HOUSE RESEARCH ORGANIZATION • TEXAS HOUSE OF REPRESENTATIVES
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HOUSE RESEARCH ORGANIZATION

daily floor report

Saturday, May 23, 2015
84th Legislature, Number 77
The House convenes at 10:30 a.m.
Part One

Eighteen bills are on the daily calendar for second-reading consideration today. The bills analyzed or digested in Part One of today's *Daily Floor Report* are listed on the following page.

Alma Allen
Chairman
84(R) - 77

HOUSE RESEARCH ORGANIZATION

Daily Floor Report
Saturday, May 23, 2015
84th Legislature, Number 77
Part 1

SUBJECT: Implementing Sunset recommendations for DADS

COMMITTEE: Human Services — committee substitute recommended

VOTE: 5 ayes — Raymond, Rose, Keough, Klick, Price

3 nays — S. King, Naishtat, Peña

1 absent — Spitzer

SENATE VOTE: On final passage, April 13 — 26-5 (Fraser, Garcia, Kolkhorst, Nichols, Watson)

WITNESSES: (*On House companion bill, HB 2699*)
For — Ellen Bauman, Michelle Dooley, Cindi Paschall, and Joe Tate, Community Now; Chase Bearden and Dennis Borel, Coalition of Texans with Disabilities; Melanie Boyte, ADAPT; John Davidson, Texas Public Policy Foundation; (*Registered, but did not testify*: Nora Belcher, Texas e-Health Alliance; Ricky Broussard, the Arc of Texas; Ashley Butler, Julian Cordova, Jomel Crayton, Andy Noser, and Gwen Noser, Texas Advocates; Cate Carroll, Volunteers of America Texas; Troy Carter, Adult Day Care Association of Texas; Amanda Fredriksen, AARP; Allen Freeze, Gulf Coast Self-Advocates; Charlie Jurek, SALSA; Marissa Machado, Texas Association for Home Care and Hospice; Maxcine Tomlinson, Texas New Mexico Hospice Organization; Sarah Watkins, Community Now; Linda Litzinger)

Against — Susan Payne, PART; and 11 individuals; (*Registered, but did not testify*: Debra Coleman and David Veith, Texas State Employees Union; Jason Smith, Abilene Chamber of Commerce; and six individuals)

On — Kevin Barker, Texana Center; Christopher Edding, Bob Kafka, Jennifer McPhail, Heiwa Salovitz, Burrell Steele, ADAPT; Jeffrey Engelke, PACSTX; Rachel Hammon, Texas Association for Home Care and Hospice; Gary Hidalgo, the Arc of Texas; Colleen Horton, Hogg Foundation for Mental Health; Erin Lawler, Texas Council of Community Centers; Ken Levine and Amy Trost, Sunset Advisory Commission;

Diana Martinez, Texas Assisted Living Association; Jeff Miller, Disability Rights Texas; Kendal Nelson, Sagora Senior Living; Nelson Peet, ADAPT/PACT; Scott Schalchlin and Jon Weizenbaum, Department of Aging and Disability Services; Albert Metz; (*Registered, but did not testify*: Cathy Cranston, Personal Attendant Coalition of Texas; Kyle Janek, Health and Human Services Commission; Alyse Meyer, LeadingAge Texas; Lee Spiller, Citizens Commission on Human Rights; Kevin Warren, Texas Health Care Association; Loretta White, ADAPT)

BACKGROUND: The Department of Aging and Disability Services (DADS) manages the state's long-term care services for Texans with disabilities and the elderly. DADS also regulates providers serving these populations in facilities or home settings. The agency was created in 2003 through the consolidation of the Department of Human Services and Department on Aging, as well as certain programs from the Department of Health, Texas Rehabilitation Commission, and the Texas Department of Mental Health and Mental Retardation.

DADS operations are overseen by a commissioner who is appointed by the executive commissioner of the Health and Human Services Commission (HHSC). The commissioner receives assistance from a nine-member council appointed by the governor.

The agency employed about 16,000 staff in 2013, a majority of whom worked in state supported living centers. These centers provide facility-based residential services for Texans with intellectual and developmental disabilities. In fiscal 2013, DADS spent more than $6.1 billion. About 60 percent of the agency's funding is federal, most of which is Medicaid. The majority of the agency's expenditures in 2013 were for nursing facilities (39 percent) and community-based services (36 percent). About 11 percent of the agency's expenditures in 2013 were for state supported living centers.

DADS is subject to abolition under the Sunset Act on September 1, 2015, unless continued by the Legislature. The Sunset commission did not recommend continuing DADS as a separate agency and instead recommended reorganization of the system agencies into a functional structure under HHSC.

DIGEST:

CSSB 204 would discontinue the Department of Aging and Disability Services (DADS) as an independent agency and transfer its administrative functions to the Health and Human Services Commission (HHSC).

The bill would implement numerous other changes related to the functions of the department, which would include:

- establishing a state supported living center (SSLC) restructuring commission and requiring that the department develop a closure plan for the Austin SSLC;
- imposing stronger sanctions for certain violations issued under the Health and Safety Code and the Human Resources Code and requiring graduated penalties; and
- establishing a crisis intervention team within the department and amending the informal dispute resolution process for nursing homes and assisted living facilities.

CSSB 204 also would make changes to day habilitation services and add requirements to long-term care consumer information provided online.

Transfer of DADS to HHSC. CSSB 204 would establish a procedure for the transfers of certain powers, duties, programs, and activities from DADS to HHSC.

By September 1, 2016, certain DADS administrative support service functions, client services functions, and council functions would be transferred to HHSC. By September 1, 2017, all remaining functions of DADS would be transferred to HHSC. Included in the transfer would be obligations and contracts, property and records, legislative appropriations and other funds, cases that are pending before the agency, and necessary personnel. A rule or policy adopted by DADS related to a transferred function would become a rule or policy of HHSC.

The bill also would repeal numerous sections of code to conform with the transfer.

State-supported living centers. CSSB 204 would establish a

restructuring commission whose purpose would be to evaluate each SSLC to determine if closure was recommended to maintain only the number of centers necessary to meet the needs of the state. Commission members could not have financial interest in or other connection with the SSLCs. In evaluating the centers, the restructuring committee would consider:

- the quality of services provided by the center and operation costs;
- compliance with the 2009 settlement agreement between the department and the U.S. Department of Justice;
- the availability of community service providers in the area;
- specialty services provided at the center;
- the availability of employment opportunities for center employees if the center closed;
- any infrastructure deficiency costs relating to the center;
- property value of, market demand for, and any deed restrictions applicable to property and facilities of the center;
- whether closure of the center would adversely affect the geographic distribution of centers in the state;
- the ability of the community to deliver the quality of care required by residents following the center's closure; and
- any other criteria the restructuring commission considered appropriate

By December 1, 2016, the restructuring committee would be required to submit to the governor, lieutenant governor, speaker of the House, and presiding officers of relevant House and Senate committees a report detailing the evaluation of each SSLC and, if applicable, proposing the closure of certain centers.

If the restructuring commission recommended the closure of one or more SSLCs, the 85th Legislature would be required to consider legislation proposing the closures; however, members could not to propose amendments to the legislation. If an SSLC was approved for closure, it would have to be closed on or before August 31, 2025.

CSSB 204 would require the department to establish a closure plan for the Austin SSLC that provided for a closure date that was not later than

August 31, 2017. On or before August 31, 2018, the department would evaluate the closure process, including how well it worked, and, if appropriate, would establish policies for improving the process for other future closures.

The executive commissioner of HHSC would have authority to establish by rule a list of services an SSLC could provide under a contract, as well as a schedule of fees to be charged for those services. In establishing the fee schedule, the executive commissioner would use the reimbursement rate for applicable services under Medicaid.

Nursing homes and related institutions. CSSB 204 would allow the department to revoke the license of a facility that had committed three violations constituting an immediate threat to health and safety related to the abuse or neglect of a resident on three separate days within a 24-month period. "Immediate threat to health and safety" would mean a situation in which immediate corrective action was necessary because the institution's noncompliance with one or more requirements had caused, or was likely to cause, serious injury, harm, impairment, or death to a resident.

Progressive sanctions and penalties. CSSB 204 would require the executive commissioner of HHSC to establish progressive sanctions by rule for violations issued under the Health and Safety Code for home and community support services, convalescent and nursing homes and related institutions, assisted living facilities, and intermediate care facilities, and adult day services.

