BILL ANALYSIS

Senate Research Center

S.B. 1838
By: Duncan
Finance
5/4/2001
As Filed

DIGEST AND PURPOSE

Currently, the nursing home industry is experiencing various crises in this state. As proposed, S.B. 1838 provides certain solutions in addressing these problems within the nursing home industry.

RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to the commissioner of insurance in SECTIONS 4.01 (Article 5.132, Insurance Code) and 4.02, to the Health and Human Services Commission in SECTIONS 7.02 (Section 531.058, Government Code), 9.01 (Section 242.855, Health and Safety Code), to the commissioner of health and human services in SECTION 7.04.

SECTION BY SECTION ANALYSIS

SECTION 1.01. Authorizes this Act to be cited as the Long-Term Care Facility Improvement Act.

SECTION 1.02. Sets forth legislative purpose.

ARTICLE 2. EXEMPLARY DAMAGES IN CERTAIN ACTIONS

SECTION 2.01. Amends Chapter 41, Civil Practices and Remedies Code, by adding Subchapter B, as follows:

SUBCHAPTER B. NURSING INSTITUTIONS

Sec. 41.051. DEFINITIONS. Defines "insurer" and "nursing institution."

Sec. 41.052. INSURER LIABILITY FOR EXEMPLARY DAMAGES IN CERTAIN CLAIMS. (a) Sets forth provisions regarding insurer liability for exemplary damages in certain claims.

(b) Provides that this section does not affect the contractual duties imposed under an insurance policy.

(c) Provides that this section does not prohibit a nursing institution from purchasing a policy to cover exemplary damages.

Sec. 41.053. NOTIFICATION OF AWARD OF EXEMPLARY DAMAGES. Sets forth provisions regarding notification of award of exemplary damages.

SECTION 2.02. Amends Chapter 242B, Health and Safety Code, by adding Section 242.051, as follows:

Sec. 242.051. INSPECTION OR SURVEY AFTER CERTAIN DAMAGE AWARDS. Requires the Texas Department of Human Services (department), under certain situations, to

conduct an inspection or survey of the institution after certain damage awards.

SECTION 2.03. Makes application of this Act prospective.

ARTICLE 3. ADMISSIBILITY OF CERTAIN EVIDENCE IN CIVIL ACTION

SECTION 3.01. Amends Section 32.021(i) and (k), Human Resources Code, as follows:

(i) Authorizes a record of the department, including a record of a department survey, complaint investigation, incident investigation, or survey report, that relates to an institution, including an intermediate care facility for the mentally retarded, to be introduced into evidence in certain proceedings if the record is admissible under the Texas Rules of Evidence. Deletes text regarding documents. Deletes text regarding state Medicaid program. Makes a conforming change.

(k) Authorizes a department surveyor or investigator to testify in a civil action under certain criteria if the testimony is admissible under the Texas Rules of Evidence. Makes conforming changes.

SECTION 3.02. Amends Chapter 242B, Health and Safety Code, by adding Section 242.050, as follows:

Sec. 242.050. ADMISSIBILITY OF CERTAIN DOCUMENTS OR TESTIMONY. Provides that Sections 32.021(i) and (k), Human Resources Code, govern the admissibility in a civil action against an institution of certain items.

SECTION 3.03. Amends Chapter 252B, Health and Safety Code, by adding Section 252.045, to make a conforming change.

SECTION 3.04. Repealer: Section 32.021(j) (relating to certain civil actions), Human Resources Code.

SECTION 3.05. Makes application of this Act prospective.

ARTICLE 4. RATE ROLLBACK FOR CERTAIN LIABILITY INSURANCE COVERAGE

SECTION 4.01. Amends Chapter 5O, Insurance Code, by adding Article 5.132, to read as follows:

Art. 5.132. TEMPORARY RATE ROLLBACKS FOR CERTAIN LIABILITY INSURANCE

Sec. 1. PURPOSE OF ARTICLE. Sets forth legislative purpose.

Sec. 2. APPLICABILITY OF ARTICLE. Set forth provisions regarding the applicability of the article.

Sec. 3. RATE ROLLBACK. (a) Requires the commissioner of insurance (commissioner), notwithstanding Chapter 40 of this code, on or before September 1 of each year, to hold a rulemaking hearing under Chapter 2001, Government Code, to perform certain actions.

(b) Requires the rate reduction adopted under this section to be based on the evidence presented at the hearing required by Subsection (a) of this section. Requires the rates resulting from the rate reductions adopted under this section to be reasonable, adequate, not unfairly discriminatory, and not excessive.

