



84th Legislative Session Wrap Up- Guide for Community Health Centers

Health centers started the 84th Legislative Session with an agenda focused around funding for priority programs and expanding access to health care coverage for Texans. At the end of session, TACHC can report successes in some areas, while other priorities will require additional work on the part of health centers and TACHC during the interim and in subsequent legislative sessions. This document outlines what happened in each priority area and then summarizes additional legislation TACHC followed throughout the session that will have an impact on health centers and the health care environment in Texas. Please contact Olga Rodriguez (orodriguez@tachc.org) with any questions.

Health Center Legislative Priorities

FIXING THE FEDERAL HEALTH CENTER FUNDING CLIFF

While the funding cliff is a federal issue rather than a state legislative issue, a key part of the health center state legislative agenda was to raise awareness of the federal funding cliff at the state level in order to bolster support from state elected officials for Congress to find a solution to fix the funding cliff. As part of the health center legislative agenda covered during member visits at the TACHC Policy and Issues Forum in January, health centers asked state legislators to send letters to Congress urging them to find a solution to the cliff. As a result, 52 state legislators sent letters to their members of Congress, including Senators Cornyn and Cruz, urging them to solve the health center funding cliff. This support from state legislators in Texas was critical in achieving a record number of signatures from Texas Congressional members on the federal health center funding appropriations letter, and ultimately all but four members of the Texas Congressional delegation voting for HR 2, the bill that extended health center mandatory funding for an additional two years.

Next Steps for Health Centers: While mandatory funding has been extended for two years through HR 2, health centers should be prepared to continue advocating for adequate discretionary funding in the federal budget. Federal health center funds are comprised of both mandatory and discretionary funding; HR 2 only addresses the mandatory portion. Health centers should look for updates from TACHC and NACHC on progress in the federal appropriations process over the coming months.

WOMEN'S HEALTH PROGRAMS- FUNDING AND CONSOLIDATION

The final state budget adds an additional \$50 million for women's health services, presumably for the new consolidated women's health program, explained below. Final funding amounts for the biennium are outlined in the table below.

Program	Texas Women's Health Program	Family Planning	Expanded Primary Health Care	Additional Women's Health Services Funding
2016-2017 Funding	\$69,310,379	\$41,559,813	\$100,000,000	\$50,000,000
2014-2015 Funding	\$71,268,654	\$43,164,601	\$100,000,000	N/A

Total spending for this women's health budget item is \$260,870,192, up almost \$50 million from the current biennium.

Through the appropriations process, legislators have moved the administration of the state women's health programs to the Health and Human Services Commission (HHSC). Over the interim, both the Family Planning and Expanded Primary Health Care (EPHC) programs will be moved from the Department of State Health Services (DSHS) to HHSC, and the final budget document moves the funding for those line items to HHSC accordingly and combines them with the Texas Women's Health Program (TWHP) budget strategy. While not explicit in the budget document, the assumption is that the EPHC and TWHP will be consolidated into a single program that will be modeled after the TWHP. The Family Planning program will remain separate and will be largely unchanged, except that it will go back to 100 percent categorical grant funding and may cover one prenatal visit.

The Senate's consolidation proposal as described to TACHC by Senate offices was presented to health centers during a webcast in April. While some program details may change, these are the parameters that will be used in developing the new program. In a nutshell, the consolidated program will cover women up to 200 percent of poverty between the ages of 15 and 45 (with parental consent for minors) who are citizens or legal residents. FQHCs will be reimbursed at their PPS rate with 10 percent grant funding available. The benefit package will be current TWHP benefits, plus follow up visits for abnormal breast and cervical cancer screenings, mammograms and cervical dysplasia treatment. There are several additional benefits, or enhancements, that may be added to the services covered under the program, including post-partum depression screening and treatment and additional reimbursement for Long-Acting Reversible Contraceptives (LARCs).

While supportive of consolidation for administrative simplification purposes, TACHC is concerned that budget estimates for the new program were based on this limited benefit package similar to TWHP rather than the comprehensive primary care services covered under EPHC. However, final details related to covered services and other aspects of the program will be ironed out at the agency level, with Legislative Budget Board approval of the final consolidated program required.