The executive commissioner would create a matrix of progressive sanctions that the department would use to assess penalty amounts and impose disciplinary actions as appropriate. The matrix would provide for increases in the amounts of administrative penalties based on type, frequency, and seriousness of violations. It also would provide guidance for determining appropriate and graduated administrative penalties to deter future violations, including guidance on considering factors for determining penalty amounts.

CSSB 204 would increase the maximum penalty for each violation from $1,000 to $5,000 for home and community support services and assisted

living facilities. For assisted living facilities, each day a violation occurred or continued would be a separate violation for purposes of imposing a penalty, which is already the case for intermediate care facilities under current law. For intermediate care facilities, the bill would remove the ceiling on penalties for violations continuing or occurring on separate days.

The executive commissioner would be required to define types of minor violations that could be corrected by home and community support services, nursing homes and related institutions, assisted living facilities, intermediate care facilities, and adult day services before the department assessed an administrative penalty. The executive commissioner would need to ensure that all other violations were not subject to a right to correct.

Crisis intervention teams. CSSB 204 would require the department to select a model for implementing a crisis intervention team. The team would consist of individuals specially trained to provide services and support to persons with an intellectual or developmental disability who have behavioral health needs or are at risk of institutionalization.

The department would evaluate the effectiveness of various models of federally funded crisis intervention teams. By March 1, 2016, the agency would select one or more models for these teams that it determined could best provide comprehensive, cost-effective support. The department would determine areas in the state where crisis intervention teams were not operated and, subject to available funding, would develop a statewide system of locally managed crisis intervention teams.

Informal dispute resolution. The bill would add requirements to an existing informal dispute resolution process for certain long-term care facilities. HHSC would be required to contract with an appropriate disinterested, nonprofit organization as part of the informal dispute resolution process for convalescent and nursing homes and related institutions to adjudicate disputes. This resolution process would concern disputes regarding a statement of violations as prepared by the department in connection with a survey of the institution or facility.

Day habilitation services. CSSB 204 would require that every community-based intellectual and developmental disabilities services provider and intermediate care facility annually submit to the department a summary report. The department would maintain information obtained from inspections of day habilitation services providers regarding conduct or conditions constituting a violation of federal or state law or of applicable department rules.

By September 1, 2015, the department would be required to establish a day habilitation program advisory committee. The committee would consider and make recommendations about whether the provision of day habilitation services in the state should be redesigned and whether providers of these services should be subject to regulation. The committee also would examine whether day habilitation service providers currently comply with federal requirements. The committee would make recommendations on issues relating to day habilitation services, including the appropriate funding for services, reimbursable settings and services, staff-to-client ratio requirements, and safety requirements. By September 1, 2016, the committee would submit to the governor, lieutenant governor, speaker of the House, and presiding officers of relevant House and Senate committees a report with the committee's recommendations and the necessity for regulation, licensure, or certification of day habilitation services providers.

CSSB 204 would require the Department of Family and Protective Services (DFPS) to prepare and submit to the department an annual report detailing the number of investigations arising from a report of abuse, neglect, or exploitation of a person with an intellectual and developmental disability (IDD) that was allegedly committed by or on the premises of a day habilitation services provider. DFPS would specify whether the report was confirmed, unconfirmed, inconclusive, or unfounded. This duty to prepare and submit a report would not affect the duty of DFPS to investigate and hold accountable a center for any abuse, neglect, or exploitation of a person who received day habilitation services from the provider.

Quality-of-care monitoring and rapid response teams. The bill would amend current law related to quality-of-care monitoring visits. Quality-of-

care monitoring visits would be required for long-term care facilities identified as medium risk. Long-term care facilities also could request a monitoring visit. The department would have to schedule a follow-up visit not later than 45 days after the initial monitoring visit.

The bill would expand circumstances under which rapid response teams could visit long-term care facilities. The rapid response teams could visit a long-term care facility that was identified as high risk by the department through its early warning system or that had committed three violations within a 24-month period that constituted an immediate threat to health and safety related to the abuse or neglect of residents. Long-term care facilities would be required to cooperate with a rapid response team that was deployed to improve the quality of care they provided.

Long-term care consumer information. The bill would require that consumer information made available on the websites of HHSC and the department include for each provider of long-term care services quality-of-care ratings and information, staffing information, and the provider's regulatory performance. The department would have to periodically solicit from users input regarding the content of information and the usability and accessibility of the website.

Sunset provision. Under CSSB 204, DADS would be discontinued on September 1, 2015. This section would take effect only if the agency was not continued in existence by any other legislation of the 84th Legislature.

The sections of the bill allowing the department to revoke the license of certain nursing homes with serious, repeated violations would take effect September 1, 2016. The remaining provisions of the bill would take immediate effect if finally passed by a two-thirds record vote of the membership of each house. Otherwise, they would take effect September 1, 2015.

SUPPORTERS SAY:

CSSB 204 would follow recommendations of the Sunset Advisory Commission to transfer the functions of the Department of Aging and Disability Services (DADS) to the Health and Human Services Commission (HHSC) and, in so doing, improve the health and safety of the vulnerable populations served by the agency.

State-supported living centers. The bill appropriately would close the Austin SSLC while authorizing a commission to recommend whether other centers should be closed. Although SSLC residents account for a small segment of the clients served by DADS, the agency spends about 10 percent of its budget on SSLCs. Maintaining this large system of state-run facilities is too expensive. It would be more cost effective to place individuals in these centers in comparable living situations in the community. With the cost to taxpayers growing unsustainably, the state should close the Austin center and consider closing some of the others that have proven most problematic.

CSSB 204 would improve services for those at the remaining SSLCs. The shift to a smaller system would allow the agency to focus on providing higher quality care to people with intellectual and developmental disabilities (IDDs) who have the greatest needs. For example, SSLCs could work to improve relationships with universities so that students could receive more training with the IDD population — and the increased community engagement also would benefit the residents. The bill also would help reduce waiting lists for community-based services by downsizing SSLCs and redirecting that money into home and community-based services. Currently, there is no waiting list for the SSLCs, but there is a waiting list for community living options for those with disabilities.

CSSB 204 would be a step toward aligning Texas' practices with those of other states. Texas, which has 13 SSLCs, is one of the few remaining states maintaining a large system of public resident institutions for the IDD population. Most states operate with three institutions on average, and large states operate about seven.

The bill would not lead to the closure of every SSLC. It would create an SSLC restructuring commission to make recommendations to the Legislature, but decisions on closures would be made by elected officials. As a result, even if many centers were closed at the end of this process, certain centers inevitably would remain open to serve those who truly cannot function within the community.

Closure of the Austin SSLC would be a good start in the effort to

downsize all SSLCs and expand community-based services. The Austin SSLC has had trouble with health and safety violations, including 33 termination warnings since 2009, which is more than any other SSLC. In closing the Austin SSLC, the bill would make residents' care the top priority. Residents would have the option of staying in Austin in a community environment, or if their level of care demanded it, they would be moved to another SSLC. Only residents deemed appropriate for community living would be moved to the community.

Nursing homes and related institutions. CSSB 204 would lead to safer convalescent and nursing homes by requiring that these facilities be subject to license revocation for having three major violations within 24 months. The bill would encourage facilities to implement safe practices to avoid license revocation. Such legislation is necessary for the protection of this vulnerable population.

CSSB 204 would affect only facilities that posed serious harm to Texas' elderly population. A recent Sunset Advisory Commission review of DADS found that in the last three fiscal years, the agency has revoked just three nursing home licenses, with no revocations in fiscal 2013. License revocation is an action taken only as a last resort. This bill would create a strong state response to facilities with serious, repeated health and safety violations that would include revoking their licenses to operate, if warranted. At the same time, the bill would be fair to these institutions in that it would allow them to pursue corrective action after a first and even second set of violations before revoking the license.

Progressive sanctions and penalties. The bill appropriately would provide for escalating sanctions and penalties for violations by certain long-term care providers. Current penalty maximums for these provider types are not consistent between similar providers and might not provide effective deterrence for serious violations. The changes in the bill would match penalty amounts to the potential harm that can result from violations of licensing regulations. These recommended changes would allow the state to more effectively deter licensees from committing the most serious violations and hold accountable those who commit multiple violations. Also, while the maximum limit for penalties would be raised, that does not mean that the maximum penalty would be imposed by

default.

