffield; Shelton; Simpson; Smith, T.; Smith, W.; Solomons; Strama; Taylor, L.; Taylor, V.; Thompson; Torres; Turner; Veasey; Villarreal; Vo; Walle; Weber; White; Workman; Zedler; Zerwas.

Absent, Excused — Creighton; Gallego; Hilderbran; Smithee; Truitt; Woolley.

Absent — Paxton.

The invocation was offered by Representative Perry.

The speaker recognized Representative Schwertner who led the house in the pledges of allegiance to the United States and Texas flags.

LEAVES OF ABSENCE GRANTED

The following members were granted leaves of absence for today because of important business:

Gallego on motion of Hochberg.

Smithee on motion of Flynn.

Truitt on motion of Alvarado.

The following member was granted leave of absence for today and the remainder of the week because of important business:

Woolley on motion of Weber.

The following members were granted leaves of absence for today because of important business in the district:

Creighton on motion of Madden.

Hilderbran on motion of Madden.

PROCLAMATION BY THE GOVERNOR OF THE STATE OF TEXAS

The chair laid before the house and had read the following proclamation by the governor:

TO THE SENATE AND HOUSE OF REPRESENTATIVES OF THE EIGHTY-SECOND TEXAS LEGISLATURE, FIRST CALLED SESSION:

WHEREAS, the people of Texas, through their state constitution, have placed the power to call the legislature into special session in the hands of the chief executive officer of the state; and

WHEREAS, the members of the Eighty-Second Texas Legislature, First Called Session, have now convened to consider items presented to them by the governor.

NOW, THEREFORE, I, RICK PERRY, Governor of the State of Texas, by the authority vested in me by Article IV, Section 8, and Article III, Section 40, of the Texas Constitution, do hereby present the following subject matter to the Eighty-Second Texas Legislature, First Called Session, for consideration:

> Legislation relating to the use of the federal Secure Communities Program by law enforcement agencies, the issuance of driver's licenses and personal identification certificates, and the abolishment of sanctuary cities in Texas.

IN TESTIMONY WHEREOF, I have signed my name officially and caused the Seal of the State to be affixed hereto at Austin, this 7th day of June 2011.

Respectfully submitted,

Rick Perry
Governor of Texas

(SEAL)
Hope Andrade
Secretary of State

RESOLUTIONS REFERRED TO COMMITTEES

Resolutions were at this time laid before the house and referred to committees. (See the addendum to the daily journal, Referred to Committees, List No. 1.)

MAJOR STATE CALENDAR
SENATE BILLS
SECOND READING

The following bills were laid before the house and read second time:

CSSB 7 ON SECOND READING
(Zerwas - House Sponsor)

CSSB 7, A bill to be entitled An Act relating to the administration, quality, and efficiency of health care, health and human services, and health benefits programs in this state.

Amendment No. 1

Representative Zerwas offered the following amendment to **CSSB 7**:

Amend **CSSB 7** (house committee printing) as follows:

(1) In SECTION 1.01 of the bill, in added Section 531.02417(d), Government Code (page 2, line 24), strike "An" and substitute "Unless the commissioner determines that the assessment is feasible and beneficial, an".

(2) In ARTICLE 1 of the bill, add the following appropriately numbered SECTION to the ARTICLE and renumber subsequent SECTIONS of that ARTICLE accordingly:

SECTION 1.____. Subchapter B, Chapter 32, Human Resources Code, is amended by adding Section 32.074 to read as follows:

Sec. 32.074. ACCESS TO PERSONAL EMERGENCY RESPONSE SYSTEM. (a) In this section, "personal emergency response system" has the meaning assigned by Section 781.001, Health and Safety Code.

(b) The department shall ensure that each Medicaid recipient has access to a personal emergency response system, if necessary, without regard to the recipient's access to a landline telephone.

(3) In SECTION 4.01 of the bill, in added Section 848.052, Insurance Code, immediately following Subsection (d) (page 95, between lines 19 and 20), insert the following:

(d-1) If a health care collaborative includes hospital-based physicians, one member of the board must be a hospital-based physician.

(4) In SECTION 4.01 of the bill, strike added Section 848.053(a)(1), Insurance Code (page 96, line 24), and substitute the following:

(1) two members of the board of directors, of which one member is the hospital-based physician member, if the health care collaborative includes hospital-based physicians; and

(5) In SECTION 4.01 of the bill, after added Section 848.053(b), Insurance Code (page 97, between lines 7 and 8), insert the following:

(c) The compensation advisory committee shall make recommendations to the board of directors regarding all charges, fees, payments, distributions, or other compensation assessed for health care services provided by a physician or health care provider who participates in the health care collaborative.

(d) Except as provided by Subsections (e) and (f), the board of directors and the compensation advisory committee may not use or consider a government payor's payment rates in setting the charges or fees for health care services provided by a physician or health care provider who participates in the health care collaborative.

(e) The board of directors or the compensation advisory committee may use or consider a government payor's payment rates when setting the charges or fees for health care services paid by a government payor.

(f) This section does not prohibit a reference to a government payor's payment rates in agreements with health maintenance organizations, insurers, or other payors.

(g) After the compensation advisory committee submits a recommendation to the board of directors, the board shall formally approve or refuse the recommendation.

(h) For purposes of this section, "government payor" includes:

(1) Medicare;

(2) Medicaid;

(3) the state child health plan program; and

(4) the TRICARE Military Health System.

(6) In SECTION 4.01 of the bill, strike added Sections 848.103(c) and (d), Insurance Code (page 107, lines 13-21), and substitute the following:

(c) Except as provided by Subsection (d), a health care collaborative may not contract for and accept payment from a governmental or private entity on a prepaid, capitation, or indemnity basis unless the health care collaborative is licensed as a health maintenance organization or insurer. The department shall review a health care collaborative's proposed payment methodology in contracts with governmental or private entities to ensure compliance with this section.

(d) A health care collaborative may contract for and accept compensation on a prepaid or capitation basis from a health maintenance organization or insurer.

(7) In ARTICLE 7 of the bill, add the following appropriately numbered SECTION to the ARTICLE and renumber subsequent SECTIONS of that ARTICLE accordingly:

SECTION 7.____. Chapter 108, Health and Safety Code, is amended by adding Section 108.0131 to read as follows:

Sec. 108.0131. LIST OF PURCHASERS OR RECIPIENTS OF DATA. The department shall post on the department's Internet website a list of each entity that purchases or receives data collected under this chapter.

(8) Add the following appropriately numbered SECTION to ARTICLE 11 of the bill and renumber subsequent SECTIONS of that ARTICLE accordingly:

SECTION 11.____. It is the intent of the legislature that the Health and Human Services Commission take any action the commission determines is necessary and appropriate, including expedited and emergency action, to ensure the timely implementation of the relevant provisions of this bill and the corresponding assumptions reflected in **HB 1**, 82nd Legislature, Regular Session (General Appropriations Act), by September 1, 2011, or the effective date of this

Act, whichever is later, including the adoption of administrative rules, the preparation and submission of any required waivers or state plan amendments, and the preparation and execution of any necessary contract changes or amendments.

(9) Add the following appropriately numbered ARTICLE to the bill and renumber the subsequent ARTICLES and SECTIONS of the bill accordingly:

ARTICLE ____. IMPROVING NUTRITION AND HEALTH OUTCOMES AMONG RECIPIENTS OF SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM BENEFITS

SECTION ____.01. The legislature finds that:

(1) Texans are committed to ensuring the health of families and children and understand the importance of the effect preventive health care measures have on population health and the state economy;

(2) consuming healthy foods such as fruits, vegetables, whole grains, fat-free and low-fat dairy products, and seafood and consuming fewer foods with sodium, saturated and trans fats, added sugars, and refined grains are important preventive health care measures; and

(3) public benefits programs that provide recipients with access to an adequate and nutritional diet should incorporate sound nutritional principles and promote the health and well-being of recipients.

SECTION ____.02. (a) The executive commissioner of the Health and Human Services Commission shall develop and seek a waiver or other appropriate authorization from the United States secretary of agriculture under Section 17, Food and Nutrition Act of 2008 (7 U.S.C. Section 2026), to make changes to the supplemental nutrition assistance program provided under Chapter 33, Human Resources Code, to improve nutrition and health outcomes among recipients of benefits under the program.

(b) In developing the waiver or other authorization under Subsection (a) of this section, the executive commissioner of the Health and Human Services Commission may consider the feasibility, including the costs and benefits, of:

(1) restricting the purchase of certain food items with minimal nutritional value under the supplemental nutrition assistance program; and

(2) promoting healthy food choices by recipients of benefits under the program.

(c) In developing the waiver or other authorization under Subsection (a) of this section, the executive commissioner of the Health and Human Services Commission shall solicit input from interested persons, including state agencies that administer nutritional assistance programs, nonprofit organizations that administer hunger relief programs, health care providers, nutrition experts, food retailers, and food industry representatives.

(d) As soon as practicable after the effective date of this Act, the executive commissioner of the Health and Human Services Commission shall apply for and actively pursue the waiver or other authorization as required by Subsection (a) of this section.

Amendment No. 2

Representative Geren offered the following amendment to Amendment No. 1:

Amend Amendment No. 1 by Zerwas to **CSSB 7** by striking item (9) of the amendment (page 4, line 5 through page 5, line 21).

(Paxton now present)

Representative Zerwas moved to table Amendment No. 2.

The motion to table was lost by (Record 9): 28 Yeas, 110 Nays, 1 Present, not voting.

Yeas — Alonzo; Alvarado; Brown; Burkett; Cain; Callegari; Christian; Davis, J.; Deshotel; Gutierrez; Hochberg; Hopson; Howard, D.; Hughes; Isaac; Kolkhorst; Lewis; Morrison; Muñoz; Pitts; Raymond; Shelton; Simpson; Strama; Taylor, V.; Weber; White; Zerwas.

Nays — Aliseda; Allen; Anchia; Anderson, C.; Anderson, R.; Aycock; Beck; Berman; Bohac; Bonnen; Branch; Burnam; Button; Carter; Castro; Chisum; Coleman; Cook; Craddick; Crownover; Darby; Davis, S.; Davis, Y.; Driver; Dukes; Dutton; Eiland; Eissler; Elkins; Farias; Farrar; Fletcher; Flynn; Frullo; Geren; Gonzales, L.; Gonzales, V.; Gonzalez; Gooden; Hamilton; Hancock; Hardcastle; Harless; Harper-Brown; Hartnett; Hernandez Luna; Howard, C.; Huberty; Hunter; Jackson; Johnson; King, P.; King, T.; Kleinschmidt; Kuempel; Landtroop; Larson; Laubenberg; Lavender; Legler; Lozano; Lucio; Lyne; Madden; Mallory Caraway; Margo; Marquez; Martinez; Martinez Fischer; McClendon; Menendez; Miles; Miller, D.; Miller, S.; Murphy; Naishtat; Nash; Oliveira; Orr; Otto; Parker; Patrick; Paxton; Peña; Perry; Phillips; Pickett; Price; Quintanilla; Reynolds; Riddle; Ritter; Rodriguez; Schwertner; Scott; Sheets; Sheffield; Smith, T.; Smith, W.; Solomons; Taylor, L.; Thompson; Torres; Turner; Veasey; Villarreal; Vo; Walle; Workman; Zedler.

Present, not voting — Mr. Speaker(C).

Absent, Excused — Creighton; Gallego; Hilderbran; Smithee; Truitt; Woolley.

Absent — Garza; Giddings; Guillen; Keffer; King, S.

STATEMENTS OF VOTE

I was shown voting no on Record No. 9. I intended to vote yes.

C. Howard

When Record No. 9 was taken, I was in the house but away from my desk. I would have voted yes.

S. King

I was shown voting yes on Record No. 9. I intended to vote no.

Muñoz

I was shown voting no on Record No. 9. I intended to vote yes.

W. Smith

Amendment No. 2 was adopted.

Amendment No. 3

Representative Zerwas offered the following amendment to Amendment No. 1:

Amend Amendment No. 1 by Zerwas to **CSSB 7** (house committee printing), in added Section 32.074, Human Resources Code (page 1, line 15), between "recipient" and "has" by inserting "enrolled in a home and community-based services waiver program that includes a personal emergency response system as a service".

Amendment No. 3 was adopted.

Amendment No. 1, as amended, was adopted.

Amendment No. 4

Representative D. Howard offered the following amendment to **CSSB 7**:

Amend **CSSB 7** (house committee printing) in SECTION 1.01(a) of the bill as follows:

(1) In added Section 531.02417(b), Government Code (page 1, line 16), between "cost-effective" and the underlined comma, insert "and in the best interests of Medicaid recipients".

(2) In added Section 531.02417(b)(1)(A), Government Code (page 1, line 22), strike "a state employee or contractor" and substitute "or under the direction of the recipient's personal physician who is licensed to practice in this state, or by a physician, physician assistant, registered nurse, or nurse practitioner who is licensed to practice in this state, and".

Amendment No. 4 was adopted.

Amendment No. 5

Representative Naishtat offered the following amendment to **CSSB 7**:

Amend **CSSB 7** (house committee printing), on page 44, by striking lines 7 and 8 and substituting the following:

(6) at least three members who are consumer representatives as follows:

(A) one member who is a recipient of long-term care services;

(B) one member who is a non-elderly consumer with disabilities; and

(C) one member who is represents families with children; and

Amendment No. 5 was adopted.

Amendment No. 6

Representative Brown offered the following amendment to **CSSB 7**:

Amend **CSSB 7** (house committee printing) as follows:

(1) In the recital to SECTION 1.15 of the bill (page 63, line 11), strike "Section 531.0697" and substitute "Sections 531.0696 and 531.0697".

(2) In SECTION 1.15 of the bill, immediately following the recital (page 63, between lines 11 and 12), insert the following:

Sec. 531.0696. CONSIDERATIONS IN AWARDING CERTAIN CONTRACTS. The commission may not contract with a managed care organization, including a health maintenance organization, or a pharmacy benefit manager if, in the preceding three years, the organization or pharmacy benefit manager, in connection with a bid, proposal, or contract with a governmental entity:

(1) made a material misrepresentation or committed fraud;

(2) was convicted of violating a state or federal law; or

(3) was assessed a penalty or fine in the amount of $500,000 or more in a state or federal administrative proceeding.

Representative Zerwas moved to table Amendment No. 6.

The motion to table was lost by (Record 10): 7 Yeas, 133 Nays, 1 Present, not voting.

Yeas — Davis, J.; Geren; Jackson; Lyne; Margo; Shelton; Zerwas.

Nays — Aliseda; Allen; Alonzo; Alvarado; Anchia; Anderson, C.; Anderson, R.; Aycock; Beck; Berman; Bohac; Bonnen; Branch; Brown; Burkett; Burnam; Button; Cain; Callegari; Carter; Castro; Chisum; Christian; Coleman; Cook; Craddick; Crownover; Darby; Davis, S.; Davis, Y.; Deshotel; Driver; Dukes; Dutton; Eiland; Eissler; Elkins; Farias; Farrar; Fletcher; Flynn; Frullo; Giddings; Gonzales, L.; Gonzales, V.; Gonzalez; Gooden; Guillen; Gutierrez; Hamilton; Hancock; Harless; Harper-Brown; Hartnett; Hernandez Luna; Hochberg; Hopson; Howard, C.; Howard, D.; Huberty; Hughes; Hunter; Isaac; Johnson; Keffer; King, P.; King, T.; Kleinschmidt; Kolkhorst; Kuempel; Landtroop; Larson; Laubenberg; Lavender; Legler; Lewis; Lozano; Lucio; Madden; Mallory Caraway; Marquez; Martinez; Martinez Fischer; McClendon; Menendez; Miles; Miller, D.; Miller, S.; Morrison; Muñoz; Murphy; Naishtat; Nash; Oliveira; Orr; Otto; Parker; Patrick; Paxton; Peña; Perry; Phillips; Pickett; Pitts; Price; Quintanilla; Raymond; Reynolds; Riddle; Ritter; Rodriguez; Schwertner; Scott; Sheets; Sheffield; Simpson; Smith, T.; Smith, W.; Solomons; Strama; Taylor, L.; Taylor, V.; Thompson; Torres; Turner; Veasey; Villarreal; Vo; Walle; Weber; White; Workman; Zedler.

Present, not voting — Mr. Speaker(C).

Absent, Excused — Creighton; Gallego; Hilderbran; Smithee; Truitt; Woolley.

Absent — Garza; Hardcastle; King, S.

STATEMENT OF VOTE

I was shown voting yes on Record No. 10. I intended to vote no.

Geren

Amendment No. 6 was adopted.

Amendment No. 7

Representative Hughes offered the following amendment to **CSSB 7**:

Amend **CSSB 7** (house committee printing) in SECTION 1.19 of the bill, in added Section 531.0025(a)(1)(A), Government Code (page 68, lines 3-4), by striking "and local community health clinics" and substituting "local community health clinics, and federally qualified health centers".