To work through these program details, HHSC is required to create an advisory committee to work with the state to ensure the new program is workable for providers and patients. The majority of the advisory committee must be providers with experience administering state women's health programs. TACHC is working with the agency to ensure adequate FQHC representation on the advisory committee.

Next Steps for Health Centers: The timeline for consolidation has not been finalized, but current plans are for the new program to roll out no later than September 2016. Health centers should monitor these developments closely and look for updates from TACHC, including when the advisory committee will hold public meetings.

PHYSICIAN EDUCATION LOAN REPAYMENT PROGRAM

The physician education loan repayment program (PELRP) was addressed both in the budget and in HB 7, described below. The 2016-2017 budget funds the program at the same level as the current biennium - \$16.9 million per year. This funding amount will support between 100 and 150 new first-year physician slots each year.

While current funding levels will be maintained in the upcoming biennium, other broader legislation on dedicated funds ([HB 7 by Darby](#)) impacts the longer term funding outlook for the program. The PELRP is funded by a dedicated account that accumulates revenues from a smokeless tobacco tax. Dedicated funds are accounts that are held outside the state's general revenue account and may only be used for the specific purposes for which they were created. As part of a broad attempt by the Legislature to reduce the practice of relying on dedicated funds to certify the state budget, HB 7 makes changes to how numerous dedicated funds can be used, including the PELRP fund.

Because funding for the program has not been appropriated by the Legislature as quickly as it has accumulated in the account, the PELRP fund became a target in this effort to reduce unspent balances in dedicated accounts by the Legislature. HB 7 suspends deposits of smokeless tobacco tax revenues into the PELRP account if there is already sufficient funding in the account to pay for existing and expected PERLP commitments during the biennium. If sufficient funding exists in the PERLP account, smokeless tobacco tax funds will instead be deposited into the general revenue account to be used for other purposes. However, any funds deposited in the general revenue account must be spent on health care related items.

In other words, while the state budget funds the PERLP at its current level, smokeless tobacco tax revenues will no longer accumulate in the PELRP dedicated fund and will instead be used for general health care purposes until the PELRP account balance is spent down. TACHC has advocated for excess PERLP funds to be spent on increasing the available slots in the program, instead of being deposited into the general account.

Next Steps for Health Centers: This is an issue that health centers must continue to push and be prepared to address again next session. If applications for the program don't exceed and number of slots available, there is no argument to increase funding.

CLOSING THE HEALTH CARE COVERAGE GAP

No progress was made related to closing the coverage gap this session. State leaders chose not to discuss the merits of health coverage expansion or potential options to draw down available federal

funding under the Affordable Care Act. Numerous bills were filed related to coverage expansion, from straight Medicaid expansion legislation to bills calling for a block grant model to draw down additional federal funds. None of these bills received a hearing in either Chamber. The House did not take a vote related to closing the coverage gap. The Senate took a vote after Senator Ellis attempted to amend the HHSC Sunset bill with language directing a coverage expansion. The amendment failed along party lines.

The reality is that more than a million Texans, many of them health center patients, remain in a coverage gap with incomes too low to be eligible for subsidies in the Health Insurance Marketplace.

Next Steps for Health Centers: Health centers must continue to work over the interim to engage patients and communities around the need to advocate for closing the coverage gap and hold state leaders accountable for failing to make health care access and coverage a priority in Texas. TACHC recently partnered with the Texas Academy of Family Practitioners (TAFP) to commission a [report](#) written by Sara Rosenbaum of the Geiger Gibson Program in Community Health Policy at The George Washington University on the impacts of the state's Affordable Care Act implementation decisions on Texans. This is the first of a series of white papers TACHC plans to release that highlight the crisis facing the health care system in Texas. TACHC will continue to rely on health centers to demonstrate the impact of state leaders' decisions on patients and communities across the state.

Other Relevant Bills by Issue Area

GRADUATE MEDICAL EDUCATION AND LOAN REPAYMENT- *Bills passed that will overhaul the state's GME programs and create a new loan repayment program for mental health professionals.*

SB 18 by Nelson

Summary: Makes changes to the current structure of GME grant funding and creates a permanent fund to support GME, which can only be used to fund graduate medical education programs in the state.