Crisis intervention teams. CSSB 204 would provide crisis support for IDD individuals in the community with high behavioral needs. One element reported to be essential in building community capacity is community crisis management. Implementation of crisis intervention teams would help people with challenging behaviors live in the community by supporting them through crises that could put them at risk for re-institutionalization.

OPPONENTS SAY:

State supported living centers. CSSB 204 inappropriately would remove certain residents from SSLCs, some of whom simply could not survive outside of these centers. For example, there are residents at SSLCs who cannot talk, feed themselves, or bathe themselves. SSLCs are the least restrictive environment for residents who need constant care. Community centers would be an inappropriate solution for some members of the IDD community.

CSSB 204 could result in moving severely disabled individuals into group homes where there is little oversight and recourse for abuse and neglect. Many SSLC residents have highly complex needs, including behavioral issues and multiple disabilities, and some already have been expelled from group homes because their care was too complicated. SSLCs are the only publicly funded, comprehensive medical and psychological care facilities for some of the most vulnerable Texans, and these centers have served the severely disabled well for decades. The state's SSLCs must remain open to continue providing highly specialized care for current residents and for future generations of Texans with intensive special needs.

CSSB 204 should not involve formation of an SSLC restructuring commission. Closure proposals and decisions should be made by elected legislators, not appointed citizen commissions.

The bill would cause the closure of the Austin SSLC, which would involve moving many Austin residents away from their families to other SSLCs. This could make family visitation difficult for some. This closure also would remove some individuals from a home they have known most of their lives. There are problems at the center that need improvement, but

those problems are not serious enough to merit closure.

Nursing homes and related institutions. While intending to help nursing home residents, CSSB 204 could lead to the closure of nursing homes or other long-term care facilities, which can be difficult for residents and their families. The goal should be to improve quality and maintain access to care, rather than shutting down facilities. This course of action could be particularly problematic in rural parts of Texas where there are not many nursing homes or other long-term care facilities. In some areas, these facilities are important employers. Shutting down a facility can punish residents, family members, and staff, when most of them have done no wrong.

Progressive sanctions and penalties. CSSB 204 unjustly would sanction and penalize assisted living facilities, for which the per-day penalty policy is not currently in use. Assisted living facilities are not nursing homes, and skilled nursing is required for their residents. That specialized care equates to more regulation both at the state and federal levels. Many assisted living facilities are small, so a daily penalty really could be a significant burden for these providers.

The bill also would establish inappropriate penalties for home and community support services and assisted living facilities. The proposed fine increase from $1,000 to $5,000 would be disproportionate and harsh.

Crisis intervention teams. People with disabilities can experience abuse, neglect, isolation, abandonment, or bullying and consequently may struggle with mental illness, such as depression and anxiety. Efforts should be focused on the mental health needs of people with IDDs, rather than establishing teams to wait for a crisis to happen.

OTHER OPPONENTS SAY:

While the changes suggested in the bill would benefit many elderly Texans and people with intellectual and physical disabilities who receive state services and supports, these measures could be undertaken without abolishing DADS and transferring its functions to HHSC. DADS is the agency best placed to oversee the reforms proposed in CSSB 204, and it should be extended beyond September 1, 2015.

NOTES:

According to the Legislative Budget Board's fiscal note, the bill would have an estimated negative impact of $20.2 million to general revenue related funds through fiscal 2016-17.

CSSB 204 differs from the Senate engrossed version of the bill in various details and in that it would discontinue DADS and transfer its functions to HHSC.

The House companion bill, HB 2699 by Raymond, was considered in a public hearing of the House Human Services Committee on March 23 and left pending.

SUBJECT: Modifying the HHSC Office of Inspector General

COMMITTEE: Human Services — committee substitute recommended

VOTE: 9 ayes — Raymond, Rose, Keough, S. King, Klick, Naishtat, Peña, Price, Spitzer

0 nays

SENATE VOTE: On final passage, April 21 — 30-0

WITNESSES: For — (*Registered, but did not testify*: Mary Nava, Bexar County Medical Society; Mark Vane, Gardere Wynne Sewell LLP; Fred Shannon, Hewlett Packard; Mariah Ramon, Teaching Hospitals of Texas; Marina Hench, Texas Association for Home Care and Hospice; Scot Kibbe, Texas Health Care Association; Michelle Romero, Texas Medical Association; David Reynolds, Texas Osteopathic Medical Association)

Against — None

On — (*Registered, but did not testify*: Kyle Janek and Karen Ray, Health and Human Services Commission; Sarah Kirkle and Danielle Nasr, Sunset Advisory Commission)

BACKGROUND: The Texas Legislature created the Office of Inspector General in 2003 as part of its reorganization of the health and human services system. The office is subject to Sunset review but not abolishment.

Office structure. The office is a division of the Health and Human Services Commission, but the office largely operates independently, separate from the commission. The office's inspector general is appointed by the governor to serve a one-year term.

Office function. The office is charged with preventing, detecting, and investigating fraud, waste, and abuse throughout the health and human services system. The office has a wide variety of functions and performed more than 100,000 investigations, reviews, and audits in fiscal 2013. The

Office of Inspector General includes five divisions: operations, compliance, internal affairs, enforcement, and chief counsel. The office also directs the operation of the Health Insurance Premium Payment (HIPP) program, which reimburses a Medicaid-eligible person or family for the cost of commercial insurance premiums when those costs are less than the cost of Medicaid services.

Funding. In fiscal 2014, the Office of Inspector General had 774 people on staff and a $48.9 million budget, which has increased by nearly 30 percent since 2011.

DIGEST:

CSSB 207 would modify rulemaking, duties and operations of the Office of Inspector General (OIG) for the Health and Human Services Commission (HHSC).

Role of the executive commissioner, OIG, and governor. The bill would require OIG to work in consultation with the executive commissioner of HHSC to adopt rules necessary to implement a power or duty related to the operations of OIG. These rules could not affect Medicaid policies.

The HHSC executive commissioner would be responsible for performing all administrative support services necessary to operate OIG, including functions of OIG related to:

- procurement processes;
- contracting policies;
- information technology services;
- legal services;
- budgeting; and
- personnel and employment policies.

HHSC's internal audit division would regularly audit OIG as part of the commission's internal audit program and would include the office in the commission's risk assessments.

OIG would closely coordinate with the executive commissioner and the

staff of programs under OIG's purview when performing functions related to the prevention of fraud, waste, and abuse in the health and human services system and the enforcement of state law related to the provision of those services, including audit utilization reviews, provider education, and data analysis.

OIG would conduct investigations independent of the executive commissioner and HHSC. OIG would rely on coordination between the office, program staff and the executive commissioner in ensuring that the office had a thorough understanding of the health and human services system for purposes of knowledgeably and effectively performing the office's duties.

Definition of fraud. The bill would change the definition of "fraud" in Government Code, sec. 531.1011(4) to specify that the term did not include unintentional technical, clerical, or administrative errors.

Criminal history background checks. OIG would enter into a memorandum of understanding with each state licensing authority that required a fingerprinted background check of a health care professional to ensure that only individuals who were licensed and in good standing as health care professionals would be Medicaid providers. The memorandum of understanding would have to include a process for OIG to confirm that a health care professional was licensed and in good standing. The licensing authority would immediately notify OIG if a provider's license had been revoked or suspended or if there had been disciplinary action against the provider. The bill would require OIG to routinely check federal databases to ensure that a provider who was excluded from the Medicaid program was not continuing to participate as a Medicaid provider.

The bill would specify other guidelines for the criminal background check, which OIG and HHSC could use to determine whether a provider would be eligible to continue to participate in Medicaid. The guidelines could not impose stricter standards for a person's eligibility to participate in Medicaid than those that a licensing authority would require for a health professional to provide services in the state. The provider enrollment contractor, if applicable, and a Medicaid managed care

organization would defer to OIG regarding whether a person's criminal history record would preclude the person from being a Medicaid provider. HHSC would adopt Medicaid eligibility guidelines by September 1, 2016.

The bill would set a timeline of 10 days for OIG to inform the HHSC or the health care professional whether the professional was denied participation in Medicaid, according to certain criteria specified in the bill.