(c) Provides that a rate reduction adopted under this section applies only to a policy delivered, issued for delivery, or renewed on or after the 90th day after the date the rule establishing the rate reduction is adopted.

(d) Provides that any rule or order of the commissioner that determines, approves, or sets a rate reduction under this section that is appealed or challenged remains in effect during the pendency of the appeal or challenge. Requires an insurer, during the pendency of the appeal or challenge, to use the rate reduction provided in the order being appealed or challenged, and provides that the rate reduction is lawful and valid during the period of the appeal or challenge.

Sec. 4. ADMINISTRATIVE RELIEF. (a) Requires a rate filed for policies described by Section 2 of this article after the adoption of a rate reduction under Section 3 of this article, except as provided by Subsection (b) of this section, to reflect the rate reduction. Requires the commissioner to disapprove a rate, subject to the procedures established by Section 7, Article 5.13-2 of this code, if the commissioner finds that the filed rate does not reflect that reduction.

(b) Provides that the commissioner is not required to disapprove a filed rate that reflects less than the full amount of the rate reduction imposed under Section 3 of this article if certain conditions exist.

Sec. 5. DECLARATION OF INAPPLICABILITY TO CERTAIN POLICIES. Requires the commissioner by order to declare this article inapplicable to insurance policies otherwise subject to this article at the time the commissioner finds, based on actuarially credible data, that rates for those policies reflect the actual experience for those policies under the legislation described by Section 1 of this article.

Sec. 6. DURATION OF REDUCTIONS. Provides that unless the commissioner grants an exemption under Section 4 or 5 of this article, each rate resulting from the reduction required under Section 3 of this article remains in effect until the first anniversary of the date the rate becomes effective.

Sec. 7. MODIFICATION. Authorizes the commissioner by bulletin or directive to, based on the evidence accumulated by the commissioner before the bulletin or directive is issued, modify a rate reduction adopted under this article if a final, unappealable judgment of a court with appropriate jurisdiction stays the effect of, enjoins, or otherwise modifies or declares unconstitutional any of the legislation described by Section 1 of this article on which the commissioner based the rate reduction.

Sec. 8. HEARINGS AND ORDERS. Requires that notwithstanding Chapter 40 of this code, a rulemaking hearing under this article be held before the commissioner or the commissioner's designee. Provides that the rulemaking procedures established by this section do not apply to any other rate promulgation proceeding.

Sec. 9. INSURER DATA REPORTING. (a) Requires each insurer that writes professional liability insurance policies for nursing institutions licensed under Chapter 242 (Convalescent and Nursing Homes and Related Institutions), Health and Safety Code, including an insurer whose rates are not regulated, to, as a condition of writing those policies in this state, comply with a request for information from the commissioner under this section.

(b) Authorizes the commissioner to require information in rate filings, special data calls, informational hearings, and any other means consistent with this code applicable to the affected insurer that the commissioner believes will allow the commissioner to perform certain procedures.

(c) Provides that information provided under this section is privileged and confidential to the same extent as the information is privileged and confidential under this code or any other law governing an insurer described by Subsection (a) of this section. Provides that the information remains privileged and confidential unless and until introduced into evidence at an administrative hearing or in a court of competent jurisdiction.

Sec. 10. RECOMMENDATIONS TO LEGISLATURE. Requires the commissioner to assemble information, conduct hearings, and take other appropriate measures to assess and evaluate changes in the marketplace resulting from the implementation of this article and to report the commissioner's findings and recommendations to the legislature.

Sec. 11. EXPIRATION. Provides that this article expires January 1, 2006. Provides that a rate resulting from a reduction adopted by the commissioner under Section 3 of this article in 2005 remains in effect until the first anniversary of the date the rate becomes effective.

SECTION 4.02. (a) Requires the commissioner of insurance by rule, notwithstanding Section 3(a), Article 5.132, Insurance Code, as added by this article, on or before October 1, 2001, to adopt an appropriate rate reduction for insurance policies described by Section 2 of that article. Requires the rate reduction adopted under this subsection to be developed without consideration of the effect of the legislation described by Section 1, Article 5.132, Insurance Code, as added by this article.

(b) Provides that notwithstanding Subsection (a) of this section, if the commissioner of insurance has not adopted rate reductions required by that subsection before January 1, 2002, a 20 percent rate reduction, measured from the base rates in effect on April 1, 2001, applies to each policy described by Section 2, Article 5.132, Insurance Code, as added by this article, which is delivered, issued for delivery, or renewed on or after January 1, 2002.