Amendment No. 7 was adopted.

Amendment No. 8

Representative Zedler offered the following amendment to **CSSB 7**:

Amend **CSSB 7** (house committee printing) as follows:

(1) In the recital to SECTION 1.19(b) of the bill (page 68, line 19), strike "Subsection (c-1)" and substitute "Subsections (c-1) and (c-2)".

(2) In SECTION 1.19(b) of the bill (page 68, between lines 26 and 27), insert the following:

(c-2) A physician who, under the medical assistance program, provides an abortion other than an abortion described by Subsection (c-1) shall report to the department not later than the 30th day after the date the abortion is provided:

(1) the type of abortion provided by the physician; and

(2) the cost of each abortion provided.

(3) Add the following appropriately numbered ARTICLE to the bill and renumber subsequent ARTICLES and SECTIONS of the bill accordingly:

ARTICLE ____. REPORTING REQUIREMENTS REGARDING ABORTION AND RELATED MEDICAL PROCEDURES

SECTION ____.01. Chapter 171, Health and Safety Code, is amended by adding Subchapter C to read as follows:

SUBCHAPTER C. REPORTING REQUIREMENTS

Sec. 171.051. REPORTING REQUIREMENTS. (a) Not later than the 15th day of each month, a physician by mail shall submit to the department the abortion reporting form required by Section 171.052 for each abortion performed by the physician in the preceding calendar month.

(b) As soon as practicable, but not later than 48 hours after the time of diagnosis or treatment, a physician by mail shall submit to the department the complication reporting form required by Section 171.053 for each illness or injury of a woman in the preceding calendar year that:

(1) the physician determines was caused by a medical complication resulting from an abortion for which the physician treated the woman; or

(2) the woman suspects was caused by a medical complication resulting from an abortion for which the physician treated the woman.

(c) The reports submitted to the department as required by this subchapter may not by any means identify the name of a woman on whom an abortion is performed.

Sec. 171.052. ABORTION REPORTING FORM; PARTIAL EXCEPTION. (a) A physician shall report to the department on the form prescribed by the department the information required by this section for each abortion performed by the physician.

(b) The form must include:

(1) the following information, which must be completed by the woman before anesthesia is administered or the abortion is performed:

(A) the woman's:

(i) age;

(ii) race or ethnicity;

(iii) marital status; and

(iv) municipality, county, state, and nation of residence and whether that residence is 100 miles or more from the facility where the abortion is to be performed;

(B) the woman's highest level of education, selected by checking one of the following:

(i) did not receive any high school education;

(ii) received some high school education but did not graduate;

(iii) is a high school graduate or recipient of a high school equivalency certificate;

(iv) received some college education but is not a college graduate;

(v) obtained an associate's degree;

(vi) obtained a bachelor's degree;

(vii) obtained a master's degree;

(viii) obtained a doctoral degree; or

(ix) received other education (specify): _____;

(C) the age of the father of the unborn child at the time of the abortion;

(D) the method or methods of contraception used at the time the unborn child was conceived, selected by checking all applicable methods from the following list:

(i) condoms;

(ii) spermicide;

(iii) male sterilization;

(iv) female sterilization;

(v) an injectable contraceptive;

(vi) an inter-uterine device;

(vii) mini pills;

(viii) combination pills;

(ix) a diaphragm;

(x) a cervical cap or vaginal contraceptive ring;

(xi) a contraceptive patch;

(xii) a sponge;

(xiii) a calendar-based contraceptive method, including rhythm method or natural family planning or fertility awareness;

(xiv) withdrawal;

(xv) no method of contraception; or

(xvi) other method (specify): _____;

(E) a space for the woman to indicate the specific reason the abortion is to be performed, selected from the following list:

(i) the woman was coerced or forced to have the abortion;

(ii) the woman does not want any more children;

(iii) economic reasons;

(iv) the woman's unborn child has been diagnosed with one or more health problems that are documented in the woman's medical records;

(v) the father of the unborn child opposes the pregnancy;

(vi) the woman's parent opposes the pregnancy;

(vii) the woman fears a loss of family support;

(viii) the woman fears losing her job;

(ix) a school counselor recommends abortion;

(x) a physician recommends abortion;

(xi) the pregnancy is the result of rape;

(xii) the pregnancy is the result of incest;

(xiii) the woman does not prefer the gender of the unborn child; or

(xiv) the woman does not want to complete this section;

(F) the number of the woman's previous live births;

(G) the number of induced abortions the woman has previously undergone;

(H) the number of miscarriages the woman has previously experienced;

(I) the source of the woman's referral to the physician for the abortion, selected from the following list:

(i) a physician;

(ii) the woman herself;

(iii) a friend or family member of the woman;

(iv) a member of the clergy;

(v) a school counselor;

(vi) a social services agency;

(vii) the department;

(viii) a family planning clinic; or

(ix) other (specify): _____;

(J) the method of payment for the abortion, selected from the following list:

(i) private insurance;

(ii) a public health plan;

(iii) personal payment by cash; or

(iv) personal payment by check or credit card;

(K) whether the woman availed herself of the opportunity to view the printed information required under Subchapter B and, if so, whether the woman viewed the information described by Section 171.014 in printed form or on the department's Internet website;

(L) whether the sonogram image, verbal explanation of the image, and audio of the heart auscultation described by Section 171.012(a)(4) were made available to the woman; and

(M) whether the woman availed herself of the opportunity to receive the sonogram image, verbal explanation of the image, and audio of the heart auscultation described by Section 171.012(a)(4); and

(2) the following information, which must be completed by the physician:

(A) the name of the facility at which the abortion was performed, the municipality and county in which the facility is located, and the type of facility at which the abortion was performed, selected from the following list:

(i) an abortion facility licensed under Chapter 245;

(ii) a private office of a licensed physician;

(iii) a licensed hospital;

(iv) a licensed hospital satellite clinic; or

(v) an ambulatory surgical center licensed under Chapter 243;

(B) the license number, area of specialty, and signature of the physician who performed the abortion;

(C) a statement that the physician screened the woman to determine whether:

(i) coercion, as defined by Section 1.07, Penal Code, is a reason that the woman is seeking the abortion; and

(ii) the woman is a victim of an offense described by Section 22.011(a)(2), Penal Code;

(D) the type of the abortion procedure performed, selected from the following list:

(i) chemical abortion, specifying the chemical used;

(ii) suction and curettage;

(iii) dilation and curettage;

(iv) dilation and evacuation;

(v) dilation and extraction;

(vi) labor and induction;

(vii) hysterotomy or hysterectomy; or

(viii) other (specify): _____;

(E) the date the abortion was performed;

(F) whether the woman survived the abortion and, if the woman did not survive, the cause of the woman's death;

(G) the number of fetuses aborted;

(H) the number of weeks of gestation at which the abortion was performed, based on the best medical judgment of the attending physician performing the procedure, and the weight of the fetus or fetuses, if determinable;

(I) the method of pregnancy verification, selected from the following list:

(i) urine test;

(ii) clinical laboratory test;

(iii) ultrasound;

(iv) not tested; or

(v) other (specify): _____;

(J) the total fee collected from the patient by the physician for performing the abortion, including any services related to the abortion;

(K) whether the abortion procedure was:

(i) covered by fee-for-service insurance;

(ii) covered by a managed care benefit plan;

(iii) covered by another type of health benefit plan (specify): _____; or

(iv) not covered by insurance or a health benefit plan;

(L) the type of anesthetic, if any, used on the woman during the abortion;

(M) the type of anesthetic, if any, used on the unborn child or children during the abortion;

(N) the method used to dispose of fetal tissue and remains;

(O) complications of the abortion, including:

(i) none;

(ii) shock;

(iii) uterine perforation;

(iv) cervical laceration;

(v) hemorrhage;

(vi) aspiration or allergic response;

(vii) infection or sepsis;

(viii) infant or infants born alive;

(ix) death of woman; or

(x) other (specify): _____;

(P) if an infant was born alive during the abortion:

(i) whether life-sustaining measures were provided to the infant; and

(ii) the period of time the infant survived; and

(Q) for each abortion performed on a woman who is younger than 18 years of age:

(i) whether:

(a) the minor's parent, managing conservator, or legal guardian provided the written consent required by Section 164.052(a)(19), Occupations Code;

(b) the minor obtained judicial authorization under Section 33.003 or 33.004, Family Code, for the minor to consent to the abortion;

(c) the woman is emancipated and permitted under law to have the abortion without the written consent required by Section 164.052(a)(19), Occupations Code, or judicial authorization; or

(d) the physician concluded and documented in writing in the patient's medical record that on the basis of the physician's good faith clinical judgment a condition existed that complicated the medical condition of the pregnant minor and necessitated the immediate abortion of her pregnancy to avert her death or to avoid a serious risk of substantial impairment of a major bodily function and that there was insufficient time to obtain the consent of the minor's parent, managing conservator, or legal guardian;

(ii) if the minor's parent, managing conservator, or legal guardian gave written consent, whether the consent was given:

(a) in person at the time of the abortion; or

(b) at a place other than the location where the abortion was performed; and

(iii) if the minor obtained judicial authorization:

(a) the process the physician or physician's agent used to inform the minor of the availability of judicial bypass as an alternative to the written consent required by Section 164.052(a)(19), Occupations Code;

(b) whether court forms were provided to the minor; and

(c) who made arrangements for the minor for the court appearance.

(c) The information required by Subsection (b)(1) must be at the top of the form. The information required by Subsection (b)(2) must be at the bottom of the form.

(d) A woman is required to complete the information required by Subsection (b)(1) unless the abortion is medically necessary, as certified by a physician, to prevent death or the serious risk of substantial impairment of a major bodily function resulting from a life-threatening physical condition that is aggravated by, is caused by, or arises from the woman's pregnancy.

(e) If the woman does not complete the required information, the physician who performs the abortion shall include in the woman's medical file a signed written statement certifying the nature of the medical emergency described by Subsection (d).

(f) A physician shall maintain a copy of each completed form in the woman's medical file until the later of:

(1) the seventh anniversary of the date on which the form was signed; or

(2) the woman's 25th birthday.

(g) A physician or the physician's agent shall provide to each woman required to complete a form under this section a copy of the completed form before the woman leaves the facility where the abortion was performed.

(h) The department shall make the abortion reporting form available on the department's Internet website.

(i) The form prescribed by this section must comply with the requirements of Section 171.014(b)(1).

Sec. 171.053. COMPLICATION REPORTING FORM. (a) A physician shall report to the department on the form prescribed by the department the information required by this section on the physician's treatment of an illness or injury related to a medical complication resulting from the performance of an abortion.

(b) The form must include the following information to be completed by the physician providing the treatment:

(1) the date of the abortion that caused or may have caused the complication;

(2) the type of abortion that caused or may have caused the complication, selected from the following list:

(A) chemical abortion, specifying the chemical used;

(B) suction and curettage;

(C) dilation and curettage;

(D) dilation and evacuation;

(E) dilation and extraction;

(F) labor and induction;

(G) hysterotomy or hysterectomy; or

(H) other (specify): _____;

(3) the name and type of the facility where the abortion complication was diagnosed and treated, selected from the following list:

(A) an abortion facility licensed under Chapter 245;

(B) a private office of a licensed physician;

(C) a licensed hospital;

(D) a licensed hospital satellite clinic; or

(E) an ambulatory surgical center licensed under Chapter 243;

(4) the name and type of the facility where the abortion was provided, if known;

(5) the license number, area of specialty, and signature of the physician who treated the abortion complication;

(6) the date on which the abortion complication was treated;

(7) a description of the complication or complications, selected from the following list:

(A) none;

(B) shock;

(C) uterine perforation;

(D) cervical laceration;

(E) hemorrhage;

(F) aspiration or allergic response;

(G) infection or sepsis;

(H) infant or infants born alive;

(I) death of woman; or

(J) other (specify): _____;

(8) the number of weeks of gestation at which the abortion was performed, based on the best medical judgment of the attending physician at the time of the treatment for the complication;

(9) the number of the woman's previous live births;

(10) the number of previous induced abortions the woman has undergone;

(11) the number of miscarriages the woman has previously experienced;

(12) whether the treatment for the complication was paid for by:

(A) private insurance;

(B) a public health plan;

(C) personal payment by cash; or

(D) personal payment by check or credit card;

(13) the total fee collected by the physician for treatment of the complication;

(14) whether the treatment for the complication was:

(A) covered by fee-for-service insurance;

(B) covered by a managed care benefit plan;

(C) covered by another type of health benefit plan (specify): _____; or

(D) not covered by insurance or a health benefit plan; and

(15) the type of follow-up care recommended by the physician after the physician provides treatment for the complication.

(c) A physician shall maintain a copy of each completed form in the woman's medical file until the later of:

(1) the seventh anniversary of the date on which the form was signed; or

(2) the woman's 25th birthday.

(d) A physician or the physician's agent shall provide to each woman for whom a form is completed under this section a copy of the completed form before the woman leaves the facility where the treatment was received.

(e) The department shall make the complication form available on the department's Internet website.

(f) The form prescribed by this section must comply with the requirements of Section 171.014(b)(1).

Sec. 171.054. CONFIDENTIAL INFORMATION. (a) Except as provided by Section 171.057 and Subsection (b), all information received or maintained by the department under this subchapter is confidential and is not subject to disclosure under Chapter 552, Government Code.

(b) A department employee may disclose information described by Subsection (a):

(1) for statistical purposes, but only if a person or facility is not identified;

(2) to a medical professional, a state agency, or a county or district court for purposes of enforcing this chapter or Chapter 245; or

(3) to a state licensing board for purposes of enforcing state licensing laws.

Sec. 171.055. PENALTIES. (a) The commissioner of state health services may assess an administrative penalty against a physician who fails to submit a report within the time required by Section 171.051 in the amount of $500 for each 30-day period or portion of a 30-day period the report remains overdue.

(b) The commissioner may bring an action against a physician who fails to file a report required under Section 171.051 before the first anniversary of the date the report was due to compel the physician to submit a complete report within a time stated by the court order or be subject to sanctions for civil contempt.

Sec. 171.056. OFFENSE; CRIMINAL PENALTY. (a) A physician commits an offense if:

(1) the physician fails to submit a report required by this subchapter;

(2) the physician intentionally, knowingly, or recklessly submits false information in a report required by this subchapter;

(3) the physician includes in a report required by this subchapter the name or identifying information of a woman on whom the physician performed an abortion; or

(4) the physician or the physician's agent discloses identifying information that is confidential under Section 171.054.

(b) An offense under this section is a Class A misdemeanor.

Sec. 171.057. PUBLIC DATA POSTING BY DEPARTMENT. (a) In order to assess the quality and efficiency of health care, the department shall aggregate the data that details the information reported under Section 171.051 during the preceding calendar year.

(b) Not later than April 1 of each year, the department shall post on the department's Internet website the statistical data aggregated under Subsection (a).

(c) Each posting under Subsection (b) must include data from the postings made under this section in previous years, including updated or corrected information for those postings. Each Internet web page containing a posting from a previous year must indicate at the bottom of the web page the date on which the data contained on the web page was most recently updated or corrected.

(d) The department shall ensure that a posting made under this section does not contain any information that could reasonably lead to the identification of:

(1) a woman on whom an abortion was performed or who received treatment for a complication resulting from an abortion; or

(2) a physician who performed an abortion or treated a complication resulting from an abortion.

SECTION ____.02. Section 245.001, Health and Safety Code, is amended to read as follows:

Sec. 245.001. SHORT TITLE. This chapter may be cited as the Texas Abortion Facility [~~Reporting and~~] Licensing Act.

SECTION ____.03. Section 245.005(e), Health and Safety Code, is amended to read as follows:

(e) As a condition for renewal of a license, the licensee must submit to the department the annual license renewal fee and an annual report[~~, including the report required under Section 245.011~~].

SECTION ____.04. Section 248.003, Health and Safety Code, is amended to read as follows:

Sec. 248.003. EXEMPTIONS. This chapter does not apply to:

(1) a home and community support services agency required to be licensed under Chapter 142;

(2) a person required to be licensed under Chapter 241 (Texas Hospital Licensing Law);

(3) an institution required to be licensed under Chapter 242;

(4) an ambulatory surgical center required to be licensed under Chapter 243 (Texas Ambulatory Surgical Center Licensing Act);

(5) a birthing center required to be licensed under Chapter 244 (Texas Birthing Center Licensing Act);

(6) a facility required to be licensed under Chapter 245 (Texas Abortion Facility [~~Reporting and~~] Licensing Act);

(7) a child care institution, foster group home, foster family home, and child-placing agency, for children in foster care or other residential care who are under the conservatorship of the Department of Family and Protective [~~and Regulatory~~] Services; or

(8) a person providing medical or nursing care or services under a license or permit issued under other state law.