Investigations. The bill would authorize OIG to issue a subpoena in connection with an investigation conducted by the office. The subpoena could be issued to compel the attendance of a relevant witness or the production of relevant evidence that was in the state.

The bill would require OIG to complete preliminary investigations of Medicaid fraud and abuse by the 45th day after the date the commission received a complaint or allegation or had reason to believe that fraud or abuse had occurred. It would require OIG to complete a full investigation by the 180th day after the date the full investigation began unless the office determined that more time was needed. Under the bill, if OIG determined that it needed more time, the office would have to notify the provider subject to the investigation of the delay and would have to specify why the office was unable to complete the investigation within the 180-day period.

These changes would apply only to a complaint or allegation received on or after September 1, 2015. The bill would not require the office to give notice to a provider if notice would jeopardize the investigation.

Peace officers. OIG could, according to federal law, employ and commission peace officers to assist the office in carrying out the duties of the office related to the investigation of fraud, waste, and abuse in the Supplemental Nutritional Assistance Program and the Temporary Assistance for Needy Families program.

Payment holds and provider notice. The bill would specify that a payment hold is a serious enforcement tool that the office imposes to mitigate ongoing financial risk to the state and that a payment hold would take effect immediately. The bill would require OIG to consult with the

state's Medicaid fraud control unit in establishing guidelines regarding the imposition of certain payment holds.

The bill would require OIG to notify a provider affected by the payment hold within five days of imposing the payment hold. The bill would require that the notice given to the provider include a detailed summary of OIG's evidence relating to the allegation and a description of administrative and judicial due process rights and remedies. These remedies would include providers' "option," rather than "right," to seek informal resolution, their right to seek a formal administrative appeal hearing, or both. The notice would have to include a detailed timeline for the provider to pursue these rights and remedies.

The bill would specify under which circumstances OIG could impose a payment hold or could find that good cause existed not to impose a payment hold, not to continue a payment hold, to impose a partial payment hold, or to convert a full payment hold to a partial payment hold. OIG could not impose a payment hold on claims for reimbursement that a provider had submitted for medically necessary services and for which the provider had obtained prior authorization unless the office had evidence that the provider had materially misrepresented documentation of the provided services.

The bill would specify that OIG could impose a payment hold without notice to a provider only if a payment hold was needed to compel the provider to give records to OIG, when requested by the state's Medicaid fraud control unit, or on the determination that a credible allegation of fraud existed.

These changes would apply only to a complaint or allegation received on or after September 1, 2015. The executive commissioner of HHSC, in consultation with the inspector general of OIG, would adopt rules necessary to implement provisions related to payment holds by March 1, 2016.

Continuation of payment holds. Under the bill, a SOAH judge would have to decide in an expedited administrative hearing if a payment hold should continue but could not adjust the amount or percent of the payment

hold. The judge's decision would be final and could not be appealed. The bill would remove the ability of a provider subject to a payment hold to appeal a final administrative order. These changes would apply only to a complaint or allegation received on or after September 1, 2015.

Administrative hearings. The bill would require OIG to file a request with the State Office of Administrative Hearings (SOAH) for an expedited administrative hearing regarding a payment hold within three days after the date the office received a provider's request for such a hearing. The bill also would require a provider to request an expedited administrative hearing within 10 days after receiving notice from OIG regarding a payment hold. Under the bill, SOAH would have to hold the expedited administrative hearing within 45 days after receiving a hearing request.

During expedited administrative hearings, the bill would:

- require the provider and the office each to limit testimony to four hours;
- entitle the provider and the office each to two continuances under reasonable circumstances; and
- require the office to show probable cause that the credible allegation of fraud that was the basis of the payment hold had an indication of reliability and that continuing to pay the provider would be an ongoing significant financial risk to the state and a threat to the integrity of the Medicaid program.

These changes would apply only to a complaint or allegation received on or after September 1, 2015.

SOAH hearing costs. The bill would remove the requirement in existing law that OIG and the provider share costs of an expedited administrative hearing. Instead, unless otherwise determined by the administrative law judge for good cause, the bill would make OIG responsible for the costs of the hearing and make the provider responsible for the provider's own costs incurred in preparing for the hearing. The bill also would remove the requirement in law that a provider advance a security payment for the costs of the hearing. These changes would apply only to a complaint or allegation received on or after September 1, 2015.

Informal resolution process. The bill would allow OIG to decide whether to grant a provider's request for a first or second informal resolution meeting. Informal resolution meetings would be confidential and any information or materials obtained by OIG would be privileged and confidential and not subject to disclosure under any means of legal compulsion for release, nor under Government Code, ch. 552 related to public information.

The bill would remove existing time requirements for when OIG would have to schedule the meeting or when the office would have to give notice of the meeting. The bill would require the informal resolution process to run concurrently with the administrative hearing process and would discontinue the informal resolution process once SOAH issued a final determination on the payment hold. These changes would apply only to a complaint or allegation received on or after September 1, 2015.

The executive commissioner would consult with OIG when adopting rules to allow a provider subject to a payment hold, other than a hold requested by the state's Medicaid fraud control unit, to seek an informal resolution.

The bill would require HHSC to have an informal resolution meeting recorded and to provide the recording to the provider at no cost, if the provider requested it in writing. HHSC could not record an informal resolution meeting unless it received a written request from a provider.

Recoupment of overpayment or debt. The bill would require HHSC or OIG to give a provider written notice of any proposed recoupment of an overpayment or debt related to Medicaid services and any damages or penalties related to a fraud or abuse investigation. The notice would have to include the specific basis and calculation of the overpayment or debt, facts and supporting evidence, a representative sample of the documents used as a basis for the overpayment or debt, the extrapolation methodology and related information, the amount of damages and penalties, and a description of due process remedies, including informal resolution.

The bill would require a provider to request an appeal of a recoupment or

overpayment of debt within 30 days of the date the provider was notified. Unless otherwise determined by the administrative law judge for good cause, OIG would be responsible for the costs of an administrative hearing.

Rules on OIG operation and duties. The executive commissioner of HHSC would set rules for opening and prioritizing cases. In addition, the executive commissioner, in consultation with OIG, would have to adopt rules detailing OIG investigation procedures and criteria for enforcement and punitive actions. These rules would include direction for categorizing provider violations according to the nature of the violation and for scaling resulting enforcement actions, taking into consideration the seriousness of the violation, the prevalence of the provider's errors, financial harm, and mitigating factors. The rules also would have to include a specific list of potential penalties.

The bill would specify that OIG would consult with HHSC regarding:

- investigations of possible fraud, waste, and abuse by certain managed care organizations;
- training and oversight of special investigative units established by managed care organizations;
- requirements for approving managed care organizations' plans to prevent and reduce fraud and abuse;
- evaluation of statewide fraud, waste, and abuse trends in the Medicaid program; and
- assistance to managed care organizations in discovering or investigating fraud, waste, and abuse;
- providing ongoing, regular training to appropriate HHSC and OIG staff concerning fraud, waste, and abuse in a managed care setting, including training related to service providers and recipients.

Extrapolation review. The bill would require OIG to review its investigative process, including its use of sampling and extrapolation to audit provider records. The bill would require the review to be performed by staff who were not directly involved in OIG investigations.

The bill also would require OIG to arrange for the Association of Inspectors General or a similar third party to conduct a peer review of the office's sampling and extrapolation techniques. Based on the review and generally accepted practices among other states' offices of inspector general, the executive commissioner of HHSC, in consultation with OIG, would rule to adopt sampling and extrapolation standards to be used by OIG in conducting audits.

The OIG inspector general would submit a report to the executive commissioner of HHSC, the governor, and the Legislature at each quarterly meeting of any advisory council responsible for advising the executive commissioner on the operation of the commission. The report would be published on OIG's website and would include information on the office's activities, performance measures, fraud trends, and recommendations for policy changes to prevent or address fraud, waste, and abuse in the health and human services system.

OIG would consult with the executive commissioner regarding the adoption of rules defining OIG's role in and jurisdiction over audits of Medicaid managed care organizations and the frequency of those audits. OIG would consult with HHSC in investigating fraud, waste, and abuse by Medicaid managed care organizations. After consulting with OIG, HHSC would rule by September 1, 2016, to define the roles of HHSC and OIG and their jurisdiction over audits of Medicaid managed care organizations. HHSC also would determine the frequency of those audits.