(c) Provides that a rate filed under an order of the commissioner of insurance issued before May 1, 2001, is not subject to the rate reduction required by this article before January 1, 2002.

ARTICLE 5. AVAILABILITY OF CERTAIN INSURANCE COVERAGE

SECTION 5.01. Amends Section 2(2), Article 5.15-1, Insurance Code, to define "health care provider."

SECTION 5.02. Amends Section 8, Article 5.15-1, Insurance Code, to add for-profit nursing homes to the provision of this section concerning punitive damages under medical professional liability insurance.

SECTION 5.03. Amends Article 5.15-1, Insurance Code, by adding Section 11, as follows:

Sec. 11. REQUIRED PROVISION FOR CERTAIN PROFESSIONAL LIABILITY POLICIES. Requires a professional liability insurance policy issued to a for-profit or not-for-profit nursing home to provide that the insurer may not settle a claim that the insurer has a duty under the policy to defend without the consent of the insured nursing home.

SECTION 5.04. Amends Chapter 5B, Insurance Code, by adding Article 5.15-4, as follows:

Art. 5.15-4. BEST PRACTICES FOR NURSING HOMES. (a) Requires the commissioner to adopt best practices for risk management and loss control that may be used by for-profit and not-for-profit nursing homes.

(b) Authorizes an insurance company or the Texas Medical Liability Insurance

Underwriting Association, in determining rates for professional liability insurance applicable to a for-profit or not-for-profit nursing home, to consider whether the nursing home adopts and implements the best practices adopted by the commissioner under Subsection (a) of this article.

(c) Requires the commissioner, in developing or amending best practices for-profit and not-for-profit nursing homes, to consult with the Health and Human Services Commission and a task force appointed by the commissioner. Requires the task force to be composed of certain representatives.

SECTION 5.05. Amends Section 2(6), Article 21.49-3, Insurance Code, to define "health care provider."

SECTION 5.06. Amends Article 21.49-3(3A), Insurance Code, by adding Subsection (c) to provide that a for-profit or not-for-profit nursing home not otherwise eligible under this section for coverage from the association is eligible for coverage if the nursing home demonstrates, in accordance with the requirements of the association, that the nursing home made a bona fide effort to obtain coverage from authorized insurers and eligible surplus lines insurers and was unable to obtain coverage.

SECTION 5.07. Amends Article 21.49-3(4B(1)), Insurance Code, (1), to provide that for purposes of this article, rates, rating plans, rating rules, rating classifications, territories, and policy forms for-profit nursing homes are subject to the requirements of Article 5.15-1 of this code to the same extent as not-for-profit nursing homes. Makes a conforming change.

SECTION 5.08. Amends Article 21.49-3(4A), Insurance Code, to read as follows:

Sec. 4A. POLICYHOLDER'S STABILIZATION RESERVE FUND. (c) Deletes "policyholder's" from the title of the reserve fund.

(d) Requires collections of the stabilization reserve fund charge, except as provided by Subsection (e) of this section, to continue only until such time as the net balance of the stabilization reserve fund is not less than the projected sum of premiums to be written in the year following valuation date.

(e) Authorizes the commissioner, if in any fiscal year the incurred losses and defense and cost-containment expenses from physicians or any single category of health care provider result in a net underwriting loss and exceed 25 percent of the stabilization reserve fund, as valued for that year, to by order direct the initiation or continuation of the stabilization reserve fund charge for physicians or that category of health care provider until the fund recovers the amount by which those losses and cost-containment expenses exceed 25 percent of the fund.

(f) Requires the stabilization reserve fund to be credited with all stabilization reserve fund charges collected from policyholders and to be charged with any deficit from the prior year's operation of the association.

SECTION 5.09. Amends Chapter 21E, Insurance Code, by adding Article 21.49-3d, to read as follows:

Art. 21.49-3d. REVENUE BOND PROGRAM AND PROCEDURES FOR CERTAIN LIABILITY INSURANCE

Sec. 1. LEGISLATIVE FINDING; PURPOSE. Sets forth provisions regarding legislative finding and purpose.

Sec. 2. DEFINITION. Defines “association,” “bond resolution,” “board,” and “insurer.”

Sec. 3. BONDS AUTHORIZED; APPLICATION OF TEXAS PUBLIC FINANCE AUTHORITY ACT. Requires the Texas Public Finance Authority to issue revenue bonds to meet certain criteria. Provides that Chapter 1232, Government Code, applies to bonds issued under this article.