SECTION ____.05. Effective January 1, 2012, Section 245.011, Health and Safety Code, is repealed.

SECTION ____.06. (a) Not later than December 1, 2011, the Department of State Health Services shall make available the forms required by Sections 171.052 and 171.053, Health and Safety Code, as added by this article.

(b) Notwithstanding Section 171.051, Health and Safety Code, as added by this article, a physician is not required to submit a report required by Section 171.051, Health and Safety Code, as added by this article, before January 1, 2012.

SECTION ____.07. Not later than April 1, 2013, the Department of State Health Services shall make the data posting required by Section 171.057, Health and Safety Code, as added by this article.

SECTION ____.08. (a) Except as provided by Subsection (b) of this section, this article takes effect on the 91st day after the last day of the legislative session.

(b) Section 171.056, Health and Safety Code, as added by this article, and Sections 245.001, 245.005, and 248.003, Health and Safety Code, as amended by this article, take effect January 1, 2012.

Amendment No. 8 was adopted. (Anchia and Strama recorded voting no.)

Amendment No. 9

Representative Simpson offered the following amendment to **CSSB 7**:

Amend **CSSB 7** (house committee printing) by adding the following appropriately lettered subsection to SECTION 1.19 of the bill and relettering subsequent subsections of SECTION 1.19 accordingly:

(____) Subchapter A, Chapter 171, Health and Safety Code, is amended by adding Section 171.006 to read as follows:

Sec. 171.006. PROHIBITED USE OF STATE OR GOVERNMENTAL ENTITY RESOURCES. This state or a governmental entity in this state may not provide support to a person or facility that performs abortions or provides abortion-related services. Support includes:

(1) directly or indirectly using state or local tax revenue to finance the performance of an abortion or a service related to an abortion; and

(2) providing preferential access to assets that are owned or controlled by this state or a governmental entity in this state through a lease, contract, or other agreement.

Amendment No. 9 - Point of Order

Representative D. Howard raised a point of order against further consideration of Amendment No. 9 under Rule 11, Section 2 of the House Rules on the grounds that the amendment is not germane to the bill.

The speaker sustained the point of order.

The ruling precluded further consideration of Amendment No. 9.

Amendment No. 10

Representative S. King offered the following amendment to **CSSB 7**:

Amend **CSSB 7** (house committee printing), in ARTICLE 7 of the bill, by adding the following appropriately numbered SECTIONS to the article and renumbering subsequent SECTIONS of that article accordingly:

SECTION 7.____. Chapter 108, Health and Safety Code, is amended by adding Section 108.0131 to read as follows:

Sec. 108.0131. NOTICE REQUIRED. A provider who submits data under Section 108.009 shall provide notice to the provider's patients that:

(1) the provider submits data as required by this chapter; and

(2) the data may be sold, collected, identified, or distributed to third parties.

SECTION 7.____. A health care provider is not required to comply with the requirements of Section 108.0131, Health and Safety Code, as added by this Act, before October 1, 2012.

Amendment No. 10 was adopted.

Amendment No. 11

Representatives Riddle and Simpson offered the following amendment to **CSSB 7**:

Amend **CSSB 7** (house committee printing) in SECTION 8.02 of the bill, in added Section 224.002(c), Health and Safety Code (page 136, line 11), by striking "The policy may" and substituting "The policy must".

Representative Zerwas moved to table Amendment No. 11.

The motion to table prevailed by (Record 11): 84 Yeas, 52 Nays, 1 Present, not voting.

Yeas — Alonzo; Alvarado; Anchia; Aycock; Branch; Burnam; Button; Callegari; Castro; Chisum; Coleman; Cook; Craddick; Crownover; Darby; Davis, J.; Davis, S.; Davis, Y.; Deshotel; Driver; Dukes; Dutton; Eiland; Eissler; Farias; Frullo; Giddings; Gonzales, L.; Gonzales, V.; Gonzalez; Gutierrez; Hamilton; Hernandez Luna; Hochberg; Hopson; Howard, D.; Hunter; Johnson; Keffer; King, T.; Kleinschmidt; Kuempel; Lewis; Lozano; Lucio; Lyne; Mallory Caraway; Margo; Marquez; Martinez; Martinez Fischer; McClendon; Menendez; Miles; Miller, D.; Miller, S.; Muñoz; Murphy; Naishtat; Oliveira; Peña; Pickett; Pitts; Price; Reynolds; Ritter; Rodriguez; Schwertner; Scott; Sheffield; Shelton; Smith, T.; Solomons; Strama; Taylor, L.; Thompson; Torres; Turner; Veasey; Villarreal; Vo; Walle; Workman; Zerwas.

Nays — Aliseda; Allen; Anderson, C.; Anderson, R.; Beck; Berman; Bonnen; Brown; Burkett; Cain; Carter; Christian; Elkins; Fletcher; Flynn; Geren; Gooden; Guillen; Hancock; Hardcastle; Harless; Harper-Brown; Howard, C.; Huberty; Isaac; Jackson; King, P.; King, S.; Kolkhorst; Landtroop; Larson; Laubenberg; Lavender; Legler; Madden; Morrison; Orr; Otto; Parker; Patrick; Paxton; Perry; Phillips; Quintanilla; Raymond; Riddle; Sheets; Simpson; Smith, W.; Taylor, V.; White; Zedler.

Present, not voting — Mr. Speaker(C).

Absent, Excused — Creighton; Gallego; Hilderbran; Smithee; Truitt; Woolley.

Absent — Bohac; Farrar; Garza; Hartnett; Hughes; Nash; Weber.

STATEMENT OF VOTE

When Record No. 11 was taken, I was in the house but away from my desk. I would have voted no.

Weber

Amendment No. 12

Representative Menendez offered the following amendment to **CSSB 7**:

Amend **CSSB 7** by adding the following and renumbering the sections accordingly:

SECTION 1. Subtitle B, Title 4, Health and Safety Code, is amended by adding Chapter 260 to read as follows:

CHAPTER 260. REPORTS OF ABUSE, NEGLECT, AND EXPLOITATION OF RESIDENTS OF CERTAIN FACILITIES

Sec. 260.001. DEFINITIONS. In this chapter:

(1) "Abuse" means:

(A) the negligent or wilful infliction of injury, unreasonable confinement, intimidation, or cruel punishment with resulting physical or emotional harm or pain to a resident by the resident's caregiver, family member, or other individual who has an ongoing relationship with the resident; or

(B) sexual abuse of a resident, including any involuntary or nonconsensual sexual conduct that would constitute an offense under Section 21.08, Penal Code (indecent exposure), or Chapter 22, Penal Code (assaultive offenses), committed by the resident's caregiver, family member, or other individual who has an ongoing relationship with the resident.

(2) "Department" means the Department of Aging and Disability Services.

(3) "Executive commissioner" means the executive commissioner of the Health and Human Services Commission.

(4) "Exploitation" means the illegal or improper act or process of a caregiver, family member, or other individual who has an ongoing relationship with the resident using the resources of a resident for monetary or personal benefit, profit, or gain without the informed consent of the resident.

(5) "Facility" means:

(A) an institution as that term is defined by Section 242.002; and

(B) an assisted living facility as that term is defined by Section 247.002.

(6) "Neglect" means the failure to provide for one's self the goods or services, including medical services, which are necessary to avoid physical or emotional harm or pain or the failure of a caregiver to provide such goods or services.

(7) "Resident" means an individual, including a patient, who resides in a facility.

Sec. 260.002. REPORTING OF ABUSE, NEGLECT, AND EXPLOITATION. (a) A person, including an owner or employee of a facility, who has cause to believe that the physical or mental health or welfare of a resident has been or may be adversely affected by abuse, neglect, or exploitation caused by another person shall report the abuse, neglect, or exploitation in accordance with this chapter.

(b) Each facility shall require each employee of the facility, as a condition of employment with the facility, to sign a statement that the employee realizes that the employee may be criminally liable for failure to report those abuses.

(c) A person shall make an oral report immediately on learning of the abuse, neglect, or exploitation and shall make a written report to the department not later than the fifth day after the oral report is made.

Sec. 260.003. CONTENTS OF REPORT. (a) A report of abuse, neglect, or exploitation is nonaccusatory and reflects the reporting person's belief that a resident has been or will be abused, neglected, or exploited or has died of abuse or neglect.

(b) The report must contain:

(1) the name and address of the resident;

(2) the name and address of the person responsible for the care of the resident, if available; and

(3) other relevant information.

(c) Except for an anonymous report under Section 260.004, a report of abuse, neglect, or exploitation under Section 260.002 should also include the address or phone number of the person making the report so that an investigator can contact the person for any necessary additional information. The phone number, address, and name of the person making the report must be deleted from any copy of any type of report that is released to the public, to the facility, or to an owner or agent of the facility.

Sec. 260.004. ANONYMOUS REPORTS OF ABUSE, NEGLECT, OR EXPLOITATION. (a) An anonymous report of abuse, neglect, or exploitation, although not encouraged, shall be received and acted on in the same manner as an acknowledged report.

(b) An anonymous report about a specific individual that accuses the individual of abuse, neglect, or exploitation need not be investigated.

Sec. 260.005. TELEPHONE HOTLINE; PROCESSING OF REPORTS. (a) The department shall operate the department's telephone hotline to:

(1) receive reports of abuse, neglect, or exploitation; and

(2) dispatch investigators.

(b) A report of abuse, neglect, or exploitation shall be made to the department's telephone hotline or to a local or state law enforcement agency. A report made relating to abuse, neglect, or exploitation or another complaint described by Section 260.007(c)(1) shall be made to the department's telephone hotline and to the law enforcement agency described by Section 260.017(a).

(c) Except as provided by Section 260.017, a local or state law enforcement agency that receives a report of abuse, neglect, or exploitation shall refer the report to the department.

Sec. 260.006. NOTICE. (a) Each facility shall prominently and conspicuously post a sign for display in a public area of the facility that is readily available to residents, employees, and visitors.

(b) The sign must include the statement: CASES OF SUSPECTED ABUSE, NEGLECT, OR EXPLOITATION SHALL BE REPORTED TO THE TEXAS DEPARTMENT OF AGING AND DISABILITY SERVICES BY CALLING (insert telephone hotline number).

(c) A facility shall provide the telephone hotline number to an immediate family member of a resident of the facility upon the resident's admission into the facility.

Sec. 260.007. INVESTIGATION AND REPORT OF DEPARTMENT. (a) The department shall make a thorough investigation after receiving an oral or written report of abuse, neglect, or exploitation under Section 260.002 or another complaint alleging abuse, neglect, or exploitation.

(b) The primary purpose of the investigation is the protection of the resident.

(c) The department shall begin the investigation:

(1) within 24 hours after receipt of the report or other allegation, if the report of abuse, neglect, exploitation, or other complaint alleges that:

(A) a resident's health or safety is in imminent danger;

(B) a resident has recently died because of conduct alleged in the report of abuse, neglect, exploitation, or other complaint;

(C) a resident has been hospitalized or been treated in an emergency room because of conduct alleged in the report of abuse, neglect, exploitation, or other complaint;

(D) a resident has been a victim of any act or attempted act described by Section 21.02, 21.11, 22.011, or 22.021, Penal Code; or

(E) a resident has suffered bodily injury, as that term is defined by Section 1.07, Penal Code, because of conduct alleged in the report of abuse, neglect, exploitation, or other complaint; or

(2) before the end of the next working day after the date of receipt of the report of abuse, neglect, exploitation, or other complaint, if the report or complaint alleges the existence of circumstances that could result in abuse, neglect, or exploitation and that could place a resident's health or safety in imminent danger.

(d) The department shall adopt rules governing the conduct of investigations, including procedures to ensure that the complainant and the resident, the resident's next of kin, and any person designated to receive information concerning the resident receive periodic information regarding the investigation.

(e) In investigating the report of abuse, neglect, exploitation, or other complaint, the investigator for the department shall:

(1) make an unannounced visit to the facility to determine the nature and cause of the alleged abuse, neglect, or exploitation of the resident;

(2) interview each available witness, including the resident who suffered the alleged abuse, neglect, or exploitation if the resident is able to communicate or another resident or other witness identified by any source as having personal knowledge relevant to the report of abuse, neglect, exploitation, or other complaint;

(3) personally inspect any physical circumstance that is relevant and material to the report of abuse, neglect, exploitation, or other complaint and that may be objectively observed;

(4) make a photographic record of any injury to a resident, subject to Subsection (n); and

(5) write an investigation report that includes:

(A) the investigator's personal observations;

(B) a review of relevant documents and records;

(C) a summary of each witness statement, including the statement of the resident that suffered the alleged abuse, neglect, or exploitation and any other resident interviewed in the investigation; and

(D) a statement of the factual basis for the findings for each incident or problem alleged in the report or other allegation.

(f) An investigator for an investigating agency shall conduct an interview under Subsection (e)(2) in private unless the witness expressly requests that the interview not be private.

(g) Not later than the 30th day after the date the investigation is complete, the investigator shall prepare the written report required by Subsection (e). The department shall make the investigation report available to the public on request after the date the department's letter of determination is complete. The department shall delete from any copy made available to the public:

(1) the name of:

(A) any resident, unless the department receives written authorization from a resident or the resident's legal representative requesting the resident's name be left in the report;

(B) the person making the report of abuse, neglect, exploitation, or other complaint; and

(C) an individual interviewed in the investigation; and

(2) photographs of any injury to the resident.

(h) In the investigation, the department shall determine:

(1) the nature, extent, and cause of the abuse, neglect, or exploitation;

(2) the identity of the person responsible for the abuse, neglect, or exploitation;

(3) the names and conditions of the other residents;

(4) an evaluation of the persons responsible for the care of the residents;

(5) the adequacy of the facility environment; and

(6) any other information required by the department.

(i) If the department attempts to carry out an on-site investigation and it is shown that admission to the facility or any place where the resident is located cannot be obtained, a probate or county court shall order the person responsible for the care of the resident or the person in charge of a place where the resident is located to allow entrance for the interview and investigation.

(j) Before the completion of the investigation, the department shall file a petition for temporary care and protection of the resident if the department determines that immediate removal is necessary to protect the resident from further abuse, neglect, or exploitation.

(k) The department shall make a complete final written report of the investigation and submit the report and its recommendations to the district attorney and, if a law enforcement agency has not investigated the report of abuse, neglect, exploitation, or other complaint, to the appropriate law enforcement agency.

(l) Within 24 hours after receipt of a report of abuse, neglect, exploitation, or other complaint described by Subsection (c)(1), the department shall report the report or complaint to the law enforcement agency described by Section 260.017(a). The department shall cooperate with that law enforcement agency in the investigation of the report or complaint as described by Section 260.017.

(m) The inability or unwillingness of a local law enforcement agency to conduct a joint investigation under Section 260.017 does not constitute grounds to prevent or prohibit the department from performing its duties under this

chapter. The department shall document any instance in which a law enforcement agency is unable or unwilling to conduct a joint investigation under Section 260.017.

(n) If the department determines that, before a photographic record of an injury to a resident may be made under Subsection (e), consent is required under state or federal law, the investigator:

(1) shall seek to obtain any required consent; and

(2) may not make the photographic record unless the consent is obtained.

Sec. 260.008. CONFIDENTIALITY. A report, record, or working paper used or developed in an investigation made under this chapter and the name, address, and phone number of any person making a report under this chapter are confidential and may be disclosed only for purposes consistent with rules adopted by the executive commissioner. The report, record, or working paper and the name, address, and phone number of the person making the report shall be disclosed to a law enforcement agency as necessary to permit the law enforcement agency to investigate a report of abuse, neglect, exploitation, or other complaint in accordance with Section 260.017.

Sec. 260.009. IMMUNITY. (a) A person who reports as provided by this chapter is immune from civil or criminal liability that, in the absence of the immunity, might result from making the report.

(b) The immunity provided by this section extends to participation in any judicial proceeding that results from the report.

(c) This section does not apply to a person who reports in bad faith or with malice.

Sec. 260.010. PRIVILEGED COMMUNICATIONS. In a proceeding regarding the abuse, neglect, or exploitation of a resident or the cause of any abuse, neglect, or exploitation, evidence may not be excluded on the ground of privileged communication except in the case of a communication between an attorney and client.

Sec. 260.011. CENTRAL REGISTRY. (a) The department shall maintain in the city of Austin a central registry of reported cases of resident abuse, neglect, or exploitation.

(b) The executive commissioner may adopt rules necessary to carry out this section.

(c) The rules shall provide for cooperation with hospitals and clinics in the exchange of reports of resident abuse, neglect, or exploitation.