OIG also would coordinate all audit and oversight activities related to providers, including external oversight activities, to minimize the duplication of activities, including those of Medicaid managed care plans. The bill would specify that OIG would seek input from the commission and consider previous audits and on-site visits made from the commission in coordinating these activities. HHSC would be required to share with OIG the results of any informal audit or on-site visit performed by the commission that could inform the office's risk assessment when determining whether to conduct an audit of a Medicaid managed care organization and the scope of that audit.

Pharmacies subject to audits. The bill would specify that a pharmacy

would have a right to request an informal hearing before the HHSC's appeals division to contest an audit that did not find that the pharmacy engaged in Medicaid fraud. The bill would require staff of the HHSC's appeals division, assisted by vendor drug program staff, to make the final decision on whether an audit's findings were accurate. It would disallow OIG staff from serving on the panel that made a decision regarding the accuracy of the audit.

OIG would have to provide pharmacies under audit with detailed information, if OIG had access to it, relating to the extrapolation methodology used as part of the audit and the methods used to determine whether the Medicaid program overpaid the pharmacy. The information would have to be in sufficient detail so that the audit results could be demonstrated to be statistically valid and fully reproducible.

By March 1, 2016, the executive commissioner of HHSC, in consultation with OIG, would have to adopt the necessary rules to implement these changes. Provisions related to pharmacies would apply to the findings of an audit made on or after September 1, 2015, or an audit that was the subject of a dispute pending on that date.

Federal medical coding guidelines for hospital reviews. OIG, including office staff and any third party would comply with federal medical coding guidelines, including guidelines for diagnosis-related group validation and related audits. The HHSC executive commissioner, in consultation with OIG, would rule to develop a process for OIG, its staff, and any third party to communicate with and educate providers about the diagnosis-related group validation criteria that OIG would use to conduct hospital utilization reviews and audits. HHSC would adopt these rules as soon as practicable after September 1, 2015.

Performance audits and audit coordination. The bill would authorize OIG to conduct a performance audit of any program or project administered or agreement entered into by HHSC or a health and human services agency, including an audit related to contracting procedures or the performance of the HHSC or a health and human services agency. In coordinating audits with HHSC, OIG would be required to seek input from the commission and to consider previous audits for purposes of

determining whether to conduct a performance audit and to request the results of an audit conducted by HHSC if those results could inform OIG's risk assessment when determining whether to conduct a performance audit or its scope.

Participation in HIPP and managed care. The bill would repeal the prohibition on an individual's participation in both the Health Insurance Premium Payment Program (HIPP) and Medicaid managed care.

Reports on the death of a child. The bill would allow a confidential draft report on an audit or investigation that concerned the death of a child to be shared with the Department of Family and Protective Services, but the draft report would remain confidential.

Federal waivers. The bill would direct a state agency needing a waiver or authorization from a federal agency to implement a provision of the bill to request that waiver or authorization. The affected state agency could delay implementation of affected provisions in the bill until the agency received the waiver or authority.

Future Sunset review. The Sunset Advisory Commission would conduct a special-purpose review of the overall performance of OIG as part of its review of agencies for the 87th Legislature in 2021. OIG would not be abolished solely because it was not explicitly continued following the review.

The bill would take effect September 1, 2015.

SUPPORTERS SAY:

CSSB 207 would help address management and due process concerns found during the Sunset review of the Health and Human Services Commission (HHSC). The bill also would provide needed structure, guidelines, and performance measures to OIG's investigative processes to reduce overzealous investigation of Medicaid providers and to ensure consistent and fair results.

Appointment of inspector general. The bill would retain appointment of the inspector general with the governor to allow an arm's-length relationship with the HHSC executive commissioner. By retaining this

arrangement, the bill would ensure accountability and independence in the inspector general position while still allowing HHSC to have input into rulemaking at OIG.

Executive commissioner. The HHSC executive commissioner would be responsible for performing all administrative support services necessary to operate OIG, which would hold the executive commissioner accountable for OIG's performance. This practice is common in other state offices of inspector general.

Sunset review. Given the lack of data to fully evaluate OIG's performance, especially related to investigations, the bill would require OIG to undergo special review by the Sunset Advisory Commission in six years. Within that period, OIG should have a case management system and the ability to track data to better illustrate its overall performance and the effectiveness and efficiency of its processes. Because OIG does not have its own Sunset date, it is subject to review, but not abolishment. Any concerns that may emerge in the six years before the next review could be addressed at the will of the Legislature and would not depend on this timeline.

Definition of fraud. By making the definition of "fraud" less broad and specifying that the definition does not include unintentional technical, clerical, or administrative errors, the bill would focus OIG's fraud investigations on those actually committing fraud and would help prevent resources from being wasted on providers who commit clerical errors. Previously, OIG cast too wide a net and spent time and money on investigating providers who made clerical mistakes but were not committing fraud. Overzealous investigations based on a broad definition of fraud also caused communities with limited health resources to unnecessarily lose access to Medicaid providers.

Participation in HIPP and managed care. The bill appropriately would remove an outdated prohibition on the participation of an individual in both HIPP and Medicaid managed care to allow Medicaid clients in the HIPP program to access long-term care services and supports through Medicaid managed care.

Payment holds and provider notice. The bill would streamline the payment hold process to more quickly mitigate state financial risks and reduce any undue burden on providers. The timelines in the bill would increase efficiency in the payment hold and appeal processes. The bill would ensure that providers were not subject to payment holds any longer than necessary. The bill also would clarify the intended serious nature of payment holds and would specify that payment holds should be reserved for significant events such as fraud and to compel the production of records. It would respond to concerns that OIG had used payment holds as a bargaining chip to encourage providers to settle their cases, even in cases that did not pose a significant financial risk to the state.

Rules on OIG operation and duties. The bill would require rules for opening cases, prioritizing cases, prioritizing investigations, and scaling penalties to the nature of the violation, which would increase workload efficiency and investigation transparency, consistency, and fairness at OIG. The rules also would ensure that Medicaid providers were not overly penalized for less serious violations. The state needs a robust network of Medicaid providers, and scaling penalties to the severity of violations would ensure that Medicaid providers' practices were not subjected to a payment hold for an unnecessarily long period of time.

Time limits on investigations. The bill would require OIG to complete preliminary investigations within 45 days of receiving a complaint or referral, which would provide time for OIG to determine whether to refer the matter to the Medicaid fraud control unit for criminal prosecution and ensure that investigations were completed in a timely manner. Requiring a 180-day time limit on full-scale investigations and requiring OIG to notify the provider if an investigation took longer than 180 days would increase transparency for providers about the investigative process while ensuring the timely completion of investigations.

Informal resolution process. Turning informal resolution meetings before a payment hold hearing into an option rather than a statutory right would aid in streamlining the hearing process and making it more efficient. It also would bring the process more in line with comparable processes before Medical Board and Board of Nursing hearings. A provider still would have a right to two informal resolution meetings

before proceeding to the hearing.

Extrapolation review. By requiring OIG to review its extrapolation methodology and provide its methodology to pharmacies subject to audits, the bill would help ensure the integrity of the sampling and extrapolation methodology the office uses in its reviews. The bill also would respond to concerns over the improper use of the office's methodology by requiring a third party to conduct a peer review of the office's sampling and extrapolation techniques

SOAH hearing costs. OIG should cover costs of expedited administrative hearings to reduce the burden to providers in accessing due process. The bill still would require providers to cover their own costs in preparing for the hearing. The bill would align payment hold hearings with the standard state practice of requiring the agency to pay for SOAH hearings.

Pharmacies subject to audits. The bill would make clear that pharmacies have the right to request a hearing to contest an OIG audit and would increase transparency by allowing pharmacies to review the methodology OIG used as part of the audit.

Hospital utilization review. The bill would increase consistency and accountability at OIG by requiring the office to use federal medical billing codes and to develop a process for using diagnosis-related group validation criteria in hospital utilization reviews.

OPPONENTS SAY:

Appointment of OIG. Current law requiring the governor to appoint the inspector general fosters confusion about whether the inspector general answers to the governor or the HHSC executive commissioner. Problems with this structure and its lack of clear accountability were illustrated by the inability of the HHSC executive commissioner to properly hold the inspector general accountable for overzealous Medicaid investigations and excessive spending on badges and other items.