Specific changes made by the bill:

- Expands one-time GME planning grants awarded by the Texas Higher Education Coordinating Board (THECB) to include planning and partnership grants awarded to hospitals, medical schools and community-based ambulatory patient care centers (including FQHCs) that are seeking to establish new GME programs with first-year residency slots, regardless of whether they currently operate a program or have operated one in the past.
- If there are more GME grant applicants than available funding, the THECB will prioritize new grants to medical specialties which are at critical shortage levels. The bill requires the Health Professions Resource Centers at DSHS to research which medical subspecialties are at critical shortage levels, and the THECB must use this research as part of the criteria in determining which specialties will be considered critical shortage for the purpose of prioritizing GME grants.
- Grant recipients in state FY 2015 will continue to receive awards if they continue to meet grant requirements.
- Abolishes the Resident Physician Expansion Grant Program.

- Creates a new permanent fund to support GME, which will be funded in large part through the potential dissolution of the Texas Medical Liability Insurance Underwriting Association if determined feasible. Any assets in excess of those needed to cover current claims will be transferred to the permanent fund for GME.

In addition to the requirements in SB 18, a budget rider further specifies how GME expansion funds are to be allocated in the upcoming biennium, as follows:

- \$1.75 million each year will go toward one-time planning and partnership grants for new GME programs established by hospitals, medical schools or community-based ambulatory patient care centers (including FQHCs).
- \$16.75 million each year will go toward new or existing GME programs to increase the number of first-year residency slots. Of this, \$6 million each year is reserved for new first-year residency slots for primary care physicians.
- \$4.875 million each year will go toward funding first-year residency slots in existing programs that were unfilled as of July 1, 2013.
- \$3.6 million each year will go toward GME programs that received a grant in state FY 2015.
- Any funds available after the above obligations are met may be used to fund any residency positions that are within requirements of current law.

Another budget rider stipulates that any funding available from the permanent fund supporting GME is to be appropriated to the GME expansion strategy to be utilized as outlined above.

Impact on Health Centers: The increased funding for and broader focus of GME grant programs in Texas may offer the opportunity for more health centers to create residency programs. TACHC supports these changes made through SB 18 that will strengthen GME programs in Texas by modifying their structure and creating a new, more permanent funding source to support GME in the state.

[SB 239 by Schwertner](#)

Summary: Creates a loan repayment program for mental health professionals. The program would help mental health providers pay off medical education loans if they serve in health professional shortage areas and provide care to recipients of Medicaid or CHIP, or people who are incarcerated. The bill specifies the maximum amount in repayment assistance providers would be eligible to receive for each year of service over five years. Several mental health provider types would be eligible for the program, including psychiatrists, psychologists, LCSWs, LPCs and psychiatric APRNs. The program is funded at \$850,000 for FY 16 and \$1.275 million for FY 17.

Impact on Health Centers: Health centers use the physician education loan repayment program as a tool to attract physicians to work in the underserved areas where they are located. This new mental health loan repayment program may also serve as a tool to bolster the mental health workforce at health centers.

[SB 295 by Schwertner](#)

Summary: Requires the THECB to establish a system to acquire and maintain data on where Texas medical school graduates choose to do their initial residency training and start their initial practices. The

data must include information on whether and how long Texas graduates work in primary care and which specialties they report as their primary medical practice, as well as the locations where they choose to practice.

Impact on Health Centers: This data collection would help Texas have a better understanding of where new medical school graduates are choosing to practice and in what specialty so that Texas can be better positioned to retain its physician workforce.

SUNSET OF HEALTH AND HUMAN SERVICES AGENCIES- *The Texas Sunset Commission reviews state agencies to determine if a need for the agency still exists and how the agency can operate more efficiently. State agencies are typically subject to the Sunset Commission process every 12 years. The Health and Human Services Enterprise, including HHSC, DSHS, DADS, DFPS and DARS, underwent the Sunset process in 2014 leading up the 2015 legislative session. Legislators then adopted Sunset recommendations to make changes to the agencies' structure and authorize their continuation.*

SB 200 by Nelson

Summary: SB 200 is the broad HHSC Sunset legislation that adopts modified recommendations to partially consolidate health and human services agencies under HHSC. Not later than September 1, 2016 all client services programs currently housed at DSHS will be moved to HHSC, including EPHC, PHC and Family Planning. During a second phase of consolidation, all regulatory functions will be transferred from DSHS to HHSC, and DSHS' sole responsibility will be its public health functions. Other agencies will also be transitioned to HHSC in phases. The new consolidated HHSC agency will be organized into divisions, the executive commissioner must develop a transition plan and a legislative committee will oversee the transition.