Sec. 260.012. FAILURE TO REPORT; CRIMINAL PENALTY. (a) A person commits an offense if the person has cause to believe that a resident's physical or mental health or welfare has been or may be further adversely affected by abuse, neglect, or exploitation and knowingly fails to report in accordance with Section 260.002.

(b) An offense under this section is a Class A misdemeanor.

Sec. 260.013. BAD FAITH, MALICIOUS, OR RECKLESS REPORTING; CRIMINAL PENALTY. (a) A person commits an offense if the person reports under this chapter in bad faith, maliciously, or recklessly.

(b) An offense under this section is a Class A misdemeanor.

(c) The criminal penalty provided by this section is in addition to any civil penalties for which the person may be liable.

Sec. 260.014. RETALIATION AGAINST EMPLOYEES PROHIBITED. (a) In this section, "employee" means a person who is an employee of a facility or any other person who provides services for a facility for compensation, including a contract laborer for the facility.

(b) An employee has a cause of action against a facility, or the owner or another employee of the facility, that suspends or terminates the employment of the person or otherwise disciplines or discriminates or retaliates against the employee for reporting to the employee's supervisor, an administrator of the facility, a state regulatory agency, or a law enforcement agency a violation of law, including a violation of Chapter 242 or 247 or a rule adopted under Chapter 242 or 247, or for initiating or cooperating in any investigation or proceeding of a governmental entity relating to care, services, or conditions at the facility.

(c) The petitioner may recover:

(1) the greater of $1,000 or actual damages, including damages for mental anguish even if an injury other than mental anguish is not shown, and damages for lost wages if the petitioner's employment was suspended or terminated;

(2) exemplary damages;

(3) court costs; and

(4) reasonable attorney's fees.

(d) In addition to the amounts that may be recovered under Subsection (c), a person whose employment is suspended or terminated is entitled to appropriate injunctive relief, including, if applicable:

(1) reinstatement in the person's former position; and

(2) reinstatement of lost fringe benefits or seniority rights.

(e) The petitioner, not later than the 90th day after the date on which the person's employment is suspended or terminated, must bring suit or notify the Texas Workforce Commission of the petitioner's intent to sue under this section. A petitioner who notifies the Texas Workforce Commission under this subsection must bring suit not later than the 90th day after the date of the delivery of the notice to the commission. On receipt of the notice, the commission shall notify the facility of the petitioner's intent to bring suit under this section.

(f) The petitioner has the burden of proof, except that there is a rebuttable presumption that the person's employment was suspended or terminated for reporting abuse, neglect, or exploitation if the person is suspended or terminated within 60 days after the date on which the person reported in good faith.

(g) A suit under this section may be brought in the district court of the county in which:

(1) the plaintiff resides;

(2) the plaintiff was employed by the defendant; or

(3) the defendant conducts business.

(h) Each facility shall require each employee of the facility, as a condition of employment with the facility, to sign a statement that the employee understands the employee's rights under this section. The statement must be part of the statement required under Section 260.002. If a facility does not require an employee to read and sign the statement, the periods under Subsection (e) do not apply, and the petitioner must bring suit not later than the second anniversary of the date on which the person's employment is suspended or terminated.

Sec. 260.015. RETALIATION AGAINST VOLUNTEERS, RESIDENTS, OR FAMILY MEMBERS OR GUARDIANS OF RESIDENTS. (a) A facility may not retaliate or discriminate against a volunteer, resident, or family member or guardian of a resident because the volunteer, resident, resident's family member or guardian, or any other person:

(1) makes a complaint or files a grievance concerning the facility;

(2) reports a violation of law, including a violation of Chapter 242 or 247 or a rule adopted under Chapter 242 or 247; or

(3) initiates or cooperates in an investigation or proceeding of a governmental entity relating to care, services, or conditions at the facility.

(b) A volunteer, resident, or family member or guardian of a resident who is retaliated or discriminated against in violation of Subsection (a) is entitled to sue for:

(1) injunctive relief;

(2) the greater of $1,000 or actual damages, including damages for mental anguish even if an injury other than mental anguish is not shown;

(3) exemplary damages;

(4) court costs; and

(5) reasonable attorney's fees.

(c) A volunteer, resident, or family member or guardian of a resident who seeks relief under this section must report the alleged violation not later than the 180th day after the date on which the alleged violation of this section occurred or was discovered by the volunteer, resident, or family member or guardian of the resident through reasonable diligence.

(d) A suit under this section may be brought in the district court of the county in which the facility is located or in a district court of Travis County.

Sec. 260.016. REPORTS RELATING TO DEATHS OF RESIDENTS OF AN INSTITUTION. (a) In this section, "institution" has the meaning assigned by Section 242.002.

(b) An institution shall submit a report to the department concerning deaths of residents of the institution. The report must be submitted within 10 working days after the last day of each month in which a resident of the institution dies. The report must also include the death of a resident occurring within 24 hours after the resident is transferred from the institution to a hospital.

(c) The institution must make the report on a form prescribed by the department. The report must contain the name and social security number of the deceased.

(d) The department shall correlate reports under this section with death certificate information to develop data relating to the:

(1) name and age of the deceased;

(2) official cause of death listed on the death certificate;

(3) date, time, and place of death; and

(4) name and address of the institution in which the deceased resided.

(e) Except as provided by Subsection (f), a record under this section is confidential and not subject to the provisions of Chapter 552, Government Code.

(f) The department shall develop statistical information on official causes of death to determine patterns and trends of incidents of death among residents and in specific institutions. Information developed under this subsection is public.

(g) A licensed institution shall make available historical statistics on all required information on request of an applicant or applicant's representative.

Sec. 260.017. DUTIES OF LAW ENFORCEMENT; JOINT INVESTIGATION. (a) The department shall investigate a report of abuse, neglect, exploitation, or other complaint described by Section 260.007(c)(1) jointly with:

(1) the municipal law enforcement agency, if the facility is located within the territorial boundaries of a municipality; or

(2) the sheriff's department of the county in which the facility is located, if the facility is not located within the territorial boundaries of a municipality.

(b) The law enforcement agency described by Subsection (a) shall acknowledge the report of abuse, neglect, exploitation, or other complaint and begin the joint investigation required by this section within 24 hours after receipt of the report or complaint. The law enforcement agency shall cooperate with the department and report to the department the results of the investigation.

(c) The requirement that the law enforcement agency and the department conduct a joint investigation under this section does not require that a representative of each agency be physically present during all phases of the investigation or that each agency participate equally in each activity conducted in the course of the investigation.

Sec. 260.018. CALL CENTER EVALUATION; REPORT. (a) The department, using existing resources, shall test, evaluate, and determine the most effective and efficient staffing pattern for receiving and processing complaints by expanding customer service representatives' hours of availability at the department's telephone hotline call center.

(b) The department shall report the findings of the evaluation described by Subsection (a) to the House Committee on Human Services and the Senate Committee on Health and Human Services not later than September 1, 2012.

(c) This section expires October 31, 2012.

SECTION 2. Chapter 2, Code of Criminal Procedure, is amended by adding Article 2.271 to read as follows:

Art. 2.271. INVESTIGATION OF CERTAIN REPORTS ALLEGING ABUSE, NEGLECT, OR EXPLOITATION. Notwithstanding Article 2.27, on receipt of a report of abuse, neglect, exploitation, or other complaint of a resident of a nursing home, convalescent home, or other related institution or an assisted

living facility, under Section 260.007(c)(1), Health and Safety Code, the appropriate local law enforcement agency shall investigate the report as required by Section 260.017, Health and Safety Code.

SECTION 3. Subchapter A, Chapter 242, Health and Safety Code, is amended by adding Section 242.018 to read as follows:

Sec. 242.018. COMPLIANCE WITH CHAPTER 260. (a) An institution shall comply with Chapter 260 and the rules adopted under that chapter.

(b) A person, including an owner or employee of an institution, shall comply with Chapter 260 and the rules adopted under that chapter.

SECTION 4. Section 242.042(a), Health and Safety Code, is amended to read as follows:

(a) Each institution shall prominently and conspicuously post for display in a public area of the institution that is readily available to residents, employees, and visitors:

(1) the license issued under this chapter;

(2) a sign prescribed by the department that specifies complaint procedures established under this chapter or rules adopted under this chapter and that specifies how complaints may be registered with the department;

(3) a notice in a form prescribed by the department stating that licensing inspection reports and other related reports which show deficiencies cited by the department are available at the institution for public inspection and providing the department's toll-free telephone number that may be used to obtain information concerning the institution;

(4) a concise summary of the most recent inspection report relating to the institution;

(5) notice that the department can provide summary reports relating to the quality of care, recent investigations, litigation, and other aspects of the operation of the institution;

(6) notice that the Texas Board of Nursing Facility Administrators can provide information about the nursing facility administrator;

(7) any notice or written statement required to be posted under Section 242.072(c);

(8) notice that informational materials relating to the compliance history of the institution are available for inspection at a location in the institution specified by the sign; [~~and~~]

(9) notice that employees, other staff, residents, volunteers, and family members and guardians of residents are protected from discrimination or retaliation as provided by Sections 260.014 and 260.015; and

(10) a sign required to be posted under Section 260.006(a) [~~242.133 and 242.1335~~].

SECTION 5. Section 242.0665(b), Health and Safety Code, is amended to read as follows:

(b) Subsection (a) does not apply:

(1) to a violation that the department determines:

(A) results in serious harm to or death of a resident;

(B) constitutes a serious threat to the health or safety of a resident; or

(C) substantially limits the institution's capacity to provide care;

(2) to a violation described by Sections 242.066(a)(2)-(7);

(3) to a violation of Section 260.014 [~~242.133~~] or 260.015 [~~242.1335~~]; or

(4) to a violation of a right of a resident adopted under Subchapter L.

SECTION 6. Sections 242.848(a) and (b), Health and Safety Code, are amended to read as follows:

(a) For purposes of the duty to report abuse or neglect under Section 260.002 [~~242.122~~] and the criminal penalty for the failure to report abuse or neglect under Section 260.012 [~~242.131~~], a person who is conducting electronic monitoring on behalf of a resident under this subchapter is considered to have viewed or listened to a tape or recording made by the electronic monitoring device on or before the 14th day after the date the tape or recording is made.

(b) If a resident who has capacity to determine that the resident has been abused or neglected and who is conducting electronic monitoring under this subchapter gives a tape or recording made by the electronic monitoring device to a person and directs the person to view or listen to the tape or recording to determine whether abuse or neglect has occurred, the person to whom the resident gives the tape or recording is considered to have viewed or listened to the tape or recording on or before the seventh day after the date the person receives the tape or recording for purposes of the duty to report abuse or neglect under Section 260.002 [~~242.122~~] and of the criminal penalty for the failure to report abuse or neglect under Section 260.012 [~~242.131~~].

SECTION 7. Subchapter A, Chapter 247, Health and Safety Code, is amended by adding Section 247.007 to read as follows:

Sec. 247.007. COMPLIANCE WITH CHAPTER 260. (a) An assisted living facility shall comply with Chapter 260 and the rules adopted under that chapter.

(b) A person, including an owner or employee of an assisted living facility, shall comply with Chapter 260 and the rules adopted under that chapter.

SECTION 8. Section 247.043(a), Health and Safety Code, is amended to read as follows:

(a) The department shall conduct an investigation in accordance with Section 260.007 after receiving a report [~~a preliminary investigation of each allegation~~] of abuse, exploitation, or neglect of a resident of an assisted living facility [~~to determine if there is evidence to corroborate the allegation. If the department determines that there is evidence to corroborate the allegation, the department shall conduct a thorough investigation of the allegation~~].

SECTION 9. Section 247.0452(b), Health and Safety Code, is amended to read as follows:

(b) Subsection (a) does not apply:

(1) to a violation that the department determines results in serious harm to or death of a resident;

(2) to a violation described by Sections 247.0451(a)(2)-(7) or a violation of Section 260.014 or 260.015;

(3) to a second or subsequent violation of:

(A) a right of the same resident under Section 247.064; or

(B) the same right of all residents under Section 247.064; or

(4) to a violation described by Section 247.066, which contains its own right to correct provisions.

SECTION 10. Section 48.003, Human Resources Code, is amended to read as follows:

Sec. 48.003. INVESTIGATIONS IN NURSING HOMES, ASSISTED LIVING FACILITIES, AND SIMILAR FACILITIES. (a) This chapter does not apply if the alleged or suspected abuse, neglect, or exploitation occurs in a facility licensed under Chapter 242 or 247, Health and Safety Code.

(b) Alleged or suspected abuse, neglect, or exploitation that occurs in a facility licensed under Chapter 242 or 247, Health and Safety Code, is governed by Chapter 260 [~~Subchapter B, Chapter 242~~], Health and Safety Code.

SECTION 11. Subchapter E, Chapter 242, Health and Safety Code, is repealed.

SECTION 12. (a) The repeal by this Act of Section 242.131, Health and Safety Code, does not apply to an offense committed under that section before the effective date of this Act. An offense committed before the effective date of this Act is governed by that section as it existed on the date the offense was committed, and the former law is continued in effect for that purpose. For purposes of this subsection, an offense was committed before the effective date of this Act if any element of the offense occurred before that date.

(b) The repeal by this Act of Sections 242.133 and 242.1335, Health and Safety Code, does not apply to a cause of action that accrues before the effective date of this Act. A cause of action that accrues before the effective date of this Act is governed by Section 242.133 or 242.1335, Health and Safety Code, as applicable, as the section existed at the time the cause of action accrued, and the former law is continued in effect for that purpose.

(c) The change in law made by this Act by the repeal of Subchapter E, Chapter 242, Health and Safety Code, does not apply to a disciplinary action under Subchapter C, Chapter 242, Health and Safety Code, for conduct that occurred before the effective date of this Act. Conduct that occurs before the effective date of this Act is governed by the law as it existed on the date the conduct occurred, and the former law is continued in effect for that purpose.

SECTION 13. (a) The Department of Aging and Disability Services shall implement Chapter 260, Health and Safety Code, as added by this Act, using only existing resources and personnel.

(b) The Department of Aging and Disability Services shall ensure that the services provided on the effective date of this Act are at least as comprehensive as the services provided on the day before the effective date of this Act.

Amendment No. 12 was adopted.

Amendment No. 13

Representative Alonzo offered the following amendment to **CSSB 7**:

Amend **CSSB 7** (house second reading) by adding the following appropriately numbered SECTION to the bill and renumbering subsequent SECTIONS of the bill accordingly:

SECTION ____. (a) Subchapter A, Chapter 533, Government Code, is amended by adding Section 533.0065 to read as follows:

Sec. 533.0065. EYE HEALTH CARE SERVICE PROVIDERS. (a) In this section, "Texas-Mexico border region" has the meaning assigned by Section 2056.002.

(b) Subject to Section 32.047, Human Resources Code, but notwithstanding any other law, the commission shall require that each managed care organization that contracts with the commission under any Medicaid managed care model or arrangement to provide health care services to recipients in a region, including a region consisting of all or part of the Texas-Mexico border region, include in the organization's provider network each optometrist, therapeutic optometrist, and ophthalmologist in the region who:

(1) agrees to comply with the terms and conditions of the organization;

(2) agrees to accept the prevailing provider contract rate of the organization;

(3) agrees to abide by the standards of care required by the organization; and

(4) has the credentials required by the organization.

(b) The Health and Human Services Commission shall conduct a study of the fiscal impact on this state of requiring each Medicaid managed care organization that contracts with the commission under any Medicaid managed care model or arrangement implemented under Chapter 533, Government Code, to include in the organization's health care provider network providing services in all or part of the Texas-Mexico border region, as defined by Section 2056.002, Government Code, each optometrist, therapeutic optometrist, and ophthalmologist who meets the requirements under Section 533.0065, Government Code, as added by this section. The study must include an analysis of cost savings to the state as a result of a reduction in the number of emergency room visits by Medicaid recipients for nonemergency eye health care services that are realized after implementation of Section 533.0065, Government Code, as added by this section.

(c) Not later than September 1, 2016, the Health and Human Services Commission shall submit to the legislature a written report containing the findings of the study conducted under Subsection (b) of this section and the commission's recommendations regarding the requirement addressed in the study.

(d) The Health and Human Services Commission shall, in a contract between the commission and a Medicaid managed care organization under Chapter 533, Government Code, that is entered into or renewed on or after the effective date of this Act, require that the managed care organization comply with Section 533.0065, Government Code, as added by this section.

(e) The Health and Human Services Commission shall seek to amend each contract entered into with a Medicaid managed care organization under Chapter 533, Government Code, before the effective date of this Act to require those managed care organizations to comply with Section 533.0065, Government Code, as added by this section. To the extent of a conflict between Section 533.0065, Government Code, as added by this section, and a provision of a contract with a managed care organization entered into before the effective date of this Act, the contract provision prevails.