Sunset review. Given the important work done by OIG and the management and other concerns uncovered in the Sunset review, it would be more appropriate for OIG to undergo special review in three years rather than six. This would permit enough time for changes to be made

without allowing any problems to get out of hand. The Legislature would have enough information to evaluate changes made by the bill and make any necessary adjustments.

Definition of fraud. The Medicaid program has had significant problems in the past with providers who were actually committing fraud, waste, or abuse and endangering the health of children. Limiting the definition of fraud might impair OIG's ability to investigate providers and find those who had legitimately committed fraud. OIG does not order payment holds with enough frequency to significantly limit access to Medicaid providers or indicate that the definition of fraud is too broad.

Informal resolution process. The bill should not allow OIG to determine whether a provider should be granted an informal resolution meeting and should not remove timelines that were just recently added to code. These changes would make the informal resolution process less transparent and slower.

SOAH hearing costs. The bill would remove recently added requirements in code for providers and OIG to share costs and provide for expedited administrative hearings. Providers agreed to share these costs and provide a security deposit for the cost of the hearing. Cost sharing would not pose an undue burden for providers.

Payment holds. The timeline proposed in the bill for how soon a provider would have to respond to notice of a payment hold to request an expedited administrative hearing is too short. Providers need more than 10 days to get billing sheets from the billing company in order to respond.

NOTES:

The companion bill, HB 3279 by Gonzales, was recommitted to the House General Investigating and Ethics committee on April 29.

The House committee substitute for CSSB 207 differs from the engrossed Senate version of the bill by:

- requiring OIG and HHSC to coordinate audit and oversight activities of Medicaid managed care organizations;
- prohibiting OIG from performing duplicative criminal history

checks of providers who received fingerprint-based checks and were in good standing with a licensing agency;

- requiring OIG to adopt guidelines on evaluating criminal history information;
- requiring OIG to make a determination on provider eligibility within 10 days;
- requiring OIG to consult with HHSC in its duties related to Medicaid managed care organizations and to provide training to OIG and HHSC staff;
- requiring OIG to request a peer review of extrapolation and sampling methodologies from a third party;
- requiring OIG to provide detailed information regarding its extrapolation methodology with a provider notice for overpayment;
- giving OIG authority to adopt rules necessary to implement its powers or duties in consultation with the HHSC executive commissioner;
- requiring OIG to employ peace officers for the purpose of investigating fraud, waste, and abuse in SNAP and TANF; and
- providing that the appeal process for pharmacy audits would apply retroactively to audits subject to a pending audit dispute on September 1, 2015.

SUBJECT: Establishing the Texas ABLE program for disabled individuals

COMMITTEE: Human Services — committee substitute recommended

VOTE: 6 ayes — Raymond, Rose, Keough, Naishtat, Price, Spitzer

0 nays

3 absent — S. King, Klick, Peña

SENATE VOTE: On final passage, April 15 — 31-0

WITNESSES: For — Erin Lawler, Texas Council of Community Centers; Chris Masey; (*Registered, but did not testify*: Laura Rosen, Center for Public Policy Priorities; Dennis Borel, Coalition of Texans with Disabilities; Kathryn Lewis, Disability Rights Texas; Jolene Sanders, Easter Seals Central Texas; Stephen Scurlock, Independent Bankers Association of Texas; Cate Graziani, Mental Health America of Texas; Greg Hansch, National Alliance on Mental Illness (NAMI) Texas; Carole Smith, Private Providers Association of Texas; Lauren Dimitry, Texans Care for Children; Diana Martinez, Texas Assisted Living Association; Lori Henning, Texas Association of Goodwills; Jamie Dudensing, Texas Association of Health Plans; Lee Johnson, Texas Council of Community Centers; Gerard Jimenez, Texas Down Syndrome Advocacy Coalition; Haley Greer, the Arc of Texas; Melody Chatelle, United Ways of Texas; Michael Hart)

Against — None

On — (*Registered, but did not testify*: Gina Perez, Health and Human Services Commission; Linda Fernandez and Cynthia Stapper, Texas Comptroller of Public Accounts)

BACKGROUND: The federal Achieving a Better Life Experience (ABLE) Act of 2014 was enacted to encourage and assist individuals and families in saving private funds for the purpose of supporting individuals with disabilities to maintain health, independence, and quality of life. The act allows a state

to establish a savings program under which contributions can be made to an ABLE account created to meet qualified disability expenses of account beneficiaries who are disabled and residents of the state.

States may pass enabling legislation to allow their residents to begin creating ABLE accounts.

DIGEST:

CSSB 1664 would establish the Texas Achieving a Better Life Experience (ABLE) Program. The ABLE program would be administered by the Prepaid Higher Education Tuition Board.

The purpose of the Texas ABLE Program, like its federal model, would be to encourage and assist disabled individuals and their families in saving funds to support individuals with disabilities. These savings would be placed in ABLE accounts, which could not be counted toward a designated beneficiary's eligibility for state assistance or benefits programs.

Designated beneficiaries. Designated beneficiaries would be Texas residents with disabilities who had certified to the board that they were eligible for the program and who were named as the designated beneficiary of an ABLE account. The bill would specify requirements for participants in the program.

ABLE account. The bill would establish the Texas ABLE savings plan account, which would be a trust fund held outside of the state treasury and administered by the board. The board could solicit and accept gifts, grants, legislative appropriations, and other funding for the program. The board also could invest ABLE participant funds in appropriate investment instruments jointly, as long as different participants' assets were tracked and reported separately. Designated beneficiaries could have only one ABLE account, and each account could have only one owner.

The board would be required to provide information to participants and families necessary to create and maintain an ABLE account. The board would enter into any agreements with financial institutions, federal agencies, or other entities as necessary to administer the program accounts. All money paid by participants into the fund would be deposited

into an individual ABLE account held on behalf of that participant in the ABLE program and promptly invested by the board.

The board could delegate certain investment decision-making and authority to financial institutions to act on their behalf. In delegating investment powers and authority, the board would be required to exercise ordinary business care and prudence.

ABLE accounts could not be considered securities and would not be subject to the restrictions and regulations of the Securities Act. Under the ABLE program, assets could be used for limited purposes, including making distributions to designated beneficiaries, paying the costs of program administration, making refunds for cancellations or excess contributions, or rolling funds over to another ABLE account.

ABLE accounts could not be used as collateral or otherwise made subject to sale, transfer, or assignment. Upon the death of a designated beneficiary, however, the state could become a permissible creditor.

Qualified disability expenses. ABLE account funds disbursed to a designated beneficiary could be used only to pay for certain disability-related expenses, including expenses for education, housing, transportation, employment training, assistive technology, legal fees, and others.

Duties and powers of board. Under CSSB 1664, the tuition board would be required to develop and implement the ABLE program, including adopting rules and establishing policies and procedures for the program that would enable it to qualify as an ABLE program under federal law.

The bill would give the board the necessary powers to carry out duties of the program, including the power to sue and be sued, enter into contracts, contract for necessary goods and services, engage the services of certain professionals, and make reports. The board also would collect administrative fees and service charges in connection to the program, though these fees could not exceed the amount necessary to cover costs of establishing and maintaining the program.

The board would be required to comply with certain reporting requirements under sec. 529A of the Internal Revenue Code, as well as making certain reports in accordance with requirements of the comptroller's office, the board's annual report, and any other reports required by state or federal law. The board also would be required to comply with its code of ethics under Education Code, sec. 54.6085.

ABLE program advisory committee. Under CSSB 1664, an advisory committee would be established to review rules and procedures related to the ABLE program and provide guidance and assistance as needed to both the board and the comptroller in creating and administering the program. The bill would specify the composition of the board, along with meetings and other requirements.

Confidentiality of ABLE records. All information related to the ABLE program would be public and subject to disclosure; however, information relating to a prospective or current participant or beneficiary, including personally identifiable information, would be confidential. Exceptions would apply in limited situations, such as providing information on an individual's account to the individual or sharing information necessary to administer the program. The tuition board, comptroller, or managers or other contractors under the program would not be required to comply with certain HIPPA requirements of covered entities under Health and Safety Code, ch. 181.

Termination or modification of ABLE program. The bill would allow the ABLE program to be altered or terminated if the comptroller found that the terms of the ABLE program were not financially feasible. In the event that the ABLE program was terminated, the bill would require the balance of each ABLE account to be paid to the participant to the extent possible.