Sec. 4. APPLICABILITY OF OTHER STATUTES. Provides that certain laws apply to bonds issued under this article to the extent consistent with this article.

Sec. 5. LIMITS. Authorizes the Texas Public Finance Authority to issue, on behalf of the association, bonds in a total amount not to exceed $75 million.

Sec. 6. CONDITIONS. (a) Authorizes bonds to be issued at public or private sale.

(b) Requires bonds to mature not more than 10 years after the date issued.

(c) Requires bonds to be issued in the name of the association.

Sec. 7. ADDITIONAL COVENANTS. Authorizes the board, in a bond resolution, to make additional covenants with respect to the bonds and the designated income and receipts of the association pledged to their payment and to provide for the flow of funds and the establishment, maintenance, and investment of funds and accounts with respect to the bonds.

Sec. 8. SPECIAL ACCOUNTS. (a) Authorizes a bond resolution to establish special accounts, including an interest and sinking fund account, reserve account, and other accounts.

(b) Requires the association to administer the accounts in accordance with Article 21.49-3 of this code.

Sec. 9. SECURITY. (a) Provides that bonds are payable only from the maintenance tax surcharge established in Section 10 of this article or other sources the fund is authorized to levy, charge, and collect in connection with paying any portion of the bonds.

(b) Provides that bonds are obligations solely of the association. Provides that bonds do not create a pledging, giving, or lending of the faith, credit, or taxing authority of this state.

(c) Requires each bond to include a statement that the state is not obligated to pay any amount on the bond and that the faith, credit, and taxing authority of this state are not pledged, given, or lent to those payments.

(d) Requires each bond issued under this article to state on its face that the bond is payable solely from the revenues pledged for that purpose and that the bond does not and may not constitute a legal or moral obligation of the state.

Sec. 10. MAINTENANCE TAX SURCHARGE. (a) Provides that a maintenance tax surcharge is assessed against certain entities.

(b) Requires the maintenance tax surcharge to be set in an amount sufficient to pay all debt service on the bonds. Provides that the maintenance tax surcharge is set by the commissioner in the same time and is required to be collected by the comptroller on behalf of the association in the same manner as applicable maintenance taxes are collected under Article 5.24 of this code.

(c) Requires the department, on determining the rate of assessment, to increase the maintenance tax rate applicable to correctly reported gross premiums for liability insurance to a rate sufficient to pay all debt service on the bonds, subject to the maximum maintenance tax rate applicable to the insurer under Article 5.24 of this code. Authorizes the department, if the resulting tax rate is insufficient to pay all debt service on the bonds, to assess an additional surcharge not to exceed one percent of correctly reported gross premiums for liability insurance to cover all debt service on the bonds. Provides that in this code, the maintenance tax surcharge includes the additional maintenance tax assessed under this subsection and the surcharge assessed under this subsection to pay all debt service of the bonds.

(d) Authorizes the association and each insurer to pass through the maintenance tax surcharge to each of its policyholders.

(e) Provides that as a condition of engaging in the business of insurance in this state, an insurer agrees that if the company leaves the market for liability insurance in this state the insurer remains obligated to pay, until the bonds are retired, the insurer's share of the maintenance tax surcharge assessed under this section in an amount proportionate to that insurer's share of the market for liability insurance in this state as of the last complete reporting period before the date on which the insurer ceases to engage in that insurance business in this state. Requires the proportion assessed against the insurer to be based on the insurer's gross premiums for liability insurance for the insurer's last reporting period. Provides that however, an insurer is not required to pay the proportionate amount in any year in which the surcharge assessed against insurers continuing to write liability insurance in this state is sufficient to service the bond obligation.

Sec. 11. TAX EXEMPT. Provides that the bonds issued under this article, and any interest from the bonds, and all assets pledged to secure the payment of the bonds are free from taxation by the state or a political subdivision of this state.

Sec. 12. AUTHORIZED INVESTMENTS. Provides that the bonds issued under this article constitute authorized investments under Article 2.10 and Subpart A, Part I, Article 3.39 of this code.

Sec. 13. STATE PLEDGE. Provides that the state pledges to and agrees with the owners of any bonds issued in accordance with this article that the state will not limit or alter the rights vested in the association to fulfill the terms of any agreements made with the owners of the bonds or in any way impair the rights and remedies of those owners until the bonds, any premium or interest, and all costs and expenses in connection with any action or proceeding by or on behalf of those owners are fully met and discharged. Authorizes the association to include this pledge and agreement of the state in any agreement with the owners of the bonds.