(f) If before implementing any provision of this section a state agency determines that a waiver or authorization from a federal agency is necessary for implementation of that provision, the agency affected by the provision shall request the waiver or authorization and may delay implementing that provision until the waiver or authorization is granted.

Amendment No. 13 was withdrawn.

Amendment No. 14

Representative Kolkhorst offered the following amendment to **CSSB 7**:

Amend **CSSB 7** (house committee printing) by adding the following appropriately numbered ARTICLE to the bill and renumbering subsequent ARTICLES accordingly:

ARTICLE ____. INTERSTATE HEALTH CARE COMPACT

SECTION ____.01. Title 15, Insurance Code, is amended by adding Chapter 5002 to read as follows:

CHAPTER 5002. INTERSTATE HEALTH CARE COMPACT

Sec. 5002.001. EXECUTION OF COMPACT. This state enacts the Interstate Health Care Compact and enters into the compact with all other states legally joining in the compact in substantially the following form:

Whereas, the separation of powers, both between the branches of the Federal government and between Federal and State authority, is essential to the preservation of individual liberty;

Whereas, the Constitution creates a Federal government of limited and enumerated powers, and reserves to the States or to the people those powers not granted to the Federal government;

Whereas, the Federal government has enacted many laws that have preempted State laws with respect to Health Care, and placed increasing strain on State budgets, impairing other responsibilities such as education, infrastructure, and public safety;

Whereas, the Member States seek to protect individual liberty and personal control over Health Care decisions, and believe the best method to achieve these ends is by vesting regulatory authority over Health Care in the States;

Whereas, by acting in concert, the Member States may express and inspire confidence in the ability of each Member State to govern Health Care effectively; and

Whereas, the Member States recognize that consent of Congress may be more easily secured if the Member States collectively seek consent through an interstate compact;

NOW THEREFORE, the Member States hereto resolve, and by the adoption into law under their respective State Constitutions of this Health Care Compact, agree, as follows:

Sec. 1. Definitions. As used in this Compact, unless the context clearly indicates otherwise:

"Commission" means the Interstate Advisory Health Care Commission.

"Effective Date" means the date upon which this Compact shall become effective for purposes of the operation of State and Federal law in a Member State, which shall be the later of:

a) the date upon which this Compact shall be adopted under the laws of the Member State, and

b) the date upon which this Compact receives the consent of Congress pursuant to Article I, Section 10, of the United States Constitution, after at least two Member States adopt this Compact.

"Health Care" means care, services, supplies, or plans related to the health of an individual and includes but is not limited to:

(a) preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care and counseling, service, assessment, or procedure with respect to the physical or mental condition or functional status of an individual or that affects the structure or function of the body, and

(b) sale or dispensing of a drug, device, equipment, or other item in accordance with a prescription, and

(c) an individual or group plan that provides, or pays the cost of, care, services, or supplies related to the health of an individual, except any care, services, supplies, or plans provided by the United States Department of Defense and United States Department of Veteran Affairs, or provided to Native Americans.

"Member State" means a State that is signatory to this Compact and has adopted it under the laws of that State.

"Member State Base Funding Level" means a number equal to the total Federal spending on Health Care in the Member State during Federal fiscal year 2010. On or before the Effective Date, each Member State shall determine the Member State Base Funding Level for its State, and that number shall be binding upon that Member State.

"Member State Current Year Funding Level" means the Member State Base Funding Level multiplied by the Member State Current Year Population Adjustment Factor multiplied by the Current Year Inflation Adjustment Factor.

"Member State Current Year Population Adjustment Factor" means the average population of the Member State in the current year less the average population of the Member State in Federal fiscal year 2010, divided by the average population of the Member State in Federal fiscal year 2010, plus 1. Average population in a Member State shall be determined by the United States Census Bureau.

"Current Year Inflation Adjustment Factor" means the Total Gross Domestic Product Deflator in the current year divided by the Total Gross Domestic Product Deflator in Federal fiscal year 2010. Total Gross Domestic Product Deflator shall be determined by the Bureau of Economic Analysis of the United States Department of Commerce.

Sec. 2. Pledge. The Member States shall take joint and separate action to secure the consent of the United States Congress to this Compact in order to return the authority to regulate Health Care to the Member States consistent with the goals and principles articulated in this Compact. The Member States shall improve Health Care policy within their respective jurisdictions and according to the judgment and discretion of each Member State.

Sec. 3. Legislative Power. The legislatures of the Member States have the primary responsibility to regulate Health Care in their respective States.

Sec. 4. State Control. Each Member State, within its State, may suspend by legislation the operation of all federal laws, rules, regulations, and orders regarding Health Care that are inconsistent with the laws and regulations adopted by the Member State pursuant to this Compact. Federal and State laws, rules, regulations, and orders regarding Health Care will remain in effect unless a Member State expressly suspends them pursuant to its authority under this Compact. For any federal law, rule, regulation, or order that remains in effect in a Member State after the Effective Date, that Member State shall be responsible for the associated funding obligations in its State.

Sec. 5. Funding.

(a) Each Federal fiscal year, each Member State shall have the right to Federal monies up to an amount equal to its Member State Current Year Funding Level for that Federal fiscal year, funded by Congress as mandatory spending and not subject to annual appropriation, to support the exercise of Member State authority under this Compact. This funding shall not be conditional on any action of or regulation, policy, law, or rule being adopted by the Member State.

(b) By the start of each Federal fiscal year, Congress shall establish an initial Member State Current Year Funding Level for each Member State, based upon reasonable estimates. The final Member State Current Year Funding Level shall be calculated, and funding shall be reconciled by the United States Congress based upon information provided by each Member State and audited by the United States Government Accountability Office.

Sec. 6. Interstate Advisory Health Care Commission.

(a) The Interstate Advisory Health Care Commission is established. The Commission consists of members appointed by each Member State through a process to be determined by each Member State. A Member State may not appoint more than two members to the Commission and may withdraw membership from the Commission at any time. Each Commission member is entitled to one vote. The Commission shall not act unless a majority of the members are present, and no action shall be binding unless approved by a majority of the Commission's total membership.

(b) The Commission may elect from among its membership a Chairperson. The Commission may adopt and publish bylaws and policies that are not inconsistent with this Compact. The Commission shall meet at least once a year, and may meet more frequently.

(c) The Commission may study issues of Health Care regulation that are of particular concern to the Member States. The Commission may make non-binding recommendations to the Member States. The legislatures of the Member States may consider these recommendations in determining the appropriate Health Care policies in their respective States.

(d) The Commission shall collect information and data to assist the Member States in their regulation of Health Care, including assessing the performance of various State Health Care programs and compiling information on the prices of Health Care. The Commission shall make this information and data available to the legislatures of the Member States. Notwithstanding any other provision in this Compact, no Member State shall disclose to the Commission the health information of any individual, nor shall the Commission disclose the health information of any individual.

(e) The Commission shall be funded by the Member States as agreed to by the Member States. The Commission shall have the responsibilities and duties as may be conferred upon it by subsequent action of the respective legislatures of the Member States in accordance with the terms of this Compact.

(f) The Commission shall not take any action within a Member State that contravenes any State law of that Member State.

Sec. 7. Congressional Consent. This Compact shall be effective on its adoption by at least two Member States and consent of the United States Congress. This Compact shall be effective unless the United States Congress, in consenting to this Compact, alters the fundamental purposes of this Compact, which are:

(a) To secure the right of the Member States to regulate Health Care in their respective States pursuant to this Compact and to suspend the operation of any conflicting federal laws, rules, regulations, and orders within their States; and

(b) To secure Federal funding for Member States that choose to invoke their authority under this Compact, as prescribed by Section 5 above.

Sec. 8. Amendments. The Member States, by unanimous agreement, may amend this Compact from time to time without the prior consent or approval of Congress and any amendment shall be effective unless, within one year, the

Congress disapproves that amendment. Any State may join this Compact after the date on which Congress consents to the Compact by adoption into law under its State Constitution.

Sec. 9. Withdrawal; Dissolution. Any Member State may withdraw from this Compact by adopting a law to that effect, but no such withdrawal shall take effect until six months after the Governor of the withdrawing Member State has given notice of the withdrawal to the other Member States. A withdrawing State shall be liable for any obligations that it may have incurred prior to the date on which its withdrawal becomes effective. This Compact shall be dissolved upon the withdrawal of all but one of the Member States.

SECTION ____.02. This article takes effect immediately if this Act receives a vote of two-thirds of all the members elected to each house, as provided by Section 39, Article III, Texas Constitution. If this Act does not receive the vote necessary for immediate effect, this article takes effect on the 91st day after the last day of the legislative session.

LEAVE OF ABSENCE GRANTED

The following member was granted leave of absence temporarily for today because of important business:

Castro on motion of Marquez.

CSSB 7 - (consideration continued)

Amendment No. 14 was adopted. (Alonzo, Alvarado, Anchia, Castro, Deshotel, Dukes, Dutton, V. Gonzales, Gonzalez, Guillen, D. Howard, Lozano, Marquez, Martinez, Martinez Fischer, McClendon, Menendez, Muñoz, Naishtat, Quintanilla, Raymond, Strama, Thompson, Turner, Veasey, and Vo recorded voting no.)

Amendment No. 15

Representative Kolkhorst offered the following amendment to **CSSB 7**:

Amend **CSSB 7** (house committee printing) by adding the following appropriately numbered ARTICLE to the bill and renumbering subsequent ARTICLES and SECTIONS of the bill accordingly:

ARTICLE ____. MEDICAID PROGRAM AND ALTERNATE METHODS OF PROVIDING HEALTH SERVICES TO LOW-INCOME PERSONS

SECTION ____.01. Subtitle I, Title 4, Government Code, is amended by adding Chapter 537 to read as follows:

CHAPTER 537. MEDICAID REFORM WAIVER

Sec. 537.001. DEFINITIONS. In this chapter:

(1) "Commission" means the Health and Human Services Commission.

(2) "Executive commissioner" means the executive commissioner of the Health and Human Services Commission.

Sec. 537.002. FEDERAL AUTHORIZATION FOR MEDICAID REFORM. (a) The executive commissioner shall seek a waiver under Section 1115 of the federal Social Security Act (42 U.S.C. Section 1315) to the state Medicaid plan.

(b) The waiver under this section must be designed to achieve the following objectives regarding the Medicaid program and alternatives to the program:

(1) provide flexibility to determine Medicaid eligibility categories and income levels;

(2) provide flexibility to design Medicaid benefits that meet the demographic, public health, clinical, and cultural needs of this state or regions within this state;

(3) encourage use of the private health benefits coverage market rather than public benefits systems;

(4) encourage people who have access to private employer-based health benefits to obtain or maintain those benefits;

(5) create a culture of shared financial responsibility, accountability, and participation in the Medicaid program by:

(A) establishing and enforcing copayment requirements similar to private sector principles for all eligibility groups;

(B) promoting the use of health savings accounts to influence a culture of individual responsibility; and

(C) promoting the use of vouchers for consumer-directed services in which consumers manage and pay for health-related services provided to them using program vouchers;

(6) consolidate federal funding streams, including funds from the disproportionate share hospitals and upper payment limit supplemental payment programs and other federal Medicaid funds, to ensure the most effective and efficient use of those funding streams;

(7) allow flexibility in the use of state funds used to obtain federal matching funds, including allowing the use of intergovernmental transfers, certified public expenditures, costs not otherwise matchable, or other funds and funding mechanisms to obtain federal matching funds;

(8) empower individuals who are uninsured to acquire health benefits coverage through the promotion of cost-effective coverage models that provide access to affordable primary, preventive, and other health care on a sliding scale, with fees paid at the point of service; and

(9) allow for the redesign of long-term care services and supports to increase access to patient-centered care in the most cost-effective manner.

SECTION ____.02. (a) In this section:

(1) "Commission" means the Health and Human Services Commission.

(2) "FMAP" means the federal medical assistance percentage by which state expenditures under the Medicaid program are matched with federal funds.

(3) "Illegal immigrant" means an individual who is not a citizen or national of the United States and who is unlawfully present in the United States.

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

(b) The commission shall actively pursue a modification to the formula prescribed by federal law for determining this state's FMAP to achieve a formula that would produce an FMAP that accounts for and is periodically adjusted to reflect changes in the following factors in this state:

(1) the total population;

(2) the population growth rate; and

(3) the percentage of the population with household incomes below the federal poverty level.

(c) The commission shall pursue the modification as required by Subsection (b) of this section by providing to the Texas delegation to the United States Congress and the federal Centers for Medicare and Medicaid Services and other appropriate federal agencies data regarding the factors listed in that subsection and information indicating the effects of those factors on the Medicaid program that are unique to this state.

(d) In addition to the modification to the FMAP described by Subsection (b) of this section, the commission shall make efforts to obtain additional federal Medicaid funding for Medicaid services required to be provided to illegal immigrants in this state. As part of that effort, the commission shall provide to the Texas delegation to the United States Congress and the federal Centers for Medicare and Medicaid Services and other appropriate federal agencies data regarding the costs to this state of providing those services.

(e) This section expires September 1, 2013.

SECTION ____.03. (a) The Medicaid Reform Waiver Legislative Oversight Committee is created to facilitate the reform waiver efforts with respect to Medicaid.

(b) The committee is composed of eight members, as follows:

(1) four members of the senate, appointed by the lieutenant governor not later than October 1, 2011; and

(2) four members of the house of representatives, appointed by the speaker of the house of representatives not later than October 1, 2011.

(c) A member of the committee serves at the pleasure of the appointing official.

(d) The speaker of the house of representatives shall designate a member of the committee as the presiding officer.

(e) A member of the committee may not receive compensation for serving on the committee but is entitled to reimbursement for travel expenses incurred by the member while conducting the business of the committee as provided by the General Appropriations Act.

(f) The committee shall:

(1) facilitate the design and development of the Medicaid reform waiver required by Chapter 537, Government Code, as added by this article;

(2) facilitate a smooth transition from existing Medicaid payment systems and benefit designs to a new model of Medicaid enabled by the waiver described by Subdivision (1) of this subsection;

(3) meet at the call of the presiding officer; and

(4) research, take public testimony, and issue reports requested by the lieutenant governor or speaker of the house of representatives.

(g) The committee may request reports and other information from the Health and Human Services Commission.

(h) The committee shall use existing staff of the senate, the house of representatives, and the Texas Legislative Council to assist the committee in performing its duties under this section.

(i) Chapter 551, Government Code, applies to the committee.

(j) The committee shall report to the lieutenant governor and speaker of the house of representatives not later than November 15, 2012. The report must include:

(1) identification of significant issues that impede the transition to a more effective Medicaid program;

(2) the measures of effectiveness associated with changes to the Medicaid program;

(3) the impact of Medicaid changes on safety net hospitals and other significant traditional providers; and

(4) the impact on the uninsured in Texas.

(k) This section expires September 1, 2013, and the committee is abolished on that date.

SECTION ____.04. This article takes effect immediately if this Act receives a vote of two-thirds of all the members elected to each house, as provided by Section 39, Article III, Texas Constitution. If this Act does not receive the vote necessary for immediate effect, this article takes effect on the 91st day after the last day of the legislative session.

Amendment No. 15 was adopted. (Turner recorded voting no.)

Amendment No. 16

Representative Riddle offered the following amendment to **CSSB 7**:

Amend **CSSB 7** (house committee printing) by adding the following appropriately numbered SECTION to ARTICLE 1 of the bill and renumbering subsequent SECTIONS of ARTICLE 1 of the bill accordingly:

SECTION 1.____. Chapter 33, Human Resources Code, is amended by adding Section 33.029 to read as follows:

Sec. 33.029. CERTAIN ELIGIBILITY RESTRICTION. Notwithstanding any other provision of this chapter, an applicant for or recipient of benefits under the supplemental nutrition assistance program is not entitled to and may not receive or continue to receive any benefit under the program if the applicant or recipient is not legally present in the United States.

Amendment No. 16 was adopted. (Alonzo, Alvarado, Castro, Deshotel, Dukes, Lozano, Marquez, Martinez Fischer, McClendon, Muñoz, Thompson, Turner, and Vo recorded voting no.)

Amendment No. 17

Representatives Christian and Coleman offered the following amendment to **CSSB 7**:

Amend **CSSB 7** by adding appropriately numbered SECTIONS to read as follows and renumbering the remaining SECTIONS accordingly.

SECTION ____. INTERIM STUDY OF INDEPENDENT PRESCRIPTIVE AUTHORITY FOR ADVANCED PRACTICE REGISTERED NURSES. (a) The speaker of the house and the lieutenant governor shall create and appoint a joint interim committee composed of a combination of legislators, state officials and citizen members to conduct a joint study as described by Subsection (b).