The bill would direct any state agency to apply for a waiver or authorization from a federal agency as needed to implement the provisions of the bill and could delay implementing those provisions until the waiver or authorization was granted.

The Prepaid Higher Education Tuition Board could begin enrolling individuals in the ABLE program as soon as practical while allowing

enough time for successful development and implementation of the program.

This bill would take immediate effect if finally passed by a two-thirds record vote of the membership of each house. Otherwise, it would take effect September 1, 2015.

SUBJECT: Modifying emergency medical services licenses, duties

COMMITTEE: Public Health — favorable, without amendment

VOTE: 8 ayes — Crownover, Naishtat, Blanco, Coleman, R. Miller, Sheffield, Zedler, Zerwas

0 nays

3 absent — Collier, S. Davis, Guerra

SENATE VOTE: On final passage, May 12 — 30-0

WITNESSES: (*On House companion bill, HB 2020*)
For — Dudley Wait, City of Schertz Emergency Medical Services; Bryan Norris, San Antonio Professional Firefighters Association; Ryan Matthews; (*Registered, but did not testify*: Randy Moreno, Austin Firefighters Association; Wayne Delanghe, San Antonio Professional Firefighters Association; Courtney DeBower, Texas Emergency Medical Services, Trauma and Acute Care Foundation (TETAF); Dan Finch, Texas Medical Association; Mike Martinez; Joseph Palfini)

Against — Cindy Zolnierek, Texas Nurses Association

On — (*Registered, but did not testify*: Joseph Schmider, Department of Safety and Health Services)

BACKGROUND: Health and Safety Code, ch. 773, also known as the Emergency Health Care Act, governs emergency medical services.

Sec. 773.0571 establishes requirements for emergency medical service provider licenses.

DIGEST: SB 1899 would allow a certified emergency medical technician-paramedic or licensed paramedic to provide advanced life support under certain circumstances, make changes to requirements for emergency medical services provider licenses, and require the Department of State Health

Services (DSHS) to institute a system for tracking and reporting on complaints, investigations, and disciplinary actions related to emergency medical services.

Advanced life support care. A certified emergency medical technician-paramedic or licensed paramedic could provide advanced life support in a facility's emergency or urgent care clinical setting, including a hospital room and a freestanding emergency medical care facility, under certain conditions. The emergency medical technician-paramedic or licensed paramedic would have to be acting under the direct supervision of a licensed physician and be authorized to provide advanced life support by a health care facility.

The bill would define "advanced life support" as health care provided to sustain life in an emergency, life-threatening situation. It would include the initiation of intravenous therapy, endotracheal or esophageal intubation, electrical cardiac defibrillation or cardioversion, and drug therapy procedures.

Emergency medical services provider licenses. The bill would authorize DSHS to develop and administer an examination for an emergency medical services (EMS) provider license applicant or EMS personnel certification applicant. The examination would be administered at least twice a year and would assess the applicant's knowledge of the Emergency Health Care Act, rules set by the Health and Human Services executive commissioner, and any other applicable laws. DSHS rules would be required to specify who must take the examination on behalf of an entity applying for an emergency medical services provider license.

The bill would add to the requirements for an EMS provider license that the applicant operated out of a physical location as the provider's primary place of business and that the applicant owned or leased all equipment necessary for safe operation of an emergency medical services provider as provided by the bill's provisions. The bill would outline criteria for what constitutes an applicable physical location and necessary equipment.

Complaints, investigations, and inspections. The bill would require DSHS to track and record any complaints the department received

regarding EMS providers and EMS personnel as well as investigations and disciplinary actions initiated by the department under the Emergency Health Care Act. The bill would specify the process by which DSHS would track and refer complaints outside department jurisdiction to other agencies. It would also require DSHS to annually report on its findings related to complaints, investigations, and disciplinary actions and make that report public via the department's website and upon request.

The bill also would allow DSHS to use an inspection performed by an entity to which the department has delegated inspection authority as a basis for a disciplinary action that could result in the revocation, suspension or nonrenewal of a license.

As soon as practicable after the bill's effective date, the executive commissioner of the Health and Human Services Commission would be required to adopt any necessary rules to implement the bill, and DSHS would develop a formal process for referring complaints outside its jurisdiction.

This bill would take immediate effect if finally passed by a two-thirds record vote of the membership of each house. Otherwise, it would take effect September 1, 2015. Provisions establishing new license requirements for emergency medical services providers would apply to licenses applied for or renewed on or after September 1, 2015.

SUPPORTERS SAY:

SB 1899 would allow emergency medical technician-paramedics and licensed paramedics to work in emergency rooms under appropriate circumstances. Currently, paramedics or licensed paramedics who wish to work in an emergency room are permitted only to be paid and employed as orderlies, which deprives health care facilities of these individuals' specialized skills honed in an emergency setting.

Allowing these types of paramedics to be employed by medical facilities in a more appropriate role could benefit both the paramedic and the medical facility. Emergency rooms often are understaffed, particularly in rural communities. Working in a hospital alongside physicians could help alleviate staffing challenges, while also helping paramedics further develop their skills.

The bill would not require any additional training for paramedics. They would be performing procedures in emergency rooms that they are already allowed to perform when providing emergency services, so this bill would just expand the scope of where they could provide them.

The bill could extend the careers of paramedics who were injured or no longer wished to provide their services in the field by allowing them to put their skills to use in a hospital environment. The bill would not attempt to substitute paramedics for nurses and would not affect nursing ratios in emergency rooms.

Providing additional licensing requirements would help ensure that recipients of emergency medical services were given a high quality of care. The bill would not, as opponents say, expose complaints and allegations about EMS service providers and care before a final determination was made. Sufficient information would be included in a complaint report that a person would be able to evaluate whether the complaint had merit.

OPPONENTS SAY:

SB 1899 could place paramedics in a field for which they were not trained. There are significant differences between the standard of care and the resources for paramedics in the field and in the hospital. Registered nurses also have a broader skill set than paramedics and are better qualified to help provide advanced life support in an emergency room.

The bill could expose complaints and allegations about EMS service providers and care before a final determination was made and the merit of the complaints was evaluated. The bill also would leave too much rulemaking discretion to the Health and Human Services executive commissioner and DSHS for implementing the bill's provisions.

NOTES:

The House companion bill, HB 2020 by Martinez, was approved by the House on May 15 and referred to the Senate Administration Committee on May 19.

SUBJECT: Explicitly classifying certain sales of aircraft as sales for resale

COMMITTEE: Ways and Means — favorable, without amendment

VOTE: 7 ayes — D. Bonnen, Bohac, Button, Darby, Murphy, Springer, Wray

3 nays — Y. Davis, Martinez Fischer, C. Turner

1 absent — Parker

SENATE VOTE: On final passage, May 6 — 31-0

WITNESSES: (*On House companion bill, HB 3287*)
For — David Norton and Cindy Ohlenforst, 2015 Fair Sales Tax Initiative for Texas Aircraft; (*Registered, but did not testify:* Allen Beinke and Tim Sorrells, Texas Aviation Advocacy Fund; John Hadley, National Business Aviation Association; Shelly Lesikar Dezevallos, Texans For General Aviation)

Against — None

On — (*Registered, but did not testify:* Karey Barton and William Hamner, Texas Comptroller of Public Accounts)

BACKGROUND: Tax Code, sec. 151.302 exempts sales for resale from the sales tax.

Sec. 151.054 provides that a sale is exempt from the tax if the seller receives a resale certificate from a purchaser stating that the taxable item is acquired for the purpose of selling, leasing, or renting it. However, under sec. 151.154, a purchaser who gives a resale certificate is liable for the sales tax if the purchaser makes any use of the item other than in demonstration or display while holding it for sale, lease, or rental.

DIGEST: SB 1396 would include in the definition of "sale for resale" an aircraft purchased for the purpose of leasing, renting, or reselling to another person in the United States or Mexico in the form in which it was acquired. Leasing or renting the aircraft would include the transfer of

operational control — i.e., authority over initiating, conducting, or terminating a flight — pursuant to a written lease in exchange for some consideration.

The purchase of an aircraft would qualify as a sale for resale regardless of whether the purchaser used the aircraft — in addition to leasing, renting, or reselling it to another person — if more than 50 percent of the aircraft's departures were made under the operational control of one or more lessee pursuant to a written lease as described above.