Sec. 14. ENFORCEMENT BY MANDAMUS. Provides that a writ of mandamus and all other legal and equitable remedies are available to any party at interest to require the association and any other party to carry out agreements and to perform functions and duties under this article, the Texas Constitution, or a bond resolution.

SECTION 5.10. Requires the commissioner of insurance, not later than December 1, 2001, to adopt the initial best practices for-profit and not-for-profit nursing homes adopted as required by Article 5.15-4, Insurance Code, as added by this article.

SECTION 5.11. Provides that Section 11, Article 5.15-1, Insurance Code, as added by this article, and Sections 2, 3A, and 4, Article 21.49-3, Insurance Code, as amended by this article, apply only to an insurance policy delivered, issued for delivery, or renewed on or after January 1, 2002. Provides

that a policy delivered, issued for delivery, or renewed before January 1, 2002, 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.

ARTICLE 6. MANDATORY LIABILITY INSURANCE FOR NURSING INSTITUTIONS

SECTION 6.01. Amends Chapter 242B, Health and Safety Code, by adding Section 242.0372, as follows:

Sec. 242.0372. LIABILITY INSURANCE COVERAGE. (a) Provides that in this section, "health care liability claim" has the meaning assigned by the Medical Liability and Insurance Improvement Act of Texas (Article 4590i, V.T.C.S.).

(b) Requires an institution, to hold a license under this chapter, to maintain professional liability insurance coverage against the liability of the institution for a health care liability claim.

(c) Requires the insurance coverage maintained by an institution under this section to meet certain criteria.

(d) Provides that to the extent permitted by federal law and applicable state and federal rules, the cost of insurance coverage required to be maintained under this section is an allowable cost for reimbursement under the state Medicaid program.

SECTION 6.02. Provides that notwithstanding Section 242.0372, Health and Safety Code, as added by this article, an institution licensed under Chapter 242, Health and Safety Code, is not required to maintain professional liability insurance as required by that section before September 1, 2003.

ARTICLE 7. SURVEYS AND RELATED PROCESSES

SECTION 7.01. Amends Chapter 22, Human Resources Code, by adding Section 22.037, to read as follows:

Sec. 22.037. TRAINING AND CONTINUING EDUCATION RELATED TO CERTAIN LONG-TERM CARE FACILITIES. (a) Defines “long-term facility,” “provider,” and “surveyor.”

(b) Requires the department to require a surveyor to complete a basic training program before the surveyor inspects, surveys, or investigates a long-term care facility. Requires the training to include observation of the operations of a long-term care facility unrelated to the survey, inspection, or investigation process for a minimum of 10 working days within a 14-day period.

(c) Requires the department to semiannually provide training for surveyors and providers on subjects that address at least one of the 10 most common violations by long-term care facilities under federal or state law.

(d) Requires a surveyor who is a health care professional licensed under the laws of this state, except as provided by Subsection (e), to receive a minimum of 50 percent of the professional's required continuing education credits, if any, in gerontology or care for individuals with cognitive or physical disabilities, as appropriate.

(e) Requires a surveyor who is a pharmacist to receive a minimum of 30 percent of the pharmacist's required continuing education credits in gerontology or care for individuals

with cognitive or physical disabilities, as appropriate.

SECTION 7.02. Amends Chapter 531B, Government Code, by adding Sections 531.056, 531.057, and 531.058, to read as follows:

Sec. 531.056. REVIEW OF SURVEY PROCESS IN CERTAIN INSTITUTIONS AND FACILITIES. (a) Requires the Health and Human Services Commission (commission) to adopt procedures to review certain criteria.

(b) Requires the commission to annually report to the speaker of the house of representatives, the lieutenant governor, and the governor on the findings of the review conducted under Subsection (a).

Sec. 531.057. QUALITY ASSURANCE EARLY WARNING SYSTEM FOR LONG-TERM CARE FACILITIES; RAPID RESPONSE TEAMS. (a) Defines "long-term care facility" and "quality-of-care monitor."

(b) Requires the commission to establish an early warning system to detect conditions that could be detrimental to the health, safety, and welfare of residents. Requires the early warning system to include analysis of financial and quality-of-care indicators that would predict the need for the commission to take action.

(c) Requires the commission to establish regional offices with one or more quality-of-care monitors, based on the number of long-term care facilities in the region, to monitor the facilities in the region on a regular, unannounced, aperiodic basis, including nights, evenings, weekends, and holidays.