(b) The study shall examine the independent authority of advanced practice registered nurses to diagnose and prescribe drugs and medical devices within the scope of the health care providers' practice and license, including:

(1) the impact on access to health care services for underserved communities and health professional shortage areas;

(2) any projected impact on patient safety and the quality of care for persons treated by advanced practice registered nurses;

(3) the effect on the state's overall health care system; and

(4) the potential cost savings and other foreseeable consequences of expanding the authority in the Nursing Practice Act of advanced practice registered nurses to prescribe medication to patients without statutory requirements for physician delegation or collaboration.

(c) Not later than January 1, 2013, the committees shall report the committees' finding and recommendations to the lieutenant governor, the speaker of the house of representatives, and the governor. The committees shall include in their recommendations specific changes to statutes and agency rules that may be necessary according to the results of the committees' study conducted under this section.

(d) Not later than November 1, 2011, the lieutenant governor and the speaker of the house of representatives shall issue the joint interim charge required by this section.

(e) This section expires January 1, 2013.

SECTION ____. (a) The Institute for Health Policy at the School of Public Health at The University of Texas Health Science Center at Houston shall study, with respect to patients who receive health care services from an advanced practice nurse, as that term is defined in Section 301.152, Occupations Code, patient safety and outcomes, including quality of care, health care costs, access to health care, and any other measures determined by the institute.

(b) Not later than October 15, 2012, the Institute for Health Policy shall report its findings to the governor, the lieutenant governor, the speaker of the house of representatives, the Senate Health and Human Services Committee or its successor, and the House Public Health Committee or its successor and the joint interim committee created and appointed to study independent prescriptive authority for Advanced Practice Registered Nurses.

(c) This section expires September 1, 2013.

Amendment No. 17 was adopted.

Amendment No. 18

Representatives V. Gonzales, Deshotel, Muñoz, and Schwertner offered the following amendment to **CSSB 7**:

Amend **CSSB 7** (house committee printing) by adding the following appropriately numbered ARTICLE to the bill and renumbering subsequent ARTICLES and SECTIONS of the bill accordingly:

ARTICLE ____. COUNTY ELIGIBILITY TO RECEIVE STATE ASSISTANCE FOR HEALTH CARE EXPENDITURES

SECTION ____.01. Section 61.037, Health and Safety Code, is amended by amending Subsections (a) and (b) and adding Subsection (b-1) to read as follows:

(a) The department may distribute funds as provided by this subchapter to eligible counties to assist the counties in providing:

(1) health care services under Sections 61.028 and 61.0285 to their eligible county residents; or

(2) health care services provided by Medicaid as described by Subsection (b)(1).

(b) Except as provided by Subsection (c), (d), (e), or (g), to be eligible for state assistance, a county must:

(1) spend in a state fiscal year at least eight percent of the county general revenue levy for that year to provide health care services described by Subsection (a) to its eligible county residents who qualify for assistance under Section 61.023 and may, subject to Subsection (b-1), include as part of the county's eight percent expenditure level any payment made by the county for health care services provided through Medicaid, including the county's direct reimbursement to health care providers and indirect reimbursement through transfers of funds to the state for health care services provided through Medicaid; and

(2) notify the department, not later than the seventh day after the date on which the county reaches the expenditure level, that the county has spent at least six percent of the applicable county general revenue levy for that year to provide health care services described by Subsection (a)(1) [~~(a)~~] to its eligible county residents who qualify for assistance under Section 61.023 or health care services provided by Medicaid as described by Subdivision (1).

(b-1) A county may not include payment for health care services provided through Medicaid as part of the county's eight percent expenditure level under Subsection (b) for a state fiscal year unless the county spends in that state fiscal year an amount to provide health care services described by Subsection (a)(1) to its eligible county residents who qualify for assistance under Section 61.023 that is at least equal to the lesser of:

(1) the amount the county spent for that purpose in the immediately preceding state fiscal year; or

(2) eight percent of the county general revenue levy in the immediately preceding state fiscal year.

SECTION ____.02. Section 61.038, Health and Safety Code, is amended to read as follows:

Sec. 61.038. DISTRIBUTION OF ASSISTANCE FUNDS. (a) If the department determines that a county is eligible for assistance, the department shall distribute funds appropriated to the department from the indigent health care assistance fund or any other available fund to the county to assist the county in providing:

(1) health care services under Sections 61.028 and 61.0285 to its eligible county residents who qualify for assistance as described by Section 61.037; or

(2) health care services provided through Medicaid as described by Section 61.037(b)(1).

(b) State funds provided under this section to a county must be equal to at least 90 percent of the actual payment for the health care services for the county's eligible residents, including any payments made by the county for health care services provided through Medicaid as described by Section 61.037(b)(1), during the remainder of the state fiscal year after the eight percent expenditure level is reached.

(c) In distributing state funds under this section, the department shall give priority to a county that spends in a state fiscal year at least eight percent of the county general revenue levy for that year to provide health care services described by Section 61.037(a)(1) to its eligible county residents who qualify for assistance under Section 61.023.

Amendment No. 18 was adopted.

Amendment No. 19

Representative Guillen offered the following amendment to **CSSB 7**:

Amend **CSSB 7** (house committee printing) in ARTICLE 1 of the bill by adding the following appropriately numbered SECTION to the ARTICLE and renumbering subsequent SECTIONS of the ARTICLE accordingly:

SECTION 1.____. (a) Subchapter B, Chapter 531, Government Code, is amended by adding Section 531.0525 to read as follows:

Sec. 531.0525. PILOT PROJECT TO ESTABLISH COMPREHENSIVE ACCESS POINT FOR LONG-TERM SERVICES AND SUPPORTS. (a) In this section:

(1) "Aging and disability resource center" means a center established under the Aging and Disability Resource Center initiative funded in part by the federal Administration on Aging and the Centers for Medicare and Medicaid Services.

(2) "Colocated long-term services and supports staff members" means:

(A) long-term services and supports staff members who are located in the same physical office; or

(B) long-term services and supports staff members who are not located in the same physical office but who work collaboratively through the use of the telephone or other technologies.

(3) "Department of Aging and Disability Services staff members" includes community services staff members of the Department of Aging and Disability Services.

(4) "Long-term services and supports" means long-term assistance or care provided to older persons and persons with physical disabilities through the Medicaid program or other programs. The term includes assistance or care provided through the following programs:

(A) the primary home care program;

(B) the community attendant services program;

(C) the community-based alternatives program;

(D) the day activity and health services program;

(E) the promoting independence program;

(F) a program funded through the Older Americans Act of 1965 (42 U.S.C. Section 3001 et seq.);

(G) a community care program funded through Title XX of the federal Social Security Act (42 U.S.C. Section 301 et seq.);

(H) the in-home and family support program; and

(I) a nursing facility program.

(5) "Long-term services and supports staff" means:

(A) one or more of the commission's Medicaid eligibility determination staff members;

(B) one or more Department of Aging and Disability Services staff members; and

(C) one or more area agency on aging staff members.

(6) "Pilot project site" means a location in an area served by the pilot project established under this section where colocated long-term services and supports staff members work collaboratively to provide information and tentatively assess functional and financial eligibility to initiate long-term services and supports.

(7) "Tentative assessment of functional and financial eligibility" means an expedited preliminary screening of an applicant to determine Medicaid eligibility with the goal of initiating services within seven business days. The tentative assessment does not guarantee state payment for services.

(b) Subject to availability of funds appropriated by the legislature for this purpose, the commission shall develop and implement a pilot project to establish a comprehensive access point system for long-term services and supports in which colocated long-term services and supports staff members work in collaboration to provide all necessary services in connection with long-term services and supports from the intake process to the start of service delivery. The pilot project must require that, at a minimum, the staff members work collaboratively to:

(1) inform and educate older persons, persons with physical disabilities, and their family members and other caregivers about long-term services and supports for which they may qualify;

(2) screen older persons and persons with physical disabilities requesting long-term services and supports;

(3) provide a tentative assessment of functional and financial eligibility for older persons and persons with physical disabilities requesting long-term services and supports for which there are no interest lists; and

(4) make final determinations of eligibility for long-term services and supports.

(c) In developing and implementing the pilot project, the commission shall ensure that:

(1) the pilot project site has colocated long-term services and supports staff members who are located in the same physical office;

(2) the pilot project site serves as a comprehensive access point for older persons and persons with physical disabilities to obtain information about long-term services and supports for which they may qualify and access long-term services and supports in the site's service area;

(3) the pilot project site is designed and operated in accordance with best practices adopted by the executive commissioner after the commission reviews best practices for similar initiatives in other states and professional policy-based research describing best practices for successful initiatives;

(4) the colocated long-term services and supports staff members supporting the pilot project site include:

(A) one full-time commission staff member who determines eligibility for the Medicaid program and who:

(i) has full access to the Texas Integrated Eligibility Redesign System (TIERS);

(ii) has previously made Medicaid long-term care eligibility determinations; and

(iii) is dedicated primarily to making eligibility determinations for incoming clients at the site;

(B) sufficient Department of Aging and Disability Services staff members to carry out the tentative functional and financial eligibility and screening functions at the site;

(C) sufficient area agency on aging staff members to:

(i) assist with the performance of screening functions and service coordination for services funded under the Older Americans Act of 1965 (42 U.S.C. Section 3001 et seq.), such as meals programs; and

(ii) identify other locally funded and supported services that will enable older persons and persons with physical disabilities to continue to reside in the community to the extent reasonable; and

(D) any available staff members from local service agencies; and

(5) the colocated long-term services and supports staff members of the pilot project site:

(A) process intakes for long-term services and supports in person or by telephone or through the Internet;

(B) use a standardized screening tool to tentatively assess both functional and financial eligibility with the goal of initiating services within seven business days;

(C) closely coordinate with local hospital discharge planners and staff members of extended rehabilitation units of local hospitals and nursing homes; and

(D) inform persons about community-based services available in the area served by the pilot project.

(d) The pilot project must be implemented in a single county or a multicounty area, as determined by the commission. The pilot project site must be located within an aging and disability resource center service area. If the commission finds that there is no aging and disability resource center that is willing or able to accommodate a pilot project site on the date the pilot project is to be implemented, the pilot project site may be located at another appropriate location.

(e) Not later than January 31, 2013, the commission shall submit a report concerning the pilot project to the presiding officers of the standing committees of the senate and house of representatives having primary jurisdiction over health and human services. The report must:

(1) contain an evaluation of the operation of the pilot project;

(2) contain an evaluation of the pilot project's benefits for persons who received services;

(3) contain a calculation of the costs and cost savings that can be attributed to implementation of the pilot project;

(4) include a recommendation regarding adopting improved policies and procedures concerning long-term services and supports with statewide applicability, as determined from information obtained in operating the pilot project;

(5) include a recommendation regarding the feasibility of expanding the pilot project to other areas of this state or statewide; and

(6) contain the perspectives of service providers participating in the pilot project.

(f) This section expires September 1, 2015.

(b) Not later than December 31, 2011, the Health and Human Services Commission shall ensure that the pilot project site is in operation under the pilot project required by Section 531.0525, Government Code, as added by this section.

Amendment No. 19 was adopted.

(Alvarado in the chair)

Amendment No. 20

Representative Eiland offered the following amendment to **CSSB 7**:

Amend **CSSB 7** (house committee printing) by adding the following appropriately numbered ARTICLE to the bill and renumbering subsequent ARTICLES and SECTIONS of the bill accordingly:

ARTICLE ____. PROVIDER NETWORK CONTRACT ARRANGEMENTS

SECTION ____.001. Subtitle F, Title 8, Insurance Code, is amended by adding Chapter 1458 to read as follows:

CHAPTER 1458. PROVIDER NETWORK CONTRACT ARRANGEMENTS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1458.001. GENERAL DEFINITIONS. In this chapter:

(1) "Affiliate" means a person who, directly or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with another person.

(2) "Contracting entity" means a person who:

(A) enters into a direct contract with a provider for the delivery of health care services to covered individuals; and

(B) in the ordinary course of business establishes a provider network or networks for access by another party.

(3) "Covered individual" means an individual who is covered under a health benefit plan.

(4) "Direct notification" means a written or electronic communication from a contracting entity to a physician or other health care provider documenting third party access to a provider network.

(5) "Health care services" means services provided for the diagnosis, prevention, treatment, or cure of a health condition, illness, injury, or disease.

(6) "Person" has the meaning assigned by Section 823.002.

(7) "Provider" means a physician, a professional association composed solely of physicians, a single legal entity authorized to practice medicine owned by two or more physicians, a nonprofit health corporation certified by the Texas Medical Board under Chapter 162, Occupations Code, a partnership composed solely of physicians, a physician-hospital organization that acts exclusively as an administrator for a provider to facilitate the provider's participation in health care contracts, or an institution that is licensed under Chapter 241, Health and Safety Code. The term does not include a physician-hospital organization that leases or rents the physician-hospital organization's network to a third party.

(8) "Provider network contract" means a contract between a contracting entity and a provider for the delivery of, and payment for, health care services to a covered individual.

(9) "Third party" means a person that contracts with a contracting entity or another party to gain access to a provider network contract.

Sec. 1458.002. DEFINITION OF HEALTH BENEFIT PLAN. (a) In this chapter, "health benefit plan" means:

(1) a hospital and medical expense incurred policy;

(2) a nonprofit health care service plan contract;

(3) a health maintenance organization subscriber contract; or

(4) any other health care plan or arrangement that pays for or furnishes medical or health care services.

(b) "Health benefit plan" does not include one or more or any combination of the following:

(1) coverage only for accident or disability income insurance or any combination of those coverages;

(2) credit-only insurance;

(3) coverage issued as a supplement to liability insurance;

(4) liability insurance, including general liability insurance and automobile liability insurance;

(5) workers' compensation or similar insurance;

(6) a discount health care program, as defined by Section 7001.001;

(7) coverage for on-site medical clinics;

(8) automobile medical payment insurance; or

(9) other similar insurance coverage, as specified by federal regulations issued under the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191), under which benefits for medical care are secondary or incidental to other insurance benefits.

(c) "Health benefit plan" does not include the following benefits if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of the coverage:

(1) dental or vision benefits;

(2) benefits for long-term care, nursing home care, home health care, community-based care, or any combination of these benefits;

(3) other similar, limited benefits, including benefits specified by federal regulations issued under the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191); or

(4) a Medicare supplement benefit plan described by Section 1652.002.

(d) "Health benefit plan" does not include coverage limited to a specified disease or illness or hospital indemnity coverage or other fixed indemnity insurance coverage if:

(1) the coverage is provided under a separate policy, certificate, or contract of insurance;

(2) there is no coordination between the provision of the coverage and any exclusion of benefits under any group health benefit plan maintained by the same plan sponsor; and

(3) the coverage is paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health benefit plan maintained by the same plan sponsor.

Sec. 1458.003. EXEMPTIONS. This chapter does not apply:

(1) to a provider network contract for services provided to a beneficiary under the Medicaid program, the Medicare program, or the state child health plan established under Chapter 62, Health and Safety Code, or the comparable plan under Chapter 63, Health and Safety Code;

(2) under circumstances in which access to the provider network is granted to an entity that operates under the same brand licensee program as the contracting entity; or

(3) to a contract between a contracting entity and a discount health care program operator, as defined by Section 7001.001.

[Sections 1458.004-1458.050 reserved for expansion]

SUBCHAPTER B. REGISTRATION REQUIREMENTS

Sec. 1458.051. REGISTRATION REQUIRED. (a) Unless the person holds a certificate of authority issued by the department to engage in the business of insurance in this state or operate a health maintenance organization under Chapter 843, a person must register with the department not later than the 30th day after the date on which the person begins acting as a contracting entity in this state.

(b) Notwithstanding Subsection (a), under Section 1458.055 a contracting entity that holds a certificate of authority issued by the department to engage in the business of insurance in this state or is a health maintenance organization shall file with the commissioner an application for exemption from registration under which the affiliates may access the contracting entity's network.

(c) An application for an exemption filed under Subsection (b) must be accompanied by a list of the contracting entity's affiliates. The contracting entity shall update the list with the commissioner on an annual basis.

(d) A list of affiliates filed with the commissioner under Subsection (c) is public information and is not exempt from disclosure under Chapter 552, Government Code.

Sec. 1458.052. DISCLOSURE OF INFORMATION. (a) A person required to register under Section 1458.051 must disclose:

(1) all names used by the contracting entity, including any name under which the contracting entity intends to engage or has engaged in business in this state;

(2) the mailing address and main telephone number of the contracting entity's headquarters;

(3) the name and telephone number of the contracting entity's primary contact for the department; and

(4) any other information required by the commissioner by rule.

(b) The disclosure made under Subsection (a) must include a description or a copy of the applicant's basic organizational structure documents and a copy of organizational charts and lists that show:

(1) the relationships between the contracting entity and any affiliates of the contracting entity, including subsidiary networks or other networks; and

(2) the internal organizational structure of the contracting entity's management.