Other changes made by SB 200:

- Requires HHSC to periodically evaluate data collected from Medicaid MCOs to ensure it continues to serve a useful purpose.
- Requires HHSC to create a streamlined Medicaid enrollment and credentialing process, including creating an internet enrollment portal. HHSC may also designate a centralized credentialing entity that has access to information in the enrollment portal so that more of the credentialing process can happen in the background. HHSC may also require all MCOs to use the centralized credentialing entity as a hub for the collection and sharing of information.
- Requires the creation of a women's health advisory committee to provide feedback on the consolidation of the women's health programs.
- Requires the Office of the Inspector General to establish by rule guidelines for evaluating criminal history background for Medicaid providers, including what types of information will result in the exclusion of a provider from Medicaid.
- Requires the creation of a system of care framework focusing on community-based services for state agencies to coordinate services for minors who have or are at risk of developing a serious emotional disturbance.
- Requires HHSC to develop a comprehensive operational plan to coordinate quality of care initiatives and outlines goals for the 1115 transformation waiver renewal.

- Terminates the NorthSTAR program in the Dallas Service Area and requires MCOs to fully integrate behavioral health into their members' primary care services.
- Requires HHSC to develop a statewide initiative with MCOs to promote maintenance of eligibility for Medicaid recipients.
- Creates a pilot program with managed care organizations to increase incentive-based provider payments in Medicaid.
- Combines the Pharmaceutical and Therapeutics Committee and Drug Utilization Review Board and outlines duties.
- Abolishes various advisory committees and requires the executive commissioner to establish and maintain new advisory committees across all major areas of the health and human services system.

Impact on Health Centers: Health centers should be aware of the broad changes to the health and human services agencies and be prepared to work with HHSC to administer state grants when the programs move over from DSHS. Health centers should also expect staffing and leadership changes as the agencies are restructured and as outgoing Commissioner Janek is succeeded by Chris Traylor as the new HHSC Commissioner. There may also be opportunities for health centers to serve on various advisory committees as they are restructured under the new agency.

MEDICAID AND CHIP- *No major changes were made to the Medicaid and CHIP programs, but several bills passed making modifications to existing requirements.*

SB 760 by Schwertner

Summary: Strengthens network adequacy standards in Medicaid managed care and imposes fees on MCOs that fail to meet new standards. Requires MCOs to publish provider directories online and update them at least monthly. The bill requires HHSC to create an expedited credentialing process for certain providers, allowing them to treat patients on a provisional basis until credentialing is completed. Providers who are part of a group already contracted with the MCO and already enrolled in Medicaid are eligible for this expedited credentialing. Increases HHSC ombudsman services for Medicaid recipients. Moves the responsibility for making initial and subsequent primary care provider assignments from the state enrollment broker to the managed care plans. Outlines requirements for the state's investigation of abuse in various types of facilities.

Impact on Health Centers: Health center patients may benefit from new network adequacy standards and ombudsman services. The new standards may also help centers that have struggled with obtaining contracts with certain MCOs or their subcontractors. Centers may also be impacted by the MCOs taking responsibility of primary care provider assignments, but the MCOs will be required to follow the same process for determining default assignment that the enrollment broker was required to utilize so it's unclear what impact, if any, this change may have.

HB 839 by Naishtat

Summary: Requires HHSC to reinstate Medicaid /CHIP eligibility for juveniles released from detention facilities within 48 hours of receiving notice of their release. Currently, HHSC terminates coverage when

a child is placed in a detention facility, causing delays in coverage while the child reapplies for coverage once released.

Impact on Health Centers: Health centers that treat this population may see an increase in continuous, uninterrupted Medicaid and CHIP coverage for minors released from juvenile facilities.

[HB 1661 by Guerra](#)

Summary: Requires HHSC to adopt rules to ensure the same standards that currently apply to a substitute physician billing Medicaid for services also apply to a substitute dentist. Under current rules, a physician enrolled in Medicaid may cover for another billing physician either under a locums tenens arrangement or a reciprocal arrangement. This bill requires those standards to be applied to substitute dentists as well, which currently have no ability to bill under a substitute dentist on an occasional basis.