(d) Requires priority for monitoring visits to be given to long-term care facilities with a history of patient care deficiencies.

(e) Prohibits quality-of-care monitors from being deployed by the commission as a part of the regional survey team in the conduct of routine, scheduled surveys.

(f) Requires quality-of-care monitors to assess certain criteria.

(g) Requires the quality-of-care monitor to include certain items in an assessment visit.

(h) Requires the identity of a resident or a family member of a resident interviewed by a quality-of-care monitor as provided by Subsection (g)(2) to remain confidential and to be prohibited from being disclosed to any person under any other provision of this section.

(i) Requires the findings of a monitoring visit, both positive and negative, to be provided orally and in writing to the long-term care facility administrator or, in the absence of the facility administrator, to the administrator on duty or the director of nursing.

(j) Authorizes the quality-of-care monitor to recommend to the long-term care facility administrator procedural and policy changes and staff training to improve the care or quality of life of facility residents.

(k) Requires conditions observed by the quality-of-care monitor that create an immediate threat to the health or safety of a resident to be reported immediately to the regional office supervisor for appropriate action and, as appropriate or as required by law, to law enforcement, adult protective services, or other responsible agencies.

(l) Prohibits any record, whether written or oral, or any written or oral communication, except as provided by Subsections (m), (n), and (o), from being subject to discovery or introduction into evidence in any civil or administrative action against a long-term care facility arising out of matters that are the subject of quality-of-care monitoring, and a person who was in attendance at a monitoring visit or evaluation is prohibited from being permitted or required to testify in any civil or administrative action as to any evidence or other matters produced or presented during the monitoring visits or evaluations.

(m) Provides that information, documents, or records otherwise available from other sources are not immune from discovery or use in a civil or administrative action solely because the information, document, or record was reviewed in connection with quality-of-care monitoring.

(n) Prohibits a person who participates in quality-of-care monitoring visits or evaluations from being prevented from testifying as to matters within the person's knowledge, but is prohibited from being asked about the person's participation in the activities.

(o) Provides that the exclusion from discovery or introduction of evidence under this section in any civil or administrative action does not apply when the quality-of-care monitor makes a report to the appropriate authorities regarding a threat to the health or safety of a resident.

(p) Requires the commission to create rapid response teams composed of health care experts that can visit long-term care facilities identified through the commission's early warning system.

(q) Authorizes rapid response teams to visit long-term care facilities that request the commission's assistance.

(r) Prohibits the rapid response teams from being deployed for the purpose of helping a long-term care facility prepare for a regular inspection or survey conducted under Chapter 242, 247 (Assisted Living Facilities), or 252 (Intermediate Care Facilities), Health and Safety Code, or in accordance with Chapter 32 (Medical Assistance Program), Human Resources Code.

Sec. 531.058. INFORMAL DISPUTE RESOLUTION FOR CERTAIN LONG-TERM CARE FACILITIES. (a) Requires the commission by rule to establish an informal dispute resolution process in accordance with this section. Requires the process to provide for adjudication by an appropriate disinterested person of disputes relating to a proposed enforcement action or related proceeding of the Texas Department of Human Services under Section 32.021(d), Human Resources Code, or Chapter 242, 247, or 252, Health and Safety Code. Requires the informal dispute resolution process to require certain criteria to be met.

(b) Requires the commission to adopt rules to adjudicate claims in contested cases.

(c) Prohibits the commission from delegating its responsibility to administer the informal dispute resolution process established by this section to another state agency.

SECTION 7.03. Amends Section 32.021(d), Human Resources Code, to require the department to include in its contracts for the delivery of medical assistance by nursing facilities provisions for monetary penalties to be assessed for violations as required by 42 U.S.C. Section 1396r, including without limitation the Omnibus Budget Reconciliation Act (OBRA), P.L. 100-203, Nursing Home Reform

Amendments of 1987, provided that the department is required to meet certain criteria.

SECTION 7.04. Requires the commissioner of health and human services, not later than January 1, 2002, to adopt any rules necessary to implement Sections 531.056, 531.057, and 531.058, Government Code, as added by this Act.

SECTION 7.05. Requires the Texas Department of Human Services, not later than January 1, 2002, to develop training necessary to implement Section 22.037, Human Resources Code, as added by this Act.

SECTION 7.06. Provides that for the transfer of certain property, records, rules, and forms from the Texas Department of Human Services to the Health and Human Services Commission, effective January 1, 2002.