Sec. 1458.053. SUBMISSION OF INFORMATION. Information required under this subchapter must be submitted in a written or electronic format adopted by the commissioner by rule.

Sec. 1458.054. FEES. The department may collect a reasonable fee set by the commissioner as necessary to administer the registration process. Fees collected under this chapter shall be deposited in the Texas Department of Insurance operating fund.

Sec. 1458.055. EXEMPTION FOR AFFILIATES. (a) The commissioner shall grant an exemption for affiliates of a contracting entity if the contracting entity holds a certificate of authority issued by the department to engage in the business of insurance in this state or is a health maintenance organization if the commissioner determines that:

(1) the affiliate is not subject to a disclaimer of affiliation under Chapter 823; and

(2) the relationships between the person who holds a certificate of authority and all affiliates of the person, including subsidiary networks or other networks, are disclosed and clearly defined.

(b) An exemption granted under this section applies only to registration. An entity granted an exemption is otherwise subject to this chapter.

(c) The commissioner shall establish a reasonable fee as necessary to administer the exemption process.

[Sections 1458.056-1458.100 reserved for expansion]

SUBCHAPTER C. RIGHTS AND RESPONSIBILITIES OF A CONTRACTING ENTITY

Sec. 1458.101. CONTRACT REQUIREMENTS. A contracting entity may not provide a person access to health care services or contractual discounts under a provider network contract unless the provider network contract specifically states that:

(1) the contracting entity may contract with a third party to provide access to the contracting entity's rights and responsibilities under a provider network contract; and

(2) the third party must comply with all applicable terms, limitations, and conditions of the provider network contract.

Sec. 1458.102. DUTIES OF CONTRACTING ENTITY. (a) A contracting entity that has granted access to health care services and contractual discounts under a provider network contract shall:

(1) notify each provider of the identity of, and contact information for, each third party that has or may obtain access to the provider's health care services and contractual discounts;

(2) provide each third party with sufficient information regarding the provider network contract to enable the third party to comply with all relevant terms, limitations, and conditions of the provider network contract;

(3) require each third party to disclose the identity of the contracting entity and the existence of a provider network contract on each remittance advice or explanation of payment form; and

(4) notify each third party of the termination of the provider network contract not later than the 30th day after the effective date of the contract termination.

(b) If a contracting entity knows that a third party is making claims under a terminated contract, the contracting entity must take reasonable steps to cause the third party to cease making claims under the provider network contract. If the

steps taken by the contracting entity are unsuccessful and the third party continues to make claims under the terminated provider network contract, the contracting entity must:

(1) terminate the contracting entity's contract with the third party; or

(2) notify the commissioner, if termination of the contract is not feasible.

(c) Any notice provided by a contracting entity to a third party under Subsection (b) must include a statement regarding the third party's potential liability under this chapter for using a provider's contractual discount for services provided after the termination date of the provider network contract.

(d) The notice required under Subsection (a)(1):

(1) must be provided by:

(A) providing for a subscription to receive the notice by e-mail; or

(B) posting the information on an Internet website at least once each calendar quarter; and

(2) must include a separate prominent section that lists:

(A) each third party that the contracting entity knows will have access to a discounted fee of the provider in the succeeding calendar quarter; and

(B) the effective date and termination or renewal dates, if any, of the third party's contract to access the network.

(e) The e-mail notice described by Subsection (d) may contain a link to an Internet web page that contains a list of third parties that complies with this section.

(f) The notice described by Subsection (a)(1) is not required to include information regarding payors who are not insurers or health maintenance organizations.

Sec. 1458.103. EFFECT OF CONTRACT TERMINATION. Subject to continuity of care requirements, agreements, or contractual provisions:

(1) a third party may not access health care services and contractual discounts after the date the provider network contract terminates;

(2) claims for health care services performed after the termination date may not be processed or paid under the provider network contract after the termination; and

(3) claims for health care services performed before the termination date and processed after the termination date may be processed and paid under the provider network contract after the date of termination.

Sec. 1458.104. AVAILABILITY OF CODING GUIDELINES. (a) A contract between a contracting entity and a provider must provide that:

(1) the provider may request a description and copy of the coding guidelines, including any underlying bundling, recoding, or other payment process and fee schedules applicable to specific procedures that the provider will receive under the contract;

(2) the contracting entity or the contracting entity's agent will provide the coding guidelines and fee schedules not later than the 30th day after the date the contracting entity receives the request;

(3) the contracting entity or the contracting entity's agent will provide notice of changes to the coding guidelines and fee schedules that will result in a change of payment to the provider not later than the 90th day before the date the changes take effect and will not make retroactive revisions to the coding guidelines and fee schedules; and

(4) if the requested information indicates a reduction in payment to the provider from the amounts agreed to on the effective date of the contract, the contract may be terminated by the provider on written notice to the contracting entity on or before the 30th day after the date the provider receives information requested under this subsection without penalty or discrimination in participation in other health care products or plans.

(b) A provider who receives information under Subsection (a) may only:

(1) use or disclose the information for the purpose of practice management, billing activities, and other business operations; and

(2) disclose the information to a governmental agency involved in the regulation of health care or insurance.

(c) The contracting entity shall, on request of the provider, provide the name, edition, and model version of the software that the contracting entity uses to determine bundling and unbundling of claims.

(d) The provisions of this section may not be waived, voided, or nullified by contract.

(e) If a contracting entity is unable to provide the information described by Subsection (a)(1), (a)(3), or (c), the contracting entity shall by telephone provide a readily available medium in which providers may obtain the information, which may include an Internet website.

[Sections 1458.105-1458.150 reserved for expansion]

SUBCHAPTER D. RIGHTS AND RESPONSIBILITIES OF THIRD PARTY

Sec. 1458.151. THIRD-PARTY RIGHTS AND RESPONSIBILITIES. A third party that leases, sells, aggregates, assigns, or otherwise conveys a provider's contractual discount to another party, who is not a covered individual, must comply with the responsibilities of a contracting entity under Subchapters C and E.

Sec. 1458.152. DISCLOSURE BY THIRD PARTY. (a) A third party shall disclose, to the contracting entity and providers under the provider network contract, the identity of a person, who is not a covered individual, to whom the third party leases, sells, aggregates, assigns, or otherwise conveys a provider's contractual discount through an electronic notification that complies with Section 1458.102 and includes a link to the Internet website described by Section 1458.102(d).

(b) A third party that uses an Internet website under this section must update the website on a quarterly basis. On request, a contracting entity shall disclose the information by telephone or through direct notification.

[Sections 1458.153-1458.200 reserved for expansion]

SUBCHAPTER E. UNAUTHORIZED ACCESS TO PROVIDER NETWORK CONTRACTS

Sec. 1458.201. UNAUTHORIZED ACCESS TO OR USE OF DISCOUNT. (a) A person who knowingly accesses or uses a provider's contractual discount under a provider network contract without a contractual relationship established under this chapter commits an unfair or deceptive act in the business of insurance that violates Subchapter B, Chapter 541. The remedies available for a violation of Subchapter B, Chapter 541, under this subsection do not include a private cause of action under Subchapter D, Chapter 541, or a class action under Subchapter F, Chapter 541.

(b) A contracting entity or third party must comply with the disclosure requirements under Sections 1458.102 and 1458.152 concerning the services listed on a remittance advice or explanation of payment. A provider may refuse a discount taken without a contract under this chapter or in violation of those sections.

(c) Notwithstanding Subsection (b), an error in the remittance advice or explanation of payment may be corrected by a contracting entity or third party not later than the 30th day after the date the provider notifies in writing the contracting entity or third party of the error.

Sec. 1458.202. ACCESS TO THIRD PARTY. A contracting entity may not provide a third party access to a provider network contract unless the third party is:

(1) a payor or person who administers or processes claims on behalf of the payor;

(2) a preferred provider benefit plan issuer or preferred provider network, including a physician-hospital organization; or

(3) a person who transports claims electronically between the contracting entity and the payor and does not provide access to the provider's services and discounts to any other third party.

[Sections 1458.203-1458.250 reserved for expansion]

SUBCHAPTER F. ENFORCEMENT

Sec. 1458.251. UNFAIR CLAIM SETTLEMENT PRACTICE. (a) A contracting entity that violates this chapter commits an unfair claim settlement practice under Subchapter A, Chapter 542, and is subject to sanctions under that subchapter as if the contracting entity were an insurer.

(b) A provider who is adversely affected by a violation of this chapter may make a complaint under Subchapter A, Chapter 542.

Sec. 1458.252. REMEDIES NOT EXCLUSIVE. The remedies provided by this subchapter are in addition to any other defense, remedy, or procedure provided by law, including common law.

SECTION ____.002. The change in law made by this article applies only to a provider network contract entered into or renewed on or after January 1, 2012. A provider network contract entered into or renewed before January 1, 2012, is governed by the law as it existed immediately before the effective date of this Act, and that law is continued in effect for that purpose.

Amendment No. 20 was adopted.

Amendment No. 21

Representative Chisum offered the following amendment to **CSSB 7**:

Amend **CSSB 7** (house committee report) by adding the following appropriately numbered ARTICLE to the bill and renumbering subsequent ARTICLES and SECTIONS of the bill accordingly:

ARTICLE ____. COVERED SERVICES OF CERTAIN HEALTH CARE PRACTITIONERS

SECTION ____.01. Section 1451.109, Insurance Code, is amended to read as follows:

Sec. 1451.109. SELECTION OF CHIROPRACTOR. (a) An insured may select a chiropractor to provide the medical or surgical services or procedures scheduled in the health insurance policy that are within the scope of the chiropractor's license.

(b) If physical modalities and procedures are covered services under a health insurance policy and within the scope of the license of a chiropractor and one or more other type of practitioner, a health insurance policy issuer may not:

(1) deny payment or reimbursement for physical modalities and procedures provided by a chiropractor if:

(A) the chiropractor provides the modalities and procedures in strict compliance with laws and rules relating to a chiropractor's license; and

(B) the health insurance policy issuer allows payment or reimbursement for the same physical modalities and procedures performed by another type of practitioner;

(2) make payment or reimbursement for particular covered physical modalities and procedures within the scope of a chiropractor's practice contingent on treatment or examination by a practitioner that is not a chiropractor; or

(3) establish other limitations on the provision of covered physical modalities and procedures that would prohibit an insured from seeking the covered physical modalities and procedures from a chiropractor to the same extent that the insured may obtain covered physical modalities and procedures from another type of practitioner.

(c) Nothing in this section requires a health insurance policy issuer to cover particular services or affects the ability of a health insurance policy issuer to determine whether specific procedures for which payment or reimbursement is requested are medically necessary.

(d) This section does not apply to:

(1) workers' compensation insurance coverage as defined by Section 401.011, Labor Code;

(2) a self-insured employee welfare benefit plan subject to the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.);

(3) the child health plan program under Chapter 62, Health and Safety Code, or the health benefits plan for children under Chapter 63, Health and Safety Code; or

(4) a Medicaid managed care program operated under Chapter 533, Government Code, or a Medicaid program operated under Chapter 32, Human Resources Code.

SECTION ____.02. The changes in law made by this article to Section 1451.109, Insurance Code, apply only to a health insurance policy that is delivered, issued for delivery, or renewed on or after the effective date of this Act. A policy delivered, issued for delivery, or renewed before the effective date of this Act is governed by the law as it existed immediately before the effective date of this Act, and that law is continued in effect for that purpose.

Amendment No. 22

Representative Schwertner offered the following amendment to Amendment No. 21:

Amend Amendment No. 21 by Chisum to **CSSB 7** (house committee printing) as follows:

(1) In added Section 1451.109(b)(1)(A), Insurance Code (page 1, lines 19 and 20), strike "laws and rules relating to a chiropractor's license" and substitute "state law".

(2) In added Section 1451.109(b)(1)(B), Insurance Code (page 1, line 23), between "practitioner" and the semicolon, insert "that an insured may select under this subchapter".

(3) In added Section 1451.109(b)(2), Insurance Code (page 1, line 26), strike "practice" and substitute "license".

Amendment No. 22 was adopted.

Amendment No. 21, as amended, was adopted.

Amendment No. 23

Representative Hardcastle offered the following amendment to **CSSB 7**:

Amend **CSSB 7** (house committee printing) by adding the following appropriately numbered ARTICLE to the bill and renumbering subsequent ARTICLES and SECTIONS accordingly:

ARTICLE ____. AUTOLOGOUS STEM CELL BANK FOR RECIPIENTS OF BLOOD AND TISSUE COMPONENTS WHO ARE THE LIVE HUMAN DONORS OF THE ADULT STEM CELLS

Section ____.01. Title 12, Health and Safety Code, is amended by adding Chapter 1003 to read as follows:

CHAPTER 1003. AUTOLOGOUS STEM CELL BANK FOR RECIPIENTS OF BLOOD AND TISSUE COMPONENTS WHO ARE THE LIVE HUMAN DONORS OF THE ADULT STEM CELLS.

Sec. 1003.001. ESTABLISHMENT OF ADULT STEM CELL BANK. (a) If the executive commissioner of the Health and Human Services Commission determines that it will be cost-effective and increase the efficiency or quality of health care, health and human service, and health benefits programs in this state, the executive commissioner by rule shall establish eligibility criteria for the creation and operation of an autologous adult stem cell bank.

(b) In adopting the rules under Subsection (a), the executive commissioner shall consider:

(1) the ability of the applicant to establish, operate, and maintain an autologous adult stem cell bank and to provide related services; and

(2) the demonstrated experience of the applicant in operating similar facilities in this state.

(c) This section does not affect the application of or apply to Chapter 162.

Amendment No. 23 - Point of Order

Representative Thompson raised a point of order against further consideration of Amendment No. 23 under Rule 11, Section 2 of the House Rules on the grounds that the amendment is not germane to the bill.

The point of order was withdrawn.

Amendment No. 24

Representative Thompson offered the following amendment to Amendment No. 23:

Amend Amendment No. 23 by Hardcastle to **CSSB 7** (house committee printing) in the chapter added by the amendment by adding the following appropriately numbered section:

Sec. ____. PURPOSE; APPLICABILITY. (a) An autologous adult stem cell bank created under this chapter operates solely for the purpose of storing and maintaining autologous adult stem cells.

(b) This chapter does not apply to a facility, entity, person, or institution that:

(1) extracts autologous cells or autologous adult stem cells;

(2) conducts research on autologous cells or autologous stem cells;

(3) provides educational instruction related to autologous cells or autologous adults stem cells at an institution of higher education; or

(4) performs therapeutic treatments involving the use of autologous cells or autologous adult stem cells.

Amendment No. 24 was adopted.

Amendment No. 23, as amended, was adopted.

Amendment No. 25

Representative Jackson offered the following amendment to **CSSB 7**:

Amend **CSSB 7** (house committee printing) by adding the following appropriately numbered ARTICLE to the bill and renumbering subsequent ARTICLES and SECTIONS accordingly:

ARTICLE ____. FORMATION OF BUSINESS ORGANIZATIONS BY CERTAIN HEALTH CARE PROFESSIONALS

SECTION ____.01. Subtitle A, Title 3, Occupations Code, is amended by adding Chapter 115 to read as follows:

CHAPTER 115. PROFESSIONAL COLLABORATION OF PHYSICIANS AND CHIROPRACTORS

Sec. 115.001. PURPOSE; CONSTRUCTION OF CHAPTER. (a) The purpose of this chapter is to:

(1) reduce barriers to a free market for health care by increasing efficiency and professional collaboration for the purpose of improving patient care and lowering costs; and

(2) authorize physicians and chiropractors to use certain business organizations to efficiently collaborate in the delivery of health care.

(b) This chapter may not be construed to modify the scope of practice of a health care professional or to allow one type of health care professional to directly or indirectly control the performance of another type of health care professional's practice.

Sec. 115.002. BUSINESS ORGANIZATIONS AUTHORIZED. (a) A person licensed under Subtitle B and a person licensed under Chapter 201 may form a partnership, professional association, or professional limited liability company according to the requirements of this section and any other applicable law.

(b) If a person licensed under Chapter 201 forms a professional entity with a person licensed under Subtitle B, as authorized by this section, the authority of each practitioner is limited by that practitioner's scope of practice. A practitioner may not exercise control over the other practitioner's clinical authority granted by the practitioner's license, including control over a treatment decision by the other practitioner through an agreement, bylaw, directive, financial incentive, or other arrangement.

(c) The Texas Medical Board and the Texas Board of Chiropractic Examiners continue to exercise each board's respective regulatory authority over license holders.

(d) A person licensed under Subtitle B who forms a professional entity under this section shall report the formation of the entity and any material change in an agreement, bylaw, directive, financial incentive, or other arrangement related to the operation of the entity to the Texas Medical Board not later than the 30th day after the date the entity is formed or the material change is made.