Impact on Health Centers: Health centers that employ dentists may benefit from substitute dentists being permitted to temporarily provide services to Medicaid patients on behalf of another dentist that is temporarily not able to provide care.

[HB 1878 by Laubenberg](#)

Summary: Requires Medicaid reimbursement for physicians for telemedicine services provided in a school-based setting even if the physician is not the child's primary care provider. The physician must be enrolled in Medicaid, the patient must be a child receiving services in a primary or secondary school-based setting, and an appropriate health professional must be on site with the child.

Impact on Health Centers: Health centers operating school-based clinics should be aware of this change.

[HB 2084 by Munoz](#) - VETOED BY GOVERNOR

Summary: Requires HHSC to ensure transparency in the rate-setting process for Medicaid and CHIP managed care organizations by requiring that HHSC publish actuarial reports. The bill outlines what information must appear in the reports, including the methodology used to determine actuarial soundness for populations covered and services provided.

Impact on Health Centers: TACHC amended this bill to require that HHSC disclose the methodology used to determine that MCO rates are actuarially sound. TACHC has worked over the past two sessions to change the way HHSC accounts for the FQHC PPS rate in setting Medicaid and CHIP MCO rates. Currently, MCOs have a disincentive for their patients to receive care in a FQHC setting, because during the rate-setting process HHSC accounts for the number of encounters occurring at FQHCs statewide and then averages those payments to apply the same FQHC adjustment to every MCO, regardless of the actual number of FQHC encounters provided to each MCOs' members. Actuarial soundness is a federal requirement for all Medicaid agencies in setting Medicaid and CHIP MCO rates. Requiring that HHSC show how actuarial soundness is achieved will help demonstrate that the current MCO rate-setting process disincentives MCOs to fully utilize FQHC services.

[HB 2718 by Parker](#)

Summary: Requires HHSC to create a program for faith- and community-based organizations to contact and offer supplemental services to applicants for Medicaid, CHIP, TANF and SNAP. At the time a person applies for one of these programs, the bill requires the applicant to be given the opportunity to enroll in

the new program. Requires HHSC to develop rules related to criteria for faith- and community-based organizations to be eligible to participate in the program and allows HHSC to create a workgroup to develop the program that may include faith- and community-based organizations.

Impact on Health Centers: Once rules are promulgated and the program begins, health centers will need to be aware of the requirement to provide the opportunity for patients to enroll in the new program when they assist with enrollment into Medicaid, CHIP, TANF and SNAP. There may also be opportunities for health centers to participate as community-based organizations to connect people to other enabling services the center provides.

HB 3823 by Price

Summary: Modifies the reimbursement methodology utilized in the program of all-inclusive care for the elderly (PACE) and requires HHSC and the Department of Aging and Disability Services to collaborate to develop a data collection process that allows for a comparison of health outcomes between Medicaid patients enrolled in the PACE program and the STAR+PLUS program. Also requires an evaluation of the PACE program in comparison to the STAR+PLUS program.

Impact on Health Centers: The PACE program is a Medicaid/Medicare program serving individuals who are 55 or older, are living with certain health care needs, are eligible by the state to receive nursing home care, and can live safely in the community. PACE covers all Medicaid/Medicare services plus additional services such as adult day care, occupational and recreational therapies, and home health care. The program currently operates in Lubbock, El Paso and Amarillo. Several health centers have expressed interest in participating as a provider in the program if it expands to new areas of the state. The outcome of the comparative analysis between the current PACE and STAR+PLUS programs required by this legislation will likely impact whether or not the program expands to additional service areas.

VETERANS ISSUES- *Several bills passed that aim to improve health care, including mental health services, for veterans. These bills focus on coordinating benefits for veterans and targeting certain types of veterans for support.*

SB 55 by Nelson

Summary: Establishes a grant program for mental health services for veterans and their families at HHSC. A budget rider sets aside \$10 million per year to fund the program. Requires HHSC to enter into an agreement with a non-profit or private entity to administer the program. All grants awarded under the program must be used for the sole purpose of supporting community programs that provide mental health services and treatment to veterans and their families and that coordinate mental health services with other support services.