ARTICLE 8. AMELIORATION OF VIOLATIONS

SECTION 8.01. Amends Section 242.071, Health and Safety Code, as follows:

Sec. 242.071. AMELIORATION OF VIOLATION. (a) Authorizes the commissioner, in lieu of demanding, rather than ordering, payment of an administrative penalty assessed under Section 242.066, rather than 242.069, in accordance with this section, to allow, rather than require, the person to use, under the supervision of the department, any portion of the penalty to ameliorate the violation or to improve services, other than administrative services, in the institution affected by the violation.

(b) Requires the department to offer amelioration to a person for a charged violation if the department determines that the violation does not constitute immediate jeopardy to the health and safety of an institution resident.

(c) Prohibits the department from offering amelioration to a person if certain conditions exist.

(d) Requires the department to offer amelioration to a person under this section not later than the 10th day after the date the person receives from the department a final notification of assessment of administrative penalty that is sent to the person after an informal dispute resolution process but before an administrative hearing under Section 242.068.

(e) Requires a person to whom amelioration has been offered to file a plan for amelioration not later than the 45th day after the date the person receives the offer of amelioration from the department. Requires the person, in submitting the plan, to agree to waive the person's right to an administrative hearing under Section 242.068 if the department approves the plan.

(f) Requires a plan for amelioration, at a minimum, to meet certain criteria.

(g) Authorizes the department to require that an amelioration plan propose changes that would result in conditions that exceed the requirements of this chapter or the rules adopted under this chapter.

(h) Requires the department to approve or deny an amelioration plan not later than the 45th day after the date the department receives the plan. Requires the department, on approval of a person's plan, to deny a pending request for a hearing submitted by the person under Section 242.067(d).

(i) Prohibits the department from offering amelioration to certain persons.

(j) Provides that in this section, "immediate jeopardy to health and safety" means a situation in which there is a high probability that serious harm or injury to a resident could occur at any time or already has occurred and may occur again if the resident is not protected from the harm or if the threat is not removed.

SECTION 8.02. Amends Section 252.071, Health and Safety Code, as follows:

(a) Makes conforming changes.

(b) Requires the department to offer amelioration to a person for a charged violation if the department determines that the violation does not constitute immediate jeopardy to the health and safety of a facility resident.

(c) Prohibits the department from offering amelioration to a person if the department determines that the charged violation constitutes immediate jeopardy to the health and safety of a facility resident.

(d) Requires the department to offer amelioration to a person under this section not later than the 10th day after the date the person receives from the department a final notification of assessment of administrative penalty that is sent to the person after an informal dispute resolution process but before an administrative hearing under Section 252.067.

(e) Requires a person to whom amelioration has been offered to file a plan for amelioration not later than the 45th day after the date the person receives the offer of amelioration from the department. Requires the person, in submitting the plan, to agree to waive the person's right to an administrative hearing under Section 252.067 if the department approves the plan.

(f) Makes conforming changes.

(g) Makes a conforming change.

(h) Requires the department to approve or deny an amelioration plan not later than the 45th day after the date the department receives the plan. Requires the department, on approval of a person's plan, to deny a pending request for a hearing submitted by the person under Section 252.066(b).

(i) Makes a conforming change.

(j) Makes a conforming change.

SECTION 8.03. Makes application of this Act prospective.

ARTICLE 9. QUALITY ASSURANCE FEE

SECTION 9.01. Amends Chapter 242, Health and Safety Code, by adding Subchapter Q, as follows:

SUBCHAPTER Q. QUALITY ASSURANCE FEE

Sec. 242.851. DEFINITION. Defines “gross receipts.”

Sec. 242.852. COMPUTING QUALITY ASSURANCE FEE. (a) Requires a quality

assurance fee to be imposed on each institution for which a license fee to be paid under Section 242.034. Sets forth provisions regarding the fee.

(b) Requires the Health and Human Services Commission or the department at the direction of the commission to set the quality assurance fee for each day in the amount necessary to produce annual revenues equal to six percent of the total annual gross receipts for institutions in this state. Provides that the fee is subject to a prospective adjustment as necessary.

(c) Requires the amount of the quality assurance fee to be determined using patient days and gross receipts reported to the department and covering a period of at least six months.

(d) Provides that the quality assurance fee is an allowable cost for reimbursement under the state Medicaid program.

Sec. 242.853. PATIENT DAYS. Requires an institution, for each calendar day, to determine the number of patient days by meeting certain criteria.

Sec. 242.854. REPORTING AND COLLECTION. (a) Requires the Health and Human Services Commission or the department at the direction of the commission to collect the fee.