Amendment No. 25 - Point of Order

Representative Schwertner raised a point of order against further consideration of Amendment No. 25 under Rule 11, Section 2 of the House Rules on the grounds that the amendment is not germane to the bill.

The chair overruled the point of order.

Amendment No. 25 was adopted.

Amendment No. 26

Representative Alonzo offered the following amendment to **CSSB 7**:

Amend **CSSB 7** (house committee printing) in ARTICLE 1 of the bill by adding the following appropriately numbered SECTION to that article and renumbering subsequent SECTIONS of the article accordingly:

SECTION 1.____. Section 61.033, Health and Safety Code, is amended by adding Subsection (c) to read as follows:

(c) In accordance with Subsection (a), if an eligible resident receives health care services from a county other than the county in which the resident resides, the county in which the resident resides is liable for those costs. This subsection applies only to a county seeking state assistance money under this chapter.

Amendment No. 26 was adopted.

Amendment No. 27

Representative Christian offered the following amendment to **CSSB 7**:

Amend **CSSB 7** (house committee printing) by adding the following appropriately numbered ARTICLE to the bill and renumbering subsequent ARTICLES and SECTIONS of the bill accordingly:

ARTICLE ____. STATE FUNDING FOR CERTAIN MEDICAL PROCEDURES

SECTION ____.01. The heading to Subchapter M, Chapter 285, Health and Safety Code, is amended to read as follows:

SUBCHAPTER M. REGULATION [~~PROVISION~~] OF SERVICES

SECTION ____.02. Subchapter M, Chapter 285, Health and Safety Code, is amended by adding Section 285.202 to read as follows:

Sec. 285.202. USE OF TAX REVENUE FOR ABORTIONS; EXCEPTION FOR MEDICAL EMERGENCY. (a) In this section, "medical emergency" means a condition exists that, in a physician's good faith clinical judgment, complicates the medical condition of the pregnant woman and necessitates the immediate abortion of her pregnancy to avert her death or to avoid a serious risk of substantial impairment of a major bodily function.

(b) Except in the case of a medical emergency, a hospital district created under general or special law that uses tax revenue of the district to finance the performance of an abortion may not receive state funding.

(c) A physician who performs an abortion in a medical emergency at a hospital or other health care facility owned or operated by a hospital district that receives state funds shall:

(1) include in the patient's medical records a statement signed by the physician certifying the nature of the medical emergency; and

(2) not later than the 30th day after the date the abortion is performed, certify to the Department of State Health Services the specific medical condition that constituted the emergency.

(d) The statement required under Subsection (c)(1) shall be placed in the patient's medical records and shall be kept by the hospital or other health care facility where the abortion is performed until:

(1) the seventh anniversary of the date the abortion is performed; or

(2) if the pregnant woman is a minor, the later of:

(A) the seventh anniversary of the date the abortion is performed; or

(B) the woman's 21st birthday.

(e) A hospital district created by general or special law that receives state funding may not:

(1) make a charitable donation or financial contribution from tax revenue of the district to an organization, agency, or entity that provides or refers for abortion or abortion-related services; or

(2) contract or affiliate with other organizations, agencies, or entities that provide or refer for abortion or abortion related services.

Amendment No. 27 - Point of Order

Representative D. Howard raised a point of order against further consideration of Amendment No. 27 under Rule 11, Section 2 of the House Rules on the grounds that the amendment is not germane to the bill.

(L. Taylor in the chair)

The chair overruled the point of order.

Amendment No. 27 - Point of Order

Representative Naishtat raised a point of order against further consideration of Amendment No. 27 under Rule 8, Section 3 of the House Rules on the grounds that the amendment violates the one subject rule.

The chair overruled the point of order.

Amendment No. 27 was adopted by (Record 12): 100 Yeas, 37 Nays, 2 Present, not voting.

Yeas — Aliseda; Anderson, C.; Anderson, R.; Aycock; Beck; Berman; Bohac; Bonnen; Branch; Brown; Burkett; Button; Cain; Callegari; Carter; Chisum; Christian; Cook; Craddick; Crownover; Darby; Davis, J.; Davis, S.; Driver; Eissler; Elkins; Fletcher; Flynn; Frullo; Garza; Geren; Gonzales, L.; Gooden; Guillen; Hamilton; Hancock; Hardcastle; Harless; Harper-Brown; Hartnett; Hopson; Howard, C.; Huberty; Hughes; Hunter; Isaac; Jackson; Keffer; King, P.; King, S.; King, T.; Kleinschmidt; Kolkhorst; Kuempel; Landtroop; Larson; Laubenberg; Lavender; Legler; Lewis; Lozano; Lyne; Madden; Margo; Martinez; Miller, D.; Miller, S.; Morrison; Muñoz; Murphy; Nash; Orr; Otto; Parker; Patrick; Paxton; Peña; Perry; Phillips; Pickett; Pitts; Price; Riddle; Ritter; Schwertner; Scott; Sheets; Sheffield; Shelton; Simpson; Smith, T.; Smith, W.; Solomons; Taylor, V.; Torres; Weber; White; Workman; Zedler; Zerwas.

Nays — Allen; Alonzo; Alvarado; Anchia; Burnam; Davis, Y.; Deshotel; Dukes; Dutton; Eiland; Farrar; Giddings; Gonzales, V.; Gonzalez; Gutierrez; Hernandez Luna; Hochberg; Howard, D.; Johnson; Lucio; Mallory Caraway; Marquez; Martinez Fischer; McClendon; Miles; Naishtat; Oliveira; Quintanilla; Raymond; Reynolds; Rodriguez; Strama; Thompson; Turner; Veasey; Villarreal; Vo.

Present, not voting — Mr. Speaker; Taylor, L.(C).

Absent, Excused — Castro; Creighton; Gallego; Hilderbran; Smithee; Truitt; Woolley.

Absent — Coleman; Farias; Menendez; Walle.

(Castro now present)

Amendment No. 28

Representative Lucio offered the following amendment to **CSSB 7**:

Amend **CSSB 7** (house committee printing) in SECTION 1.12 of the bill (page 38, line 1, through page 59, line 22) by adding the following appropriately lettered subsection to the SECTION and relettering subsequent subsections of the SECTION accordingly:

(____)(1) In converting the hospital reimbursement systems used under the medical assistance program under Chapter 32, Human Resources Code, to the diagnosis-related groups (DRG) methodology to the extent possible as required by Section 536.005, Government Code, as added by this section, and in any rebasing of the hospital reimbursement rates using a methodology based on a statewide standard dollar amount (SDA), the executive commissioner of the Health and Human Services Commission shall adopt reasonable reimbursement rate maximums and may adopt reasonable reimbursement rate minimums for the state fiscal biennium ending August 31, 2013, that ensure that:

(A) each hospital in this state that participates in the medical assistance program, other than a hospital that received a reimbursement rate in the state fiscal year ending August 31, 2011, that exceeds the rate maximum adopted by the executive commissioner under this subsection for the state fiscal biennium ending August 31, 2013, does not experience a decrease of more than 10 percent in the highest reimbursement rate received by the hospital during the state fiscal year ending August 31, 2011; and

(B) hospital reimbursement rates are sufficient to encourage enough hospitals to participate in the medical assistance program to ensure that services are available to recipients under the program at least to the extent those services are available to the general public.

(2) Notwithstanding Subdivision (1)(A) of this subsection, the executive commissioner of the Health and Human Services Commission may adopt reimbursement rates that result in a decrease in rates that exceeds the limitation prescribed by that provision if the commission determines that those rates are necessary to provide services within the amounts appropriated in the General Appropriations Act and other appropriations acts.

Amendment No. 29

Representative Zerwas offered the following amendment to Amendment No. 28:

Amend Amendment No. 28 to **CSSB 7** by Lucio as follows:

(1) Strike page 1, lines 16 through page 2, line 1 and substitute the following:

that include for the state fiscal year ending August 31, 2012 a transition rate that limits to eight percent, for hospitals in this state that participate in the medical assistance program, any loss resulting from rebasing hospital reimbursement rates using a methodology based on a SDA.

(2) On page 2, line 2, strike "Subdivision (1)(A)" and substitute "Subdivision (1)".

Amendment No. 29 was adopted.

Amendment No. 28, as amended, was adopted.

(Speaker in the chair)

CSSB 7, as amended, was passed to third reading by (Record 13): 91 Yeas, 47 Nays, 1 Present, not voting.

Yeas — Aliseda; Anderson, C.; Anderson, R.; Aycock; Beck; Berman; Bohac; Bonnen; Branch; Brown; Burkett; Button; Cain; Callegari; Carter; Chisum; Christian; Cook; Craddick; Crownover; Darby; Davis, J.; Davis, S.; Driver; Eiland; Eissler; Elkins; Fletcher; Flynn; Frullo; Geren; Gonzales, L.; Gooden; Hamilton; Hancock; Hardcastle; Harless; Harper-Brown; Hopson; Howard, C.; Huberty; Hughes; Hunter; Isaac; Jackson; Keffer; King, P.; King, S.; Kleinschmidt; Kolkhorst; Kuempel; Landtroop; Larson; Laubenberg; Legler; Lewis; Lyne; Madden; Margo; Miller, D.; Miller, S.; Morrison; Murphy; Nash; Orr; Otto; Parker; Patrick; Paxton; Perry; Phillips; Pitts; Price; Riddle; Ritter; Schwertner; Scott; Sheets; Sheffield; Shelton; Smith, T.; Smith, W.; Solomons; Taylor, L.; Taylor, V.; Torres; Weber; White; Workman; Zedler; Zerwas.

Nays — Allen; Alonzo; Alvarado; Anchia; Burnam; Castro; Davis, Y.; Deshotel; Dukes; Dutton; Farias; Farrar; Giddings; Gonzales, V.; Gonzalez; Guillen; Gutierrez; Hochberg; Howard, D.; Johnson; King, T.; Lavender; Lozano; Lucio; Mallory Caraway; Marquez; Martinez; Martinez Fischer; McClendon; Menendez; Miles; Muñoz; Naishtat; Oliveira; Peña; Pickett; Quintanilla; Raymond; Reynolds; Rodriguez; Simpson; Strama; Thompson; Turner; Veasey; Villarreal; Vo.

Present, not voting — Mr. Speaker(C).

Absent, Excused — Creighton; Gallego; Hilderbran; Smithee; Truitt; Woolley.

Absent — Coleman; Garza; Hartnett; Hernandez Luna; Walle.

ADJOURNMENT

Representative Otto moved that the house adjourn until 10 a.m. tomorrow.

The motion prevailed.

The house accordingly, at 4:47 p.m., adjourned until 10 a.m. tomorrow.

ADDENDUM

REFERRED TO COMMITTEES

The following bills and joint resolutions were today laid before the house, read first time, and referred to committees, and the following resolutions were today laid before the house and referred to committees. If indicated, the chair today corrected the referral of the following measures:

List No. 1

HCR 12 (By Dutton), Congratulating country-pop superstar Kenny Rogers on his achievements.

To Rules and Resolutions.

HR 11 (By Alonzo), Congratulating Julian Rodriguez on being named the 2011 valedictorian of Adamson High School in Dallas.

To Rules and Resolutions.

HR 12 (By Alonzo), Congratulating Adan Gonzalez on being named the 2011 salutatorian of Adamson High School in Dallas.

To Rules and Resolutions.

HR 13 (By Alonzo), Congratulating Kevin Prado on being named the 2011 valedictorian of Molina High School in Dallas.

To Rules and Resolutions.

HR 14 (By Alonzo), Congratulating Leticia Gallegos on being named the 2011 salutatorian of Molina High School in Dallas.

To Rules and Resolutions.

HR 15 (By Alonzo), Congratulating Gustavo Castillo on being named the 2011 valedictorian of Trini Garza Early College High School in Dallas.

To Rules and Resolutions.

HR 16 (By Alonzo), Congratulating Jocelyn Velasquez on being named the 2011 salutatorian of Trini Garza Early College High School in Dallas.

To Rules and Resolutions.

HR 17 (By Alonzo), Congratulating Xochitl Escobar on being named valedictorian of Sunset High School in Dallas.

To Rules and Resolutions.

HR 18 (By Alonzo), Congratulating Veronica Flores on being named salutatorian of Sunset High School in Dallas.

To Rules and Resolutions.

HR 19 (By Alonzo), Congratulating Kathy T. Do on being named the 2011 valedictorian of Grand Prairie High School.

To Rules and Resolutions.

HR 20 (By Alonzo), Congratulating Juan C. Cerda on being named the 2011 Salutatorian of Grand Prairie High School.

To Rules and Resolutions.

HR 21 (By Alonzo), Congratulating Rosa Walker on her induction into the Texas AFL-CIO Hall of Fame.

To Rules and Resolutions.

HR 22 (By Sheffield), Congratulating Ervin and Janice Schwindt of Belton on their 50th wedding anniversary.

To Rules and Resolutions.

HR 23 (By Sheffield), Congratulating Dr. Vernon D. Holleman and Shirley Holleman of Temple on their 50th wedding anniversary.

To Rules and Resolutions.

HR 24 (By Sheffield), Honoring Roy and Eloisa Donoso of Temple on their 50th wedding anniversary.

To Rules and Resolutions.

HR 25 (By Sheffield), Honoring Carl and Patsy Feller of Salado on their 60th wedding anniversary.

To Rules and Resolutions.

HR 26 (By Huberty), Congratulating Matthew Simpson of Huffman on being named valedictorian of the Class of 2011 at Hargrave High School.

To Rules and Resolutions.

HR 27 (By Huberty), Congratulating Paige Alan Sullivan on her graduation from Kingwood High School.

To Rules and Resolutions.

HR 28 (By Workman), Congratulating Lake Travis High School basketball coach Jan Jernberg on his retirement.

To Rules and Resolutions.

HR 29 (By Patrick), In memory of Ronald Gene Howell of Arlington.

To Rules and Resolutions.

HR 30 (By Y. Davis), Recognizing the Best Southwest Partnership on the occasion of the 25th anniversary of its incorporation.

To Rules and Resolutions.

HR 31 (By Paxton), Congratulating Burks Elementary School in McKinney on earning recognition as a Healthy Zone School.

To Rules and Resolutions.

HR 32 (By L. Gonzales), Congratulating Patti Jurena Wiggs of Round Rock on her retirement as a teacher at Park Crest Middle School in Pflugerville.

To Rules and Resolutions.

HR 33 (By Torres), Congratulating R. E. "Bob" Parker on his induction into the Corpus Christi Business Hall of Fame.

To Rules and Resolutions.

HR 34 (By Torres), Congratulating the marketing and community relations department of Driscoll Children's Hospital in Corpus Christi on winning three 2011 Aster Awards.

To Rules and Resolutions.

HR 35 (By Torres), Congratulating the Destination ImagiNation teams from Baker Middle School in Corpus Christi for advancing to the 2011 Destination ImagiNation Global Finals.

To Rules and Resolutions.

HR 36 (By Torres), Congratulating David Richter on his induction into the Corpus Christi Business Hall of Fame.

To Rules and Resolutions.

HR 37 (By Torres), Congratulating Dr. Robert R. Furgason on his induction into the Corpus Christi Business Hall of Fame.

To Rules and Resolutions.

HR 38 (By Torres), Congratulating Elizabeth Chu Richter on her induction into the Corpus Christi Business Hall of Fame.

To Rules and Resolutions.

HR 39 (By Dutton), Congratulating Gertrude Jack Lewis of Houston on the occasion of her 100th birthday.

To Rules and Resolutions.

HR 40 (By Cain), Congratulating Second Lieutenant Jermaine Dewayne Wright of Sulphur Springs on his graduation from the United States Military Academy at West Point.

To Rules and Resolutions.

HR 42 (By Guillen), In memory of Eladio Carrera of Rio Grande City.

To Rules and Resolutions.

HR 43 (By Guillen), Congratulating Homero Juan Salmon on his retirement as constable of Starr County Precinct 4.

To Rules and Resolutions.

HR 44 (By Dutton), Commemorating EXPO 2011, hosted by the Houston Minority Supplier Development Council.

To Rules and Resolutions.

HR 45 (By Guillen), Commending the Honorable John A. Pope III of McAllen for his distinguished work in the legal profession.

To Rules and Resolutions.

HR 46 (By Guillen), Honoring Lino Canales, Jr., for his contributions to the community as founder of the Starr County Town Crier.

To Rules and Resolutions.

HR 47 (By Guillen), In memory of Nidia Ann Leal.

To Rules and Resolutions.

HR 48 (By Guillen), Honoring Immaculate Conception Church in Rio Grande City for its service to the community.

To Rules and Resolutions.

APPENDIX

STANDING COMMITTEE REPORTS

Favorable reports have been filed by committees as follows:

June 7

Public Education - **HB 6**

State Sovereignty, Select - **HB 5**