Impact to Health Centers: Health centers may have the opportunity to participate in the grant program.

SB 1304 by Menendez

Summary: Requires DSHS to create a women veterans mental health initiative under the mental health intervention for veterans program.

Impact on Health Centers: The legislation does not provide details on the initiative, but there may be opportunities for health centers to have a role as mental health providers for veterans.

[SB 1305 by Menendez](#)

Summary: Requires DSHS to create a rural veterans mental health initiative under the mental health intervention for veterans program.

Impact on Health Centers: The legislation does not provide details on the initiative, but there may be opportunities for rural health centers to have a role as mental health providers for veterans.

[HB 19 by King, Susan](#)

Summary: Requires the Veterans Commission and DSHS to partner to create a statewide program to coordinate mental health benefits for veterans, including providing training and technical assistance to volunteer coordinators/peers and recruiting community and faith based organizations. The statewide coordination program must include a community collaboration initiative to encourage local communities to work across sectors to synchronize available benefits for veterans and military families.

Impact on Health Centers: Health centers may have opportunities to participate in community collaborations as part of the statewide coordination efforts.

[HB 867 by Hernandez](#)

Summary: Creates a Texas Women Veterans Program at the Veterans Commission to “ensure that the women veterans of this state have equitable access to federal and state veterans’ benefits and services.” Requires the designation of a women veterans coordinator for the state. The program will perform outreach to promote access to services, assess the needs of this population and review other programs addressing the needs of women veterans. The program will propose legislative initiatives and promote public awareness of issues they face. The program will partner with government and private entities to provide services to women veterans, educate them about available benefits and disseminate information on opportunities.

Impact on Health Centers: Health centers may have opportunities to partner with the program to provide services and promote available benefits to women veterans.

[HB 1762 by Otto](#)

Summary: Requires the Veterans Commission to establish a health care advocacy program focused on resolving access issues raised by the state veterans hotline, researching programs designed to improve access to care for veterans, evaluating the effectiveness of the state Veterans Commission and making recommendations to improve access to care. The health care advocacy program is funded through a budget rider that sets aside \$785,702 each year for the program.

Impact on Health Centers: As health centers continue to see their veteran population rise, there may be an opportunity to partner to improve access to health care for veterans.

1115 TRANSFORMATION WAIVER- *Several bills passed that are aimed at facilitating participation in the 1115 waiver by creating new opportunities for local funding sources to draw down federal matching dollars for DSRIP projects. Some areas without local funding through a hospital district have struggled to find local governmental funds eligible for a federal match under the waiver. These bills would create local provider participation funds, made up of fees paid by local hospitals, to be administered by counties*

or municipalities for the sole purpose of obtaining federal matching funds under the waiver. Each bill, linked below, applies only to certain counties or municipalities in the state. Health centers located in these areas may have a renewed opportunity to participate in DSRIP projects.

Senate Bills

[SB 1587 by Eltife](#)- Applies to Bowie, Cherokee and Gregg Counties in Northeast Texas

[SB 1387 by Creighton](#)- Applies to the City of Beaumont

House Bills

[HB 2280 by VanDeaver](#)- Applies only to Rusk County

[HB 2809 by Anderson](#)- Applies only to McLennan County

[HB 2913 by Aycock](#)- Applies only to Bell County

[HB 3175 by Simpson](#)- Applies only to Hays County

[HB 3185 by Raney](#)- Applies only to Brazos County

OTHER HIGHLIGHTED LEGISLATION OF INTEREST

[SB 195 by Schwertner](#)

Summary: Transfers the Texas Prescription Monitoring Program (TPMP) and the Prescription Access in Texas program from the Department of Public Safety (DPS) to the Texas State Board of Pharmacy (TSBP). Authorizes TSBP to enter into an interoperability agreement with other states to share information via a central database. Enables providers to auto-enroll in the TPMP upon renewal of their occupational license or registration.

Impact on Health Centers: Providers that prescribe controlled substances are required to register with DPS under the TPMP. The program will be moved to the pharmacy board and the registration process should be streamlined with the license renewal process.