A transaction between related persons involving an aircraft would be exempt from the sales tax if the same transaction between unrelated persons also would be exempt. Certain uses of an aircraft by an owner, member, or affiliate of the purchaser of the aircraft also would be exempt from the sales tax.

The bill would specify other conditions under which an aircraft brought to, stored, or used in Texas would not be subject to sales tax, including an aircraft:

- brought to Texas for the purpose of being completed, repaired, remodeled, or restored;
- brought to Texas by a person who had not acquired it directly from a seller by means of a purchase; and
- that made more than half of its departures from locations outside the state for a year after either the acquisition of the aircraft or its first flight containing passengers or property, whichever date was later.

Under the bill, the purchase, sale, or use of an aircraft operated under certain fractional ownership programs would not be subject to the sales tax.

This bill would take effect September 1, 2015.

SUPPORTERS SAY:

SB 1396 would clarify current law to ensure that the state did not charge sales taxes on sales that were actually made for resale. Operations and transfers of aircraft are governed largely by technical requirements

established by the Federal Aviation Administration (FAA). This bill is the product of work between the comptroller and industry groups. It provides specific language that would make clear that a lease complying with the FAA lease terms was a lease for Texas sales tax purposes.

The bill would provide clear and objective standards, giving guidance to the comptroller and the industry. Because of the current ambiguity in tax liability, operators of aircraft have avoided bringing aircraft into Texas, which results in significant lost revenue to the state. The latest version of the Legislative Budget Board's fiscal note, which takes this into account, estimates no significant fiscal impact to the state and concludes that the bill should improve voluntary compliance with respect to transactions that remain taxable.

In addition, the comptroller historically has treated similar transactions differently, depending on the relation of the parties. This bill would serve as a confirmation of current law and ensure that parties were treated equally regardless of whether they were related.

This bill is purely prospective in its authority and would not affect any ongoing litigation.

OPPONENTS SAY:

SB 1396 could result in a reduction of tax revenue because it would create a definable category of sales that would be exempt from the sales tax.

NOTES:

The House companion bill, HB 3287 by Paddie, was sent to the Calendars Committee on May 11.

SUBJECT: Allowing transportation network companies to operate at DFW airport

COMMITTEE: Transportation — committee substitute recommended

VOTE: 9 ayes — Pickett, Martinez, Burkett, Fletcher, Israel, Murr, Paddie, Phillips, Simmons

0 nays

4 absent — Y. Davis, Harless, McClendon, Minjarez

SENATE VOTE: On final passage, April, 9 — 31 – 0 on local and uncontested calendar

WITNESSES: *(On House companion bill, HB 1954)*
For: — (*Registered, but did not testify*: Larry Casto, City of Dallas; TJ Patterson, City of Fort Worth; James Crites, DFW International Airport; Michael Crain, Uber Technologies)

BACKGROUND: Transportation Code, sec. 22.081 allows joint boards that govern airports to license taxicabs that transport passenger to or from the airport and impose fees for issuing the licenses.

DIGEST: CSSB 530 would amend Transportation Code, sec. 22.081 to allow joint boards of airports shared by populous home-rule cities to license passenger transportation services providing services to or from the airport for compensation. Joint boards also could impose license fees.

This bill would take immediate effect if finally passed by a two-thirds record vote of the membership of each house. Otherwise, it would take effect September 1, 2015.

SUPPORTERS SAY: CSSB 530 is needed to allow the joint board of the Dallas/Fort Worth (DFW) International Airport to allow transportation network companies such as Uber and Lyft to operate at the airport. Under current statute, DFW airport has only the ability to license taxicabs. This bill would ensure that the DFW airport board had the authority to license transportation network companies as well.

CSSB 530 would improve competition for ground transportation at DFW airport by licensing transportation network companies to pick up passengers there. The City of Dallas is working with the other jurisdictions in the DFW Metroplex to establish consistent ordinances designed to ensure the safety of riders across the region, and licensed transportation network companies at DFW airport would operate under safety rules similar to those in other cities in the metropolitan area.

OPPONENTS SAY:

Because it is unclear if transportation network companies such as Uber and Lyft meet the same safety standards as those observed by taxicab companies, CSSB 530 could be taking a chance with passenger safety by allowing these companies to operate at DFW airport.

NOTES:

Unlike the version engrossed by the Senate, CSSB 530 specifically would refer to "passenger transportation services providing services to or from the airport for compensation." The Senate-engrossed version would have referred to vehicles for hire "transporting passengers to or from the airport."

The House companion bill, HB 1954 by Parker, was placed on the local, consent, and resolutions calendar for May 5. It was withdrawn, returned to the Local and Consent Calendars Committee, then transferred to the House Calendars Committee.

SUBJECT: Changing certain requirements of the Texas Enterprise Zone Program

COMMITTEE: Economic and Small Business Development — favorable, without amendment

VOTE: 9 ayes — Button, Johnson, C. Anderson, Faircloth, Isaac, Metcalf, E. Rodriguez, Villalba, Vo

0 nays

SENATE VOTE: On final passage, April 14 — 31-0

WITNESSES: For — Brandon Aghamalian, City of Corpus Christi; (*Registered, but did not testify*: Ramiro Garza, City of Edinburg; Keith Patridge, McAllen Economic Development Corp.; Nelda Olivo, Port of Corpus Christi; Adina Christian, Ryan LLC; Fred Shannon, Texas Association of Manufacturers)

Against — None

BACKGROUND: The Texas Enterprise Zone Program is a program administered by the Texas Economic Development Bank. The enterprise zone program was created to encourage local communities to partner with the state in job-creation efforts and capital investment, particularly in economically distressed areas of the state.

Under the program, communities can nominate a company as an enterprise project. Designated projects may apply for a refund of state sales-and-use taxes paid on expenditures at the qualified business site. The amount of the refund is related to capital investment and jobs retained or created at the qualified business site. The largest enterprise projects are designated as double and triple jumbo projects.

DIGEST: SB 100 would make various changes to the Texas Enterprise Zone Program, including placing limits on benefits to enterprise projects designed to retain, rather than create, jobs.

The bill would amend certain requirements related to project eligibility for various designations and benefits. Projects designed to retain jobs could receive a maximum refund of $1.25 million, whereas current law allows certain projects designed to retain jobs to receive a maximum refund of $3.75 million. Projects could be designated as double jumbo and triple jumbo only if they created new permanent jobs. Approved enterprise projects no longer would be eligible to receive a franchise tax credit.

The bill also would allow a project designation to be split into two half designations. A half designation would use one-half of one of the enterprise project designations allowed to a nominating body and to the bank. A project that received a half-designation, referred to as a "half enterprise project," could receive a maximum refund not to exceed $125,000 in each state fiscal year.

Besides residents of an enterprise zone or economically disadvantaged individuals, military veterans would be among those of whom a business could commit to hiring a certain percentage to become qualified to receive benefits from the program. The bill also would amend the definition of "qualified employee" under the program to include transportation workers who resided within 50 miles of and reported to the business site.

The bill would remove the requirement that a county must have a population greater than 1 million in order to nominate a business for designation as an enterprise project. Before a county could make a nomination, the county that made a request to the program would have to enter into an interlocal agreement with the municipality that had jurisdiction of the territory in which the project would be located. The agreement would have to state whether the county or the municipality had administrative authority over the project and that both the nominating county and municipality had to approve the nomination.

This bill would take effect September 1, 2015, and would apply only to the designations of an enterprise project or an application for a designation of an enterprise project made on or after that date.

SUPPORTERS SAY:

SB 100 would help grow the Texas economy by shifting the focus of the enterprise zone program from retaining jobs to creating new jobs.

Currently, most of the program benefits are directed toward job retention instead of job creation. This bill would help expand the workforce, which would benefit economically distressed areas by increasing employment. It also would increase access to gainful employment among veterans by including them in the objectives of the program.

The bill would promote flexibility and collaboration between counties and municipalities by requiring nominating counties to seek interlocal agreements with municipalities that would be affected by the project or activity. During the implementation of a project, disagreements can arise between cities and counties. This bill would help address that issue.

OPPONENTS SAY:

SB 100 could distort the free market by favoring some businesses over others. Small businesses already face difficulty competing in the market. When the government props up big companies with grants and incentives, other businesses have trouble competing. Texas should focus on creating a low-tax environment with a limited government that treats all businesses the same.