(b) Requires each institution to meet certain criteria.

Sec. 242.855. RULES; ADMINISTRATIVE PENALTY. (a) Requires the Health and Human Services Commission to adopt rules for the administration of this subchapter, including rules related to the imposition and collection of the quality assurance fee.

(b) Prohibits the Health and Human Services Commission from adopting rules granting any exceptions from the quality assurance fee.

(c) Prohibits an administrative penalty assessed under this subchapter in accordance with Section 242.066 from exceeding one-half of the amount of the outstanding quality assurance fee or $20,000, whichever is greater.

Sec. 242.856. QUALITY ASSURANCE FUND. (a) Provides that the quality assurance fund is a fund outside the state treasury held by the Texas Treasury Safekeeping Trust Company. Requires the comptroller, notwithstanding any other law, to deposit fees collected under this subchapter to the credit of the fund.

(b) Provides that the fund is composed of certain monies.

(c) Provides that money deposited to the fund remains the property of the fund and may be used only for the purposes of this subchapter.

(d) Provides that subject to legislative appropriation, quality assurance fees collected under this chapter, combined with federal matching funds, will support or maintain an increase in Medicaid reimbursement for institutions.

Sec. 242.857. REIMBURSEMENT OF INSTITUTIONS. (a) Requires the Health and Human Services Commission to use money in the quality assurance fund, together with any federal money available to match that money, for certain purposes.

(b) Requires the Health and Human Services Commission or the department at the direction of the commission to devise the formula by which amounts received under this

section increase the reimbursement rates paid to institutions under the state Medicaid program.

Sec. 242.858. INVALIDITY; FEDERAL FUNDS. Requires the commission, if any portion of this subchapter is held invalid by a final order of a court that is not subject to appeal, or if the Health and Human Services Commission determines that the imposition of the fee and the expenditure as prescribed by this subchapter of amounts collected will not entitle the state to receive additional federal funds under the Medicaid program, to stop collection of the quality assurance fee and to return, not later than the 30th day after the date collection is stopped, any money collected, but not spent, under this subchapter to the institutions that paid the fees in proportion to the total amount paid by those institutions.

Sec. 242.859. LEGISLATIVE REVIEW; EXPIRATION. Requires the 79th Legislature to review the operation and effectiveness of this subchapter. Provides that unless continued in effect by the 79th Legislature, this subchapter expires effective September 1, 2005.

SECTION 9.02. Provides that notwithstanding Section 242.852, Health and Safety Code, as added by this article, the quality assurance fee imposed under Subchapter Q, Chapter 242, Health and Safety Code, as added by this article, that is effective for the first month following the effective date of this Act is equal to $5.25 multiplied by the number of patient days as determined under that subchapter. Provides that the quality assurance fee established under this section remains in effect until the Health and Human Services Commission, or the Texas Department of Human Services at the direction of the commission, obtains the information necessary to set the fee under Section 242.852, Health and Safety Code, as added by this Act.

SECTION 9.03. Requires the Health and Human Services Commission to adopt rules as necessary to implement Subchapter Q, Chapter 242, Health and Safety Code, as added by this Act.

SECTION 9.04. Requires the agency affected by the provision, if before implementing any provision of this article a state agency determines a waiver or authorization from a federal agency is necessary for implementation of that provision, to request the waiver or authorization and may delay implementing that provision until the waiver or authorization is granted.

ARTICLE 10. TEXAS DEPARTMENT OF INSURANCE STUDY AND REPORT

SECTION 10.01. DEFINITIONS. Defines “commissioner” and “department.”

SECTION 10.02. STUDY. Requires the Texas Department of Insurance (department) to study the implementation of Articles 2, 3, 4, 5, and 6 of this Act and, in particular, to study certain other information.

SECTION 10.03. REPORTS. (a) Requires the commissioner, not later than December 1, 2002, to submit an interim report on the study conducted under Section 10.02 of this Act to the governor, lieutenant governor, and speaker of the house of representatives.

(b) Requires the commissioner, not later than December 1, 2004, to submit a final report on the study to the governor, lieutenant governor, and speaker of the house of representatives. Requires the final report to include a recommendation as to whether the changes in law made by Articles 5 and 6 of this Act should be repealed, continued, or modified.

SECTION 10.04. EXPIRATION. Provides that this article expires September 1, 2005.

ARTICLE 11. EFFECTIVE DATE

SECTION 11.01. Effective date: upon passage or September 1, 2001.