[SB 460 by Schwertner](#)

Summary: Makes changes to the licensing and regulation of pharmacies in Texas, including the following:

- Allows pharmacies to dispense up to a 30-day supply of a dangerous drug without the prescribing provider's authorization in the event of a natural or man-made disaster if certain specifications are met.
- Allows the pharmacy board to review a pharmacy's financial information as part of an investigation of a complaint.
- Increases the number of maximum number of times an applicant for a license to practice pharmacy may retake the licensing examination.
- Decreases from one year to 91 days the amount of time a pharmacy's license can be expired before the pharmacy cannot renew the license.
- Extends the timeframe from 10 days to 30 days that a pharmacy has to notify the board of a change in location.

- Repeals requirements that a pharmacist display a specified sign regarding the availability of a less expensive generically equivalent drug and that a pharmacist publicly display the pharmacist's license to practice pharmacy and license renewal certificate in the pharmacist's primary place of practice.

Impact on Health Centers: Health centers with on-site pharmacies should be aware of the changes.

[SB 1128 by Zaffirini](#)

Summary: Requires that women be tested for syphilis in the third trimester of pregnancy in addition to HIV as currently required. The bill attempts to reduce the incidence of congenital syphilis by aligning testing requirements with HIV requirements.

Impact on Health Centers: Health centers should be aware of this new testing requirement.

[SB 1243 by Burton](#)

Summary: Establishes a prescription drug donation pilot program in municipalities with a population between 500,000 and a million. Under the pilot, drugs will be donated to DSHS and stored in a centralized repository with an electronic database so that charitable clinics and physician's offices may search for and request available donated drugs for their patients.

Impact on Health Centers: Health centers are included as charitable clinics under the legislation and are eligible to participate in the pilot.

[SB 1462 by West](#)

Summary: Allows opioid antagonists, drugs which are used to completely or partially reverse a person's overdose due to opioids, to be prescribed to people at risk of an opioid-related drug overdose or their friends and family members. A pharmacist is not subject to civil or criminal liability or disciplinary action for dispensing or failing to dispense an opioid antagonist under a valid prescription or any outcome associated with the eventual administration of the drug to a person.

Impact on Health Centers: Health center physicians and pharmacists should be aware of this change. Previously, opioid antagonists were only available to hospitals and first responders in the event of a person presenting with an opioid-related overdose. This legislation attempts to increase access to these drugs in the community in order to reduce the incidence of opioid-related overdose deaths.

[HB 1514 by Sheffield](#)

Summary: Requires health plans to label insurance cards with the acronym QHP to indicate when a patient has a qualified health plan purchased through the federal Health Insurance Marketplace.

Impact on Health Centers: TACHC opposed this bill because it does not solve any problem and may open the door to discrimination against patients that have purchased their insurance through the Marketplace.

[HB 2641 by Zerwas](#)

Summary: HB 2641 set regulations for sending or receiving health information through a health information exchange (HIE). Specifically, the bill:

- Requires HHSC to ensure that all future agency data systems used to send/receive protected health information with providers be able to exchange information in accordance with applicable electronic data exchange standards. This requirement will promote interoperability and applies to all procurements as of September 2015.
- Allows, subject to requirements related to privacy and consent, health-related information to be transmitted through HIEs to the appropriate state agencies.
- Permits the HHSC by rule to develop and implement a system to reimburse Medicaid providers for the review and transmission of electronic health information, if feasible and cost-effective.
- Provides that providers whose patient medical records are shared through an HIE receive protection from liability where another person obtains or uses the information in violation of privacy law.

Impact on Health Centers: Health centers should be aware of changes the state makes to facilitate the exchange of health-related data.

[HB 3781 by Crossover](#)

Summary: Establishes the Texas Health Improvement Network to address health care challenges and improve the health care system through the development of health care initiatives, policies and best practices. The purpose of the Network is to reduce the per capita costs of health care, improve the experience of health care and improve the health of Texans. The Network will serve as an evaluator of health initiatives and provide support to local communities, including data analysis, grant writing support, leadership training and community health assessments. The Network will be housed at the University of Texas System which will provide administrative support. The Network will have an advisory council comprised of experts in various health care areas and a presiding officer.

Impact on Health Centers: The Network's goals are modeled after the Triple Aim, a nationally recognized strategy to reform the health care system through improving patient experience, reducing costs and improving health outcomes. There may be opportunity for health center leaders to serve on the advisory committee or partner with the network for local support.